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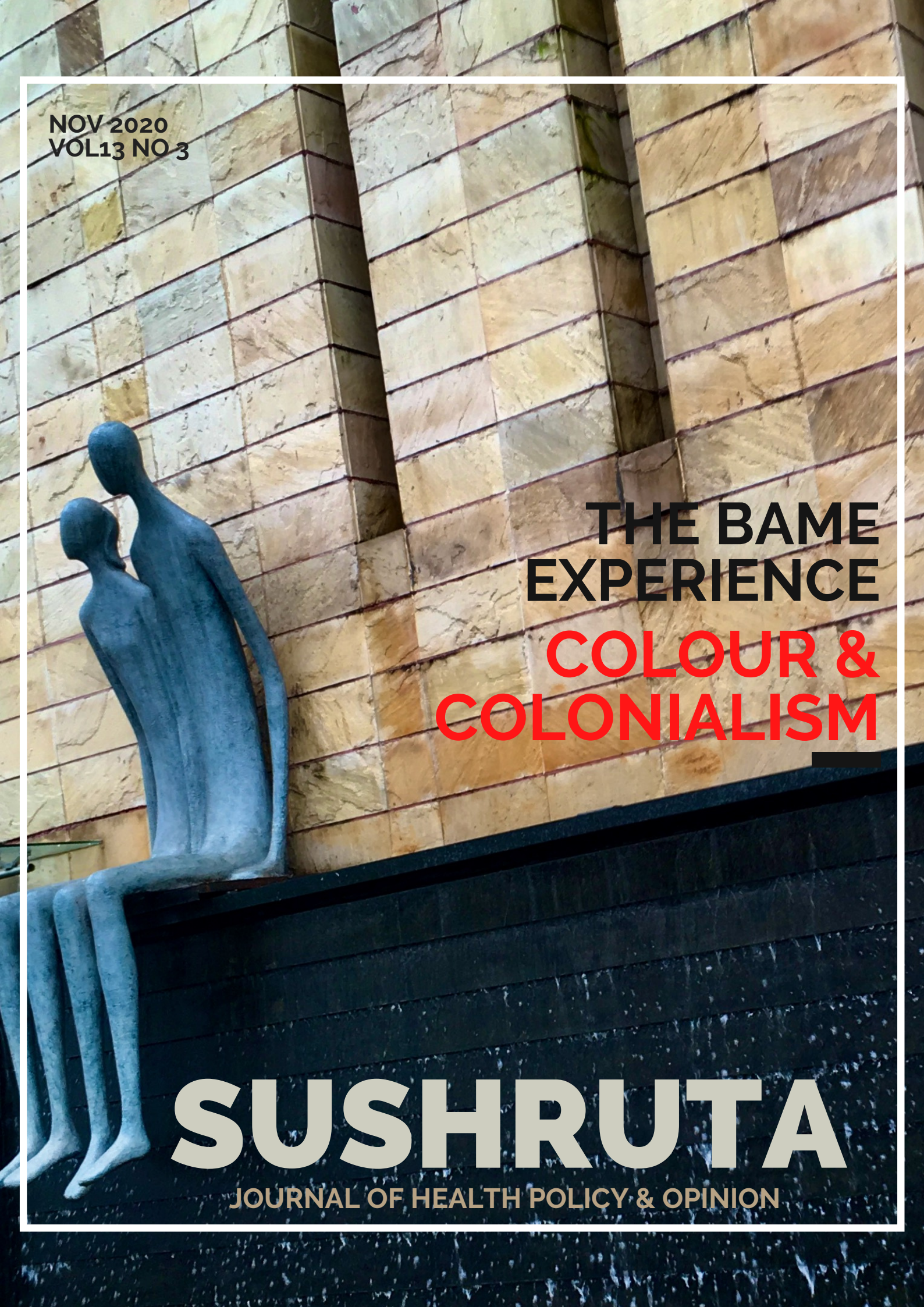

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JOURNAL OF HEALTH POLICY & OPINION

British Association of Physicians of Indian Origin

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20-22 November 2020

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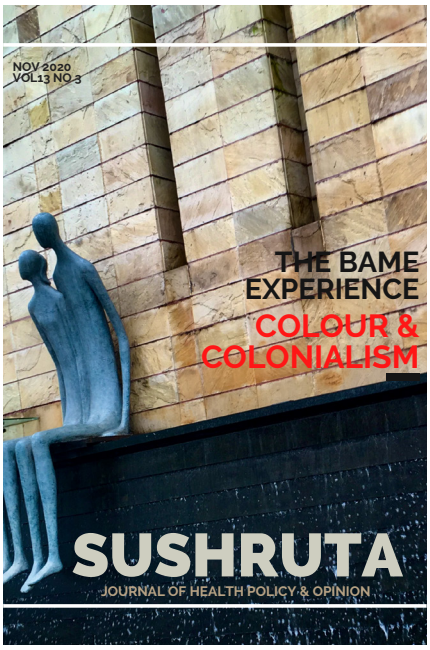

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EDITORIAL

A Rainbow Paper

Tackling inequalities, a neo-liberal order in a world after Corona

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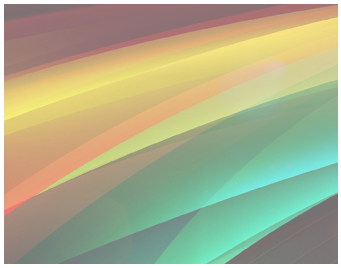

The COVID-19 pandemic has exposed the devastating impact of inequalities that have plagued societies for generations. The timing of the events spiralling from the unlawful killing of an apparently innocent black man in the United States of America, led to an uprising of sorts across many countries. It touched the psyche of the people in the UK and came at a time when the British Association of Physicians of Indian origin reaches it 25th anniversary (1996-2021). One of the fundamental visions and values that the organisation was created on, was to promote excellence through equality and diversity. Therefore in its silver jubilee year, BAPIO launches an over-arching Alliance for Equality in Healthcare Professions. The Alliance is tasked to conduct a review of the evidence of differential attainment across the spectrum of healthcare careers, engage with stakeholders from the grassroots to the responsible organisations and finally generate an expert consensus on recommendations for the changes necessary to tackle such inequalities.

Keywords
BAME, Health inequalities, differential attainment

Introduction

Twenty twenty, the year that may turn out to be one of the most transformative in the history of the modern world. The world as we know it, is changing. Economist and nobel laureate Amartya Sen, believes that the COVID-19 pandemic has inadvertently exposed the cracks in the liberal values of society, and this seismic event has created the conditions among the 'common people' for increased awareness of the vast inequalities that have existed for centuries. He cites an example in the events unfolding and gaining momentum following the brutal killing of George Floyd in the form of the 'BlackLivesMatter' movement. (1) (2) The recognition of the inequalities spread to many countries including the United Kingdom, where there were widely publicised desecration of public statues of controversial individuals, led by the common public, most notably the toppling of the statue of Edward Colston, a 17th century slave trader from the Royal African Company. (3) Sen, argues that it is sometimes easier to change laws but unless there is public awakening, wider recognition and a willingness to change from within, there is little hope of changing society.

Inequalities exist in every walk of life, in every profession and affect us all and more often than not, result in substantial loss of life and livelihood to the individual with significant social and economic cost to societies. In matters of health, the World Health Organisation describes inequities in the health status and distribution of resources between populations determined by how we are born, live, work and age. (3) What the COVID-19 pandemic has also done is to effectively expose to the public the stark inequalities that have existed for centuries, consistently recognised by policy makers, epidemiologists and scientists but not tackled on an organisational or governmental level (4). COVID-19 is profound in how it has affected people differently. In the early days of the pandemic when more homogeneous societies in the far east were experiencing the surge of cases, this inequity of how SARS-CoV-2 affected people based on their non-biological factors was not apparent. When the early figures were analysed in Europe the narrative was still based on factors such as obesity, advanced age and comorbidities.

It is only with the arrival of the pandemic in the UK and United States of America, that a new phenomenon of differential outcomes based on race or ethnicity became clear. What COVID-19 related early deaths has done is expose the inequalities that exist is how organisations deal with their staff based on factors other than their ability. The brutal message

from the faces of healthcare staff who had died from COVID-19 was that of the colour of their skin. It took several more weeks and the work of organisations such as BAPIO that the country and its leaders recognised that all the poor outcomes that were being so consistently documented in people of Black, Asian and Minority Ethnic (BAME) groups were not attributable to them as individuals but to how the state and the system treated them. (5)

Colour, race and ethnicity are a few of the many facets of an unequal society which are recognised in all professions, but the mortality and morbidity data from COVID made them much more clear and transparent among health and care professionals. The Workplace Race Equality Standards (WRES) were established in the UK by the NHS equality and diversity council in 2014, and since 2015, all NHS Trusts have a legal duty to report their results against the 9 different standards. (6) However, the data from WRES in 2019 show little change in the levels of inequality over the previous 5 years since the standards were established. Clearly, more needs to be done and the NHS's first People Officer Prerana Issar, expresses her impatience at the pace of change, extolling the virtue of having the 'right culture' through the NHS People Plan (2020/21). A culture where people have the space and the ability to speak up especially about patient outcomes, where they get the development and career progression that they want and where there's a sense of belonging to the team that they work in. In essence, where they are valued and treated with fairness and equality. (7)

The story of differential attainment (DA) in healthcare professions is no different. Doctors from ethnic minority backgrounds face disadvantage throughout their careers, despite being selected for high academic achievement, end up performing worse on average than their white counterparts during education and training. Differential attainment appears at medical school and persists after qualification. As a result, ethnic minority graduates of UK medical schools have worse outcomes during recruitment for foundation, specialty training, and consultant posts; are more likely to fail examinations; and progress more slowly through training even when exam failure has been accounted for. Differential attainment is a difference in average group performance, not individual performance. (8) It is far worse for doctors who have their primary medical qualification in countries outside of the UK. It is not a phenomenon exclusive to the UK, but it is recognised in other countries where there is a large proportion of international medical graduates like the USA and Australia. A similar phenomenon is recognised in referral to the regulators, in how doctors are treated within organisational disciplinary processes and by the regulatory bodies. Fundamentally, this phenomenon exists not due to individual factors but organisational and societal disparities in cultures, support, attitudes and in many cases overt or covert racism. (8)

In 1996, the British Association of Physicians of Indian Origin (BAPIO) was conceived and created to address the vast inequalities that existed in access to career progression, unfair handling of disciplinary procedures and more importantly to support and mentor doctors from the Indian subcontinent, who were a substantial proportion of the workforce of the UK National Health Service. (9) In the quarter century of its existence, BAPIO has grown to be a significant influencer in supporting several other voluntary healthcare professional bodies, shaping organisational and governmental policy as well as expanding its remit to include all healthcare professions and mutually supportive partnerships with key institutions in matters of health including the General Medical Council, Medical Royal Colleges and Health Education England.

BAPIO has been steadfast in taking seriously its responsibility to the fundamental principles of equality. In 2013-14, BAPIO took the Royal College of General Practitioners (RCGP) to court on its failure to act on the differential attainment of BAME and IMG doctors in the clinical skills assessment. The RCGP stated that it would take further action to support trainees who fail the MRCGP exam, after a High Court judge said 'the time has come to act' on differentials in the pass rates between white and non-white candidates. Although, Mr Justice Mitting found in favour of the RCGP, adding that the clinical skills assessment was a 'proportional' way of deciding who can practise as a General Practitioner, despite differences between the pass rates of white and non-white medical graduates, however, the court did say that 'the time has come' for the RCGP to address the differentials in the pass rates. He said that the claim – made by the British Association of Physicians of Indian Origin – was made in 'good faith by an organisation acting in the best interests of the public', adding that BAPIO had 'achieved, if not a legal success, then a moral success'.(10)

It has been over 5 years since the landmark judgement and the GMC report on health of medical education and progress in tackling DA, still highlights the significant and persistent disparities that continue to tarnish the image of a caring, fair culture within the 'caring profession'. (11,12) The causes of DA are complex and often difficult to disentangle and in many cases data is limited. Organisations responsible for education and training have variable engagement, understanding and motivation to explore these differences and make a positive change. There are some clear leaders in this area and the Royal College of Physicians (RCP) has been a trailblazer in this field. Professor Andrew Goddard, the current President of the RCP London, reiterates his commitment,
'There is no room for complacency, as leaders it is our responsibility to do better. Our renewed focus starts today by asking all the leaders in our organisation to have conversations with the staff and members they work with to draw attention to this and to our commitment to ensure that the RCP is doing everything it can to eradicate racism and structural inequalities'. (13,14)

BAPIO agrees with the sentiment expressed by Professor Goddard. What the COVID-19 pandemic and the #BlackLivesMatter campaign have highlighted to the broader society is that such disparities in access to universal health and education must be rooted out to establish fairness and equality, and that a caring and nurturing culture is fundamental to our values. BAPIO approaches its silver jubilee year in 2021, and at this opportune time is committed to establishing a milestone in the journey of tackling differential attainment. Through a series of thematic reviews, roundtables and consensus workshops, BAPIO will engage with grassroots, experts and stakeholders

collaboratively creating an 'Alliance to tackle inequalities in healthcare professions'.

This alliance will produce a seminal document as a first step in creating an organisational change laboratory process to transform medical education, training and practice supporting the fundamental principles of the NHS People Plan. There was much debate on what the team should call this document. Many were uncomfortable with the connotations of the traditional descriptors such as 'white paper', 'green paper' and finally the eureka moment came from one of the team (Dr Sunil Daga, a Nephrologist from Leeds, UK) who suggested the innovative term, 'rainbow paper'. Although the establishment may not be ready to accept the term 'rainbow paper' just yet, we believe the society certainly is.

Healthcare professionals have always been quick to accept innovation and change when the evidence is robustly presented. It is therefore the responsibility of the 'Alliance' to review the evidence, understand the impact and implications working closely with those who have 'lived experiences', deliberate with the experts and lead the way.

In this issue of Sushruta Journal of Health Policy, the alliance team present the concept, framework and terms of reference of the 'rainbow paper' - 'Bridging the Gap'.

The work starts now and we are excited to lead the ever growing members of the 'Alliance for tackling differential attainment in healthcare professions'. (14) It is your time for reckoning too if you care passionately about equity and equality in the health and social care systems, to join up. Individually we can make a collective difference.

References

1. Chomsky and Sen want neo-liberal order thrown off its perch post COVID [Internet]. OnManorama. [cited 2020 Aug 6]. Available from: https://www.onmanorama.com/news/kerala/2020/06/26/noam-chomsky-amartya-sen-on-blm-movement-covid-19-kerala-dialogue.html
2. Black Lives Matter. In: Wikipedia [Internet]. 2020 [cited 2020 Aug 6]. Available from: https://en.wikipedia.org/w/index.php?title=Black_Lives_Matter&oldid=971334380
3. WHO | 10 facts on health inequities and their causes [Internet]. WHO. World Health Organization; [cited 2020 Aug 6]. Available from: http://www.who.int/features/factfiles/health_inequities/en/
4. The NHS is 72 this year, covid-19 has taught us some tough lessons [Internet]. The BMJ. 2020 [cited 2020 Aug 6]. Available from: https://blogs.bmj.com/bmj/2020/07/31/the-nhs-is-72-this-year-covid-19-has-taught-us-some-tough-lessons/
5. BAPIO sends letter to NHS employers regarding COVID-19: Disproportionate high mortality rates in BAME health and social care (HSCW) workers [Internet]. BAPIO Training Academy (BTA). 2020 [cited 2020 May 24]. Available from: https://www.bapiotrainingacademy.com/bapio-sends-letter-to-nhs-employers-regarding-covid-19-disproportionate-high-mortality-rates-in-bame-health-and-social-care-hscw-workers/
6. NHS England » NHS Workforce Race Equality Standard [Internet]. [cited 2020 Aug 6]. Available from: https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
7. Impatient for change: Prerana Issar on leadership and the NHS workforce [Internet]. The King's Fund. [cited 2020 Aug 6]. Available from: https://www.kingsfund.org.uk/audio-video/podcast/prerana-issar-leadership-nhs-workforce
8. Linton S. Taking the difference out of attainment. BMJ [Internet]. 2020 Feb 12 [cited 2020 Jul 8];368. Available from: https://www.bmj.com/content/368/bmj.m438
9. British Association of Physicians of Indian Origin. In: Wikipedia [Internet]. 2020 [cited 2020 Aug 6]. Available from: https://en.wikipedia.org/w/index.php?title=British_Association_of_Physicians_of_Indian_Origin&oldid=954594994
10. Kaffash J. RCGP vows to take action on MRCGP failure rates after High Court ruling [Internet]. Pulse Today. [cited 2020 Aug 6]. Available from: http://www.pulsetoday.co.uk/news/gp-topics/education/rcgp-vows-to-take-action-on-mrcgp-failure-rates-after-high-court-ruling/20006403.article
11. Data & research [Internet]. [cited 2020 Aug 6]. Available from: https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment/data-and-research
12. Woolf K. Fair Training Pathways for All: Understanding Experiences of Progression - Final Report. :69.
13. Rimmer A. RCP is to highlight gap in performance between overseas doctors and UK graduates. BMJ [Internet]. 2014 Dec 2 [cited 2020 Aug 6];349. Available from: https://www.bmj.com/content/349/bmj.g7441
14. Racism, health and why we must do more [Internet]. RCP London. 2020 [cited 2020 Aug 6]. Available from: https://www.rcplondon.ac.uk/news/racism-health-and-why-we-must-do-more

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Editorial

Colonial India

Health care and lessons

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The colonial legacy of health care under the European powers in India especially the East India Company and the British Raj

While turning pages of history often feels like opening a pandora's box; interpretations vary according to era and purpose. The preserved records may be fossils but provide a mirror to the past for those who want to learn valuable lessons from it.

The history of colonial India since 16th century has given the land a paradigm shift in the health care sector. The Portuguese were the first to introduce Western medicine into India. In 1759, a dedicated hospital was built in Panelim. The first ever medical school in South East Asia with professors from the Coimbra University started in 1801 that later became the Escola Medica-Cirurgica de Nova Goa in 1842 in Panaji and still stands as the Goa Medical College. The French in Pondicherry in as early as 1690 established the L'Hopital Militaire and in 1823, established L'École de Médicine de Pondichéry that became the JIPMER in independent India.

The 6th Century also saw the East India Company bringing in the medical officers with its first fleet of ships[1]. They setup facilities for providing medical relief to the troops and employees of the East India Company. In 1775 hospital boards were established and Medical departments were setup in Bengal, Madras, and Bombay presidencies in 1785, looking after both military personnel and British civilians.

Interestingly from 1750 onwards, the British East India Company encouraged scientific research into Indian medicinal plants and established botanical gardens to cultivate and study local plants that might be exported or used as cures[2]. Europeans and Indians freely shared their knowledge of medicinal plants with each other. Not only that but some medically trained Orientalists were known to have translated the classical Ayurvedic and Unani texts. As time went by Europeans began to study traditional Indian treatises without the help of Indian practitioners for the knowledge of Indian pharmacopoeia. By 1789, the Journal of Asiatic Research was founded by Sir William Jones, an Orientalist who supported research into Indian medical systems and medicinal plants.

In Britain, St Bartholomew's Hospital, commonly known as Barts, was founded in 1123, the first known teaching hospital in the City of London. Over next centuries Britain expanded training facilities. This would have significant benefit to India when some of these professionals were deployed by the East India Company. The health professions from the western world were also employed by the then Kings.

A Native Medical Institution was established in Calcutta in 1822 to provide medical training to Indians. The first batch of 20 young Indian students were recruited and instructed in the vernacular medium as texts in anatomy, medicine, and surgery were translated into the local languages, while parallel instructions were delivered in both Western and indigenous medical systems. In 1826, classes on Unani medicine were held at the Calcutta madrasa, while the Sanskrit college conducted classes in ayurvedic medicine. Successful native graduates were offered the government jobs. The efforts to help learn and practice Western medicine, through an Indian medical school was started in Southern Bombay, with surgeon John McLennan as the superintendent. This school, however, did not run beyond 6 years.

By 1830s, many of cultural educational policies started by the vernacularists and orientalists were overturned. Charles Trevelyan, an ardent Westernizer, objected to the policy of educating Europeans in the languages and cultures of the East, recommending that the Asians ought to be educated in "the sciences of the West." The debate ended in 1834 with a report Lord John Grant which criticized the medical training and assessment conducted by the Native Medical Institution. It recommended that the state should establish a medical college for the "education of natives." The various branches of medical science should be taught to students, as in Europe. The trainees should be able to read and write in English, Bengali, and Hindustani, and must be proficient in arithmetic., Thomas Macaulay, in 1835 recommended that the government withhold further grants to institutions, "conferring instruction in the native languages."

On the 28th January, 1835, the Native Medical Institute was abolished and the establishment of a dedicated Medical College for imparting western medical education promulgated by Lord Bentinck occurred. This became the Calcutta Medical College that literally overnight shattered the taboo of dissecting a corpse by Indians and heralded a new wave of liberal thinking in a renaissance on 10th January, 1836. The first batch passed out in 1840 and in 1845, 4 students made the journey to England to achieve higher diplomas in the Royal Colleges, the very first time that Indian medical graduates did so in colonial South East Asia.

Taking Calcutta's lead, Madras Medical College made an emergence, one week after Calcutta followed by the Grant Medical College in Bombay in 1843, the Agra Medical School in 1854, the King Edward Medical College in Lahore in 1860, the King Edward Medical School in Indore in 1878 and the Byromjee Jeejebhoy Medical College in Poona in 1878. With these institutions of medical learning, came state of the art tertiary teaching hospitals that were quick to imbibe then medical science breakthrough processes and practices and applied to their own along with intense medical academia and publications.

Following the Mutiny of 1857 in India, the British Government exerted full colonial political power over the Indian territories A landmark ruling that year saw the establishment of 3 universities in the 3 presidencies of the East India Company in Calcutta, Bombay and Chennai who formally recognised the medical courses in the presidencies. Simultaneously, these courses were also recognised by the Royal Colleges of England and Scotland. It can be noted that in 1857-1858, during the Sepoy Mutiny, some Indian doctors trained in western medicine sided with the rebels.

GMC certification became obligatory in the 1860s and from 1892, the GMC recognised Indian diplomas. The first medical school in the 20th century was the King George Medical School, Lucknow in 1905 and by 1938, there were 27 medical schools in India up and running some of which were private. It can be noted that in 1857-1858, during the Sepoy Mutiny, some Indian doctors trained in western medicine sided with the rebels.

Not unsurprisingly, there was a cultural clash in terms of religion, practices, ethos and philosophy between traditional forms of native medicine and western medicine. The medical graduates who were trained in medicine essentially went against their own societal norms that was not easy. It took a lot of courage and conviction, but over a period of time, Indian society in general saw the benefits of western medicine and started to embrace it. Under the eyes of the government, traditional medicine like Ayurveda, Unani and Hakimi medicine were not suppressed and continued in tandem with western medicine.

At this time the British mainland was also going through many reforms for improving health conditions. Britain expanded Health boards in Wales 1848–1875, in areas such as Cardiff, Swansea, Merthyr Tydfil, Aberdare and Maesteg3. In India, several health bodies like Indian Medical Service, the Central and Provincial Medical Services, and the Subordinate Medical Services were set up for medical care and improving public health. In 1869, the medical departments in the three Indian presidencies were amalgamated into the Indian Medical Service.

For the first time a competitive examination was conducted in London to recruit people into the Indian Medical Service. The European officers of the Indian Medical Service headed the military and civil medical operations in the three presidencies. They needed trained assistants and supporting staff such as apothecaries, compounders, and dressers in their work. Thus, a new a system of medical education in India was established to recruit local staff.

The physicians and surgeons of this period, whether trained in Western or indigenous systems of medicine, provided care as generalists. It was the 19th century that saw more Medical specialization in most of the Western world. Britain was slow to adopt these advances and this has evidently reflected in the absence of references to specialized physicians in India. The physicians and surgeons of this period, whether trained in Western or indigenous systems of medicine, provided care as generalists. Training of Indian women in medicine started gaining momentum in 1880s, with the establishment of the Dufferin Fund. Women were encouraged to get medical licenses as well as degrees to increase facilities for the treatment of female patients.

The Royal College of Physicians was established in Britain in 1518. Over the centuries more specialities became attraction for students from abroad. Though in small numbers, many doctors born in India came to Britain and registered with these institutions.

In India, period from 1900 saw emergence of more doctors trained in Western medicine. As the training medium was English language, the Western medicine had a significant presence in big cities and towns.

Priorities in medicine and its relevant development have been dictated by prevailing conditions of diseases and ailments. During 17th to 19th century Malaria was a major problem followed by Plague, typhoid, cholera, tuberculosis, typhus, and smallpox; most of these carried on in 20th century. The lacklustre and sometimes punitive efforts of the Raj government to control the great plague of the Bombay Presidency in 1896-1897 led to the first political assassination since the Mutiny of the British plague inspector by a group of 3 Marathi brothers. This, in many ways heralded in the path of violent armed struggle for independence in India.

The two World Wars leading to mass sufferings by war injuries, poverty and diseases speeded up advances in science and technology with new inventions across many fields.

The National Health Service (NHS) has used migrant workers since its inception. In 1957, a random sampling by the Willink Committee on medical manpower found that 12% of doctors were overseas trained4. In 1970, the Royal Commission on the NHS estimated that between 18,000–20,000 registered doctors in the UK were born outside the UK, with half of these being from India or Pakistan. Today an estimated 65,000 doctors are of Indian origin5.

In the 1950s and 1960s, large numbers of Irish and Caribbean nurses were recruited to assist expansion of NHS services, a pattern that was replicated in the early 2000s when nurses from Africa, India and the Philippines came to the UK. A 2005 report found that in 2003, 29.4% of NHS doctors were foreign-born and that 43.5% of nurses recruited to the NHS after 1999 were born outside the UK.

The legacy of the British Raj in India is the introduction of the modern medicine and development of training and service providing institutions. This was done in an era when Ayurveda and Unani systems had been falling in tatters for few centuries.

Institutions providing training in modern medicine grew fast after independence leading to mass production of healthcare workers. India was thus able to provide the United Kingdom with highly educated and trained professionals to fill the gap in the NHS

Britain has managed to maintain excellence in medical education and thus continue to attract trainees from Indian subcontinent. Many of them decide to settle down in the country because of better quality of life.

The role overseas doctors were playing in the UK was summed up by Lord Cohen of Birkenhead in a debate in the House of Lords in 1961 saying : 'The Health Service would have collapsed if it had not been for the enormous influx from junior doctors from such countries as India and Pakistan6. Echoed by Lord Taylor of Harlow in the same debate who said: 'They are here to provide pairs of hands in the rottenest, worst hospitals in the country because there is nobody else to do it.'

Doctors of Indian origin are known as the backbone of the NHS. Their contribution to the health of the nation has been significant academically as well as clinically. Unfortunately, the colonial belief about immigrants is a mind-set that still prevails. They are vulnerable to be treated differentially and may face blocks in career progression. BAPIO, over the years, has been challenging unfair treatment of these doctors with some success. It is time that the Indian contribution to the health services in the UK is given its due recognition.

References:

1. Anshu and A Supe. Evolution of medical education in India: The impact of colonialism. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5105212/
2. The Establishment of Calcutta Botanic Garden: Plant Transfer, Science and the East India Company, 1786-1806, Adrian P. Thomas; Journal of the Royal Asiatic Society, (2006)
3. Michael, P. Public Health in Wales (1800-2000) A brief history. http://www.wales.nhs.uk/documents/090203historypublichealthen[1].pdf
4. Simpson, J.M., Esmail, A., Kalra, V.S., Stephanie, J., Snow, L. Writing migrants back into NHS history: addressing a 'collective amnesia' and its policy implications, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951177/
5. Khanna, A. Indian doctors answer UK call for retired medics to join coronavirus fight. Outlook 20 Mar 20. https://www.outlookindia.com/newsscroll/indian-doctors-answer-uk-call-for-retired-medics-to-join-coronavirus-fight/1774346
6. Weekes-Bernard, D. Nurturing the Nation The Asian Contribution to the NHS since 1948.http://www.nurturingthenation.org.uk/uploads/Nurturing-the-Nation.pdf

Archive picture of Medical College Kolkata, circa 1835

RACISM AND DISCRIMINATION: *Let's practice what we preach*

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Abstract
With the world in turmoil, an unexpected and tragic consequence of the SARS-CoV-2 pandemic has been its disproportionate impact on the British Asian and Minority Ethnic (BAME) communities. The pandemic led to an excessive number of deaths in these populations and revealed long-standing inequalities that began many years ago. This indictment raises questions about the extent to which racism and discrimination remain deeply rooted in British society. Have the diverse groups that together constitute the rich fabric of British society not heard, or do they choose to be deaf and blind to thesuffering caused by racism and discrimination?

Keywords
BAME, racial discrimination, pay-gap, differential attainment

Racism can be an individual or an institutional problem, but both are born from pervading prejudices, attitudes, and culture. Ethnic minorities are overrepresented in the more disadvantaged ends of society, with poorer incomes, housing and education, and lack opportunities available for the better off. However, let us not forget that the British rich list also consistently incudes at the top, members of the BAME communities. For most of the population however, disparities are widespread and occur throughout the NHS and academia as well. Sadly, racism is just one of the many prejudices that exist which include those against sex, age, disability, religious belief, and sexual orientation.

In this article, we try to provide a constructive approach to the problem of inequalities and inequities.
• What can be done by the individual and what can society do?
• How can BAME professionals support, and build resilience and confidence in their communities?

The simple answer to the question implicit in the title of this commentary, is that BAME professionals expect fair treatment, and should adhere themselves to the same equitable standards they expect of others. So how could BAME professionals contribute to actions to address racism and discrimination?
First, we need to know the facts. There is a growing body of evidence on how racism and discrimination result in variations in access to health care, and also act through biological pathways leading to a disproportionately greater burden of disease (1). The British Medical Journal's special issue on Racism in Medicine (2) this year was but one recently published concentrated source of facts, figures and information. It was also a reminder of how much more we need to know, given the scale of the challenges facing the NHS workforce and our communities. Evidence gathering and sharing need to be an ongoing process, one that this journal is ideally placed to lead.

Second, we need to act on the evidence already available. Until now, research has focused mainly on understanding how personal discrimination affects health, but the disproportionate impact of COVID-19 on the BAME communities has shifted the spotlight on to the hitherto neglected dimension of structural and institutional racism. As far back as in 2004, the Health Survey for England showed the health inequalities with the lives of white English people aged 61-70 to be equivalent to that of Caribbean people in their late 40s or early 50s, Indians in their early 40s, Pakistanis in their late 30s, and Bangladeshis in their late 20s or early 30s (3).

BAME professionals have the voice and leadership to investigate and help address the lifetime of disadvantage and discrimination which this reflects. However, our influence and impact must depend on whether we face up to

our own biases. For example, to what extent are Asian male doctors in the NHS committed to supporting BAME female peers to achieve their full potential and get the recognition they deserve?

Research has shown that within different ethnic groups, Asian British women staff have the largest gender pay gap (4), a finding confirmed by the NHS Digital analysis of ethnic pay gaps among all NHS medical staff (5). We note that Asian male medical staff have been most successful in narrowing the pay gap in comparison with their white male counterparts. We have also pointed out the continuing gender imbalance that is evident in many BAME professional organisations.

Studies carried out across several decades have also consistently demonstrated differential attainment by ethnicity in the medical workforce across all measures of training and career progression. Furthermore, in a hierarchy of differential attainment, BAME UK medical graduates perform better than their international peers. The British Association of Physicians of Indian Origin (BAPIO's) commitment to race equality could not have been better demonstrated than in 2014, when the organisation challenged the lawfulness of the Royal College of General Practitioner's clinical skills examination which ethnic minority UK graduates were nearly 4 times, and international medical graduates 14 times as likely to fail in their first attempt, compared with white candidates (5). Six years later, differential attainment remains unresolved.

Many BAME medical professionals are now involved in specialty training. However, what evidence is there, that they are actively working to support the international medical graduates recruited to the NHS each year, whose educational and career attainments appear destined to remain at the bottom of the hierarchy?

Conclusions

Experiences of racism differ between individuals, as have ours. Therefore, we know it can be difficult to "put oneself fully into another's shoes". However, we must try to understand, because racism can leave permanent emotional scars and as we have seen in the case of George Floyd, Steven Lawrence and far, far too many others, can lead to death and lasting damage to communities.

Racism is real and each one of us has an obligation to call it out. We would prefer to focus actions on root causes, legal protections, and societal and attitudinal change. We do not believe that erasing evidence of historical racism is helpful. History is a great teacher, and as Theodore Roosevelt once remarked, "the more you know about the past, the better prepared you are for the future". If humankind is to eliminate racism, future generations need evidence that it existed; removing such evidence-from memory would be totally counterproductive.

As protests against racism sweep across the world we must guard against the danger that views, beliefs and perceptions will be polarised, distorted or even willfully misappropriated, and that legitimate dialogue will be stifled. It would also be honest to accept that racism is a deeply rooted and profoundly unpleasant component of all humans and not the prerogative of any one group, race, or section of society. White on white, brown on brown, black on black racism not only exists, but also has led to the most horrific genocides the world has seen, such as in Nazi Germany, the Indian sub-continent, and Rwanda to name only a few examples.

Additionally, racism shares features with other forms of discrimination, such as those predicated on sex, age, disability, belief, sexual orientation, marital status and pregnancy, and many individuals will suffer on several counts. Our personal experiences of sexism and misogyny from members of our own communities have been as great as our experience of racism.

Therefore, as the world rightly calls for an end to racism, we ask also for an end to all forms of discrimination. We end with quoting Mahatma Gandhi, let us "be the change that you wish to see in the world".

References

1. Evans MK, Rosenbaum L, Malina D, Morrissey S, Rubin EJ. Diagnosing and treating systemic racism. N Engl J Med 2020. 383;3:274-276
2. The BMJ. Born Equal? Racism in medicine. 2020. 368:211-260
3. Becares L, Kapadia D, Nazroo J. Population research ignores older people from ethnic minority backgrounds. BMJ 2020;368:m212
4. Schlepper L, Appleby J. 2018. The gender pay gap in the English NHS: how does it vary by ethnicity? Nuffield Trust https://www.nuffieldtrust.org.uk/newsitem/the-gender-pay-gap-in-theenglish-nhs-how-does-it-vary-byethnicity
5. NHS Digital. NHS basic pay. Ethnicity facts and figures. Published 27 September 2018, updated on 14 May 2019. https://www.ethnicity-factsfigures.service.gov.uk/workforce-andbusiness/public-sector-pay/nhs-basicpay/latest

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Does Gender or Religion Contribute to the Risk of COVID-19 in Hospital Doctors in the UK?

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Abstract:
The novel coronavirus pandemic is posing significant challenges to healthcare workers (HCWs) in adjusting to redeployed clinical settings and enhanced risk to their own health. Studies suggest a variable impact of COVID-19 based on factors such as age, gender, comorbidities and ethnicity. Workplace measures such as personal protective equipment (PPE), social distancing (SD) and avoidance of exposure for the vulnerable, mitigate this risk. This online questionnaire-based study explored the impact of gender and religion in addition to workplace measures associated with risk of COVID-19 in hospital doctors in acute and mental health institutions in the UK.
The survey had 1206 responses, majority (94%) from BAME backgrounds. A quarter of the respondents had either confirmed or suspected COVID-19, a similar proportion reported inadequate PPE and 2/3 could not comply with SD. One third reported being reprimanded in relation to PPE or avoidance of risk. In univariate analysis, age over 50 years, being female, Muslim and inability to avoid exposure in the workplace was associated with risk of COVID-19. On multivariate analysis, inadequate PPE remained an independent predictor with a twofold (OR 2.29, (CI - 1.22-4.33), p=0.01) risk of COVID-19.
This study demonstrates that PPE, SD and workplace measures to mitigate risk remain important for reducing risk of COVID-19 in hospital doctors. Gender and religion did not appear to be independent determinants. It is imperative that employers consolidate risk reduction measures and foster a culture of safety to encourage employees to voice any safety concerns.

Key words: COVID-19, gender, BAME, religion, hospital doctors, reprimand, PPE

Introduction:
The COVID-19 pandemic has posed a global threat affecting people from all backgrounds (1). Healthcare workers (HCWs) inevitably carry a high risk of contracting the disease (2,3). Several studies have shown significant disparity in the severity of COVID-19 and outcomes based on ethnicity, among other factors (4-8). Multiple factors including comorbidities and social deprivation have been proposed to contribute to high mortality in Black, Asian and Minority Ethnic (BAME) people (5-8). Even after adjusting for inherent differences, people of BAME backgrounds are twice as likely to die from COVID-19 as compared to their white counterparts (9). This is also seen in HCWs in the UK National Health Service (NHS), where the BAME community makes up 20% of the overall workforce but accounts for two-thirds of COVID-19 related deaths (10). Furthermore, BAME doctors form 44% of NHS doctors, and 94% of the mortality statistics (11).
Population based data from China and Italy has shown that men appear to be at a higher risk of COVID-19 infection (12,13). However, studies from HCWs in other countries suggest a higher proportion of females (average 70%) in COVID-19 (14,15). This may be due to a higher number of frontline HCWs being female. At least one analysis of HCW who died in the UK showed that 3

Table 1: Data variables used to collect the responses for the survey

Variables

Demographics

a. Clinical setting - Teaching hospital, non-teaching hospital or Mental health trust
b. Gender - Male, Female, Transgender, Prefer not to disclose
c. Number of additional family members in the same household
d. Ethnicity - Caucasian (British/Irish Traveller/Any); South Asian- Indian /Pakistani/Bangladeshi/Other; Black/ African/ Afro-Caribbean/ African- American; Arab/ Middle-eastern/ North African; Chinese/ SE Asian; Mixed; Any other ethnicity and Do not wish to declare)
e. Religion - Christian, Muslim, Hindu, Buddhist, Jewish, Sikh, No religion, Do not want to state, Other
f. Age groups (20-30;30-40; 40-50; 50-60; 60-70;70+ years)
g. Any comorbidities - Highly Vulnerable (where you have been asked to shield and stay at Home); Vulnerable (where social distancing at work and home/community is recommended) or Healthy and none of above.

Workplace measures

a. Work in areas - Patients with COVID-19 (suspected or confirmed) are cared for; Patients with Non-COVID-19 only are cared for; Both
b. Access to PPE to do the job safely - Strongly agree; Somewhat agree; Neither agree nor disagree; Somewhat disagree; Strongly disagree
c. Able to comply SD at work - All of the times; Most of the times; Some of the times; A few of the times; None of the times
d. Able to negotiate changes in work - Work from home; Work in low COVID-19 risk areas; Virtual consultations; None allowed by employer; Other; Not applicable
e. Reprimanded from wearing or asking PPE - Always; Usually; Sometimes; Rarely; Never
f. Redeployed to an area that cares for - COVID-19 patients (Suspected or confirmed); Non-COVID-19 patients; Both of the above; None of the above

COVID-19 status

a. Never had suspected or confirmed COVID-19 infection
b. Confirmed COVID-19 infection (by a PCR test)
c. Suspected COVID-19 infection
d. Self-isolating due to exposure to suspected or confirmed case of COVID-19 infection at Home
e. None of above options

Results

(i) Population

The survey received 1206 responses between 26 April and 29 May 2020. Table 2 shows the characteristics of the respondents and Table 3 summarises the status of workplace measures reported by the respondents. Majority (65.6%) were working in a teaching hospital setting, 38.8% were over 50 years of age, 70.9% were male, 93.7% were from BAME background and their religious identities were Hindu (44.5%), Muslim (32.1%) or Christian (10.4%).

About a quarter identified themselves as 'vulnerable' according to PHE defined criteria. Age distribution of the respondents is shown in Figure 1. COVID-19 diagnosis was confirmed in 104 (8.6%) and, 213 (17.7%) were in self-isolation due to symptoms compatible with COVID-19 (suspected COVID-19) as shown in Figure 2.

Figure 1: Age distribution as per gender of the respondents

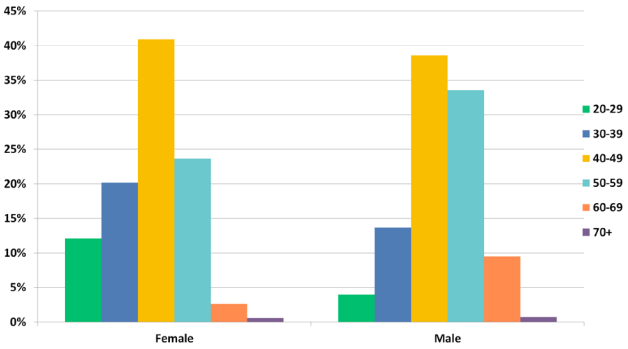


Figure 2: COVID-19 related status of the respondents

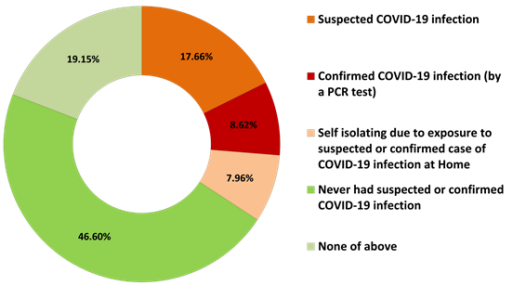


Figure 3: Proportions of self-reported COVID-19 in relation to adequate PPE

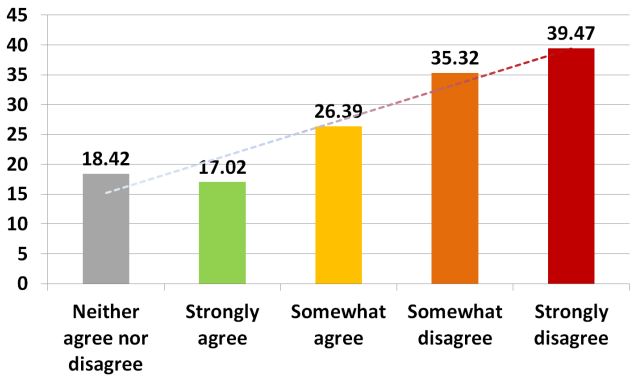
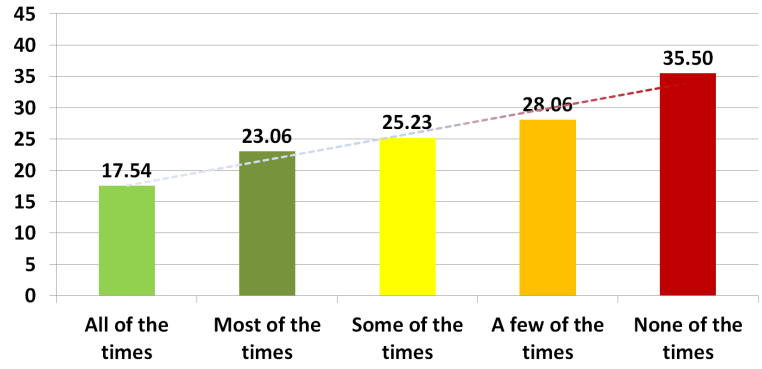


Figure 4: Proportions of self-reported COVID-19 in relation to ability to comply with SD



Workplace measures are summarised in Table 3, Figures 3 and 4. 87.5% of respondents who reported COVID-19 were working in areas that cared for patients with suspected or confirmed COVID-19. Only 61.3% reported (strongly or somewhat) adequate access to PPE, 35.7% were able to comply with SD (most or all times) and 68.9% were able to negotiate different working environment to reduce risk. There was an incremental rise in COVID-19 with inadequate PPE and inability to comply with SD at work (Figures 3 and 4). (ii)

The Impact of Gender

In our survey, 1202 responses were included for analysis to explore gender differences in risk of COVID-19. Female respondents were of a younger age (73.2 % versus 56.3 %; p <0.0001) and a lower proportion identified as 'vulnerable'. Our analysis showed no gender differences in accessing to PPE, ability to comply with SD, redeployment or working in high risk areas (Table 3). A higher proportion of female respondents reported confirmed or suspected COVID-19 (30% versus 25%; p =0.04). Male respondents had a higher proportion of confirmed cases (9.6% versus 6.3%, p =0.07).

(iii) The Impact of Religion

The majority of respondents identified themselves as Christians (n=125, 10.4 %), Muslim (n=387, 32.1%) or Hindu (n=537,

Table 2: Characteristics of respondents to survey (*as per PHE (28,29))

Variables	All
Number	1206
Institution	
Teaching	791 (65.59%)
Non-teaching	266 (22.06%)
Mental Health	149 (12.35%)
Household members	
≤ 5	1165 (96.60%)
>5	41 (3.40%)
Ethnicity	
BAME	1130 (93.70%)
White	72 (6%)
Did not wish to state	4 (0.33%)
Age	
≤ 50	738 (61.19%)
>50	468 (38.81%)
Gender	
Male	855 (70.9%)
Female	347 (28.8%)
Prefer not to state	4 (0.33%)
Religion	
Christian	125 (10.37%)
Hindu	537 (44.53%)
Muslim	387 (32.1%)
Other religion	45 (3.73%)
Did not wish to state	40 (3.32%)
No religion	72 (5.97%)
*Health status**	
Vulnerable	303 (25.12%)
Healthy	903 (74.88%)

44.5%). The remaining respondents (n = 157, 13%) who identified themselves as Sikh, Jewish, Buddhist, or with no religion (see Table 3) were in small numbers and thus were excluded from analysis. Amongst Christians, 95 were from BAME background, whilst 30 were white.

Access to PPE was significantly lower (24% versus 30.5%, p = 0.0133) amongst Muslims. A higher proportion of Muslims (35 % versus 28%, p =0.01) reported being reprimanded for wearing or asking for PPE. There was no difference between Hindu or Muslim respondents in other workplace variables, such as working with COVID-19 patients, ability to practice SD or redeployment compared to either overall Christian or BAME-Christian respondents.

In this cohort, Muslims had a higher prevalence of suspected or confirmed COVID-19 compared to Hindus (34.6 % versus 19.3%, OR 2.18; 95% CI 1.52 - 2.95, p <0.001); but not to 'all Christians (29.6%)' or 'BAME-Christians (28.4%)'.

(iv) Risk of COVID-19

Univariate analysis:

All variables related to workplace measures (except re-deployment) were significantly associated with higher risk of COVID-19 (Table 4). There was a higher self-reported COVID-19 in respondents below the age of 50 years. Other variables; such as number of household members, ethnicity or vulnerability were not significant (Table 4).

Multivariate analysis

(a) Model I: This model included Hindu and Muslim respondents only, thus excluding 282 respondents (125 Christians and 157 'others' and with 'no religious' identity). In this model, none of the demographic variables were significant predictors of COVID-19. Out of the six variables determining occupational risk, inadequate PPE was an independent predictor for COVID-19 (OR 2.22 (95% CI 1.31 - 3.76, p = 0.003).

(b) Model II: This model compared Hindu (547), Muslim (387) and Christian-BAME respondents (95) (excluding 30 white respondents) (Table 5). In this model, none of the demographic variables were found to be significant predictors of COVID-19. Inadequate PPE remained the only independent predictor for self-reported COVID-19 (OR 2.29 (95% CI 1.22-4.33, p =0.01)).

Table 3: Workplace measures - overall and distribution as per religion and gender (responses from Christian religion - expressed as all and separate BAME-Christian to allow comparison of proportions with responses from Muslim and Hindu religion which were all from BAME ethnicity)

Variables	All	All-Christ	BAME-Chris	Muslim	Hindu	Female	Male
Number (%)	1206	125	95	387	537	347	855
Ward area							
Non-COVID-19 Only	151 (12.5)	12 (9.6)	12 (12.6)	52 (13.4)	67 (12.5)	48(13.8)	103 (12.05)
COVID-19	1055 (87.5)	113 (90.4)	83 (87.4)	335 (86.6)	470 (87.5)	299 (86.2)	752 (87.95)
Access to PPE							
Agree	739 (61.3)	77 (61.6)	55(57.9)	217 (56.1)	348 (64.8)	208 (60)	529 (61.9)
Disagree	315 (26.1)	28 (22.4)	26 (27)	118 (30.5)	129 (24)	94 (27)	220 (25.7)
Neither agree or disagree	152 (12.6)	20 (16)	14 (14.7)	52 (13.4)	60 (11.2)	45 (13)	106 (12.4)
Able to comply with Social Distancing							
Most/all	430 (35.7)	46 (36.8)	36 (37.9)	139 (35.9)	193 (36)	120 (34.6)	308 (36)
Some, few or none	776 (64.3)	79 (63.2)	59 (62)	248 (64.1)	344 (64)	227 (65.4)	547 (64)
Able to negotiate							
None	224 (18.6)	18 (14.4)	17 (17.9)	69 (17.8)	105 (19.6)	57(16.4)	166 (19.4)
Yes	831 (68.9)	85 (68)	45 (47)	271 (70)	378 (70.4)	222 (64)	607 (71)
Not applicable	151 (12.5)	22 (17.6)	33 (34.7)	47 (12.1)	54 (10)	68 (19.6)	82 (9.6)
Reprimanded for PPE							
yes	360 (29.9)	28 (22.4)	24 (25.3)	135 (34.9)	154 (28.7)	98 (28)	259 (30)
Rare/Never	846 (70.1)	97 (77.6)	81 (85.3)	252 (65.1)	383 (71.3)	249 (72)	596 (70)
Redeployed to area that cares							
Non-COVID-19 only	68 (5.6)	4 (3.2)	3 (3.2)	32 (8.3)	27 (5)	13 (3.7)	55 (6.4)
COVID-19	455 (37.7)	41 (32.8)	27 (28.4)	164 (42.4)	200 (37.3)	130 (38)	323(38)
Not applicable	683 (56.6)	80 (64)	65 (68.4)	191 (49.4)	310 (57.7)	204 (58.8)	477 (55.8)

Table 4: Univariate analysis looking at risk factors for COVID19 (* Fisher Exact 2-tail test)

Variables	COVID19 susp/+ve	COVID -ve	p*
Number	317 (26.28%)	889 (72.71%)	
Institution			
Teaching	210 (66.24%)	581 (65.35%)	ref
Non-teaching	69 (21.77%)	197 (22.16%)	ns
Mental Health	38 (11.99%)	111 (12.49%)	ns
Household members	ns		
≤ 5	303 (95.58%)	862 (96.96%)	
>5	14 (4.41%)	27 (3.04%)	
Ethnicity	ns		
BAME	291 (91.80%)	839 (94.40%)	
White	22 (6.94 %%)	50 (5.60%)	
Age	0.0031		
≤ 50	216 (68.14%)	522 (58.72%)	
>50	101 (31.86%)	367(41.28%)	
Gender	0.036		
Male	210 (66.25%)	645 (72.55%)	
Female	106 (33.44%)	241 (27.11%)	
Religion			
Christians (Overall)	37 (11.67%)	88 (9.90%)	ns
Christians (BAME)	27 (8.52%)	68 (7.65%)	ns
Hindu	104 (32.81%)	433 (48.71%)	<0.001
Muslim	134 (42.27%)	253 (28.46%)	ref
PHE guidance	ns		
Vulnerable	79 (24.92%)	224 (25.20%)	
Healthy	238 (75.08%)	665 (74.80%)	
Ward area	0.0132		
Non-COVID-19	27 (8.52%)	124 (13.95%)	
COVID-19	290 (91.48%)	765 (86.05%)	
Access to PPE	<0.0001		
Agree	173 (54.57%)	566 (63.67%)	
Disagree	116 (36.59%)	199 (22.39%)	
Comply with SD	0.0203		
Most/all of the times	96 (30.28%)	334 (33.57%)	
Some, few or none	221 (69.72%)	555 (62.43%)	
Able to negotiate	0.0167		
None	67 (21.14%)	157 (17.66%)	
Yes	183 (57.73%)	648 (72.89%)	
Reprimanded for PPE	<0.0001		
Yes	123 (38.80%)	237 (26.66%)	
Rare/Never	194 (61.20%)	652 (73.34%)	
Redeployed to area	ns		
Non-COVID-19	21 (6.63%)	47 (5.29%)	
COVID-19 only	141 (44.48%)	314 (35.32%)	

Discussion

COVID-19 pandemic continues to be a major public health challenge. As far as we are aware, that this is the first survey that has studied gender and religion in the context of hospital doctors and risks of self-reported COVID-19. Hospital doctors are at an increased risk due to a higher exposure while caring for COVID-19 patients but also due to inconsistent access to appropriate PPE and compliance to SD at work (22,23,24). This is in addition to any applicable population-based risk factors (such as age, gender and comorbidities (4-9,12,24).

Many researchers have suggested risk assessment frameworks to minimise harm to those at highest risk (25,26) but these appear to be based on models of clinical risks and extrapolation of general population data. More recently, there has been a suggestion to include occupational factors in such a framework (27). We have previously reported data on HCWs including hospital doctors from the UK, demonstrating workplace measures and ethnicity were independent predictors of COVID-19 (22,23). The current study further explores additional characteristics such as gender and religion as risk factors COVID-19.

We found that women were more likely to report a diagnosis of COVID-19 but this was not found to be significant on multivariate analysis. Our study population included a higher proportion of women under 40 years of age (32% versus 17%), who were more likely to report a diagnosis of COVID-19. This may be representative of the demographics of the NHS frontline workforce (18,19). We found that gender and age were not independent predictors of COVID-19 in our study, in multivariate analysis. There is an excess risk of intensive care admissions and mortality from COVID-19 in men and those above 70 years (4). Some NHS trusts have already started risk stratification and are selectively redeploying BAME staff above 55 years, away from high risk areas (30,31).

This survey was open to all hospital doctors in the UK, however most responses received are likely from members of the two organisations representing doctors from Indian sub-continent heritage. Hence, it is not surprising that

Table 5: Binary Logistic regression analysis modelling for risk of COVID-19

Variable	Model I		Model II	
	OR (CI)	p-value	OR (CI)	p-value
Demographic factors				
Gender (male)	0.86 (0.41-1.81)	0.69	0.97 (0.5-1.73)	ns
Religion -Hindu	0.71 (0.39-1.29)	0.26	0.72 (0.4-1.31)	ns
Religion - Muslim	Reference	-	Reference	-
Religion - Chris(BAME)	Not applicable	-	0.62 (0.18-2.11)	ns
Age (>50)	0.76 (0.46-1.68)	0.71	0.93 (0.5-1.73)	ns
Vulnerability as per PHE	1.27 (0.62-2.62)	0.51	ns	
Workplace measures				
Inadequate access to PPE	2.40 (1.25-4.61)	0.008	2.29 (1.22-4.33)	0.01
Inability to SD	0.79 (0.40-1.59)	0.51	0.84 (0.43-1.63)	ns
Area with COVID-19	0.90(0.27-3.31)	0.92	0.92 (0.28-3.03)	ns
Reprimanded for PPE	0.93 (0.47-1.84)	0.83	0.95 (0.49-1.83)	ns
Not able to Negotiate	1.10 (0.56-2.17)	0.77	0.97 (0.51-1.85)	ns
Redeployed COVID-19	2.48 (0.72-8.55)	0.15	0.92 (0.28-3.03)	ns

a significant majority of our respondents were from a BAME background and from three major religions practiced in the Indian sub-continent. Religious identity was not found to be statistically significant in determining risk, when adjusted for other factors in the multivariable analysis (Table 5).

Compliance with social distancing remains a challenge. Almost 2/3rd of hospital doctors reported not being able to comply with social distancing and this was associated with increased risk of COVID-19. In the home, overcrowding and multi-generational households are also factors linked to higher exposure and hence increased risk to people from BAME background. Our survey in hospital doctors did not support this hypothesis. Data presented in the paper using a cut-off of five household numbers, but it was not significant even when analysing for a threshold of 2 and 3 (similar to average household numbers in UK (32). This could be because the socio-economic backgrounds of BAME hospital doctors are not comparable to the general population.

PPE is known to be one of the key measures ensuring safety of staff from occupational risk of COVID-19. There has been continued debate in the profession regarding the supply and timely delivery of appropriate PPE. We, and others have previously reported that many healthcare workers were not getting access to PPE as per PHE or WHO recommendations.[ref] In this survey, 61% hospital doctors reported appropriate access to PPE which is an improvement from 22% demonstrated previously (22,23). However, after adjusting for confounding variables, inadequate PPE remained an independent predictor with two-fold increased risk of COVID-19, in this cohort.

Lack of PPE may be associated with a degree of anxiety and stress for staff, in high risk clinical settings. In a previous survey by BMA, 64% of BAME staff felt pressured to work in settings with inadequate PPE (20). We found almost 30% hospital doctors reported being reprimanded for requesting PPE or risk avoidance measures (such as social distancing or redeployment in lower risk areas) and this was more commonly reported by Muslims. It would not be surprising that doctors facing discrimination are unlikely to raise concerns about inadequate workplace measures. The 2019 NHS staff survey and data from workforce race relations standards 2019 report (WRES) (18,19) indicates that overall 13% staff reported discrimination and another 31% reported facing bullying and undermining behaviour. The proportions were higher for BAME staff. Ethnicity was reported as the most common reason (eight times higher compared to the religious identity).

Our survey cohort is not directly comparable with the NHS staff survey as all our respondents were doctors and majority were male and BAME background, compared to 7.9% doctors 76% female and 20-40% from a BAME background). The fact that one-third of hospital doctors' reported being reprimanded is deeply concerning. If hospital doctors (who have a more favourable educational and socio-economic background) report facing this degree of discrimination, it is likely that the experience may indeed be worse in other HCWs, more so from BAME backgrounds. This needs to be addressed by NHS organisations and staff support groups.

This study has a few limitations. A key comparator to workplace measures would have been between Caucasians and black ethnic respondents which had lower representation in our survey. General limitations to online surveys are also applicable to our survey.

Conclusions:

This survey contributes to the growing evidence of risk factors for COVID-19 amongst BAME doctors. Although the NHS has introduced risk assessment frameworks, these are based on demographics, and the scored on individual characteristics but not occupational or organisational influences. Access to PPE, although improved compared to results from April, still remains prevalent and inadequate access resulted in doubled the risk of COVID-19 for hospital doctors. Inability to comply with SD at work poses a similar challenge. Gender and religion did not contribute to additional risk, after adjusting to other variables in this study.

The unfortunate culture in the NHS, of being reprimanded or experiencing bullying and undermining contributes to an unsafe workplace for staff and where mistakes are more likely to lead to harm for patients. Hence, the focus needs to be on developing a culture of openness where the concerns can be raised safely and appropriate measures are taken to mitigate risks for staff and patients alike.

Author's contribution and conflict of interest statements:
Contributions are study design (SKD, GM, JSB & IC); data collection (All); analysis and interpreting the results (SKD & IC); writing the manuscript (SKD, SJ, MA, SG, IC); editing the manuscript and agreeing with final submission (All).
The authors do not declare any conflict of interest.

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References:

1. https://www.partner-religion-development.org/members/religion-in-times-of-covid-19/international partnership on religion and sustainable development.
2. Hunter E Price DA Murphy E et al. First experience of COVID-19 screening of health-care workers in England. Lancet. 2020; 395: e77-e78
3. Olgueira MD, Munoz-Ruiperez C, Alonso-Lopez MA, Delgado R. SARS-CoV-2 infection in health care workers in a large public hospital in Madrid, Spain, during March 2020. April 27, 2020 (https://www.medrxiv.org/content/10.1101/2020.04.07.2005572 3v2. opens in new tab). Preprint
4. Intensive Care National Audit and Research Centre. ICNARC report on COVID-19 in critical care 24 April 2020.https://www.icnarc.org/OurAudit/Audits/Cmp/Reports accessed 25th April 2020
5. Platt L, Warwick R. Are some ethnic groups more vulnerable to COVID-19 than others? Institute for Fiscal Studies, Nuffield Foundation. 2020
6. Office for National Statistics. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. 2020. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/cor onavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020.
7. The Open SAFELY Collaborative, Williamson E, Walker A et al. Open SAFELY: factors associated with COVID-19-related hospital death in the linked electronic health records of 17 million adult

NHS patients. medRxiv preprint posted 7 May 2020
8. Yang, J., et al., Prevalence of comorbidities and its effects in coronavirus disease 2019 patients: A systematic review and meta-analysis. Int J Infect Dis, 2020. 94: p. 91-95
9. https://www.gov.uk/government/publications/covid -19-review-of-disparities-in-risks-and-outcomes
10. Exclusive: deaths of NHS staff from COVID-19 analysed. 2020. Health Services Journal. https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.
11. https://www.cebm.net/wp-content/uploads/2020/05/BAME-COVID-Rapid-Data-Evidence-Review-Final-Hidden-in-Plain-Sight-compressed.pdf12. Chen N, Zhou M, Dong X et al. Epidemiological and clinical characteristics of 99 cases of 2019 novel corona virus pneumonia in Wuhan, China: a descriptive study. Lancet 2020; 395 (10223):507-13
13. Remuzzi A, Ramuzzi G. COVID-19 and Italy: what next? Lancet 2020 S 0140-6736 (20) 306277-9
14. CDC COVID-19 Response Team. Characteristics of health care personnel with COVID-19 — United States, February 12–April 9, 2020. MMWR Morb Mortal Wkly Rep 2020;69:477-481
15. https://www.rki.de/DE/Content/InfAZ/N/ Neuartiges_Coronavirus/Situationsberichte/2020-04-21-en.pdf
16. Channappanavar R, Fett C, Mack M et al. Sex- based differences in susceptibility to severe acute respiratory syndrome coronavirus infection. J Immunol 2017;198(10): 4046-53
17. Matsyama R, Nishiura H, Kutsuna S et al. Clinical determinants of security of Middle East respiratory syndrome (MERS): a systematic review and meta-analysis: BMC Public Health 2016 ; 16(1):1203
18. http://www.nhsstaffsurveyresults.com/homepage/national-results-2019/trends-questions-2019/
19. NHS Staff Survey 2019. National Results debriefing. Feb2020. http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/01/P3255_ST19_National-briefing_FINAL_V2.pdf
20. https://www.bma.org.uk/media/2464/bma-covid-19-survey-results-for-hospital-doctors-14-may-2020.pdf
21. https://www.bma.org.uk/news-and-opinion/bame-doctors-hit-worse-by-lack-of-ppe
22. Chakravorty, I., Daga, S., Dave, S et al; An Online Survey of Healthcare Professionals in the COVID-19 Pandemic in the UK: : Perceptions of Risk Factors. SUSHRUTA J of Health Policy & Opin 2020, 13(2)
23. Daga, S., Chakravorty , I. ., Bamrah, J.et al Self-reported Occupational Risk for COVID-19 in Hospital Doctors from Black Asian & Minority Ethnic Communities in UK. The Physician,2020; 6(1) https://www.doi.org/1.6.1.9
24. Chu DK Akl EA Duda S et al. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. Lancet. 2020; (published online June 1.) https://doi.org/10.1016/S0140-6736(20)31142-9
25. https://www.fom.ac.uk/wp-content/uploads/Risk-Reduction-Framework-for-NHS-staff-at-risk-of-COVID-19-infection-12-05-20.pdf
26. https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff
27."Is It Safe for Me to Go to Work?" Risk Stratification for Workers during the Covid-19 Pandemic. Marc R. Larochelle NEJM May 26, 2020
28. https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
29.https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing/staying-alert-and-safe-social-distancing
30.https://www.guysandstthomas.nhs.uk/resources/coronavirus/occupational-health/risk-assessment-matrix-vulnerable-staff-COVID19.pdf
31.https://gov.wales/sites/default/files/publications/2020-05/covid-19-workforce-risk-assessment-tool.pdf
32.https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2017

Reasons for Smoking Among English-speaking Adults in Leicester - A Pilot Study

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Abstract
Cigarette smoke contains around 7000 chemicals that are harmful to health and cause premature death. Most smokers acknowledge the harm they are doing to them yet continue to smoke. This pilot study was designed to understand the impact of cigarette smoking, the addictive effect of nicotine, and also to hypothesize a recommendation for smoking cessation.
Methods: This study recruited English speaking adult participants who were either current, occasional, and ex-smokers from NHS Stop Smoking clinics in Leicester, United Kingdom, using a self-completed questionnaire.
Results: Out of 32 participants, white British and Asian were top two ethnicities with majority of males as respondents. Stress, boredom, nervousness, and 'just like it', were the main reasons quoted for cigarette smoking. Irritation & mood swings were top reasons for craving. The visual stimuli and 'smell of smoking' were reported as top two strong cues. Majority of the participants reported having several health problems mainly due to cigarette smoking such as respiratory cough, feel like tightening of lungs, asthma, high blood pressure, difficulty in losing weight, excess fat accumulation near waist, poor appetite, fatigue, sleeping disturbances, darkened teeth as well as an inability to differentiate between taste.
Conclusion: Our study suggested that cigarette smoking maybe more like a habit than an addiction. which unable to relieve stress or boredom but keeps smoker hooked to the habit.

Keywords
Cigarette smoking, health impact, behaviour, smoking cessation.

BACKGROUND

Smoking is the biggest cause of preventable deaths across the globe killing approximately 8 million individuals. Interestingly 7 million individuals' death resulted from direct smoking, but 1.2 million non-smokers lost their life due to second-hand smoking. [1] Smoking is a practice by which tobacco gets burned, and the resulting smoke gets inhaled in to be tasted and absorbed into the bloodstream. The most common substance used for smoking is the dried leaves of the tobacco plant. Smoking, sniffing, or chewing are considered the most common ways to consume tobacco. Tobacco smoking caused premature death among approximately 6 million people worldwide [2] and about 96,000 people every year in the UK. [3]
In the United Kingdom, the Policy Exchange Report of 2010 states that the total cost of smoking to society and the economy was GBP £13.4 billion. [4] Various fiscal, legal restriction, and intervention measures were adopted to stop the availability and spread of this harmful addiction. Despite these comprehensive measures, 1 in 5 people still smoke. [5] Leicester City Clinical Commissioning Group (LCCG) suggested national smoking prevalence estimated at 17.3% for Leicester, which is statistically higher than the national rate (14.4%). Further, it suggested that smoking

prevalence among Leicester males (21%) and females (13.6%) is significantly higher as compared to England males (16.4%) and females (12.6%). [6]

Effects on health

Tobacco smoking results in respiratory, cardiovascular, and malignant diseases. 'Stop Smoking' considered being a key medical intervention to curb tobacco dependence. However, the addictive properties of cigarette smoking, especially nicotine inhalation, leave smokers quitting attempts unsuccessful. The continuous use of cigarettes leads to addiction among many users. Nicotine is one of the proven addictive drugs, which is more addictive than heroin, and cocaine. [7] Despite knowing that smoking is bad for health, smokers failed to give up the habit which clearly emphasize addiction towards nicotine. Nicotine craving activates the dopamine reward pathway in smokers. Failure to supply nicotine when the body craves for it, leads to withdrawal symptoms, which slows the smoking cessation rate. Hence, to handle this domino effect, it is essential to address the withdrawal symptoms, as well as the time window between two cigarettes. These two aspects will give rise to an effective novel way to enhance the cessation rate. Hence it is essential to understand the behavioural changes in smokers to curb smoking habits. [8-10]

Many cigarette smokers continuing cigarette smoking as they believe that cigarettes help them to deal with stress, boredom and/or they 'just like it'. Conversely, cigarette smoking does not relieve stress and/or boredom. It makes the smoker hooked to the habit of smoking, where the smoker feel the need to take specific amounts of nicotine rush every time 'to feel normal'.

The relationship between cigarette smoking and its cariogenic effects are widely known however, the deleterious impact of cigarette smoke on other organs and immune system are not widely known. Following table 1 illustrated a brief overview of ten harmful chemicals found in cigarette and its associated symptom, possible diseases, its impact on the immune system, behavioural changes, and ultimately affecting vital organs.

Interventions are also necessary to effectively handle the 'window time' between two cigarettes. Current information suggested that smoking cessation treatments are not yet cost-effective, primarily due to the high price of tobacco replacement products. It prompts to develop a cost-effective intervention, which will provide a strong pillar to curb tobacco consumption via interventions. This approach needs to cater at an individual level. [11]

Various novel approaches are being subjected to current studies such as rimonabant based novel approach to Stop Smoking, the use of selegiline based therapeutic agent in curbing the smoking habit and immunomodulation via vaccination is gaining an increasing level of attention from a wider research community. Governments all over the world and especially in UK has introduced various measures to curb smoking. These measures range from imposing higher taxes on tobacco products, introducing a ban on advertising, display materials promoting tobacco, cigarette smoking, and to engage in hosting Stop-Smoking clinics under the NHS flag. Though these programs are showing some significant results, there is still more to be done.

Nicotine replacement products are currently available to all smokers who showed interest in NHS Stop Smoking initiatives. The proposed hypothesis suggests as cigarette smoking is due to habit and not because of addiction. Under the long tail phenomenon, smokers who smoke due to addiction fall in a small group (towards the tail) as compared to the smokers who smoke due to habit. Therefore, by chopping off the large chunk of smokers who continue smoking due to sheer habit will have only qualified access to subsidize nicotine replacement products. In addition, the focus can be shifted from an approach of prescribing nicotine replacement products to inventing more innovative ways to deal with the boredom, which was one of the main reasons for many heavy smokers to engage in smoking behaviour. It will ease of NHS budget to a certain extent. However, Smokers who smoke under addiction need to be treated more effectively and carefully to improve smoking cessation.

Methods

This pilot study was conducted under academic activity, performed with limited resources, money, and time. As a result, this study was completed within a small sample size with a pragmatic approach. [12] Participation in this study was voluntary. This study was conducted at three different NHS Stop Smoking clinics within Leicester, with 32 respondents (twenty-three males and nine females) who were either current, occasional, or ex-smokers. Participants from varied ethnicities and with the age limit between 18 to 85 years from Leicester were included in this study. The self-completing questionnaire method was used to get insights from the respondents, mainly to understand the respondent's lifestyle choices towards smoking, exercise, diet, and its impact on their physiological and psychological health. The questions also gave straightforward information and facts about various diseases/ disorders and symptoms those individuals were experiencing.

Due to the sensitive nature of the study, age, gender, ethnicities were asked, but the name of the respondents was not requested. A participation information sheet (PIS) was provided to all participants before participation to explain the scope of the study. Each participant's consent was gained before the study. A self-completed questionnaire in printout form was

deployed to gain the optimum response during the survey. There were total 7 questions in the questionnaire, which required approximately 7-10 minutes to complete (per participant).
Smoking is considered a sensitive topic, especially in the case of a person's health. Therefore, this study gained De Montfort university ethic committee's approval (on 20 August 2013) and consents from all stakeholders before recruiting respondents.

Confidentiality & Data protection
The information collected was used in an aggregated form to conclude. The collected paper data was stored in the lock and key, and the digital data was stored on the university cloud. Only the researcher and authorized personnel will have access to the surveyed information. This research adhered to all the laws and requirements of the Data Protection Act 1998, grants personal data processing privacy to the individual as well as De Montfort University established rules and guidelines for collecting, storing, and disposing of the data.

Research venues and duration
The total study duration from conceptualization to submitting a thesis happened under seven months. The research was conducted at the following three venues, such as Stop Smoking clinics at Boots Oadby, Highem pharmacy and Leicester Railway Station. (As part of public awareness, the Stop Smoking initiative was organized to install a Stop Smoking desk at Leicester Railway Station).

Results
This pilot study indicates that smokers do tend to show similar illnesses and health effects, as outlined in the literature review. A total of thirty-two participants participated in this study, including nine females and twenty-three males. The top two ethnicities were White British and Asian, with 13 & 9 participants, respectively. Majority of the participants were reported to consume over ten cigarettes per day. Surprisingly, these heavy smokers were found to be engaged in some form of exercise. It was observed that “stress, boredom, and just like it” were the leading top three reasons behind the consumption of cigarette smoking. Irritation and mood swings were top two reasons for craving for cigarette smoking observed among heavy smokers (who smoke over ten cigarettes per day).

Visual stimuli and smell of smoking were reported as top cues for smoking. Respiratory cough feels like tightening of lungs, and asthma were highest observed effects under respiratory system. High cholesterol and high blood pressure were highest observed effects under cardiovascular system. Respondents suggested various issues related to gastrointestinal disorders. Poor appetite and excess fat accumulation around the waist and difficulty in losing weight were some of the prominent effects in case of gastrointestinal system. Fatigue and sleep disturbances were observed among studied cohort. Darkened teeth, bad breath and an inability to differentiate between the taste were the most observed effects in case of Ear, Nose and Throat (ENT) and oral health.

As per the existing literature, smokers do not follow a healthy diet and a regular exercise pattern. However, this pilot study reveals that smokers followed a relatively healthy diet, and they were engaged in regular exercise.

To enhance cessation rate, it is important to address the withdrawal symptoms, as well as to handle the time window between two cigarettes to delink the vicious circle of cigarette smoking.
While most of the key findings support the available literature review on the deleterious impact of cigarette smoke, responses on ‘reasons for smoking’ from heavy smokers (10+ cigarettes/day) is providing a basis for formulating a new hypothesis that smoking is more like a habit than an just an addiction.

Limitation and future study
This pilot study was conducted with a small number of participants using NHS Stop Smoking clinic umbrella at three different locations within Leicester. The maximum numbers of the respondents were recruited from Leicester Rail station's Stop Smoking clinic site. The recruitment day was a declared school holiday due to which a large proportion of professionals may be working from home, attending their children. It might lead to a biased sample as this was possibly less representative of commuters at all timings, which mean the professionals who would commute to work, or return would not have received adequate representation. Females representation was less as compared to males. All respondents were from one geographical area which was Leicester, UK, instead of diverse. Further research is warranted within non-smokers to compare the results. Therefore, future study needs factor such limitations during project planning phase and ensure a larger sample size with well-rounded recruitment strategy.

References
1. World Health Organization (2020) Tobacco. [Online] WHO. Available from: https://www.who.int/news-room/fact-sheets/detail/tobacco [Accessed 05.07.20].
2. World Health Organization (2013). WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion, and sponsorship. Geneva: WHO.
3. Action on Smoking and Health (2016). Smoking statistics: Who smokes and how much? London: ASH; Retrieved from http://www.ash.org.uk/files/documents/ASH_106.pdf
4. Action on Smoking and Health (ASH) (2013)

The Economics of Tobacco. Government of the United Kingdom.
5. HM Government (2010) Healthy Lives, Healthy People: Our Strategy for public health in England. London: Department of health.
6. Leicester City Clinical Commissioning Group (2020) Tobacco [WWW] LCCG. Available from: https://www.leicester.gov.uk/media/186431/tobacco-jsna-chapter-2020.pdf [Accessed 31.07.20].
7. University of Minnesota (2003) Nicotine Addiction [WWW] University of Minnesota. Available from: http://www1.umn.edu/perio/tobacco/nicaddct.html [Accessed 12.10.2013].
8. NINEHAM, L. (2010) Habit not addiction that fuels cigarette cravings [WWW] The stop smoking lounge. Available from: http://www.thestopsmokinglounge.com/smoking-hypnosis-news/4846/habit-not-addiction-that-fuels-cigarette-cravings/ [Accessed 11.11.2013].
9. Ussher M., Brown J., Rajamanoharan A., & West R. (2014). How do prompts for attempts to quit smoking relate to method of quitting and quit success? ANNALS OF BEHAVIORAL MEDICINE,, 358–368.
10. Fidler J., & West R. (2011). Enjoyment of smoking and urges to smoke as predictors of attempts and success of attempts to stop smoking: A longitudinal study. DRUG AND ALCOHOL DEPENDENCE, 30–34.
11. TOBIAS, R. et al. (2012) Nicotine Vaccines to Assist with Smoking Cessation: Current Status of Research. Adis international, 72, pp. e1-e16.
12. DENSCOMBE, M. (2010) The Good Research Guide: For small- scale social research projects. Open University Press, (4).
13. Qiu, F., Liang, C.-L., Liu, H., Zeng, Y.-Q., Hou, S., Huang, S., … Dai, Z. (2017). Oncotarget 268 www.impactjournals.com/oncotarget Impacts of cigarette smoking on immune responsiveness: Up and down or upside down? Oncotarget, 8(1), 268–284.
14. DUTTA, N. (2013) World No Tobacco Day2013: 10 dangerous chemicals in cigarettes [WWW] Health. Available from: http://health.india.com/diseases-conditions/world-no-tobacco-day-2013-10-dangerous-chemicals-in-cigarettes/ [Accessed 02/09/2013].
15. Di Chiara, G. (2000). Role of dopamine in the behavioural actions of nicotine related to addiction. European Journal of Pharmacology, 393(1–3), 295–314. https://doi.org/10.1016/S0014-2999(00)00122-9.
16. Smith, M. T. (2010). Advances in understanding benzene health effects and susceptibility. Annual Review of Public Health, 31, 133–148.
17. Gillis, B., Gavin, I. M., Arbieva, Z., King, S. T., Jayaraman, S., & Prabhakar, B. S. (2007). Identification of human cell responses to benzene and benzene metabolites. Genomics, 90(3), 324–333.
18. Mehta, H., Nazzal, K., & Sadikot, R. T. (2008). Cigarette smoking and innate immunity. Inflammation Research, 57(11), 497–503. https://doi.org/10.1007/s00011-008-8078-6
19. Kosmider, L., Cox, S., Zaciera, M., Kurek, J., Goniewicz, M. L., McRobbie, H., … Dawkins, L. (2020). Daily exposure to formaldehyde and acetaldehyde and potential health risk associated with use of high and low nicotine e-liquid concentrations. Scientific Reports, 10(1), 1–10. https://doi.org/10.1038/s41598-020-63292-1
20. Campbell, R. C. J., Stephens, W. E., & Meharg, A. A. (2014). Consistency of arsenic speciation in global tobacco products with implications for health and regulation. Tobacco Induced Diseases, 12(1), 1–8. https://doi.org/10.1186/s12971-014-0024-5
21. Pappas, R. S., Fresquez, M. R., Watson, C. H., Branch, V., & Services, A. (2016). Filters : Implications for Exposure, 39(1), 45–51. https://doi.org/10.1093/jat/bku115.Cigarette.
22. Ganguly, K., Levänen, B., Palmberg, L., Åkesson, A., & Lindén, A. (2018). Cadmium in tobacco smokers: A neglected link to lung disease? European Respiratory Review, 27(147), 1–8.
23. Seeman, J. I., & Carchman, R. A. (2008). The possible role of ammonia toxicity on the exposure, deposition, retention, and the bioavailability of nicotine during smoking. Food and Chemical Toxicology, 46(6), 1863–1881. https://doi.org/10.1016/j.fct.2008.02.021
24. Mahernia, S., Amanlou, A., Kiaee, G., & Amanlou, M. (2015). Determination of hydrogen cyanide concentration in mainstream smoke of tobacco products by polarography. Journal of Environmental Health Science and Engineering, 13(1), 1–6. https://doi.org/10.1186/s40201-015-0211-1
25. Zevin, S., Saunders, S., Gourlay, S. G., Jacob, P., & Benowitz, N. L. (2001). Cardiovascular effects of carbon monoxide and cigarette smoking. Journal of the American College of Cardiology, 38(6), 1633–1638. https://doi.org/10.1016/S0735-1097(01)01616-3
26. Brown, B. G., Borschke, A. J., & Doolittle, D. J. (2003). An Analysis of the Role of Tobacco-Specific Nitrosamines in the Carcinogenicity of Tobacco Smoke. Nonlinearity in Biology, Toxicology, Medicine. https://doi.org/10.1080/15401420391434324
27. Muggli, M. E., Ebbert, J. O., Robertson, C., & Hurt, R. D. (2008). Waking a sleeping giant: The tobacco industry's response to the polonium-210 issue. American Journal of Public Health, 98(9), 1643–1650. https://doi.org/10.2105/AJPH.2007.130963
28. Zagà, V., Lygidakis, C., Chaouachi, K., & Gattavecchia, E. (2011). Polonium and lung cancer. Journal of Oncology, 2011. https://doi.org/10.1155/2011/860103
29. Bernhard, D., Rossmann, A., & Wick, G. (2005). Metals in cigarette smoke. IUBMB Life, 57(12), 805–809. https://doi.org/10.1080/15216540500459667

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Career View

Role of an International General Practitioner in Post Covid-19 Britain

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Abstract
The General Practitioner (GP) is the first line of contact for patients, providing continuity of care, and approaching the patient in a holistic manner taking into consideration the physical, emotional and social aspects. (1) This is extremely challenging, satisfying, and exciting because a GP comes across patients of all ages with diverse backgrounds. The opportunities for a GP in the UK are innumerable including GP with Special Interest (GPwSI), research and development, education, training, and occupational health services among other areas.1 This article focuses on the pathways an Internationally trained GP could choose so as to train and work as a GP in the UK and briefly throws light on the prospects of MRCGP (INT). It also highlights how the workforce could be increased to meet the demands of the post-COVID-19 pandemic.

Keywords International General Practitioner; Post COVID-19

An Internationally trained General Practitioner (iGP) could choose from one of the following routes to work or train as a GP in the United Kingdom (UK):

1. International GP recruitment scheme
2. Induction scheme
3. CEGPR (Certificate of Eligibility for GP Registration)
4. GP Speciality training

International GP recruitment scheme

This scheme was started to meet the shortages in the number of GPs. The General Practice Forward View (GPFV) published in April 2016 was to strengthen the workforce which includes recruiting suitably qualified overseas doctors from EU and Australia into general practice.(2) It gives the opportunity to practise in an area of England of one's choice, and to opt to be either a generalist or to develop skills in a specific area as a GP with a Special Interest.2 Although every year GP training positions are increasing and many GPs are returning to practice, it was observed that some practices were facing recruitment challenges. This was because more often than not newly qualified GPs prefer to work temporarily (known as locum) rather than taking up a permanent GP position. Furthermore, some older GPs were retiring from the profession early. This created a gap between the number of GPs that practices wanted, and the numbers they were able to successfully recruit and retain.(2) Hence, recruitment of overseas GPs was introduced.

Induction scheme

It aims to provide a safe, supported, and direct route for qualified GPs to join the UK National Health Service (NHS) general practice. The induction route is for a doctor who has never worked as an NHS GP. Additionally, a GP who has previously worked in the NHS but has been out of NHS general practice for more than two years and would like to return to work in UK can follow the refresher scheme. The portfolio route is for a GP who has worked in the NHS but has been also been practising medicine abroad for less than 10 years. (3) The requirements for this scheme

are a completed formal training as a general practitioner in the UK [CCT (Certificate of Completion of Training) or JCPTGP (Joint Committee on Postgraduate Training for General Practice)], approved European Union (EU) qualification or a CEGPR.(3)

CEGPR

This route is for doctors who have trained and worked as a general practitioner outside the UK and believe that their training, qualifications, and experience are equivalent to that of the UK general practice training. It requires a qualification in general practice or at least six months specific training in general practice from anywhere in the world.(4) This pathway involves robust documentation and is often viewed as a 'tedious' process. As a general rule, most applications contain 500-800 pages of evidence which equates to around 100 electronically uploaded documents, demonstrating that the UK curriculum capabilities have been achieved.(5) The RCGP (Royal College of General Practitioners) has also introduced a streamlined process for Australia, New Zealand, Canada and South Africa as the curriculum including the health care context, training and assessments from these countries were found to be similar in many aspects to the UK GP training programme. Hence, the amount of evidence required for the Streamlined CEGPR application is significantly less.(6)

GP Speciality Training

Another route would be to undergo three years of GP Specialty Training (GPST), which includes 18 months in an approved training practice and a further 18 months in approved hospital posts.(7) This pathway requires the individual to sit the Multi-Speciality Recruitment Assessment (MSRA). The General Practice National Recruitment Office (GPNRO) co-ordinates this program. Recruitment takes place three times a year, twice for August commencement and once for the February commencement. On successful completion of training, the doctor is awarded CCT. (8) Gaining MRCGP UK (Member of the Royal College of General Practitioners), is a pre-requisite for CCT, which comprises three components including an Applied Knowledge Test (AKT), a Clinical Skills Assessment (CSA) and Workplace Based Assessment (WPBA).

MRCGP [INT]

The MRCGP [INT] examination meets the rigorous standards, which are set and accredited by the RCGP. However, it does not confer holders of this qualification any right to practice as a GP in the UK. The curriculum on which the MRCGP [INT] examination is based is unique to the country it was developed for, and is therefore different from the MRCGP curriculum in the UK.9 Each MRCGP[INT] examination is suitable for those candidates who plan to work in the country in which they sit the exam. They are locally developed and locally relevant, reflecting local epidemiology and medical practices.(9) This is because the practice of family medicine varies from region to region. Currently, the countries where one could sit for this exam are Cyprus, Dubai, Egypt, Kosovo, Kuwait, Malta, and South Asia. The MRCGP [INT] comprises of two exams including AKT and Objective Structured Clinical Examination (OSCE). On successful completion, one could become an International member of RCGP.

Post pandemic challenges

The Covid-19 pandemic has brought about several changes in the practice of a GP. One of the biggest changes has been the rise in telephone and video consultations. Surgeries are also using video calls to hold daily practice meetings with staff, and with local nursing homes. (10)

'Hot hubs' or red zones are being established. These are dedicated clinics to care for people with confirmed or suspected Covid-19 infection who also need treatment for other medical problems. In this way, they remain separated from non-Covid-19 patients in 'cold hubs' or green zones.(10) In some rare circumstances, a single 'hot room' within the practice has been set up which is decontaminated after use. Technology companies are providing video technology packages to GPs which can be used on personal mobile devices without exposing the clinicians' personal contact details. Several free webinars and online learning courses have been introduced by RCGP to support all returning GPs and primary healthcare professionals in the response to Covid-19.(11) The burden of non-Covid-19 diseases could be expected to escalate post this unprecedented pandemic. This would include routine presentations, treatment of long-term conditions, routine health checks, vaccinations, and cancer screening. Many health issues have been ignored by patients who have willingly delayed it due to the fear of either contracting the disease or causing a spread by being asymptomatic carriers. As the lockdown eases and the panic of Covid-19 lowers, there could be an exponential rise in health seeking.

In the next several years the health system could be expected to see a surge in the complications causally related to Covid-19 as well as long term sequalae, to be followed up and reviewed by the GP. The primary care and community health services will have to meet the immediate and long-term care needs of patients discharged following an acute episode of Covid-19.12 Patients with pre-existing health conditions may require immediate or long-term changes to the management of those conditions as a result of their Covid-19 episode.

Some of the long term sequalae of Covid-19 include lung fibrosis, thromboembolism, acute myocardial injury, heart failure, peripheral arterial disease, acute kidney injury, hospital acquired muscle weakness, chronic fatigue, and neurocognitive disorders. Furthermore, there could be psychological issues presenting as post-traumatic stress disorder, depression, anxiety disorders, psychosis, recurrence of longstanding mental health problems and insomnia, to name a few. There have also been reports of post-intensive care syndrome (PICS). (12)(13)

PICS refers to the health problems that persist after critical illness. They are present when the patient is in the ICU and may persist after the patient returns home. These problems can involve the patients physical self, thoughts, feelings, or mind and may affect the entire family as well. PICS may present as drawn-out muscle weakness (ICU-acquired weak-

ness); as problems with thinking and judgment (cognitive dysfunction); and as other mental health problems. (13) Besides the above-mentioned complications, dealing with situations of bereavement, financial, and job losses could have an impact on mental health. The stress of social distancing, shielding, having to self- isolate, staying away from family members, working from home, home schooling and changes from the normal routines might take a toll on the psychological wellbeing of an individual. These issues would be required to be dealt by the GP and be duly referred in some circumstances.

A potential second wave or local peaks of Covid-19 is being expected. With winter in a few months, it would only add up to the challenge. Winter is always a busy time for general practice, as it is across the NHS, because GPs deal with many patients suffering from flu and other common winter illnesses in the community.(14) A lot more research would be required to unfold the unknown facts of Covid-19 as it is still being
considered a young disease. In such a situation the demand for a GP could escalate and primary care would definitely benefit if the workforce is expanded.

Contribution of an International GP

In my view, the scope for a non-training job in general practice similar to that of other specialities, which currently does not exist could be a possible solution. The target doctors could be Internationally qualified GPs irrespective of their nationality. This coupled with adequate induction and supervision from an experienced GP, would be an excellent option to deal with the crisis. It would address the shortages in primary care, and also decrease the stress and burden on the NHS. It could prevent GP burnout considerably. Such a post would attract more International GPs both internationally and nationally (those who are already residing in the UK and do not qualify for the above-mentioned routes or have not opted to go through CEGPR), eventually increasing the GP workforce. This is a possible area where Internationally trained GPs could contribute effectively. IMGs (International Medical Graduates) have always been shown to be resilient, as they adapt to a new country, different policies and rules, the entire system, and the variegated culture and climate. The degree of resilience coupled with the skills of being bilingual or multilingual is an added advantage which could be used to deal with the diverse UK population.

Another contemplation could be to make use of the skills of MRCGP [INT] holders. They could possibly be considered for the Induction scheme. Alternatively, a new scheme could be created to bridge the gaps in training in order to match the UK perspective. Assessment examinations could be introduced and on successful completion of this, they could be enrolled in to a targeted training program prior to working as an independent general practitioner. Certainly, the expertise, knowledge, and experience of Internationally qualified GPs (irrespective of their country of origin and MRCGP [INT] holders), could be utilized to benefit the NHS, during these trying times. With the ongoing estimations of a second wave of Covid-19 this winter and with the ease of lockdown, it would be extremely advantageous to be prepared with an excellent workforce to combat the situation.

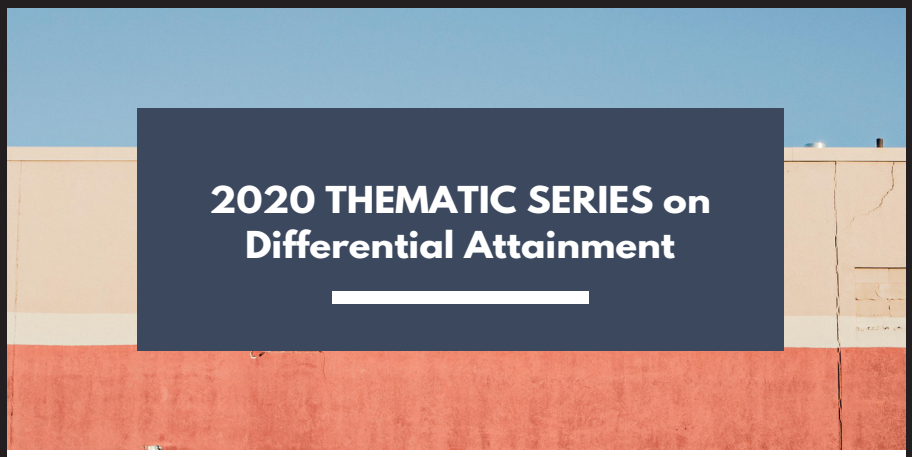
Conclusion

Extraordinary times require extraordinary measures. Careful planning and usage of the proficiencies and experiences of extraordinary Internationally trained GPs would definitely benefit the population in this hour of need.

References

1. General practice doctor job profile | Prospects.ac.uk [Internet]. [cited 2020 Jul 23]. Available from: https://www.prospects.ac.uk/job-profiles/general-practice-doctor
2. NHS England » About international GP recruitment [Internet]. [cited 2020 Jul 23]. Available from: https://www.england.nhs.uk/gp/the-best-place-to-work/international-gp-recruitment/about/
3. I&R (Eng) - Who can apply [Internet]. [cited 2020 Jul 23]. Available from: https://gprecruitment.hee.nhs.uk/Induction-Refresher/Who-can-apply
4. CEGPR [Internet]. [cited 2020 Jul 23]. Available from: https://www.rcgp.org.uk/training-exams/discover-general-practice/qualifying-as-a-gp-in-the-nhs/certificate-of-eligibility-for-gp-registration-cegpr.aspx
5. sat---ssg---general-practice---dc2298_pdf-48457725.pdf [Internet]. [cited 2020 Jul 23]. Available from: https://www.gmc-uk.org/-/media/documents/sat---ssg---general-practice---dc2298_pdf-48457725.pdf
6. Streamlined process for Australia (SPA) [Internet]. Royal College of General Practitioners; Available from: https://www.rcgp.org.uk/training-exams/discover-general-practice/qualifying-as-a-gp-in-the- nhs/streamlined-process-for-australia.aspx
7. The GP Training Programme [Internet]. [cited 2020 Jul 23]. Available from: https://gprecruitment.hee.nhs.uk/recruitment/training
8. General Practice ST1 [Internet]. [cited 2020 Jul 23]. Available from: https://gprecruitment.hee.nhs.uk/Recruitment/Applicant-Guidance/GPST1
9. International membership [Internet]. [cited 2020 Jul 23]. Available from: https://www.rcgp.org.uk/rcgp-near-you/rcgp-international/international-membership.aspx
10. Algorithm based smartphone apps to assess risk of skin cancer in adults: systematic review of diagnostic accuracy studies | The BMJ [Internet]. [cited 2020 Jul 23]. Available from: https://www.bmj.com/content/368/bmj.m127
11. Royal College of General Practitioners - Online Learning Environment [Internet]. [cited 2020 Jul 23]. Available from: https://elearning.rcgp.org.uk/
12. C0388-after-care-needs-of-in-patients-recovering-from-covid-19-5-june-2020-1.pdf [Internet]. [cited 2020 Jul 23]. Available from: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0388-after-care-needs-of-inpatients-recovering-from-covid-19-5-june-2020-1.pdf
13. SCCM | Post-intensive Care Syndrome [Internet]. Society of Critical Care Medicine (SCCM). [cited 2020 Jul 23]. Available from: https://sccm.org/MyICU-Care/THRIVE/Post-intensive-Care-Syndrome
14. Comprehensive plans to deal with winter pressures and potential COVID-19 second wave 'vital', says College [Internet]. [cited 2020 Jul 23]. Available from: https://www.rcgp.org.uk/about-us/news/2020/july/comprehensive-plans-to-deal-with-winter-pressures-and-potential-covid-19-second-wave-vital.aspx

Conflict of Interest
None declared



2020 THEMATIC SERIES on Differential Attainment

Recruitment

#Theme 1

all aspects of DA in recruitment from UG to senior roles

Assessment

#Theme 2

summative and formative assessments

Career Progression

#Theme 3

How DA affects career progression in medical professions

Leadership Roles

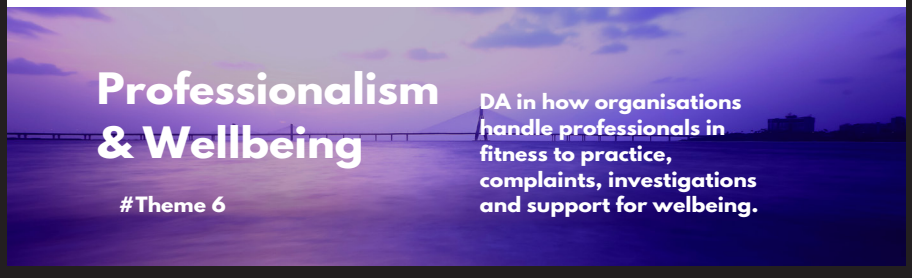
#Theme 4

Access to institutional or national leadership roles

Research & Academia

#Theme 5

DA in academic progression, research grants and publication



Professionalism & Wellbeing

#Theme 6

DA in how organisations handle professionals in fitness to practice, complaints, investigations and support for welbeing.

BAPIO Annual C

DAY 1 – Friday, 20 November 2020
In Collaboration with Health Education England: Global Engagement

09:00-09:25 Registration
09:25-09:30 Welcome
Chairman Organising Committee: B Simon &
BAPIO Chairman: JS Bamrah
09:30-10:30 Inauguration of British Indian Nurses Association
Chairman - C Marimouttou,
President - Ramesh Mehta
Lighting the Lamp to officially launch BINA
R May, Chief Nursing Officer, NHSE/I
Welcome Messages:
o H.E. G Kumar High Commissioner India
o Rt H. R Sunak MP, Chancellor Exchequer
o T. D. Kumar, President. Indian Nursing Council
o J White, Chief Nursing Officer, Wales
o N Evans, Chief Executive, HEE
o Dame D Kinnair, Chief Executive, RCN
o P Issar, Chief People Officer, NHSE/I
o Professor Roy K George, President TNAI
BINA – Progress Update: S Packiam, Secretary
10:30-11:10 Session 1: Career Opportunities/Journeys
Chairs: V Jadhav & L Macaden
Facilitator: S Jacob
• Staff Nurse to Dy Chief Nurse, England, NHSE/I: S Tranka
• Staff Nurse to Service Director: A Day
• Staff Nurse to Sn Lecturer: B Krishnamoorthy
11:10-11:20 Coffee break
11:20-12:00 Session 2: Covid-19 and the Nursing Workforce
Chairs: D Burton & M Pallam
Facilitator: R Metri
Impact of Covid-19 on Indian Nurses: M Radford
Challenges & Lessons Learnt: O Amadi
Inclusive & Compassionate Leadership: H Naqvi
12:00 -12:15 BINA: Video Messages
Vote of Thanks – K Swaminathan
12:15-13:00 Session 3: Passage from India to NHS:
Tales of Toil and Triumph
Chairs: R Murali & J Arayambath
Facilitator: J Jith
Nurse's perceptive: R Sanju
Doctor' observation: P Doddamani
Newly arrived Allied Health Care member:
13:00-13:25 Lunch Break Visit Sponsors' Booths
13:25-13:50 Session 4: An Introduction to HEE's Global Learners Programme
Chair: P Singhal & K Nisal
Facilitator: K Parvez
Speakers: D Keen & M Thompson
BTA Pastoral Care Programme for Nurses
Speaker: A Khandelwal
13:50 14:10 Keynote Address
Chairs: M Hemadri & M Ahson
Facilitator: K Pancholi
' International Healthcare Workers in the NHS play a Key Role in Ensuring Quality Patient Care'- G Byrne
14:10-14:25 Guest Speaker
Chairs: K Sidhu & V Patil
Facilitator: A Vijay
'Changing Role of Primary Care in Patient-centric Care'- M Lakhani

14:25-15:15 Session 5: Career Opportunities in a Multi Professional Working Environment
Chairs: A Sajayan & S Periyasami
Facilitator: G Ravi
Nurse Consultant – A Thomas
Physician Associate: N Esat
Pharmacist: M Patel
From Therapist to Adv Care Pract: R Pothini
15:15-15:25 Coffee Break
15:25-16:25 GAPIO Session: How Covid-19 has changed the world
Chairs: Professor A Sibal (India) & A Hiremath
Facilitator: F Hamza
UK: F Rizvi
AAPI: S Jonnalagadda
Australia: S Chaturvedi
American University of Antigua: N Simon
Canada: A Garg
Panel discussion
16:25-16:30 Vote of Thanks: Mala Khiroya

Conference 2020

Day 2: Saturday 21 November 2020
AURORA
The Dawn of a New EraDelivering Patient-centric Care

09:00 – 10.00 Registration
10:00 – 10:45 MAIN AUDITORIUM
Welcome: Convener, Organising Com; V Jadhav
Chairman BAPIO - JS Bamrah
Inauguration Presidential Address – R Mehta
Lighting the Lamp
Guest of Honour, HE G Kumar, HC India
Rt H. M Hancock MP, Secretary of State Health & Social Care (TBC)
Rt Hon. Lord Kakkar PC, Chair, King's Fund
10:45: 11:15 Session 1: Circum COVID
Chairs: G Menon & R Mappilakkandy
Facilitator: M Vadakkayil
Impact of COVID on British Asians- K Khunti
New challenges for doctors - C Nagpaul
Impact on mental health – Dame Clare Gerada
11:15-11:30 Guest Lecture
Chairs: K Chand & A Deodhar
Facilitator: R Jha
"Fighting COVID - what we are learning about building a truly equitable and inclusive health service for all"
Baroness Dido Harding, Chair NHSI, Interim Executive Chair, National Institute for Health Protection.
11:30-11:35 Coffee Break
11:35 – 12:25 Session 2: Mind the Gap!
Chairs: S Mathew & M Zaman
Facilitator: A Nair
Making gender equality count: Dame J Dacre
Equality in academic world: N Canagarajah
Race equality myth buster: M Rao
12:25-12:45 Launch of BAPIO Training Academy Initiatives
Chair: V Daga
International Fellowship Scheme (2+2) P Singhal
Teleheal Charitable project - W Arian
12:45-13:15 Lunch, Poster Viewing and Visit Booths
13:00 -13:30 Quilter Session
Chairs: A Shah & A Chopada
'Getting your finances right' –TBC
13:30 – 14:00 MAIN AUDITORIUM Guest Lectures
Chairs: J Grover & J Mangwani
Facilitator: S Sunil
GMC's Role in Tackling Racism & Discrimination in the Medical Profession - C Massey
Tackling Systemic Inequalities in NHS - I Singh
14:00 to 16:00 RESEARCH HUB | PARALLEL SESSION (2 hours)
Research & Innovation Presentations
Chairs: S Daga & N Reddy
Facilitator: C Joseph
Short listed candidates will present their research to a panel of judges to select 4 winners who will be invited to do presentations in plenary session on Sunday.
14:00 -14:45 MAIN AUDITORIUM
Session 3: Initium Novum, novus challenges!
Chairs: S Chakravorty & R Krishnamoorthy
Facilitator: AP Mendonca
Health impact on children and adolescents - R Viner
Health care delivery challenges in the virtual world -R Patel
Evolving Medicine in changing world – A Goddard
14:45-15:00 Coffee Break
15.00 -15:30 Session 4: Futurum doctrina
Chairs: V Patel & S Agarwal
Facilitator: A Zubair
Training Priorities in the new era - H Stokes-Lampard
Supporting Learning and Learner wellbeing in the virtual world - S Gregory
15:30-16:00 Session 5: Caring for the Workforce
Chairs: R Sinha & M Mohamed
Facilitator: M Ramakrishnan
Changing boundaries of healthcare workforce – G Byrne
Evolving Priorities for Women in the NHS - N Modi
16:00-17:00 The Leadership: To be led or not to lead, is it our destiny?
Chairs: Muralidharan & J Srinivas
Facilitator: N Jacob
Leadership perspectives and Aspirations:
Junior doctor - A Arif
Junior Nurse -K Patel
Reflections of an Asian leader: K Singh
How did I do it: N Evans
17:00-17:05 Vote of Thanks: Rakhee Saxena
18:00 Awards and Entertainment –
Archana Nair & Rahul Jha

BAPIO Annual Conference

Day 3 Sun 22 Nov 20

09:30 – 10.00 Registration
10:00 – 10:05 Welcome:
R Mappilakkandy, Director, E Midlands BTA.
V Daga, Dir Med Edu, BTA
10:05 – 10:35 Session One: How Training has changed in COVID times?
Chairs: M Zaman & V Gupta
New Training init: N Scarborough / M Bakhai
Adaptation to pre-exciting training: T Kapasi
10:35-11:05 Work Shops
Parallel Sessions
1: General Practice Training
Chairs: A Rajimwale
GP Training – Professor Fahad Rizvi

2: CESR Preparation
Chair: R Jainer & P Gupta
CESR Successful applic – F Macdonald (GMC)

3: How to build a successful portfolio?
Chair: A Rashid
Portfolio as a tool for success – A Farooqi

4: Nurses Career Progressions options
Chairs: S Packiam
Nursing portfolio – A David & S Sundersingh

11:05-11:15 Coffee break
11:15-12:00 Parallel Sessions

1: Leading with Compassion: H Mancini

2: Secrets of getting funding and publications; M Pareek, I Brown - Publication
R Prasad & B Ochieng – Funding

12:00-12:45 Parallel Sessions

1. Mentoring and Coaching - M Roshan & A Prasad
2. Mental wellbeing and Mindfulness
Mindfulness - C Sanders
Wellbeing – Leading the change that matters - Z Kapasi

12:45-13:15 Lunch Break

13:15-14:15 The Research Plenary
Chairs: I Chakravorty, D Patel & A Doshani

14:15 to 15:00 BIHR Bridging the Gap – Differential Attainment
Chair: A Goddar
Moderator - M Fisher, S Chakravorty & S Sharma
Theme Presentations followed by discussion on Solutions
Themes: Recruitment, Assessment and Career Progression

15:00 to 15:15 Coffee break

15:15 to 16:00 BIHR Bridging the Gap – Differential Attainment
Chair: S Carr, Deputy Medical Director GMC
Moderators: M Fischer, S Chakravorty
Research/Academia, Leadership & Excellence and Professionalism
16:00 to16:15 Research winners and Prizes
Chairs: G Menon & P Singhal
Moderator: S Daga

16:15-16:30 Closing Remarks:
F Rizvi, Vice Chair Conference Committee
Vote of Thanks: B Simon, Chair, Org Committee
V Jadhav, Convenor, Org Committee

BAPIO Annual Awards
Healthcare Excellence

Nurse of the Year	Hansa Nair
BAPIO Women's Role Model	Nithya Krishnan
Doctor of the Year	Amit Kochhar
COVID-19 Award	
Service to Stranded docs	Raka Maitra
	Shevonne Matheiken
	K Gajanan
	Samir Shah
	Emmeline Lagunes Cordoba
	Kabir Garg
	Arun Enara
Outstanding Contribution to Diversity and Equality	Sir Simon Stevens
Professional Excellence	Anil Mane
	Gordon Bannister
Imran Yousaf Memorial	Arpan Mehta
Outstanding Service to BAPIO	Fahad Rizvi
Quilter award Young Leaders	Nikhil Aggarwal
	Shyam Gokani
President's award for Philanthropy	Ritu Chhabria
Excellence in Leadership:	David Carter
	Martin Barclay

Protocol for Thematic Synthesis of Differential Attainment in the Medical Profession

'Bridging the Gap' Series

Alliance For Equality In Healthcare Professions

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Differential Attainment is a phenomenon, recognised globally, where certain cohorts of people tend to have poorer career outcomes based on factors other than capability, academic effort or motivation. Although by no means unique to or exclusive to, it is indeed well described and monitored in the health education/ training, and affects professionals throughout their entire career journey from admission to retirement. It is a marker of an unfair system and affects individuals as well as organisations adversely. It is the responsibility of all organisations, policy makers and regulators to urgently understand the causes, find solutions and support those that are disadvantaged as a result of this inequality.

The British Association of Physicians of Indian Origin addressing its declared mission of achieving excellence through promoting equality and diversity, along with its collaborative partners and a panel of international experts has created an Alliance for Equality in Health Professions. This Alliance will spearhead a thematic analysis of the entire spectrum of differential attainment in medical professions.

This paper describes the protocol for the thematic synthesis of evidence, the priority setting partnerships for undertaking a critical integrative analysis and the process for combining evidence from experts with lived experiences of grassroot professionals to produce meaningful solutions, actions and policy enablers. The output will be published as a series of papers in Sushruta and culminate in a seminal report in 2021, when BAPIO turns 25.

Keywords; Differential attainment, BAPIO, Alliance for Equality in Health Professions, Thematic synthesis

Background

It is recognised that there is inherent inequality in many aspects of education, training, career progression or handling of human resource procedures/ protocols, and disparity in the experience of different people within the health professions, based on factors which are beyond an individual's ability, motivation or engagement. (1,2) Differential Attainment (DA) is defined as the observed gap in the achievements of different cohorts of individuals based on factors beyond their individual ability. It exists globally, in both undergraduate and postgraduate contexts, across exam pass rates, recruitment and progression/ outcomes and can be an indicator that training and medical education may not be fair. These include differentials connected to age, gender, race, ethnicity or other diverse characteristics and experiences. The UK General Medical Council and 'fair society' standards require training pathways, assessment and opportunities to progress, should be fair for everyone.(3)

Since 2014, when British Association of Physicians of Indian Origin (BAPIO) led a legal challenge against the Royal College of General Practitioners there has been a seismic shift in transparency and reporting of differential attainment data for many examinations and specialty progression reports.(2) Acting on the recommendations of the independent commission on DA, led by Professor Esmail, GMC, Association of Medical Royal Colleges (AoMRC), Medical Schools Council, Health Education England have undertaken a multi-pronged approach from reviewing of curricula, training of examiners/ surrogates, and investing in enablers within different regions for bridging the DA gap. (4,5)

However, sequential data from 2015-2020 suggests that there is little progression achieved so far in bridging this gap. There are many areas of uncertainty and much more research is needed. There have been two major events in 2020, which have exposed the devastating impact of societal inequalities on both lives and livelihoods (#COVID-19) and the persistence of disparities in society as a whole (#BlackLivesMatter).(6,7)

Five years on from the landmark ruling in 2014,(8) BAPIO working with its alliance partners is keen to pursue its mission to achieve equality through bridging the gap(9) DA Change Lab thematic synthesis. (10)

This project will start with focus on the medical professionals (doctors) and then we hope to expand our learning and solutions to encompass the full multiprofessional spectrum of healthcare professions. Through a series of roundtables and workshops, the 'Alliance for Equality in Health Professions' (AEHP) chaired by BAPIO will engage in exploring the achievements and challenges in implementing equality in medical education and training. The output will be a seminal paper (Bridging the Gap)(11) to be presented in 2021 when BAPIO celebrates 25 years of contributions to healthcare. This will include a comprehensive, systematic review of the evidence to date for causes and solutions and recommendations for further research, policy enablers and actions for individual organisations.

Aim

The purpose of this review is to conduct a thematic synthesis to identify high-level messages and themes from an exploration of the current literature, data (published and unpublished) on DA, capture the lived experience from the grassroots, measure broad impacts on the individual, organisations and society, deliberate the evidence with subject experts and, finally seek solutions to recommend or implement at different levels including policy change.

Only a few broad research questions will be adopted at the outset, as the researchers will allow for the themes and messages to emerge organically as the review progresses, rather than setting highly specific research questions. There are six broad sections of the journey of medical professionals which will be explored through this exercise. (1) recruitment, (2) career progression, (3) assessment, (4) leadership roles, (5) research & academia, (6) professionalism and wellbeing.

Governance

Each of the above six themes will have leads appointed by consensus. The section leads will create a priority setting partnership, direct and supervise the literature review, manage the thematic analysis, the data categorisation, writing of the scoping document and producing the draft recommendations. Overall coordination of the work of each team, compliance and adherence to the agreed protocol, timely delivery of documents and facilitation of the engagement (roundtables, workshops and focus groups) will be managed by dedicated coordinators.

The editorial team will be responsible for all documents including the coordination, editing and publication of all output in Sushruta Journal of Health Policy.

Themes

I Recruitment
Undergraduate, Postgraduate, Specialty, Consultant

II Career Progression
Trainees, Specialty & Associate Specialty doctors, Clinical Fellows, Primary Care & Consultant

III Assessment (Formative & Summative)
Undergraduate & Postgraduate, PLAB/ Medical Licensing, CESR-CCT

IV Leadership Roles & Recognition
Clinical, Management, Educational & Clinical Excellence

V Research & Academia
Appointments, Grants, Academic Promotions & Publications

VI Professionalism & Wellbeing
Disciplinary Pathways & Process, Bullying & Undermining, Impact & support

Table 2: Grassroots members/ organisations

(Allied Health Professionals including Nursing & Midwifery)
Academic Lecturers/ Educational Fellows
Consultants, Tenured academics: professor/ /associate professor/assistant professors/ reader/senior lecturer/lecturers
International medical graduates
Locally employed doctors/ Locum doctors (or those between specialties or in a career break)
Out-of-Programme doctors
Physicians Associates
Postgraduate Doctors in Training
Primary Care (General Practitioners/ Partners/ Salaried; GP Registrars) including those in Public Health
Research Fellows/ Teaching fellows/ Clinical Lecturers/ Academic Fellows
Speciality & Associate Specialist doctors
Undergraduate (MBBS) students
Widening Participation students/ doctors

Priority Setting Partnerships
Similar to the process defined in the James Lind Alliance (JLA) model, a series of formal broad based, balanced and representative collaborations will be set up with members from the grassroots, organisational stakeholders and subject experts for each of the six focus areas. It is a vital aspect of this work and will ensure the production of educationally-relevant research that is strategic and inter-disciplinary in its approach therefore delivering benefits to all medical professionals affected by DA, their peers and essentially for patients. Process Map
The following seven steps will be carried out (1) setting the research question, (2) searching the literature (3) sampling of quantitative and qualitative data (4) determination of potential impact (5) thematic synthesis, (6) developing a consensus and (7) producing the final paper via expert peer review including solutions. (figure 1)
Defining the Research Question
Using JLA principles, subjects, stakeholders and researchers will work together to agree which, among the uncertainties, matter most and deserve priority attention. Research on the effects of interventions often overlooks the shared interests of people most affected by them. As a result, questions that they all consider important are not addressed and many areas of potentially important research are therefore neglected. Even when researchers address questions of importance to subjects and scientists, they often fail to provide answers that are useful in practice. Hence using the same principles, we will ensure that the research questions provide the evidence needed to develop impactful solutions which will address the persistent mismatch which exists between the performance of medical professionals irrespective of their academic potential, motivation or effort.
Literature Review
Preferred reporting items for systematic review and meta-analysis protocol (PRISMA P) guidelines (12) will inform the protocol for the current review with divergences from the guidelines implemented to meet the specific needs of the review. The main focus of the review will be qualitative, however, quantitative data may emerge during data extraction and will be incorporated. Such data may include demographics and sample sizes from the studies and a tabulation of the frequency of products from the studies, which will be included in the synthesis. Our approach will synthesise both qualitative and quantitative data, as a critical interpretive synthesis (13), utilising purposive sampling rather than the traditional inclusion criteria to determine higher-order messages rather than produce an integrative review (14) of research in DA.
A purposive structured search will be carried out in an exhaustive manner to ensure that all relevant materials are collected. In the context of the current review, materials include conference presentations, study protocols, published peer-reviewed papers/abstracts, unpublished manuscripts, internal symposia, tweets/LinkedIn/ ResearchGate/Facebook information, workshops/ masterclasses, documents related to archived datasets, newsletters and feedback to participants.
An infographic would be designed by the research team as a means to launch each theme of the project to all the relevant stakeholders, international expert community and invited theme leaders from each section of the project to send the authors their dissemination materials.
The most recent annual reports for organisations will be screened as a means to gather citations of all reported dissemination activities including published and in preparation peer-reviewed papers and abstracts. Any posters or oral presentations presented at national and international conferences, workshops or seminars that are referred to in the annual report will be recorded and sought from the researchers.
Traditional literature search methodology using differential attainment, outcomes and names of all researchers will be used as the search terms using ScienceDirect, PsycInfo, CINAHL and PubMed. The researchers in the Alliance will also be contacted to provide unpublished manuscripts, abstracts, and theses (where applicable) that arose from aligned projects. The Twitter pages, ResearchGate and LinkedIn profiles of all the researchers will be collected and recorded and their accounts searched for any discussion or comments related to the DA projects. Where necessary, freedom of information (FOI) requests will be made to all educational, regulatory or academic organisations responsible for designing, implementing careers, delivering assessments, managing curricula, and employers relevant to the journey of medical professionals.
A database of all dissemination materials and products will be created once all items have been gathered. Materials collected during sampling will be recorded using a Microsoft Excel database.

Sampling
No eligibility criteria for the studies will

be applied since all data production is considered relevant. Given the exclusive nature of the search to DA projects, quality appraisal techniques (15) will be applied to the materials to ensure rigour in the selection of materials and products collected in the search stage.

Determination of Impact

All documents and data generated through the search will be categorised on two levels (e.g., high or low) with greater weight assigned to those materials identified as high. The features of this categorisation will include for instance the level of detail of content contained in the product in relation to DA or the type of content included in the materials (e.g., results of a study). Decisions regarding categorisation will be dependent on the content of the materials collected and will be made as the appraisal process is on-going and will be discussed by the authors with the thematic leads and the relevant members of the expert panel throughout the review process. Materials may be eliminated from the review during this stage if they are deemed to not be relevant to the review.

Thematic synthesis

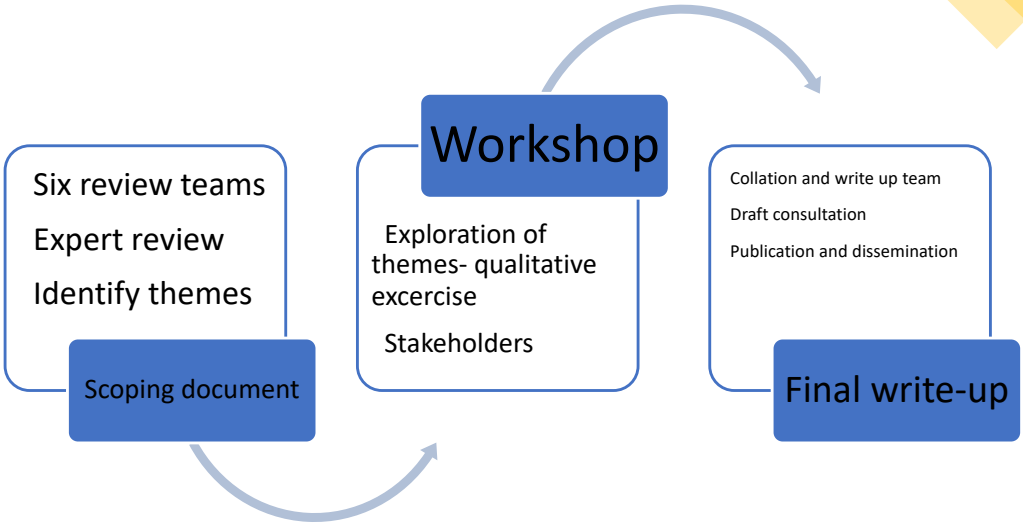
The data that emerge from data extraction will be subjected to thematic synthesis. (16) Similar to analysis of primary qualitative datasets, thematic synthesis involves the systematic coding of data and generating of descriptive and analytical themes. It is an inductive approach which is critical given the aim to generate higher-order themes and key messages from the projects. It is a three stage process (17) which begins with line-by-line coding of text where findings from the materials collected will be entered word-for-word into the database and each line of text will be coded according to its meaning and content. Following this step is the development of descriptive themes which involves translating the concepts from one study to another and a hierarchical structure will be created by grouping the codes based on similarities and differences between the codes. Finally, the generation of analytical themes that go beyond the content of the original articles is a critical stage where descriptive themes are used to determine the key messages. Themes and messages will be reviewed independently to consider implications and then discussed as a group to allow for the emergence of more abstract messages and themes that go beyond the content in the original materials.

Scoping Document

The result of the literature review, categorisation and determination of potential impact will result in a scoping document which will provide both a broad overview of the current state of art, sampling of relevant evidence (quantitative and qualitative) and extent of impact to stakeholders. The authors working with section leaders will then generate a draft list of potential solu-

Table 4: Causes of Differential Attainment

I	Educational	
		Learning styles (problem based/ taught/ self-directed)
		Access to resources, guidance or tutoring
		Schooling (independent or state)
		Impact of economic status on educational opportunity
		Parental/ family (influence of parental education, support, expectation or motivation)
		Assessment (multiple choice, viva, observed clinical assessments)
		Impact of unrecognised dyslexia or dyspraxia
II	Cultural	
		Linguistics (IELTS)
		Previous life experiences
		Conflict/ refugees
		Societal norms/ expectations (introvert vs extrovert)
		Influence of reverence of those more senior or in authority
		Segregation (wilful or forced)
III	Bias	
		Racial, ethnicity, gender, disability
		Impact of illness or health impairment
IV	Support	
		Family, friends
		Formal supervision
		Mentorship
		Networking
V	Economic	
		Deprivation
		Access to bursaries
		Cost of examinations/ preparation
		Family responsibilities
VI	Others	
		Health (physical/ mental)
		Immigration related stresses
		Wellbeing, Stress and Burnout
		Caring responsibilities



tions, recommendations or a gap analysis. This scoping document will then be presented to all stakeholders (grassroots to organisations) for deliberation.

Developing a Consensus

The next stage will be a process of deliberation through a series of invited roundtables, thematic workshops and focus groups where the evidence presented in the scoping document and the draft recommendations/ solutions will be subjected to a defined process of rigour by independent facilitation and a consensus document produced.

Before each roundtable or workshop discussion, the section leads will present a defined set of issues to discuss based on thematic synthesis to the participants prior to the session. At the session, there will be a predefined amount of discussion time allocated for each of the agreed themes.

The discussions will be solution focussed and the outcome will be expected in the format of (a) well defined action, (b) recommendation, (c) policy or (d) area for further research/ evidence gathering/ pilot project.

All discussion and deliberations for each of the roundtable, workshops or focus groups will be transcribed, thematically analysed, synthesised and incorporated into the pre-final document.

Peer review
The final stage of the process will involve a peer review of the pre-final document by our invited expert panel, and comments integrated to produce the final consensus paper.

Discussion/ Limitations

This thematic review is designed to be the first comprehensive synthesis of the broad spectrum of differential attainment in the medical profession for more than a generation. Although the concept of differential attainment has been recognised for over three decades now, there has been little if any tangible progress, as highlighted in the Ottawa consensus statement in 2018. (18)

This review is ambitious in its scope and remit but also realistic in recognising that the need of the hour is to be solution focussed and to prioritise areas for quick interventions that is important to the stakeholders (those that are personally impacted by DA and organisations that are responsible to provide equality and diversity in their processes).

Ultimately, this desire to offer a 'level playing field' is critical for a fair society, supportive professional excellence and sustainable, and safe healthcare delivery to our patients. (19) Based on the ideals

of our priority setting partnerships, this review will pick and explore areas in depth as determined by our collaborators and to provide the maximum impact to the profession.

Hence, it is not designed and neither aspires to be an exhaustive systematic analysis nor aim to cover every minutest aspect of differential attainment that may exist on a theoretical framework. This review will cover every aspect as deemed important from our exhaustive engagement with stakeholders and as categorised by our international expert panel. Hence, it is highly unlikely that this review will miss any aspect of DA that may have an impact.

We propose that to provide practical guidance, moving beyond single-site, single method analyses and acknowledging that DA is a complex, multi-level, dynamic phenomenon. Accordingly, we must expand our methodological approaches acknowledging the interaction between selection methods, progression and the philosophy as well as policy-making in relation to medical education and training. Solutions that emerge from our consensus process should use sophisticated evaluation approaches and theoretical frameworks to better inform those involved in education, training and medical careers regarding how to best deal with issues such as the weighting and sequencing as well as addressing diversity and workforce shortages. (18)

This responsibility of ensuring that medical education, training, or careers offer equality, celebrate diversity and combine professionalism with nurture, rests with the regulators whose duties are enshrined in law and enacted through parliament. Hence, from the outset the review team are engaged in working closely with our regulators both in the UK and internationally to support them in delivering their legal responsibility to the public. And, through them we will aim to inform and engage with the lawmakers, where policy changes/ enablers may be required.

Dissemination plan

One means for researchers to effectively target specific knowledge users is with clear and concise messages aimed at a specific audience delivered in a way that the recipients want and that are supported by a credible body. The results of the current review will be targeted at a range of stakeholders and knowledge users such as researchers, health and social care professionals as well as users. A dissemination plan based upon the model developed by will be implemented and involve messages and themes identified transmitted in a series of short videos, podcasts, policy briefs and newsletters with specialist input from key stakeholders such as researchers, practitioners, policy makers and users and carers of palliative care services.

References

1. Woolf K, Viney R, Rich A, Jayaweera H, Griffin A. Organisational perspectives on addressing differential attainment in postgraduate medical education: a qualitative study in the UK. BMJ Open [Internet]. 2018 Mar 9 [cited 2020 Jan 21];8(3). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5855204/
2. General Medical Council (Great Britain). The state of medical education and practice in the UK, 2014. [Internet]. 2014 [cited 2020 Aug 1]. Available from: http://www.gmc-uk.org/SOMEP_2014_FINAL.pdf_58751753.pdf
3. Woolf K. Fair Training Pathways for All: Understanding Experiences of Progression - Final Report. :69.
4. Iacobucci G. Specialty training: ethnic minority doctors' reduced chance of being appointed is "unacceptable". BMJ [Internet]. 2020 Feb 12 [cited 2020 Aug 18];368. Available from: https://www.bmj.com/content/368/bmj.m479
5. Linton S. Taking the difference out of attainment. BMJ [Internet]. 2020 Feb 12 [cited 2020 Jul 8];368. Available from: https://www.bmj.com/content/368/bmj.m438
6. Why are more black and minority ethnic people dying from Covid-19 in hospital? – Race Equality Foundation [Internet]. [cited 2020 Aug 1]. Available from: https://raceequalityfoundation.org.uk/health-care/why-are-more-black-and-minority-ethnic-people-dying-from-covid-19-in-hospital/
7. Black Lives Matter. In: Wikipedia [Internet]. 2020 [cited 2020 Aug 6]. Available from: https://en.wikipedia.org/w/index.php?title=Black_Lives_Matter&oldid=971334380
8. R (BAPIO) v Royal College of General Practitioners & General Medical Council [2014] EWHC 1416 (Admin) [Internet]. Equally Ours. [cited 2020 Aug 18]. Available from: https://www.equallyours.org.uk/0033-r-bapio-v-royal-college-of-general-practitioners-general-medical-council-2014-ewhc-1416-admin/
9. The Physician- Academic Journal for Healthcare Professionals [Internet]. [cited 2020 Aug 18]. Available from: https://www.thephysician.uk/differential-attainment-themes-contribute
10. Chakravorty I, Bamrah JS, Mehta R. A Rainbow Paper - Tackling inequalities, a neo-liberal order in a world after Corona. Sushruta Journal of Health Policy & Opinion [Internet]. 2020 Aug 6 [cited 2020 Aug 18];13(3). Available from: http://sushrutajnl.net/index.php/sushruta/article/view/88
11. Campaigns [Internet]. BAPIO | British Association of Physicians of Indian Origin. [cited 2020 Aug 6]. Available from: https://www.bapio.co.uk/differential-attainment-in-healthcare-professionals/
12. Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. Systematic Reviews. 2015 Jan 1;4(1):1.
13. Critical interpretive synthesis: what it is and why it is needed | Colloquium Abstracts [Internet]. [cited 2020 Aug 18]. Available from: /2006-dublin/critical-interpretive-synthesis-what-it-and-why-it-needed
14. Beyea SC, Nicoll LH. Writing an integrative review. AORN Journal. 1998;67(4):877–80.
15. Ting DK, Boreskie P, Luckett-Gatopoulos S, Gysel L, Lanktree MB, Chan TM. Quality Appraisal and Assurance Techniques for Free Open Access Medical Education (FOAM) Resources: A Rapid Review. Seminars in Nephrology. 2020 May 1;40(3):309–19.
16. Nicholson E, Murphy T, Larkin P, Normand C, Guerin S. Protocol for a thematic synthesis to identify key themes and messages from a palliative care research network. BMC Res Notes [Internet]. 2016 Oct 21 [cited 2020 Aug 8];9. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5073737/
17. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med Res Methodol. 2008 Jul 10;8:45.
18. Patterson F, Roberts C, Hanson MD, Hampe W, Eva K, Ponnamperuma G, et al. 2018 Ottawa consensus statement: Selection and recruitment to the healthcare professions. Medical Teacher. 2018 Nov 2;40(11):1091–101.
19. Differential attainment [Internet]. [cited 2020 Aug 18]. Available from: https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment

Differential Attainment in Summative Assessments within Post-graduate Medical Education & Training

2020 Thematic Series on Tackling Differential Attainment in Medical Professions

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Summary

This discussion paper has been prepared for the expert roundtable exploring the 'Differential Attainment in PG Medical Education and Training' planned for 17 September 2020. This will be the first engagement exercise launching the 2020 Thematic series on Tackling differential attainment in Healthcare professions, bringing together an interdisciplinary Alliance on equality in healthcare professions.

This paper presents a preliminary outline of the current evidence on differential attainment in high stakes postgraduate summative assessment, explores its impact, deliberates on known causes and discusses a number of potential solutions. This paper is written with a view to present the case for tackling DA in PG summative assessments and will be accompanied by a prioritised selection of 'focused questions and solutions' to be discussed at the roundtable with subject experts.

This paper and roundtable will form part of, and contribute to the thematic synthesis in the section on 'Assessment - formative and summative'. Therefore, as described in the 'protocol', will be followed by a focused systematic review, engagement with priority setting partnerships (via questionnaires, focus groups and workshops) and culminate in an expert consensus. The final outcome will be presented as synthesized recommendations, solutions, policy enablers and areas for further research.

Keywords
Differential Attainment; Summative assessments; postgraduate medical education;

What is Differential Attainment?

Differential attainment (DA) is a term used to describe the variations in levels of educational achievement that occur between different demographic groups undertaking the same assessment. UK doctors from Black and Minority Ethnic (BAME) groups, and International Medical Graduates (IMG) i.e. doctors whose Primary Medical Qualification (PMQ) is from a medical school outside of the UK have, consistently, poorer outcomes in assessments and recruitment compared to white doctors and UK medical school graduates. 1 2 Differential attainment has been recognised as a challenge for medical professionals and educators since the 1990s.

How big is the problem?

Ethnic minority medical graduates in the UK have 2.5 times higher odds of failing high-stakes exams. 3 Summative assessments for the membership of the Royal Colleges of Physicians (MRCP), General Practitioners (MRCGP) and Psychiatrists (MRCPsych), amongst others have shown a consistent medium sized ethnicity effect and a larger country of PMQ effect. This translates to a 10-15% gap in pass rates for UK BAME candidates and a larger approximately 30-50% gap in pass rates for IMGs. The CSA – Clinical Skills Assessment exam of the Royal College of General Practitioners has a number of specific issues which makes the issue of DA particularly problematic.

Impact of COVID-19

COVID-19 pandemic led to cancellation of both applied knowledge test (AKT) 4 and Clinical Skills Assessment (CSA)5 and alternative solutions being considered. After concerns from General Practice registrars (GPRs) and various organisations including British Association of Physicians of Indian Origin (BAPIO), the RCGP has provided an interim alternative to the CSA in form of Recorded Consultation Assessments (RCA).5 This format involves recording thirteen consultations i.e. same number as CSA of in audio, video or face-to-face format and submitting it to the panel of examiners, who will carry out objective assessments using same criteria as used in the CSA.6 The advantage is that the GPRs can select from the consultations carried out in their own surgery environment rather than in an artificial environment that involved actors.

Although understandably, this is posing some logistical challenges for the trainees, especially those working remotely due to personal risks such as pregnancy or other health conditions, this format may well give a basis or a 'trial run' of an alternative option. There is also concern that the CSA may well be an outdated method of assessment and not reflective of the changing nature of general practice.7 8

Why is Differential Attainment a problem?

Moral and Ethical Impact

Clearly, the significant attainment gap based on ethnicity (and country of origin) poses a significant social justice issue. The fact that these attainment gaps have persisted for decades with no institutional redressal, compounds the ethical and moral problem and makes the case for urgent remediation.

For IMGs, whose visas or permission to remain in the UK may be dependent on exam success, this creates uncertainty, economic instability, anxiety and undue distress. In practice, the attainment gap serves to multiply the microaggressions that BAME students, trainees and staff face in clinical and educational settings. 9 BAPIO has received testimonies from a large number of individuals where exam related stress has been specifically identified as a source of great personal and professional difficulties. 10

Workforce and Financial Impact

Around a third of UK medical students (n ~ 11000) and graduates (who are not Consultants or GPs) are of BAME origin (n ~ 28000).11 IMGs also constitute a very large part of the workforce and especially so in some specialities such as Psychiatry and General Practice where they constitute >35% of the workforce.12 In 2019, the number of IMGs entering the General Medical Council (GMC) register exceeded the number of UK graduates. 13 These numbers illustrate the scale and extent of the impact of DA.

The inevitable necessity of the UK National Health Service (NHS) in depending on IMGs to deliver patient care is evident also in the high number of vacancy rates across the country in many clinical specialties, in various geographical locations and in the high cost of providing locum cover to run essential services.14 If clinical examinations prove an unfair barrier to career progression, this may represent a significant workforce challenge with direct adverse impact on patient care.15 Furthermore, the costs of failure in high stakes examinations costs (approximately £65,000 per failure) pose huge economic burden in further education and ancillary costs and organisational level. 16, 17

Impact on Patient Care

A sense of equality among health workers translates to better team working which inevitably leads to better patient outcomes and satisfaction for the organisation. It is known that the proportion of staff believing the employing organisation provides equal opportunities for career progression or promotion "was a very important predictor of patient satisfaction." 9 Unfortunately, BAME staff routinely report microaggressions at work.18

However, there is currently little evidence linking success or failure in high stakes exams with a direct or indirect impact on patient care and safety 19 there may even be evidence to the contrary, demonstrating that overseas trained IMGs delivered improved patient outcomes. 20 Moreover, there are concerns on the OSCE (Objective Structured Clinical Examination) as a valid assessment reflecting clinical reality particularly in certain specialties. 21

Given the multicultural and diverse population in the UK, it is important to address inequalities in medical education and training to ensure patients can benefit from an ethnically diverse medical workforce. 22

Legal Impact

Mr Justice Mitting's ruling in the BAPIO vs. RCGP legal action has clearly indicated that providers and standard setters of education and training viz.

Health Education England, Deaneries, Health Boards and Royal Colleges in the UK are subject to the Public Sector Equality Duty and hence have a legal and regulatory obligation to monitor and tackle inequalities. 23

Causes of DA in PG Medical Assessment

Several factors have been implicated as causative or contributory in DA. Prior educational attainment generally predicts future academic attainment, but multivariate analysis of data shows that DA in medical school finals persist even after accounting for prior educational attainment. DA persists even after accounting for socio-economic deprivation. In fact, ethnic differences in attainment persist even after controlling for type of school, personality, motivation, study habits and mental health of candidates as well as linguistic ability, often cited as a cause for DA. Ethnic differences in attainment persist after controlling for one's own first language and parents' first language. 24

There are a range of factors related to either the examination itself or to the training environment leading up to the examination that may explain DA. IMGs often face additional difficulties which impede examination success due to differences in educational experience, content familiarity and language, some of which may be potentially amenable to modification or additional support.25

Apart from the factors that have been ruled out (see above), possible candidate factors that have been implicated include relationship with peers, relationship with educators, the presence of undiagnosed and undetected learning disability such as dyslexia and undue pressure from expectations of passing/failure. 24

Factors relating to examinations may include unconscious or conscious bias in examiners, in the recruitment of examiners, in the choice of exam questions or case selection for OSCE stations or in standard setting and/or applying the set standards in the exam. 26, 27

Are summative exams unfair?

Esmail and Roberts' study analysing the data of academic performance of ethnic minority candidates and discrimination in the MRCGP examinations between 2010 and 2012 showed that, even after controlling for performance on the machine-marked AKT, ethnic minority UK graduates were nearly four times and international medical graduates 14 times as likely to fail their first CSA attempt as white candidates. The authors concluded that "subjective bias due to racial discrimination in the CSA may be a cause of failure for UK trained candidates and IMGs. 28, 29

However, in the courts the examination was judged lawful. Others too, have argued that DA is indicative of a true attainment gap based on consistent and correlated DA seen in candidates taking both MRCGP and MRCP (UK) exams 30 31 lack of proven ethnicity or gender bias in examiners in MRCP exams on two-examiner stations 32 or the lack of proven role player bias in CSA exams. 33 It is indeed worth noting that gender or ethnicity bias have not been disproven in single examiner stations. Unconscious bias training often provided to examiners and role players to mitigate against DA has proved to be ineffective 34 and while systematic review evidence suggests that discrimination is unlikely to be the sole cause of DA, 3 the current evidence clearly does not rule out covert or overt discrimination as a cause of DA.

Assessment oversight committees and annual programmatic evaluations, while recommended, will not guarantee fairness within postgraduate medical education programs, but they can provide a window into 'hidden' threats to fairness, as everything from training experiences to assessment practices may be open to scrutiny. 35

Ensuring Fairness in Clinical Training and Assessment: Principles and examples of good practice, was recommended by the BMA outlined a few principles that need to be considered with respect to assessment methods.

Current Difficulties with Objective Structured Clinical Examinations (OSCE)

When evaluated against the standard criteria, independent of its ethnicity effect, a few problems emerge with the current traditional OSCE format.

Firstly, the artifice of OSCEs makes validity a significant concern. Rating scales and checklist assessment tools used to improve reliability ends up rewarding mechanistic "performance" from candidates. A striking example of this problem is the paradoxical third person rating of empathy often used in OSCEs assessing communication skills. OSCEs that reward feigning empathy rather than actual empathy have been blamed for the striking reduction in empathy seen in medical students as they progress through their medical training.36 Validity depends on high levels of fidelity but that is usually lacking as OSCEs usually test isolated skills in a fragmented fashion. 37 38

OSCEs improve on their reliability coefficients by increasing the duration of the exam but these remain susceptible to biases in sampling of stations. Standard setting in high-stakes exams is done variably for different cohorts and while this could be improved, there remains the variability in examiners. All exams do review the "hawks and doves" in their examiner pool but again this categorical distinction may mask granular details for e.g. the finding that IMG examiners may be more hawkish. 39

Another interesting finding relates to the finding that performance at the MRCGP clinical skills assessment in IMGs was better predicted by scores on a situational judgment test, evaluating interpersonal skills, than by achievement on a knowledge-based test. 17 This finding is also supported by previous reports that GMCs Professional and Linguistic Assessment Board examination (PLAB) part 2 scores, rather than those for part 1, predicted performance in the clinical components of MRCP and MRCGP CSA exams. 31 This is of concern particularly given the known ethnicity discriminatory effect (against BAME candidates) that is a consistent feature of the Situational Judgement Test. 40

Assessment does drive learning and clearly summative examinations have a role in not merely quality assurance but in also promoting essential learning and practice that delivers high quality and safe care for patients. However, this

does depend on high quality, specific and credible feedback being delivered to failed candidates with tailored remediation. Currently, the feedback given to failed candidates fails to meet any of these criteria. Pertinently, there is no evidence to link success or failures in OSCE-style exams with patient safety or patient outcomes.

Alternatives to OSCEs - Programmatic Assessment; multiple low stakes assessments

There is some shift in focus within medical education, from learning discrete skills and knowledge to continuous learning with authentic tasks focused on transfer to clinical practice. GMC's Generic Professional Capabilities Framework signals this direction very clearly and is now leading to changes in postgraduate curricula across the board. 41 The underlying message is clear – we need to move from "shows how" to "does".

The public expect their doctors to be capable of working in a range of different situations and settings and there is wide understanding that no single assessment method can capture it all. Current assessment strategy focusing as it does, on summative assessment at a single point of time, provides little weightage for longitudinal assessments.

Narrative feedback embedded in a dialogue (rather than one-way provision of feedback) is significantly more impactful in developing complex clinical skills than scores. Longitudinal and more diverse programmatic assessment can address the inherent difficulties in relying on a single data point viz. the summative OSCE examination. Moving from a sum of a few summative/formative assessments to a programme of multiple low-stakes assessment would provide multiple data points which can be optimised for learning. The format of assessments can be varied at various data points which would improve the validity of assessment.

Current summative examinations are focused on delivering a categorical pass/fail distinction and considerable effort is expended in designing exams that are defensible- the main focus of the assessment is this decision rather than on the primary function of assessment, which is to drive patient-centred learning.

Switching from decision-oriented to feedback-oriented multiple assessments with varying degrees of stakes at each data point would generate feedback focused on improving the quality of care for patients, something that current assessment strategies do not emphasise. Crucially, such longitudinal assessment delivers non-surprising results in the final stages of the assessment. The fact that the failure in high-stakes assessment comes as a surprise to both trainers and trainees has been a significant problem with current summative exams. Those likely to fail should be identified earlier on in their learning trajectory and remedial action instituted.

Such programmatic assessments are being used in many centres across the world including the USA, Canada and Holland. Within the UK setting, the current system of Workplace Based Assessments, Annual Review of Competency Progression and summative paper exams including OSCEs should be adapted relatively easily to create a more longitudinal systematic and programmatic assessment. This will empower trainers to use their professional judgement (rather than relying on standard setting or on narrow checklists which have been associated with reduced validity). Increasing the number of data points will increase the diversity of the assessment sample, potentially increase the diversity in the examiner pool and aided by procedural bias reduction methods should deliver an exam that puts person-centred care and learning rather than pass/fail decisions at the heart of assessment.

Initiatives so far

- Following the legal challenge, the GMC and some Royal Colleges have had regular discussions with BAPIO and have produced examination preparation resources as well as enhanced guidance for trainers.
- RCGP has introduced an exceptional 5th attempt for some candidates in the CSA.
- A Health Education North West Pilot programme for enhanced training has been shown to improve outcomes of CSA resits.

Recommendations

- Use real patients rather than role players.
- Two examiners may mark rather than one at every station or virtual examiners as employed in some USA systems may reduce undue stress
- Video of the assessment should be made available to failing candidates
- Number of attempts may be increased or made unlimited as long as the doctor is continuing in active medical practice.
- Culvert Scoring: The Education Supervisor provides a 'culvert score' to the trainee about 6 months prior to proposed finishing date of training. This score ranges from 0-3 depending on the overall performance of the candidate during the whole period of training and will be influenced by overall knowledge, communication skills, quality of the WPBA and several other factors. This score is not disclosed to the trainee but is available to the examining body. If a candidate is marginally falling short of CSA pass score, this culvert score may be added to the marks obtained in the CSA examination. If the candidate has already scored the pass marks, there is no need to use a culvert score.
- Weight allocation: "Weights" may be provided to the current three parts of the assessments (i.e. WPBA, AKT and CSA). Weighted scores from all three assessments then may be combined to provide the accreditation score. The accreditation score may be fixed beforehand again based on the survey results, for example 65% or 70%. Actual weights may be decided following a survey conducted from the trainees, trainers and examiners.
- Promoting cultural safety, cultural humility and decolonization of the curriculum and content
- Address the conscious and unconscious biases that exist amongst tutors as well as examiners

References

1. The state of medical education and practice in the UK. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk.
2. Woolf, K. Fair Training Pathways for All: Understanding Experiences of Progression - Final Report. 69.
3. Woolf, K., Potts, H. W. W. & McManus, I. C. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ 342, d901 (2011).
4. MRCGP | Applied Knowledge Test (AKT). https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-applied-knowledge-test-akt.aspx.
5. MRCGP: Clinical Skills Assessment (CSA). https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-clinical-skills-assessment-csa.aspx.
6. MRCGP: Recorded Consultation Assessment (RCA). https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx.
7. March 2016, 16. Former RCGP chair suggests CSA exam should be scrapped. Pulse Today http://www.pulsetoday.co.uk/news/gp-topics/education/former-rcgp-chair-suggests-csa-exam-should-be-scrapped/20031376.article.
8. Covid-19: changes to GP assessment should only be the beginning. The BMJ https://blogs.bmj.com/bmj/2020/06/05/covid-19-changes-to-gp-assessment-should-only-be-the-beginning/ (2020).
9. NHS Staff Surveys - NHS Staff Survey Results. https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/.
10. Woolf, K., Viney, R., Rich, A., Jayaweera, H. & Griffin, A. Organisational perspectives on addressing differential attainment in postgraduate medical education: a qualitative study in the UK. BMJ Open 8, (2018).
11. NHS workforce. https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#by-ethnicity-and-grade-medical-staff.
12. Valero-Sanchez, I., McKimm, J. & Green, R. A helping hand for international medical graduates. BMJ 359, (2017).
13. O'Dowd, A. More non-UK graduates than home grown clinicians joined medical register in past year. BMJ 367, (2019).
14. Rimmer, A. Locum pay since the cap. BMJ 357, (2017).
15. Background | Falling short: the NHS workforce challenge. Health Foundation https://reader.health.org.uk/falling-short/background.
16. Entry Through the Narrow Door.
17. Fielding, S. et al. Do changing medical admissions practices in the UK impact on who is admitted? An interrupted time series analysis. BMJ Open 8, (2018).
18. inclusion-report-aug-2017.pdf.
19. Archer, J. et al. The impact of large scale licensing examinations in highly developed countries: a systematic review. BMC Med. Educ. 16, 212 (2016).
20. Norcini, J. J. et al. Evaluating the quality of care provided by graduates of international medical schools. Health Aff. Proj. Hope 29, 1461–1468 (2010).
21. Hughes, N. S. et al. Exit examination: a survey of UK psychiatrists' views. BJPsych Bull. 39, 254–259 (2015).
22. Krishnan, A., Rabinowitz, M., Ziminsky, A., Scott, S. M. & Chretien, K. C. Addressing Race, Culture, and Structural Inequality in Medical Education: A Guide for Revising Teaching Cases. Acad. Med. J. Assoc. Am. Med. Coll. 94, 550–555 (2019).
23. Dyer, C. RCGP is cleared of ethnic discrimination in clinical skills assessment. BMJ 348, (2014).
24. Woolf, K., Rich, A., Viney, R., Needleman, S. & Griffin, A. Perceived causes of differential attainment in UK postgraduate medical training: a national qualitative study. BMJ Open 6, e013429 (2016).
25. Pattinson, J., Blow, C., Sinha, B. & Siriwardena, A. Exploring reasons for differences in performance between UK and international medical graduates in the Membership of the Royal College of General Practitioners Applied Knowledge Test: a cognitive interview study. BMJ Open 9, e030341 (2019).
26. Stone, J. & Moskowitz, G. B. Non-conscious bias in medical decision making: what can be done to reduce it? Med. Educ. 45, 768–776 (2011).
27. Epstein, R. M. Assessment in Medical Education. N. Engl. J. Med. 356, 387–396 (2007).
28. Academic performance of ethnic minority candidates and discrimination in the MRCGP examinations between 2010 and 2012: analysis of data | The BMJ. https://www.bmj.com/content/347/bmj.f5662.
29. Linton, S. Taking the difference out of attainment. BMJ 368, (2020).
30. Wakeford, R., Denney, M., Ludka-Stempien, K., Dacre, J. & McManus, I. C. Cross-comparison of MRCGP & MRCP(UK) in a database linkage study of 2,284 candidates taking both examinations: assessment of validity and differential performance by ethnicity. BMC Med. Educ. 15, (2015).
31. McManus, I. C. & Wakeford, R. PLAB and UK graduates' performance on MRCP(UK) and MRCGP examinations: data linkage study. BMJ 348, (2014).
32. McManus, I. C., Elder, A. T. & Dacre, J. Investigating possible ethnicity and sex bias in clinical examiners: an analysis of data from the MRCP(UK) PACES and nPACES examinations. BMC Med. Educ. 13, (2013).
33. Denney, M. & Wakeford, R. Do role-players affect the outcome of a high-stakes postgraduate OSCE, in terms of candidate sex or ethnicity? Results from an analysis of the 52,702 anonymised case scores from one year of the MRCGP clinical skills assessment. Educ. Prim. Care Off. Publ. Assoc. Course Organ. Natl. Assoc. GP Tutors World Organ. Fam. Dr. 27, 39–43 (2016).
34. Atewologun, D. & Tresh, F. Unconscious bias training : An assessment of the evidence for effectiveness. /paper/Unconscious-bias-training-%3A-An-assessment-of-the-Atewologun-Tresh/509a580783bb5df10f3af42e8df720d8ad57dbd0 (2018).
35. Colbert, C. Y., French, J. C., Herring, M. E. & Dannefer, E. F. Fairness: the hidden challenge for competency-based postgraduate medical education programs. Perspect. Med. Educ. 6, 347–355 (2017).
36. Gillett, G. Communication skills and the problem with fake patients. BMJ 357, (2017).
37. Schuwirth, L. W. T. & van der Vleuten, C. P. M. How 'Testing' Has Become 'Programmatic Assessment for Learning'. Health Prof. Educ. 5, 177–184 (2019).
38. Vleuten, C. P. M. van der & Swanson, D. B. Assessment of clinical skills with standardized patients: State of the art. Teach. Learn. Med. 2, 58–76 (1990).
39. Denney, M. L., Freeman, A. & Wakeford, R. MRCGP CSA: are the examiners biased, favouring their own by sex, ethnicity, and degree source? Br. J. Gen. Pract. 63, e718–e725 (2013).
40. de Leng, W. E., Stegers-Jager, K. M., Born, M. P. & Themmen, A. P. N. Integrity situational judgement test for medical school selection: judging 'what to do' versus 'what not to do'. Med. Educ. 52, 427–437 (2018).
41. Generic professional capabilities framework. https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework.

Conflict of Interest

None declared

Author's Contributions

SD conducted the scoping review, IC and SD wrote the manuscript and all authors contributed to the design, scope, editing and finalising the manuscript.

TACKLING DIFFERENTIAL ATTAINMENT IN THE MEDICAL PROFESSIONS

ROUNDTABLE ON SUMMATIVE ASSESSMENTS

Report & Recommendations
17 September 2020
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EXECUTIVE SUMMARY

The United Kingdom National Health Service (NHS) is the 5th largest employer in the world with one of the most diverse workforces in the public sector. Nearly 40% of its employees are of BAME (Black, Asian and Minority Ethnic) background, have migrated from outside the UK or have disabilities or other protected characteristics. This rich diversity of professional and cultural experience of its workforce would ideally serve as a national resource for the NHS, but instead the recognised phenomenon of differential outcomes or attainment, has become a hurdle for many, based on gender, ethnicity, disability or other protected characteristics. The experience is often far worse for employees who have qualified overseas.

Differential Attainment or outcomes or award (DA) is a euphemistic phrase that describes the historical and persistent differences in award levels based on factors other than academic/ professional capability or effort. The impact of this endemic discrimination of affected individuals/ groups has profound impact on careers and wellbeing on a personal (micro) level on them, a productivity, team-working or patient safety impact at organisational (meso) level and at a much larger societal/ socio-economic level (macro) level for the country.

This roundtable sponsored jointly by British Association of Physicians of Indian Origin (BAPIO) and the Royal College of Physicians (RCP) is the first of a series of events organised by BAPIO Institute for Health Research (BIHR) exploring DA across the journey of a medical professional from entry to medical school all the way to retirement.

This roundtable is focussed on DA as observed in summative assessments in high stakes professional examinations, which are essential for entry, progression or accreditation. The findings and recommendations of this series will be published in the rainbow paper "Bridging the Gap" celebrating diversity in the NHS. This report should be read in conjunction with the scoping paper which presents the evidence base for the discussion and recommendations. (Dave et al., 2020)

Key Findings

1. In the UK doctors from BAME groups, and International Medical Graduates (IMG) i.e. doctors whose primary medical qualification (PMQ) is from a medical school outside of the UK have, consistently, poorer demonstrated outcomes in assessments when compared to white doctors and UK medical school graduates.

2. The quantum of this difference varies across examinations and cohorts, but usually equates to about 10-15% gap between UK BAME and UK White doctors and about 30-50% gap between IMGs and UK graduates. Clearly these are group differences with many individual outliers that defy the norm.

3. The impact of DA is manifold and pernicious.

3.1 It is a moral imperative that assessment systems and practices are equitable. Implicit bias and discrimination leads to a non-compassionate organisational perception amongst its staff fundamental principles of 'Our People Plan' (NHS England » We Are the NHS: People Plan for 2020/2021 – Action for Us All, n.d.) and the 'NHS Constitution'.(The NHS Constitution for England, n.d.)

3.2 Assessments are important in maintaining clinical standards and patient safety. However, inequitable assessment systems lead to loss of psychological safety and reduced freedom to speak up with consequences for patient safety.

3.3 The financial cost of inequitable assessments for the NHS is significant. It is estimated that in 2019, it costs £88,000 for an additional year of training for general practitioners. Moreover, it limits the number of new trainees that can be trained, creating further pressures on workforce capacity.

3.4 There is a significant wellbeing cost of inequitable assessments in terms of psychological and physical weathering, moral injury and demoralisation. Demoralisation in the workforce is associated with productivity costs and poorer patient outcomes. Individual stories of personal and professional tragedy abound, in many cases associated with significant morbidity and sadly in some with untimely mortality.

4. DA in summative examinations offer a lens to the differential experiences and outcomes that occur throughout the educational journey and as such systemic issues should not be lost sight of, whilst focussing on high-stakes examinations. Workplace based assessments or supervisor assess-

ments may not be free from bias or from grade-inflation and therefore may not offer a silver bullet to replace summative examinations. Improving educational supervision, educational and clinical supervisors' confidence and skill in addressing the differential learning needs of trainees including IMGs and BAME trainees is important.

5. However, the disproportionate impact of COVID19 on BAME patients and BAME workforce and the Black Lives Matter movement have shone a spotlight on the real impact of structural inequalities. There is a necessity and an opportunity to be bold and courageous in our response, in contrast to the traditional ways of dealing with complex issues that are often ponderous even if incremental and this applies specifically to the inequalities in outcomes associated with summative examinations.

6. Summative examinations offer a single point of assessment to determine competence and progression. Making a judgement about competence to practice is a complex process. The reliance on this single point to determine progression ignores the richness of assessment data available from the educational journey. Integrating and formally linking information available from multiple assessment points conducted by a range of assessors over a period of time, allows for multi-dimensional assessment and can potentially neutralise the bias that may reside in a single point assessment.

7. Discussions about DA are not new. DA has been highlighted for over two decades but previous efforts at addressing DA have failed to bear fruit despite high profile legal challenges (BAPIO) and high-level meetings with Colleges. This coalition comes at a time when many summative examinations and assessments have had to be reformed or reshaped completely in the wake of COVID19. This offers a unique opportunity to transform the assessment landscape for postgraduate summative assessments in the UK.

8. Developing an equitable assessment process that does not discriminate between candidates is not only fair but is also vital in retaining public confidence in the assessment system. Patients and public need to have the confidence that doctors who are excellent clinical practitioners are able to progress and not failed by the system of assessment.

Recommendations

RECOMMENDATIONS

1. Build on the consensus achieved with partners including Health Education England (HEE), General Medical Council (GMC), NHS England and Improvement (NHS E/I) and the Royal Colleges at the roundtable and declare a firm, public commitment and accountability for addressing the inequalities demonstrated through DA and strive to create a fair, responsive and transparent system.

2. Identify and clarify the roles of individual stakeholders in ensuring a coordinated 4-nation response in addressing DA. (NHSE/I)

3. To retain the current system of summative assessments but demonstrate robust equality and diversity impact assessment of the entire process from question writing, standards setting and training of examiners. (Academy of Medical Royal Colleges)

4. To reform the provision of targeted support to candidates known to be disadvantaged by DA and supervisors in increasing awareness, cultural competency and resources to provide mentorship, educational guidance and career oversight. (Health Education England)

5. Set up a Task and Finish group (T&FG) from members of this roundtable, learners able to offer a 'lived experience' and subject experts to create an options appraisal, identifying alternatives to rethink the current assessment systems that facilitate a transition to a fairer, comprehensive, multi-modality and valid judgement about candidate that will determine progression/ accreditation. (HEE & GMC)

BRIDGING THE GAP

DIFFERENTIAL ATTAINMENT IN LEADERSHIP ROLES IN THE UK NHS

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Abstract
Aim – to review the evidence on differential attainment in leadership positions in the NHS and develop an expert consensus

In this review we will explore in-depth, the current data surrounding differential attainment in leadership roles in the UK NHS, possible reasons for these disparities and what interventions may address this inequality. This scoping review forms part of the Alliance for Equality in Healthcare Professions project on DA chaired by the British Association of Physicians of Indian Origin (BAPIO) and will be integrated into the Bridging the Gap project undertaken by BAPIO Institute for Health Research (BIHR).

Keywords Leadership roles; NHS; Differential Attainment

INTRODUCTION

Differential attainment (DA) is the term used to describe a gap between different groups undertaking the same assessment based on factors related to gender, race, ethnicity, disability, protected characteristics as defined by the Equality Act of 2010, other socio-economic factors or country of origin.1 Differential attainment exists within and outside the medical profession extending to many walks of life and reflects inherent inequalities that exist in society.2

The UK National Health Service (NHS) has one of the most diverse workforces in the world with up to 40% from ethnic minority groups. However, the majority of leadership positions in the NHS are usually taken up by white employees rather than those from ethnic minorities and there exists similar disparities in respect to gender, sex, race and protected characteristics.3 Several studies have highlighted that white and ethnic minority staff have different experiences in terms of career progression.4 The NHS recruitment processes have been shown to favour white, male applicants.5 Compared with their white colleagues, ethnic minority staff are more likely to report bullying, harassment and referred to a formal disciplinary process.6 Ethnic minority doctors are also less likely to be shortlisted and appointed as consultants, indeed they hold 57% of staff grade or associate specialist posts.7 Ethnic minority consultants also earn 4.9% less than their white counterparts.8 This may be further compounded for female staff. Although women make up 77% of the NHS workforce, they only constitute 42% of NHS board members9 and there exists a 23% gender pay gap across the NHS.10

In this review we will explore in-depth, the current data surrounding differential attainment in leadership roles in the UK NHS, possible reasons for these disparities and what interventions may address this inequality. This scoping review forms part of the Alliance for Equality in Healthcare Professions project on DA chaired by the British Association of Physicians of Indian Origin (BAPIO) and will be integrated into the Bridging the Gap project undertaken by BAPIO Institute for Health Research (BIHR).

Why is this important?

The UK NHS was founded upon the principle that every person is treated fairly, equally and free from discrimination regardless of their 'gender, race, disability, age etc.'11 There is strong evidence that diversity and equality in leadership has a positive impact on the performance and culture of an organisation,12 including non-profit organisations.13 Further benefits of an equal and representative leadership is a widening of the leadership talent, better understanding or engagement with local communities or partners and priorities.14 It can help to cultivate a culture of care and values, ensuring that the NHS adheres to its pledges and guiding principles. Furthermore, it has been shown to help deliver a better standard of care with more sensitivity to patients and their families. 14 As the NHS is perpetually in a workforce challenge, improving diversity and inclusivity will play an important role in becoming a better place to work and develop careers.15

What are the latest figures?

In 2014, Roger Kline assessed the progress of racial equality in the NHS following the NHS Race Equality Action Plan.16 His survey of the leadership in London's NHS trusts showed a large gap between the NHS Trust's governance and leadership and the communities they served.17, 5 The report found that despite years of support for initiatives aimed at addressing barriers to the progression of Black Asian and Minority Ethnic (BAME) staff, little progress had been made.5 In 2015, the Workforce Race Equality Standard (WRES) was created to improve the transparency of data, increase awareness and tackle the inequalities.18-19 Besides, NHS England and NHS improvement (NHSEI) have committed to monitoring their performance on race equality.20 In March 2020, Sir Simon Stevens announced that NHSEI would be committing to a target of 19 % representation of ethnic minority employees at every pay band within the joint organisation by 2025 to reflect the make-up of the wider NHS, where 19.7% of NHS trust and commissioning staff are from an ethnic minority background.6,21

The most recent analysis of the national data was carried out by WRES in NHS Trusts. 6 Here we evaluate the key results for the following five measures:

- Representation of ethnic minorities in leadership roles
- Impact of gender in leadership roles
- Impact of Ethnicity and Gender on Pay
- Clinical Excellence awards

Ethnic minorities in leadership roles

Ethnic minorities are over-represented in NHS Agenda for Change (AfC) pay band 5 and significantly underrepresented above band 8a, which includes very senior managers (VSM) i.e. chief executives, executive directors, and other senior managers with board-level responsibility. As the pay bands increase there is a demonstrable reduction in the proportion of ethnic minority staff, from 24.5% in band 5 to 6.5% at very senior manager levels (Figure 1). 6 This is significantly lower than the 19.7% of NHS staff who are from BAME groups across the country.

Table 16 does show that there has been an increase in the proportion of VSM staff in NHS Trusts from 5.4% in 2016 to 6.5% in 2019. However, the proportion of BAME staff increased from 17.7% in 2016 to 19.7% in this period, which has led to a greater differential between the proportion of overall BAME staff and representation at VSM (Table 2).6 This highlights the need to accelerate opportunities for BAME staff representation at senior levels across the workforce, as set out in the NHS Long Term Plan.

Overall, there has also been an increase in the percentage of BAME board members within NHS Trusts from 7.4% in 2018 to 8.4% in 2019. There has also been a decrease in the proportion of NHS Trusts with no BAME representation on the board, from 96 in 2018 to 73 in 2019. 6 More data is required for primary care along with more granularity of the data from secondary care. This will help us understand further the extent of this differential representation.

Impact of Gender in leadership roles

Ruth Sealy's report, 'NHS women on boards: 50:50 by 2020' found that although women make up 77% of the NHS workforce, the percentage of women on NHS boards is only 42%. Currently, there are still 209 NHS Trust boards that do not demonstrate gender equality in the constitution of their boards. The report suggests the need for an additional 500 women in NHS Trust boards would be required to achieve gender balance by 2020.9

Currently, no data is showing the percentage of BAME women that hold leadership positions.22 The Athena Swan Charter is a framework which is used across the globe to support and transform gender equality within higher education (HE) and research. Established in 2005 to encourage and recognise the commitment to advancing the careers of women in science, technology, engineering, maths and medicine (STEMM) employment, the Charter is now being used across the globe to address gender equality more broadly, and not just barriers to progression that affect women.

A study looking at the effectiveness of the Athena Swan initiative found that 90% of Athena Swan champions agreed that it had impacted positively on gender issues and 65% agreed that there had been a positive impact on women's career progression.23 Women felt that the Athena Swan had helped to improve their self-confidence and enhanced their leadership skills. The initiative also was found to impact positively on institutional practices by helping them to identify challenges to gender equality, supporting women returners and facilitating factors for delivering institutional change.23 There are fears however that the Athena Swan initiative may be scrapped.

Impact of Ethnicity & Gender on pay

NHS Digital equality and diversity statistics show that in 2019, 34.1% of the consultants in England were from BAME groups compared to 56.4% white.24 Doctors from ethnic minority backgrounds, working in the same roles are paid substantially less than their white colleagues.8 In senior positions, such as consultant posts, BAME staff earn 2.3-3.3% less than their white colleagues. While in management positions African, Caribbean and British black managers earn 14.2% less and Asian managers 7.9% less than their white colleagues.8

Currently, women make up 36% of consultants in the UK, although they represent two-thirds of doctors in training. The current gender pay gap for women doctors is 17%, while the overall NHS gender pay gap is 23%.10 There is no data on the gender pay difference related to BAME women.

Clinical excellence awards

Clinical Excellence Awards (CEAs) recognise and reward medical consultants, dentists and academic General Practitioners who provide evidence of clinical excellence and demonstrate achievements that are significantly over and above, what would normally be expected for their roles. The Advisory Council on Clinical Excellence Awards (ACCEA) is an independent body which reports annually the figures from the clinical excellence

awards allocations.25

The ACCEA sub-committees currently have 336 members, with only 19.9% from BAME backgrounds. Out of the 14 medical vice-chairs and 14 chairs, only 14.3% and 7.1% were from BAME backgrounds, respectively (Table 3). Only 32.7% of the members and 7.1% of the medical chairs or vice-chairs were female (Table 4).25

In 2018, from 36% of consultants from BAME backgrounds, made 22% of the applications and received only 16% of the awards. The number of BAME recipients and applicants was lower than in previous years, and the lowest since 2014. The likelihood of success for BAME applicants was 23.3% compared to 31.8% for white applicants and the gap between the two had increased in the last few years (Table 5).25
The gender pay gap has been magnified further as majority of CEA awards (77.9%) were given to men. There is an even bigger gap for the higher awards; (only 17% for silver and gold and 14% of platinum awards were given to women), amplified by the lower proportion of women making up the eligible consultant workforce (36%) but the likelihood of success was similar, (Table 6).25

What are the potential causes?

Even though the data on DA is well known, there is evidence that progress in tackling these inequalities has been slow, and there are few if any, effective interventions. This responsibility is often left to local organisations with little national guidance or policy enablers. 18 This is not an issue just within the NHS but is true for many walks of life and other industries.
The lack of diversity in the NHS leadership is mirrored nationally. An independent review by Sir John Parker found that only 8% of Financial Times Stock Exchange (FTSE) top 100 company directors were from BAME backgrounds, out of a total of 1,087 positions. The Parker Review (2016) also found that over half of the 500 largest charities within England and Wales, had 'all-white governance' while 22.6% had between 1-10% BAME representation on their boards.17

Causes of DA in leadership

There is a range of factors which may lead to this lack of representation and prevent people from applying to leadership roles in the NHS. Research has shown that the causes of these differences are not usually individual factors but likely to be systemic.

<u>Macro level</u>
Although the NHS was founded on the principles of equality, societal or institutional racism is common and has been highlighted by the societal disparities revealed by the COVID-19 pandemic.26 Analysis by the Health Service Journal revealed 63% of UK health and social care workers, who died from COVID-19, were from BAME backgrounds.27 The latest WRES report from NHS England shows several factors which have led to BAME staff feeling more discriminated. These include:6

- BAME staff reporting greater levels of bullying and harassment, discrimination at work and likelihood of having disciplinary hearings, compared to white colleagues
- A much lower proportion of BAME staff believing that trusts provide equal opportunity for career progression, compared to white colleagues
- Greater likelihood of white applicants being appointed to all jobs, leadership or senior managerial positions, compared to those from BAME backgrounds.

Bullying & harassment and likelihood of being referred for disciplinary hearings

The WRES 2019 report shows that the relative likelihood for BAME staff entering a formal disciplinary hearing compared to white staff has reduced from 1.56 in 2016 to 1.22 in 2019.6 The Fair to Refer report28 by the UK General Medical Council found that there may be several reasons for this. Doctors from ethnic backgrounds, especially those trained outside the UK were not given the support they needed by their supervisors/managers and colleagues and are more likely to end up being blamed and facing disciplinary action when things go wrong.29 The report recommended that each organisation should provide frequent, honest feedback, support, and integrating staff within teams. There was also a need for more senior leadership role models, being representative of the diversity of the whole NHS workforce will help.28

Other indicators in the WRES 2019 report, however, have deteriorated.6 For example, 29% of ethnic minority staff report having experienced bullying, harassment, or abuse from other staff in the past 12 months, compared to 24.2% of white colleagues, up from 27% in 2016. Over 15% of ethnic minority staff report experiencing discrimination at work from a manager, team leader or another colleague, up from 13% in 2017 and is more than double the proportion of white colleagues reporting discrimination (6.4%).

Equal opportunity for career progression

Only 69.9% of BAME staff believed that their Trust provided equal opportunities for career progression compared with 86.3% of their white colleagues, which has dropped in 2018 (Table 7).6

In a survey of ethnic minorities working in the NHS, by King's fund respondents were asked,
'How would you describe your experience of being an ethnic minority within the NHS?' One of the responses was:
'Being a BAME person in the NHS has many challenges with limited job opportunities to progress to junior/senior management. The biggest impact on me is the feeling of being silent and not good enough to lead/manage a team regardless of one's knowledge or experience or qualifications'18

Likelihood of being appointed

Across the NHS in 2019, the relative likelihood of white applicants being successfully appointed across all posts was 1.46, compared to BAME applicants, dropping from 1.57 in 2016, although the gap remains significant.6 Yvonne Coghill, the Vice-President of the Royal College of Nursing and director of WRES, reported in an interview for the British Medical Journal, that she applied unsuccessfully for five directors of nursing posts. The people who got the jobs were 'invariably white' and

she mentions how this made her,
"question herself, rather than question the system." 30

A study exploring consultant appointments found that there were 46% white, compared to 33.4% of Chinese and 30.6% of black doctors, which was significantly out-of-proportion to the proportions of doctors from each of these ethnic groups in the same organisations.31 Ethnic minority doctors were more likely to apply for more consultant posts before being successful than white doctors (1.66 versus 1.29).32 Public attitudes to are often entrenched in racial profiling or discrimination as there have been many reported cases of patients asking to see 'a white doctor'.

Meso Level

Lack of opportunities

Research has shown that many employees from a BAME background do not have access to contacts, networks, or prospects to successfully climb the career ladder.33 Guidance on how to apply for roles, mentoring and development programmes may help to tackle this. There is little available data from applicants with other protected characteristics or disabilities.

Lack of role models

The lower representation of women or BAME role models in leadership positions is yet another factor limiting the progression in balancing these inequalities, where a vicious cycle perpetuates the lack of representation of women or BAME aspirants in leadership roles. A report by King's Fund, 'Workforce race inequalities and inclusion in NHS providers'18 highlighted some of the challenges and impacts that a lack of diversity in leadership positions in the NHS can have.
'I don't see anybody of my kind there [on the board], it's just all white faces. So, they don't fully understand, I don't think they understand the difficulties that BAME people go through, you know, which is slightly different to our white colleagues. And so our profile is a lot lower because there's not many of us.' 18
This is also demonstrated when there is diversity in leadership roles within an organisation.
'I think seeing a more diverse board of directors shows that equality is working. Yes, I think it would inspire other staff. You'll find that there is somebody you can speak to, somebody you can relate to, somebody to talk to' 18

Micro Level

Individual factors that may lead to BAME staff not applying for leadership roles include:

- a lack of awareness of the NHS governance system or of how the role works, and
- the lack of support, mentorship or potential self-confidence due to discrimination, the experience of bullying or harassment or trust in senior leadership.
- There may be socio-economic factors.14

POTENTIAL SOLUTIONS

Macro level - organisational engagement

- Benchmarking - An evaluation of WRES showed that the impact of its work depends on how well trusts engaged with the race equality agenda before the standards were introduced.19 Thus, it is questionable how well the annual reporting of WRES alone, will help to improve racial inequality in the NHS. Further data on primary care and a detailed breakdown of secondary care consultants are required as well as on representation of BAME women, and extending to other protected characteristics in leadership positions. A Charter mark for DA in line with Athena Swan innovation may be beneficial.
- Setting targets – The NHSEI have produced 'The model employer report: Increasing black and minority ethnic representation at senior levels across the NHS' to explore ways of tackling the low representation of BAME in leadership positions.34 One of the aspirations is to reach equality in BAME representation across the workforce by 2028. For example, in the VSM category, the model will mean, that one in every four of all VSM staff recruited in NHS Trusts, are from a BAME background. This is, therefore, an additional 41 BAME VSM recruits across all NHS Trusts per year. The plan recommends that organisations discuss their implementation innovations openly at board meetings and develop an action plan.34
- Cultural Transformation - The model also mentions how the NHS is planning to tackle the under-representation of BAME in leadership positions with a cultural and transformational change across the entire workforce. The focus will be on growing and supporting the existing BAME talent from within the NHS and attracting talent from outside of the NHS.

Meso level

- Coaching & Mentoring - The plan is to develop support interventions such as mentoring and coaching and hold organisations to account. Data and progress will be monitored and benchmarked for continuous improvement.34
- Initiatives such as Athena Swan.23 Possibility of expanding or tailoring this to BAME staff.
- Leadership development - programmes for ethnic minority staff in the NHS aspiring to progress to more senior roles
- Regional talent management functions should be rebuilt in the new joint NHS England and NHS Improvement regional teams. 4 One example of this was by Bradford NHS Trust who developed a 'Moving Forward' Programme. The programme aimed to equip staff in band 5 and 6 roles with leadership skills and learning experience to help them apply for and be successful in securing more senior positions. It shows that if the trust is willing to accept and tackle the problem then a solution can be found. The programme has now become available to other trusts in the local area.18
- An independent task force launched by the NHS confederation to support NHS organisations to increase non-executive diversity on their boards and governing bodies.14 Various independent consultancies offering support on recruiting for diversity and implementing equality, diversity and inclusion interventions
- Staff Networks - The NHS has numerous staff networks that promote equality. These include voluntary organisations such as BAPIO, which was formed to tackle inequality

and differential attainment. BAPIO was created in 1996 and has gone on to be a significant influencer in supporting several other voluntary healthcare bodies, shaping organisational and governmental policy as well as expanding its remit to include all healthcare professionals and mutually supportive partnerships with key institutions.35,36 There are several key benefits to staff networks, the main one being that it can help promote a sense of solidarity and create a 'psychological safe space' for discussing aspects of inclusion, diversity and equality.17

- Equality and diversity champions, BAME groups and representatives at every organisation who have direct links to the board with an accountable Non-executive member.
- Other key benefits, highlighted by the NHS England Survey, include creating a pipeline of talent and potential future leaders and fostering empathy and collaboration among staff.37 However some staff feel that these groups can lead to segregation. Others feel that taking actions to progress race equality should not be the role of members that have been on the receiving end of discrimination and marginalisation in the first place.17
- Unconscious bias - This is training that can raise awareness of issues around equality and diversity.38 However, it can lead to mixed results and may take the focus away from how well an organisation as a whole is performing rather than on individuals addressing their biased behaviours.17 Universal access to leadership courses that increase awareness of senior leaders of the inequalities and measures to tackle the lack of diversity.

MICRO LEVEL

- Reverse Mentoring - An intervention which is focused on promoting inclusion and diversity at an individual level is reverse mentoring, which involves pairing a junior employee with a senior one (ideally from different backgrounds). The aim is to address 'advantage blindness' among leaders through sharing experiences.39 There are no formal evaluations of the benefit of this, but the experience of senior leaders who have taken part appears to have been a positive one.
- In accessing non-mandatory training and continuous professional development.

What would race equality and inclusion 'success look and feel like?

The survey by King's Fund showed that there were several ways staff felt more included in their organisations.18 These included:

- a reduction in levels of bullying, harassment, and abuse
- a reduction in the percentage of ethnic minority staff referred to a formal disciplinary process
- an increase in the representation of ethnic minority staff overall (including in leadership positions)
- an increase in the percentage of ethnic minority staff accessing non-mandatory training and continuous professional development.

'And I think… having some of those changes at the senior leadership has given a sense of… I hate to use this word, a sense of hope for people who might feel, oh, gosh, it's always the same face at the top, you know, it's always male or it's always white male, you know. And the trust is so diverse, so our leaders must represent that diversity, which I think it does, and it continues to examine itself, I would say' 18

Conclusion

This scoping review of DA in Leadership roles highlights that so far, no NHS Trust has achieved equality in offering a genuine level playing field for all of its employees to achieve their potential. The disparities in terms of ethnicity or gender continue to be significant and improvements are minuscule. Initiatives such as WRES and NHSEI action plans are still to be implemented or enforced at the local or regional level. There is little or no data for the impact of intersectionality (eg BAME and gender) or the impact of disability or any of the other protected characteristics in leadership. There is a significant and persistent disparity with culture, support, mentorship and ingrained discrimination or bullying and harassment for a large proportion of staff. The handling of disciplinary proceedings, referral to the regulators and support to achieve recognition for clinical excellence awards is poor in local and national levels. There are few, if any, role models in local and national bodies, that represent the diversity of the NHS workforce. Initiatives such as WRES and NHSEI action plans lack teeth and there are no accountability or punitive action for organisations that continue to fail these standards. There silence and lack of leadership at the national level and hardly any policy enablers. 40

Even after the poor outcomes for BAME patients or healthcare staff that has been highlighted in the COVID-19 pandemic, there is still a lack of serious commitment from policy leaders and many organisations remain in dormancy. The Equality, diversity and inclusion incentives are inadequate and lack of accountability or sanctions remains a major policy weakness.

Future research

Application of Athena Swan type of principles to tackle DA may help to increase awareness, transparency but ultimately sanctions may be necessary to shift this impasse.
Initiative to improve access to support, mentorship and opportunities for leadership and reduce differential attainment in the healthcare settings will need to be funded and explored by robust research
Initiatives to improve applications for Clinical excellence awards will need to be undertaken along with serious mentorship and diversification of the assessment boards

References

1. Shah R, Ahluwalia S. The challenges of understanding differential attainment in postgraduate medical education. Br J Gen Pract. 2019 Aug 29;69(686):426-427. doi: 10.3399/bjgp19X705161
2. Mountford-Zimdars, A.K., Sanders, J., Jones, S., Sabri, D. and Moore, J., 2015. Causes of differences in student outcomes, Higher Education Funding Council for England. https://dera.ioe.ac.uk/23653/1/HEFCE2015_diffout.pdf
3. Milner A, Baker E, Jeraj S, et al. Race-ethnic and gender differences in representation within the English National Health Service: a quantitative analysis BMJ Open 2020;10:e034258. http://dx.doi.org/10.1136/bmjopen-2019-034258
4. West, M., Dawson, J. and Kaur, M., 2015. Making the difference: Diversity and inclusion in the NHS. The Kings Fund. https://www.kingsfund.org.uk/sites/default/files/media/Mandip_Kaur.pdf
5. Kline, R., 2014. The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and the potential im-

pact on patient care in London and England. https://doi.org/10.22023/mdx.12640421.v1
6. WRES Implementation Team (2020). NHS Workforce Race Equality Standard: 2019 data analysis report for NHS trusts [online]. NHS England website. Available at: https://www.england.nhs.uk/publication/ workforce-race-equality-standard-data-reporting-2019 (accessed on 27 February 2020).
7. Kmietowicz Zosia, Ladher Navjoyt, Rao Mala, Salway Sarah, Abbasi Kamran, Adebowale Victor et al. Ethnic minority staff and patients: a health service failure BMJ 2019; 365 :l2226 https://doi.org/10.1136/bmj.l2226
8. Moberly Tom. Doctors from ethnic minority backgrounds earn less than white colleagues BMJ 2018; 363 :k5089 doi: https://doi.org/10.1136/bmj.k5089
9. Sealy, R., NHS Women on Boards by 2020. NHS, 2017 https://www.nhsemployers.org/-/media/Employers/Publications/NHS-Women-on-Boards-report.pdf
10. Department of Health and Social Care (2019) 'New data on gender pay gap in medicine.' GOV.UK website. Available at: https://www.gov.uk/government/news/new-data-on-gender-pay-gap-in-medicine
11. Department of Health and Social Care (2015). 'The NHS Constitution for England'. GOV.UK website. Available at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
12. Rimmer Abi. NHS must do more to tackle white male dominance of leadership roles, Labour Party says BMJ 2016; 354 :i4610 doi: https://doi.org/10.1136/bmj.i4610
13. Medina, S., 2017. The diversity gap in the nonprofit sector. https://philanthropynewsdigest.org/columns/the-sustainable-nonprofit/the-diversity-gap-in-the-nonprofit-sector
14. Confederation, N.H.S., 2019. Chairs and non-executives in the NHS: The need for diverse leadership. https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Chairs-and-non-executives-in-the-NHS.pdf
15. Beech, J., Bottery, S., Charlesworth, A., Evans, H., Gershlick, B., Hemmings, N., Imison, C., Kahtan, P., McKenna, H., Murray, R. and Palmer, W., 2019. Closing the gap: key areas for action on the health and care workforce. London, UK: Kings Fund. https://www.nuffieldtrust.org.uk/research/closing-the-gap-key-areas-for-action-on-the-health-and-care-workforce
16. DEPARTMENT OF HEALTH. (2004). Race Equality Action Plan. Available: http://webarchive.nationalarchives.gov.uk/+/http://www. dh.gov.uk/en/Publicationsandstatistics/Bulletins/DH_4072494.
17. Bolden, R., Adelaine, A., Warren, S., Gulati, A., Conley, H. and Jarvis, C., 2020. Inclusion: The DNA of leadership and change. https://uwe-repository.worktribe.com/output/852067/inclusion-the-dna-of-leadership-and-change
18. Ross, S., Jabbal, J., Chauhan, K., Maguire, D., Randhawa, M., and Dahir, S., 2020. Workforce race inequalities and inclusion in NHS providers The King's Fund website. Available at: https://www.kingsfund.org.uk/sites/default/files/2020-07/workforce-race-inequalities-inclusion-nhs-providers-july2020.pdf
19. Dawson J, Sampson F, Rimmer M, Buckley Woods H, West M, Nadeem S (2019). Evaluation of the NHS Workforce Race Equality Standard (WRES) [online]. NHS England website. Available at: https://www.england.nhs.uk/publication/evaluation-of-the-nhs-workforce-race-equality-standard-wres
20. NHS Equality and Diversity Council (2019b). Equality and Diversity Council: narrative and terms of reference [online]. NHS England website. Available at: www.england.nhs.uk/publication/equalityand- diversity-council-narrative-tor
21. NHS England (2020a). 'NHS England chief pledges "head office" will match diversity of health service'. Press release, 5 March. Available at: https://www.england.nhs.uk/2020/03/nhs-chief-pledge-shq- will-match-diversity-of-health-service
22. Equality and Human Rights Commission (2011) Sex and Power. Equality and Human Rights Commission, London. https://www.equalityhumanrights.com/en/publication-download/sex-and-power-2011
23. Rosser SV, Barnard S, Carnes M, Munir F. Athena SWAN and ADVANCE: Effectiveness and lessons learned. Lancet 2019. 9;393(10171):604-608 DOI: https://doi.org/10.1016/S0140-6736(18)33213-6
24. NHS Digital 2019. NHS Workforce statistics September 2019 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2019
25. Advisory Committee on Clinical Excellence Awards. Annual report covering the 2018 awards round. 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/867066/ACCEA_Annual_Report_2019.pdf
26. Bamrah J, Chand K. The best birthday present for the NHS? An end to its institutional racism [Internet]. the Guardian. 2020 [cited 19 July 2020]. Available from: https://www.theguardian.com/society/2020/jul/03/best-birthday-present-nhs-end-institutional-racism
27. Cook T, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from covid-19 analysed. Health Service Journal. 2020 Apr 22;22. https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article
28. Atewologun, D., Kline, R. and Ochieng, M., 2019. Fair to Refer. Reducing disproportionality in fitness to practise concerns reported to the GMC. https://www.gmc-uk.org/-/media/documents/fair-to-refer-report-pdf-79011677_pdf-79021583.pdf
29. Majid Aisha. What lies beneath: getting under the skin of GMC referrals BMJ 2020; 368 :m338 doi: https://doi.org/10.1136/bmj.m338
30. Jones Helen. Yvonne Coghill: cultural transformation through conversation BMJ 2020; 368 :m474 doi: https://doi.org/10.1136/bmj.m474
31. Rimmer Abi. White doctors are still over-represented in top NHS jobs, study finds BMJ 2020; 368 :m571 doi: https://doi.org/10.1136/bmj.m571
32. Linton Samara. Taking the difference out of attainment BMJ 2020; 368 :m438 doi: https://doi.org/10.1136/bmj.m438
33. Nath, V. Are opportunities still limited for black and minority staff in health care leadership? 2016. The King's Fund website. Available at: https://www.kingsfund.org.uk/blog/2016/04/BME-staff-health-care-leadership
34. NHS Improvement., 2019. A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf
35. McGregor-Smith R (2017). Race in the workplace: the McGregor-Smith review [online]. GOV.UK website. Available at: https://www.gov.uk/government/publications/race-in-the-workplace-the-mcgregorsmith- review
36. Chakravorty, I., Bamrah, J., & Mehta, R. (2020). A Rainbow Paper - Tackling inequalities, a neo-liberal order in a world after Corona. Sushruta Journal of Health Policy & Opinion, 13(3). DOI https://doi.org/10.38192/13.3.14
37. ENGLAND, NHS., 2017. Improving through inclusion Supporting staff networks for black and minority ethnic staff in the NHS. https://www.england.nhs.uk/publication/improving-through-inclusion-supporting-staff-networks-for-black-and-minority-ethnic-staff-in-the-nhs/
38. Atewologun, D., Cornish, T. and Tresh, F., 2018. Unconscious bias training: An assessment of the evidence for effectiveness. Equality and Human Rights Commission Research Report Series. https://www.equalityhumanrights.com/sites/default/files/research-report-113-unconcious-bais-training-an-assessment-of-the-evidence-for-effectiveness-pdf.pdf
39. Fuchs B (2019). 'Talking leadership: Ben Fuchs on "advantage blindness"'. The King's Fund website. Available at: https://www.kingsfund.org.uk/publications/talking-leadership-advantage-blindness
40. Coghill Y (2020). '"Our NHS people matter" – five years of the Workforce Race Equality Standard (WRES)'. Blog. Available at: https://www.kingsfund.org.uk/blog/2020/02/five-years-workforce-raceequality-standard-wres

A Scoping Review of Differential Attainment in Undergraduate Medical Education

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Abstract
Differential attainment exists in all professions and is a manifestation of systemic factors creating an unequal environment where individual careers and aspirations may be thwarted. Although, this inequality which affects some groups of students unfairly, has been recognised over the last 2 decades, it remains a significant issue.

This scoping review explores the causes and contributors in relation to undergraduate medical education. Using thematic analysis, the authors present the case for tackling the disparity in education and training. There are evidence based solutions for individuals, organisations and at societal level. The recommendations from this review will be discussed and debated in the series of workshops, as part of the 'Bridging the Gap' series from the Alliance for Tackling Inequalities in Health, chaired by the British Association of Physicians of Indian origin. The output of the consensus building workshops and thematic synthesis with the accompanying qualitative research will be presented in the final report due in 2021.

Keywords
Differential attainment, undergraduate medicine, Bapio Institute for Health Research

Background

Differential attainment (DA) is broadly defined as the variation in achievement amongst individuals based on their demographic background or attributes 1, often independent of their personal effort, ability or potential. These are common due to gender, ethnicity, socio-economic status or disability and are an indicator of inequalities in society. In the context of medical education, ethnicity and international primary medical qualification stand out as ones with the largest effect sizes and impact. DA is found in both undergraduate and postgraduate training 2 and is reported in formative and summative assessments, practical skills tests and in recruitment processes. The impact of DA is pernicious; not only does it directly retard the career progression of affected professionals, but also reduces their access to senior/ more deserving roles, resulting in a deterioration of morale, higher turnover of the skilled workforce, lower retention, and subsequently poor value for money for human resources, in the NHS [3].3

Medical school admission committees are an important gatekeeper to maintain the high standards of capability as well as the vocational aptitude of the future medical workforce, as expected by the population they are meant to serve. The admission policies and processes have a critical role in ensuring that the healthcare workforce reflect the needs of the healthcare service, therefore are subject to stricter workforce criteria by all government agencies and regulatory bodies. They are also entrusted to address some of the significant disparities that exist by geography, racial or ethnic differentials in the country. It is unfortunate, therefore, when members of the medical

school admissions committee display significant unconscious white preference, despite acknowledging almost 'zero' explicit preferences 4. Throughout medical education including clinical placements, the opportunities to undertake electives, access research, mentorship, or targeted support remains an uneven playing field. Unconscious bias can tarnish the lived experience of students, influence decisions to pursue or avoid certain specialties, cause demoralisation and lead to isolation. Surveys amongst undergraduate and postgraduate learners often report an unacceptably high prevalence of discrimination, daily microaggressions, and sometime, being tasked as race/ethnic "ambassadors," expected to speak on behalf of their demographic groups 5.

There is a broader ethical impact of attainment gap, for it signifies unresolved institutional issues of bias and inequality of opportunity, which undermines the principles of universality (in access to health), enshrined in the NHS Constitution 6. The potential snowball detrimental impact of these systemic biases 7 need to be borne in mind, given the significant percentage of the healthcare workforce, that is either of minority ethnic origin or with primary qualification from outside the UK 8. This article will focus broadly on DA in undergraduate education and specifically in medical education, and present findings from a thematic review, exploring the underlying causes and contributors.

DA in Undergraduate Higher Education

Much of the current literature on the causes of DA, and interventions targeting DA, is largely focused on postgraduate medical education 2,9. While many factors may apply equally to undergraduate and postgraduate learners, there are fundamental differences between them. Postgraduate examinations vary significantly in their structure, timing and method, which may have an influence on DA. Moreover, certain issues, isolationism, adjustment to the prevalent culture of campuses, transition away from home and economic hardship, may have a differential impact on undergraduate learners.

Socio-economic factors

Nearly 80% of all medical school admissions usually represent the most socio-economically advantaged quintile of the population. Independent school students form <10% of all students, but attain more than a quarter of all medical school admissions 10. The educational pre-attainment, parental education, household income, number of members in the house-hold, targeted support provided in high school and factors determined by the geographical and economic background of students have a significant impact on the likelihood of admission to higher ranked institutions. There is 10 a significant difference in students gaining a degree, or obtaining a graduate-level job when comparing the most disadvantaged (fifth quintile) to the least disadvantaged socioeconomic group (first quintile).

Ethnicity

Ethnicity is another significant factor in DA. The gap between White and Black or minority ethnic student groups is widest in relation to the achievement of first or upper second-class degrees. This gap is not explained by prior attainment or performance. When comparing students with equivalent prior educational achievement (e.g. BBB grades in A-level examination) White students are significantly more likely to be awarded an upper second- or first-class degree, compared to black and minority ethnic students (70% vs 50%). National student surveys show that black and minority ethnic as well as students with a disability, are less likely to report receiving support and encouragement from teaching staff, have lower confidence in the fairness of assessment tools, or being satisfied with opportunities / access to learning offered by their course organisation 11. Woolf et al. 12 explored study habits, personality, and socio-economic background but found ethnicity emerged as an independent factor influencing DA in final examination scores, with higher scores and a greater merit or distinction rate in students of a White heritage.

Gender, Sexual Orientation or Disability

In its traditional binary sense, men and women reflect different attitudes, behaviours and skills. Gender is recognised to have an important determinant in medical education. Medical student evaluations vary depending on the gender of the student and even of the evaluator, demonstrating a gender bias in qualitative assessment of learners, obtaining letters of recommendations, where male students are described with a more positive tone and use of professional/ authoritative descriptors as compared to female residents. Fewer women are invited to speak at grand rounds and there are 'traditional' differences in the less formal introductions offered to female speakers. 13

In a postal study on their own perceptions of attributes of a good doctor, there were fundamental gender-based differences. Men felt better equipped with attributes of leadership, curiosity, tolerance of uncertainty compared to the women, who felt more confident in demonstrating a caring and compassionate nature, supporting their teams, and in the ability to forge better interpersonal relationships.14 Gender also features prominently in stereotypical choices, medical professionals make or are encouraged to make. Throughout medical education, surgery is predominantly preferred by men and gynaecology, paediatrics and general practice by women. 15

The major theoretical framework tends to be the socialization or sex-role theory, while other influencers are usually structural such as the availability of support or mentorship that women and men experience differently in making their career decisions. Women are socially programmed to expect family demands to hamper career plans, and often early negative experiences or lack of encouragement, deter women from choosing (eg. surgery) a career. Recent studies suggest that these stereotypes are shifting as lifestyle choices may influence both female and male students.16 Also, the intersectionality of gender and minority ethnic bias, often poses a double challenge for students aspiring for certain specialties.

However, this definition does not include other non-racial or ethnic groups that may be underrepresented in medicine, such as lesbian, gay, bisexual, transgender, or questioning/queer or Asexual (LGBTQ+A) individuals, where data may not yet be reported. There is an estimated prevalence of 8.7% of persons with disabilities in the general population, while the prevalence of physicians with disabilities is estimated to be a mere 2.7%. 17

Stereotypes also inadvertently play a significant role in medical education. Presentation of patients and clinical vignettes often begin with a patient's age, presumed gender, and presumed racial identity. Automatic associations and mnemonics help medical students remember that, on examination, a black child with bone pain may have sickle-cell disease or a white child with recurrent respiratory infections may have cystic fibrosis. These learning associations are often based on true prevalence rates, but may not apply to individual patients, thus may lead to premature closure of the process of derivation and missed diagnoses. 13

Compared with heterosexual peers, LGBTQ+A populations experience disparities in physical and mental health outcomes. Stigma and bias (both conscious and unconscious) projected by medical professionals toward the LGBTQ+A population play a major role in perpetuating these disparities and are victims of such stereotyping themselves.18 Non-white LGBTQ+A medical students experience medical school at an intersection of sexual-identity oppression and racial discrimination, often witness the unfair attitudes towards LGBTQ+A patients, feel isolated, abandon hopes of creating close relationships with educators and end up suppressing important aspects of their identities This hostile and non-inclusive environment may lead to additional stress in the work environment, contributing to poor mental health. 192021

Mentorship

Optimal mentoring relationships appear to be relational, where shared values, trust, and a personal connection is important and may be more important than gender concordance. Thus students often express a desire for access to female mentors, but when a mentor and mentee develop a personal connection, the gender of the mentor becomes less important. Gender-based assumptions and stereotypes can affect mentoring relationships and influence what may be disclosed to (male) mentors and mentors in positions of power.22 One-to-one mentoring can create conditions to develop professional competences, such as reflective capacity, emotional competence and the feeling of belonging to a professional community. 23

In addition to tensions of gender or sexual orientation, DA in access to mentorship can stem from issues such as power differentials or personality conflicts 24 and racial, social or cultural differences between the mentor and mentee. Often lack of role models, inexperience of the mentor, lack of motivation or institutional support may affect the access to membership for certain disadvantaged or minority groups. Teachers who share the same ethnic background as students, often demonstrate better understanding of the multi-factorial challenges, favourably judge their language proficiency in their mother tongue and perceive students as more proficient 25 than, ethnically unmatched teacher groups.

Age & Less than Full time

Age can be a factor for determining career choices, offering hurdles, disincentives and deterrence for choices and progression. Graduate entrants to medicine are more likely to seek to immediately progress into specialty training, compared with their peers who did medicine as a primary first degree. 26 Many of the IMGs, who enter postgraduate medical training in the UK are usually older than their counterparts, having spent time in postgraduate training in their home countries. There is a perception that, they therefore, are less likely to be able to adapt to the ways of the UK and take longer in acculturation. This is likely to be a determinant in their progression.
Physicians with disabilities and those training in less than full time roles, often feel compelled to work twice as hard for acceptance, struggle with social stigma and microaggressions, and encounter institutional climates of isolation and othering. 27

Bias from Patients/ Service Users

Reports of biased behaviour range from patient refusal of care and explicit racist, sexist, or homophobic remarks to belittling compliments or jokes. Targeted physicians report an emotional toll that includes exhaustion, self-doubt, and cynicism. Nontargeted bystanders report moral distress and uncertainty about how to respond. Affected individuals often respond by withdrawing from clinical roles, feel a heightened pressure in making clinical decisions, and an inexplicable fear of committing any errors. Barriers to effective functioning for students affected by such responses include lack of skills in coping with discrimination, insufficient support from senior colleagues and the institution, and perception of lack of utility associated with responding. 28

Curricula and Diversity of the Learning Environment

Mountford-Zimdars at al. 11 in reviewing the causes of differential outcomes in undergraduate education emphasise the importance of the learning environment noting that the learning, teaching and assessments practices of institutions are not mindful of student groups that fall outside the majority. Minority student groups do not find a 'sense of belonging' within their learning environments or indeed with the content of the curriculum and this strains relationships between staff and students or demotivates them. Due to the socio-cultural and economic capital of black and minority ethnic medical students being different from their peers, there is often a philosophical disconnect that in turn impacts their ability to network.

Woolf et al. 29 report that black and minority ethnic medical students experience reduced social support and an adverse learning environment, leading to a culture of discrimination. Isik et al. 30 found that autonomous motivation was more prevalent in ethnic minorities, when comparing the motivational styles with that of the majority group in Dutch medical schools. It is likely therefore that the negative learning culture and experience that Woolf et. al. describe for black and minority ethnic students may force them away from autonomous to controlled de-motivation. Similar observations have been reported from Majumder et al who describe medical education in South East Asia, as being "colonial-biased, subject-oriented, teacher-centred and hospital-based" indicating a role for a non-autonomous/ unempowering learning culture in leading to DA for certain groups. 9.

In a UK General Medical Council (GMC) commissioned review de Bere et al. 31 found that the causes of DA were multifactorial and embedded in educational and social factors. In order

to unpick the factors explaining DA in UK medical schools, a thematic scoping review was commissioned by BAPIO Institute for Health Research (BIHR) to identify themes associated with DA. The aim of this review is to identify the mechanisms that facilitate and impede DA in UK undergraduate medical students. Identifying these themes will provide a starting point to work towards reducing inequalities in educational attainment. A brief overview of the review's methodology and key findings are presented below.

Methods:

Seven online databases including PubMed, Scopus, and ERIC were searched. A formal grey literature search was also conducted for any relevant documents through the BMA, the GMC and HEE National Grey Literature Collection. Inclusion criteria included studies dated from January 1995 to present, therefore only those pertaining to the last 25 years. Further, this review only considers UK medical students as the ethnic mix and circumstances of communities in the UK cannot be validly compared to other developed nations. All types of literature were considered, provided they were in English. Thirteen papers form the preliminary findings, selected as they provided high quality, detailed narratives on DA. The analysis has created a conceptual framework for a further mixed methods analysis. These themes have been interlinked and form the basis from which the narrative synthesis progresses.

Results

Five key themes emerged from the preliminary analysis of the thirteen papers. These themes were being 'different', social capital, continuum of discrimination, intersectionality, institutional factors, and level of external support (summarised in the table 1).

Table 1: Themes associated with DA in undergraduate medical education

Theme	Constructs
Being Different	Recognising individuals have different back grounds and to be mindful of these differences.
Social Capital	Each individual brings their own social and cultural background which others may be unfamiliar with. Those in positions of responsibility for teaching need to be aware of the socio-cultural differences.
Continuum of Discrimination	Discriminatory ideas and practices follow students throughout their education and beyond, impacting their ability to aspire and their confidence.
Institutional Factors	Institutions have not set interventions in place to tackle the DA in their educational environments – partnerships between those widening access and Universities need to be strengthened.
Level of External Support	Differential in support systems for BAME students, where they have less access to help or feel less able to reach out for help – including mentoring schemes.

i: *Being Different*

Black and minority ethnic undergraduate medical students in higher education, experience social isolation being of a minority culture or religion, contributing to the perception of being "different" and being 'othered'. Ethnically-defined social networks influence the informal transfer of knowledge impacting academic performance and isolating minority groups from useful academic information. The evidence that being different poses a significant disadvantage is clear - from being unable to attend social and academic functions for cultural or family reasons to feeling the pressure to change their behaviour to combat negative stereotypes in a variety of contexts, "fitting in" can be a challenge. 32 In all analyses, after accounting for confounding variables, grading disparities favour White students, 33 and ethnicity predicts final exam scores. 34 While subjective bias in grading, cannot be ruled out as a cause of lower grades in clinical training, 35 ethnic stereotyping of learning styles does not appear to be a major36,37) contributory factor. Ethnicity-related differences in clinical grades are demonstrably smaller in broadly sampled than in global assessments, however, when supervisors are allowed to deviate from original grades, ethnicity-related differences in clinical grades are reintroduced. Hence there is evidence of discrimination on the basis of ethnicity. 38 The modality of assessment may lend itself to gender related disparity. Female students tend to perform better in personal and professional development, course assessment and short answer questions, while men do better in anatomy and physiology and examinations containing multiple choice or True-False-Abstain (TFA) formats (Males were 17 times more likely than females to do better on an assessment, if it had any questions using the TFA format). 39

When comparing national and international students, differential item functioning analyses may demonstrate items with bias ranging from 34% to 36%. While more complex items with more alternatives favoured the (predominately white) local students, shorter items and fewer alternatives favoured international students, indicating the role of linguistic ability and cultural familiarity in theoretical tests. 40

ii *Social Capital*

Social networks provide access to a number of resources, creating channels through which resources can potentially flow between members. Connections within a close social circle, in higher education can be a significant factor in determining attainment. These networks help individuals to cope, through support and reinforcement of identity and are links between like-minded people. Cohesive groups tend to do better in medical school exams, than those outside these networks. Woolf et. al. found that students were more likely to be friends with others of the same gender and ethnicity. 12 Bringing people from different social and cultural backgrounds together, helps

individuals to get access to resources unavailable within their close network. Students from non-white, Muslim and lower achieving groups are least likely to gain from the benefits of social capital resulting from interaction with members from more diverse social groups. Lower levels of social capital that mediates interaction with peers, tutors and clinicians may be the cause of underperformance by ethnic minority students. Due to gaps in their social network, minority students may be cut off from potential and actual resources that facilitate learning and achievement. 41

iii- *Continuum of Discrimination*

Black and minority ethnic students report feeling less satisfied with their educational experience, report anxiety and negativity in their professional interactions. This is underpinned by negative stereotypes from staff members associated with minority groups (e.g. the stereotype that Asian students are poor at communication skills). Non-native speakers are awarded significantly lower mean scores in communication stations, while female native speakers out-perform male students. 42
The use of narrative feedback has been shown to depend on gender or minority ethnic status, which suggests implicit bias. However, words that differ by gender usually refer to personal attributes, such as "lovely" in evaluations of women, while those that represent competency behaviours, such as "scientific" appear frequently in evaluations of men. It is more common for minority ethnic students being described by personal attributes, such as "pleasant" then, competency-related behaviours, such as "knowledgeable". 43 The experience of students with disability or belonging to LGBTQ+A sexual determination is no different. Some institutions recommend best practices include utilising the affirming name and pronouns for all applicants and not asking gender identity during an interview unless self-disclosed. 44

iv- *Support & Mentorship*

Black and minority ethnic students are less likely to receive external support such as mentoring or sponsorship suggesting areas that universities could improve to help reduce DA. A key factor emerging from the literature is that of the repetitive, continuing nature of microaggressions. Data outlining these differentials in spheres such as postgraduate examinations or in career opportunities, serves to create a negative “continuum of discrimination” that impacts on black and minority ethnic students at multiple milestones along their career pathway.

Strategies to address DA

Our scoping review demonstrates clearly that DA is complex and exists in undergraduate medical education. The evidence from various studies also suggests measures that may help to mitigate the causes and contributors. Any strategies should include measures at individual, organisation and regional/ national level.

i. Macro level - a Culture of Inclusion

Organizations can commit to a roadmap of building capacity for change by recruitment of a critical mass of underrepresented individuals, reflecting the population that they serve and the diversity that is reflected in their workforce. Organisations should be benchmarked for the recruitment of culturally competent leaders who take the role of change agents and have the power to create diverse and equitable environments. These leaders need not themselves be from minority or underrepresented groups because culture change requires the involvement of allies within the majority groups (eg, men, white people, and cis-gender heterosexual individuals).

Committing to a culture of inclusion at the medical school level involves creating a deliberate strategy for medical student admission and evaluation and hiring, promotion, and retention of a diverse and culturally competent faculty. The Athena Swan benchmarking to encourage gender equality and recent measures to tackle the gender pay gap, had limited success. 45

i*i -the power of data*

Strategies for achieving diversity through medical school admissions, which includes having admissions committee members undertake robust training and reflection on potential biases, appointing women, minorities, and junior medical professionals (students or junior faculty), emphasizing the importance of different perspectives and backgrounds. There are initiatives for widening participation from socio-economically deprived communities by offering targeted support and similar incentives. Some students, however, are hampered by uncertainty as to their place within higher education, therefore need extra reassurance that their experience and beliefs are valued if they are to realise their potential. 46 Collection and benchmarking of medical schools admission data on the socio-economic profile of medical students and applicants, including characteristics such as ethnicity, gender and educational background has been achieved using the wide array of data brought together by the UK Medical Education Database, or UKMED. UKMED is run jointly by the Medical Schools Council and GMC, and in compiling the data section of the new report extensive use was made of the Higher Education Statistics Authority data within UKMED. The Selection Alliance has been using UKMED to build on these data and produce a clearer picture of the barriers faced by applicants in applying to medicine, as well as on their progress in medical school and after qualification.47

There is support from the governmental and regulatory agencies through Teaching Excellence Framework, the selection for excellence projects in encouraging medical school admissions from state school pupils, applicants with disability, but there have been many ideological counter-challenges. Applicants to higher education and students from an ‘Asian or Asian British’ or ‘Black or Black British’ background are also over-represented when compared to the UK population as measured in the 2011 UK census. Students with a declared disability have increased representation in medical schools from 6.6% in 2011 to 9.9% in 2015. 10

Organizations should undertake, publish and implement actions from benchmarking surveys of staff perceptions of inclusivity, engagement, a sense of belonging and provide safe, responsive avenues to report experiences of bias on the grounds of cultural or demographic factors (e.g. freedom to speak up guardians). The NHS staff survey and the Workforce

Race Equality standards 48 have been in existence for some years. They provide a publicly available data set and national benchmarks for organisations to measure themselves against their peers. However, there is an unfortunate picture of sluggish movement towards improvement in the measures. There is transparency but lack of accountability for organisations which fail to act.

Commitment to reform from the highest leadership combined with transparency of survey data can help organizations to ensure that their training on unconscious bias and promotion of cultural humility lead to long-term positive change. Many institutions undertook a pledge to tackle discrimination and racism, with ceremonial demonstration of the phenomenon of 'taking the knee' in support of the resurgence of 'Black lives matter' movement in 2020.49 Institutions through the equality, diversity and inclusion committees, should seek and offer recommendations, from the students themselves, relate to diversity and allyship, curriculum change, open conversations, and safe spaces.

ii. Meaningful Diversity Training

Although the measures taken by the UK General Medical Council and Health Education England in training and accreditation of clinical and educational supervisors, in ensuring that equality, diversity and unconscious bias training is mandatory for all participation in education, recruitment etc, there has been little meaningful change in the markers of inequality and discrimination.

iii. (Micro) Deliberative Reflection

Before encounters that are likely to be affected by bias (such as trainee evaluations, letters of recommendation, feedback, interviews, committee decisions, and patient encounters), deliberative reflection can help an individual recognize their own potential for bias and correct for this. It is also a good time to consider the perspective of the individual whom they will be evaluating or interacting with and the potential impact of their biases on that individual. Participants can be encouraged to evaluate how their own experiences and identities influence their interactions.
This motivated self-regulation based on reflections of individual biases has been shown to reduce stereotype activation and application.

iv. Strategies to address personal bias

Individuals may question how they can actively counter stereotypes and bias in observed interactions. The active-bystander approach adapted from the Kirwan Institute can provide insight into appropriate responses in these situations.

v. (Meso) Cultural Competency

The term "cultural competence" implies that one has achieved a static goal of championing inclusivity. This approach imparts a false sense of confidence in leaders and healthcare professionals and fails to recognize that our understanding of cultural barriers is continually growing and evolving. Other synonymous terms include "cultural sensitivity" and "cultural curiosity." By training leaders and professionals that they do not need to be and ultimately cannot be experts in all the intersecting cultures that they encounter, leaders can focus on a readiness to learn that can translate to greater confidence and willingness in caring for patients of varying backgrounds. By integrating cultural humility into healthcare training procedures, organizations can strive to eliminate the perceived unease healthcare professionals might experience when interacting with individuals from backgrounds or cultures unfamiliar to them. 50

vi. (Meso) Counter stereotypical Interactions

Exposing individuals to counter stereotypical experiences can have a positive impact on unconscious bias. Therefore, intentional efforts to include faculty from underrepresented groups as preceptors, educators, and invited speakers can help reduce the unconscious associations of these responsibilities as unattainable. Furthermore, in medical training, while deliberate curricula involving disparities and care of underrepresented individuals are beneficial, educators must be aware of the impact of the hidden curriculum on their trainees. The term "hidden curriculum" refers to the aspects of medicine that are learned by trainees outside the traditional classroom/didactic instruction environment. It encompasses observed interactions, behaviours, and experiences often driven by unconscious and explicit bias and institutional climate. Students can be taught to actively seek out the hidden curriculum in their training environment, reflect on the lessons, and use this reflection to inform their own behaviours.

Individuals can intentionally diversify their own circles, connecting with people from different backgrounds and experiences. This can include the occasionally awkward and uncomfortable introductions at professional meetings or at community events, making an effort to read books by diverse authors, or trying new foods with a colleague. These are small behavioural changes that, with time, can help to retrain our brain to classify people as "same" instead of "other."

vii. Mentorship and Sponsorship

Mentors can, at any stage in one's career, provide advice and career assistance with collaborations, but sponsors are typically more senior individuals who can curate high-profile opportunities to support a junior person, often with potential personal or professional risk if that person does not meet expectations. Possible reasons include lack of mentors from similar backgrounds or ineffective mentoring in discordant mentor-mentee relationships.

Conclusion

DA, is present in all aspects of undergraduate medical education and contributes to inequalities in higher education and impact on the healthcare workforce, as well as patient care. The mechanisms underlying DA are complex and include many causes and contributing factors from social, economic and demographic factors but also include explicit or implicit bias and processes of recruitment to assessment. There are several barriers and cultural incompetence of the majority, as well as hindered engagement from the minority, which continue to remain live issues.

Understanding the underlying mechanisms for DA is a pre-requisite for designing interventions aimed at ensuring fair educational outcomes among disadvantaged students. While ethnicity may emerge as an independent risk factor for DA, gender intersectionality with factors such as socio-economic status or disability need to be considered. The current literature exploring DA within medical education has largely focused on summative assessments, particularly in the setting of final-year undergraduate exams.

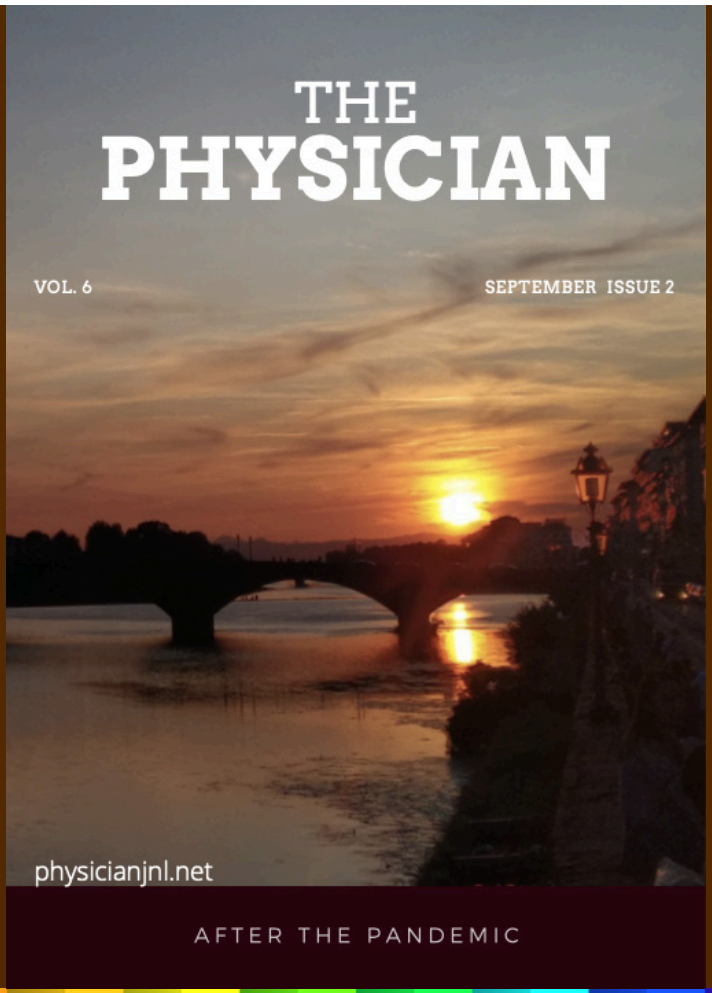
Given the findings of the importance of learner-educator interactions, of the learning culture in Universities, the importance of culturally competent leadership, transparency of data, benchmarking and accountability, diverse social networks including targeted support (mentorship and sponsorship), will be important to address DA.

Our research outlines areas where interventions might be targeted. Piloting such interventions would be a natural next step. Stakeholders including medical schools, GMC and BAPIO need to be at the forefront, urgently executing these interventions to tackle DA if we are to avoid leaving behind yet another generation of doctors.

References

1. Protocol for Thematic Synthesis of Differential Attainment in the Medical Profession - 'Bridging the Gap' Series | Sushruta Journal of Health Policy & Opinion. Accessed October 31, 2020. https://www.sushrutajnl.net/index.php/sushruta/article/view/91
2. Dave S, Chakravorty I, Menon G, Sidhu K, Bamrah JS, Mehta R. Differential Attainment in Summative Assessments within Postgraduate Medical Education & Training: Sushruta J Health Policy Opin. 2020;13(3). doi:10.38192/13.3.15
3. Executive summary | Falling short: the NHS workforce challenge. Health Foundation. Accessed October 31, 2020. https://reader.health.org.uk/falling-short/executive-summary
4. Capers Q, Clinchot D, McDougle L, Greenwald AG. Implicit Racial Bias in Medical School Admissions. Acad Med J Assoc Am Med Coll. 2017;92(3):365-369. doi:10.1097/ACM.0000000000001388
5. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. JAMA Netw Open. 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723
6. The NHS Constitution for England. GOV.UK. Accessed August 31, 2020. https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
7. Cognitive and Human Factors in Expert Decision Making: Six Fallacies and the Eight Sources of Bias | Analytical Chemistry. Accessed October 31, 2020. https://pubs.acs.org/doi/10.1021/acs.analchem.0c00704
8. Lempp H, Seale C. Medical students' perceptions in relation to ethnicity and gender: a qualitative study. BMC Med Educ. 2006;6:17. doi:10.1186/1472-6920-6-17
9. Woolf K. Fair Training Pathways for All: Understanding Experiences of Progression - Final Report. :69.
10. msc-selection-alliance-2017-report.pdf. Accessed October 31, 2020. https://www.medschools.ac.uk/media/2388/msc-selection-alliance-2017-report.pdf
11. Mountford-Zimdars A, Sanders J, Moore J, Sabri D, Jones S, Higham L. What can universities do to support all their students to progress successfully throughout their time at university? Perspect Policy Pract High Educ. 2017;21(2-3):101-110. doi:10.1080/13603108.2016.1203368
12. Woolf K, Rich A, Viney R, Needleman S, Griffin A. Perceived causes of differential attainment in UK postgraduate medical training: a national qualitative study. BMJ Open. 2016;6(11):e013429. doi:10.1136/bmjopen-2016-013429
13. Marcelin JR, Siraj DS, Victor R, Kotadia S, Maldonado YA. The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It. J Infect Dis. 2019;220(Supplement_2):S62-S73. doi:10.1093/infdis/jiz214
14. Clack GB, Head JO. Gender differences in medical graduates' assessment of their personal attributes. Med Educ. 1999;33(2):101-105. doi:10.1046/j.1365-2923.1999.00268.x
15. Alers M, van Leerdam L, Dielissen P, Lagro-Janssen A. Gendered specialities during medical education: a literature review. Perspect Med Educ. 2014;3(3):163-178. doi:10.1007/s40037-014-0132-1
16. Riska E. Gender and medical careers. Maturitas. 2011;68(3):264-267. doi:10.1016/j.maturitas.2010.09.010
17. Meeks LM, Herzer KR. Prevalence of Self-disclosed Disability Among Medical Students in US Allopathic Medical Schools. JAMA. 2016;316(21):2271-2272. doi:10.1001/jama.2016.10544
18. Valdiserri RO, Holtgrave DR, Poteat TC, Beyrer C. Unraveling Health Disparities Among Sexual and Gender Minorities: A Commentary on the Persistent Impact of Stigma. J Homosex. 2019;66(5):571-589. doi:10.1080/00918369.2017.1422944
19. Toman L. Navigating medical culture and LGBTQ identity. Clin Teach. 2019;16(4):335-338. doi:10.1111/tct.13078
20. Sánchez NF, Rankin S, Callahan E, et al. LGBT Trainee and Health Professional Perspectives on Academic Careers--Facilitators and Challenges. LGBT Health. 2015;2(4):346-356. doi:10.1089/lgbt.2015.0024
21. Dimant OE, Cook TE, Greene RE, Radix AE. Experiences of Transgender and Gender Nonbinary Medical Students and Physicians. Transgender Health. 2019;4(1):209-216. doi:10.1089/trgh.2019.0021
22. Levine RB, Mechaber HF, Reddy ST, Cayea D, Harrison RA. "A good career choice for women": female medical students' mentoring experiences: a multi-institutional qualitative study. Acad Med J Assoc Am Med Coll. 2013;88(4):527-534. doi:10.1097/ACM.0b013e31828578bb
23. Kalén S, Ponzer S, Silén C. The core of mentorship: medical students' experiences of one-to-one mentoring in a clinical environment. Adv Health Sci Educ Theory Pract. 2012;17(3):389-401. doi:10.1007/s10459-011-9317-0
24. Kow CS, Teo YH, Teo YN, et al. A systematic scoping review of ethical issues in mentoring in medical schools. BMC Med Educ. 2020;20(1):246. doi:10.1186/s12909-020-02169-3
25. Glock S, Schuchart C. The ethnic match between students and teachers: evidence from a vignette study. Soc Psychol Educ. 2020;23(1):27-50. doi:10.1007/s11218-019-09525-2
26. Scanlan GM, Cleland J, Stirling SA, Walker K, Johnston P. Does initial postgraduate career intention and social demographics predict perceived career behaviour? A national cross-sectional survey of UK postgraduate doctors. BMJ Open. 2019;9(8):e026444. doi:10.1136/bmjopen-2018-026444
27. Meeks LM, Herzer K, Jain NR. Removing Barriers and Facilitating Access: Increasing the Number of Physicians With Disabilities. Acad Med J Assoc Am Med Coll. 2018;93(4):540-543. doi:10.1097/ACM.0000000000002112
28. Wheeler M, de Bourmont S, Paul-Emile K, et al. Physician and Trainee Experiences With Patient Bias. JAMA Intern Med. 2019;179(12):1678. doi:10.1001/jamainternmed.2019.4122
29. Woolf K, Viney R, Rich A, Jayaweera H, Griffin A. Organisational perspectives on addressing differential attainment in postgraduate medical education: a qualitative study in the UK. BMJ Open. 2018;8(3). doi:10.1136/bmjopen-2017-021314
30. Isik U, Wouters A, Ter Wee MM, Croiset G, Kusurkar RA. Motivation and academic performance of medical students from ethnic minorities and majority: a comparative study. BMC Med Educ. 2017;17(1):233. doi:10.1186/s12909-017-1079-9
31. Nunn S. Understanding differential attainment across medical training pathways: A rapid review of the literature. :89.
32. Claridge H, Stone K, Ussher M. The ethnicity attainment gap

among medical and biomedical science students: a qualitative study. BMC Med Educ. 2018;18(1):325. doi:10.1186/s12909-018-1426-5
33. Low D, Pollack SW, Liao ZC, et al. Racial/Ethnic Disparities in Clinical Grading in Medical School. Teach Learn Med. 2019;31(5):487-496. doi:10.1080/10401334.2019.1597724
34. Woolf K, McManus IC, Potts HWW, Dacre J. The mediators of minority ethnic underperformance in final medical school examinations: The mediators of minority ethnic underperformance in final medical school examinations. Br J Educ Psychol. 2013;83(1):135-159. doi:10.1111/j.2044-8279.2011.02060.x
35. Stegers-Jager KM, Steyerberg EW, Cohen-Schotanus J, Themmen APN. Ethnic disparities in undergraduate pre-clinical and clinical performance. Med Educ. 2012;46(6):575-585. doi:10.1111/j.1365-2923.2012.04265.x
36. Stegers-Jager KM, Brommet FN, Themmen APN. Ethnic and social disparities in different types of examinations in undergraduate pre-clinical training. Adv Health Sci Educ Theory Pract. 2016;21(5):1023-1046. doi:10.1007/s10459-016-9676-7
37. Stegers-Jager KM. Is it them or is it us? Unravelling ethnic disparities in undergraduate clinical performance. BMC Med. 2017;15(1):190. doi:10.1186/s12916-017-0959-5
38. van Andel CEE, Born MP, Themmen APN, Stegers-Jager KM. Broadly sampled assessment reduces ethnicity-related differences in clinical grades. Med Educ. 2019;53(3):264-275. doi:10.1111/medu.13790
39. Kelly S, Dennick R. Evidence of gender bias in True-False-Abstain medical examinations. BMC Med Educ. 2009;9:32. doi:10.1186/1472-6920-9-32
40. Cecilio-Fernandes D, Bremers A, Collares CF, Nieuwland W, Vleuten C van der, Tio RA. Investigating possible causes of bias in a progress test translation: an one-edged sword. Korean J Med Educ. 2019;31(3):193-204. doi:10.3946/kjme.2019.130
41. Vaughan S, Sanders T, Crossley N, O'Neill P, Wass V. Bridging the gap: the roles of social capital and ethnicity in medical student achievement. Med Educ. 2015;49(1):114-123. doi:10.1111/medu.12597
42. Schoonheim-Klein M, Hoogstraten J, Habets L, et al. Language background and OSCE performance: a study of potential bias. Eur J Dent Educ Off J Assoc Dent Educ Eur. 2007;11(4):222-229. doi:10.1111/j.1600-0579.2007.00459.x
43. Rojek AE, Khanna R, Yim JWL, et al. Differences in Narrative Language in Evaluations of Medical Students by Gender and Under-represented Minority Status. J Gen Intern Med. 2019;34(5):684-691. doi:10.1007/s11606-019-04889-9
44. Weinand JD, Ehlinger EP, Conniff JF, Hayon RL, Kvach E. Supporting Transgender and Nonbinary Residents. Transgender Health. 2019;4(1):222-225. doi:10.1089/trgh.2018.0074
45. Rosser SV, Barnard S, Carnes M, Munir F. Athena SWAN and ADVANCE: effectiveness and lessons learned. Lancet Lond Engl. 2019;393(10171):604-608. doi:10.1016/S0140-6736(18)33213-6
46. Garlick PB, Brown G. Widening participation in medicine. BMJ. 2008;336(7653):1111-1113. doi:10.1136/bmj.39508.606157.BE
47. Medical school widening participation work boosted by powerful data tool | Medical Schools Council. Accessed October 31, 2020. https://www.medschools.ac.uk/news/medical-school-widening-participation-work-boosted-by-powerful-data-tool
48. NHS England » NHS Workforce Race Equality Standard. Accessed May 24, 2020. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
49. Black Lives Matter. In: Wikipedia. ; 2020. Accessed August 6, 2020. https://en.wikipedia.org/w/index.php?title=-Black_Lives_Matter&oldid=971334380
50. Roberts LW. Belonging, Respectful Inclusion, and Diversity in Medical Education. Acad Med. 2020;95(5):661–664. doi:10.1097/ACM.0000000000003215



Impact of COVID-19 pandemic on training of junior doctors in the UK: Implications for BAME trainee doctors

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Abstract
The recent coronavirus disease (COVID-19) pandemic has caused detriment to all factions of society on a global scale. This article aims to examine the impact of COVID-19 pandemic on trainees, particularly from ethnic minorities and the steps that employer and educators can take to support them.

Keywords COVID19; medical training; junior doctors; BAME

Background

Coronavirus disease (COVID-19) is a recently discovered virus. The ensuing pandemic has led to mass disruptions in countries around the world. From curfews and lockdowns to a near shutting down of economic activity, it is clear that COVID-19 has had a huge impact on all members of the community.
A striking feature of the recent pandemic has been the increased risk of mortality and severe morbidity faced by Black, Asian and

Minority Ethnic (BAME) communities in the United Kingdom. A comparison carried out by the Office for National Statistics (ONS) (1) showed that even when factors such as age, socio-demographic factors and disability were accounted for, risk of COVID-19 related deaths in the BAME community was higher than those of white ethnicity. A seminal report by the Royal College of Psychiatrists (2) examining the impact of COVID-19 reported that around two- thirds of healthcare staff who have died are from a BAME background despite representing only one fifth of the workforce. This discrepancy has prompted several organisations to study wider factors that could explain the higher risk in BAME communities.
A recent review by The Lancet (3) associated quarantine with a negative psychological effect, even months and years after the outbreak has passed and quarantine has ended. A study in Singapore (4) evidenced the prevalence of depression, stress, anxiety and post-traumatic stress disorder (PTSD) among a large section of healthcare workers who were at work during the pandemic. A host of factors have been implicated - the loss of social interaction, confinement to a single place of residence and stress about the health risks for oneself and family can all contribute to the psychological impact of quarantine.

Why are BAME healthcare workers at higher risk?
The ONS findings mentioned above indicate that a BAME background is an independent risk factor regardless of other characteristics such as age, gender, socio-economic status, etc. This is further supported by the analysis carried out by Goldacre et al. (5), who found that people of Asian and Black ethnic origin were found to be at a higher risk of death. It is pertinent to note that the majority of the Healthcare Workers (HCWs) who succumbed to COVID19 were international HCWs. The study goes on to suggest that higher prevalence of medical conditions such as hypertension and diabetes accounts for only a small portion of excess risk, further supporting the idea that BAME background is a risk factor independent to any others.

It is difficult to pinpoint the reason(s) for this discrepancy. Different theories have been postulated, one such being that of overcrowded housing. According to government data on overcrowded households (6), 30% of Bangladeshi households, 16% of Pakistani households and 15% of Black African households were classified as overcrowded in 2014-2017. This is compared to 2% of White British households. Goldacre et al. (7) also suggest that over-representation on the front-line may also play a role in the increased risk for BAME communities. This is demonstrated in government data (8,9) which reports that 29.7% of medical staff working for the National Health Service (NHS) in England are of Asian ethnicity as of March 2019, despite representing 7.5% of the overall population in England and Wales at the time of the 2011 census. The

Workforce Race Equality Standard (WRES) report in 2019 (10) also unveiled several reasons why BAME healthcare workers may be at higher risk for reasons pertaining to the work environment. BAME workers were less likely to report personal experience of discrimination and less likely to raise concerns, for example with regards to lack of Personal Protective Equipment (PPE). They may also face discrimination around ϑit testing for PPE due to cultural reasons such as keeping a beard or wearing a veil or turban. Chakravorty et al. (11) found early on in the pandemic that almost half of BAME hospital doctors reported that they did not have access to appropriate PPE in accordance with Public Health England guidance. The same report also showed that 75% of BAME doctors were not able to comply with social distancing guidance when at work or commuting to work. Surveys conducted by the Royal College of Psychiatrists (12), British Medical Association (BMA) (13) and British Association of Physicians of Indian Origin (BAPIO) (14) suggest that doctors were not equipped with an appropriate level of PPE. Big proportions of Foundation trainees were not provided with any formal training or support for their personal safety during the COVID-19 outbreak. (15) BAME doctors are overrepresented in Specialist and Associate Specialist doctors and may be overrepresented in on call and frontline rotas (16), which worrying contributory factor for the disproportionate death rate in IMG and BAME staff.

Trainee specific issues during COVID-19 pandemic in the UK
Due to COVID-19, a number of changes were implemented across NHS, which meant a change in learning environment and opportunities. Some doctors were being asked to serve in different roles and tasks that are non-related to their primary specialty (17). They have been asked to cover gaps and shortages in personnel in other specialty as other colleagues are being isolated, shielding or infected with COVID-19. (18) According to a survey, training in the new clinical areas had its own demands with some anxiety in their new role and requirements. The varying level of demands on the department resulted at times some doctors felt they were not needed in their new role and placement. (19) More than 20,000 doctors were supposed to be rotate to their new placement area during the pandemic, but these moves were paused to avoid disruptions to services. With scheduled rotations paused, trainee doctors may experience a reduction in learning opportunities due to a shift towards unscheduled, acute care and lack of availability of senior staff capable of supervising learning activities. During the pandemic most elective surgeries were cancelled, and only small number of procedures were undertaken (mainly cancer procedures, emergencies, and obstetrics). Because of lower needs, junior surgical trainees lost opportunities for solo lists and hands-on experience. Only senior trainees had access to emergency procedures with limited number of theatre staff, so they had pressure to perform all procedures with minimal or no supervised learning environment.

There was a significant reduction in number of cases trainees could record in their procedural logbook, for example in Orthopaedic specialty (76% reduction for core surgical trainees and 90% reduction for Specialty registrars) (20). In anaesthetic specialty, due to change in processes around airway management, some hospitals had set up specific teams managing intubation and extubation of most of the COVID – 19 patients. Though it helped in limiting staff exposure to Aerosol Generating Procedures, such specific teams didn't involve junior trainees. Similarly, airway skill exposure was lower as most of the elective cases were performed under regional anaesthesia. In cardiac surgeries, all operative procedure were high risks, so most of the surgical procedures performed by consultants, hence there was a greater diminish in number of cases and training opportunities for trainees. (21) During pandemic most of the outpatient face to face clinic were converted to virtual clinics, such as telephone or video consultation. Trainees were not allowed to be participate in virtual clinics, hence no learning opportunities for consultation in outpatient department.

A survey during the pandemic suggested challenges around Workplace Based Assessments (WBA) and reduction in confidence in practical procedures amongst trainees. Trainees did not have same opportunities to complete audit cycles compared to pre-COVID era. (22). The Academy of Royal Colleges (AoMRC) made the decision to cancel all exams in the wake of COVID restrictions. While examination fees were deferred, this was small mitigation given the level of disruption. Deferred exams mean renewal of subscriptions for preparation materials, an added year of stress, and more distraction during arduous times. These challenges were reflected in Annual Review of Competence Progression (ARCP) and various colleges relaxed usual stringent standards to allow progression to next steps.

What may concern training of BAME junior doctor during pandemic?

One specific group amongst healthcare professionals plagued with uncertainty are doctors in training from BAME doctors and International Medical Graduates (IMGs) (16). The WRES report in 2019 (10) findings suggests BAME workers are more likely to fear being reported or warned for raising concerns around risks in the workplace, or for requesting safer alternatives. Raising concerns may adversely affect job security if they are on a temporary visa, or adversely influence career progression and pay. The 'Fair to Refer' report (23) carried out by the General Medical Council found that BAME workers are less

likely to receive constructive feedback, which can be a barrier to raising concerns. Furthermore, a report by Public Health England (24) found that BAME community stakeholders felt that racism and discrimination experienced by BAME key workers was a root cause affecting health, exposure risk and disease progression risk. Possible attributions included - fear of diagnosis, fear of speaking out and hesitancy in seeking help in early stages of disease progression.

A string of additional issues such as inadequate induction and support, difficulties accessing leadership teams and being heard, blame cultures that exacerbate feelings of being an outsider, lack of sense of belonging, bias and stereotyping were also found. All these issues can increase the likelihood of adverse outcomes due to reduced input into teams and rotas, less willingness to challenge what is given to them, and less confidence to speak out. Thus, due to prior inequalities and differential attainment in BAME or IMG doctors, the concerns of compounded effect of change in learning environment and opportunities is major.

Mitigation of potential risks to the trainees

At the centre of mitigating strategy is the need for clear, robust communication. The aforementioned Royal College of Psychiatrists report recommends a full risk assessment featuring an open collaborative conversation, with open questions aimed to give BAME workers a platform to voice their concerns without fear (11). Furthering this, a clear channel of communication could be by setting up BAME network at each NHS Trusts, to allow BAME colleagues to safely voice any concerns, take part in healthy discussion and work on generic issues such as stress, poor morale or inequality at work. One key driver for change will be the quality of equality and diversity training. Enhanced diversity training using simulation and incorporating the lived experience of BAME healthcare workers may address the criticism that such training serves to tick the political correctness box. Such training is particularly important for Educational and Clinical Supervisors and for Clinical Managers to equip them with the requisite skills to have sensitive conversations about ethnicity and culture. The need for such training was highlighted in the current pandemic with the requirement for structured risk assessments for BAME staff.

Another key change needed is greater diversity in leadership. WRES data has shown that BAME staff members are significantly underrepresented at leadership levels. The absence of visible role models is an important barrier to equity in the workplace. Diaspora organisations such as BAPIO and British Indian Psychiatric Association along with the BMA and Doctors' Association UK as representatives of doctors, are in a unique position to provide a voice to support colleagues who want to speak up about issues in their workplace related to adverse outcomes for BAME staff. Additionally, they can ensure that proposed solutions or policy changes are informed by the lived experience of BAME/IMG staff. With the right attitude, appropriate actions and engagement from across the employment spectrum, it is very possible for this pandemic to serve as a platform upon which a new, positive equitable environment can be built for IMGs and BAME colleagues.

With recovery plans been implemented with return of clinical services, educational supervisor and training program director needs to promote and safeguard training needs. Trainees should have dedicated time to catch up with WBAs, signing up other competencies, and other training needs to allow them progress in their career. Novel virtual technologies such as web-based teaching, virtual realities and simulations need to be used for training whilst we continue with safe social distancing and lack of larger seminar rooms. Similarly, trainee doctors should be trained to utilise virtual consultations with patients and supervised out-patient training. Measures needs to be in place to ensure trainees mental health and wellbeing is maintained, particularly with BAME doctors who may face uncertainties not only in NHS but also from home abroad with family members effected with COVID-19 pandemic. A BAME trainee specific representative or Training Programme Director for BAME trainees should be considered to develop further insights into complex issues. Regular anonymous surveys should be conducted to gauge challenges and progress in training needs by Health Education England (HEE) and training directors.

Conclusion

The COVID-19 pandemic has exposed deep routed inequalities in the society and healthcare settings across the globe. Junior doctors or trainee are main frontline medical doctors who are exposed to heightened risk of exposure to COVID-19 but also significant change in their work environment with lesser training opportunities. In addition to mitigating the risk of COVID-19 related morbidity and mortality, training needs are important to consider. These needs to be part of recovery and resilience planning as we move out of COVID-19.

References

1. Office for National Statistics, Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020 [accessed 20/07/20]
2. Royal College of Psychiatrists, Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings | assessment and management of risk, https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/impact-of-covid19-on-bame-staff-in-mental-healthcare-settings-report-2020.pdf?sfvrsn=22a9083a_2 [accessed 20/07/20]
3. S. Brooks et. al, 2020, The psychological impact of quarantine and how to reduce it: rapid review of the evidence, The Lancet, issue 10227, volume 398, p. 912-920
4. B. Tan et. al, 2020, Psychological Impact of the COVID-19 Pandemic on Health Care Workers in Singapore, , https://www.acpjournals.org/doi/10.7326/M20-1083 [accessed 20/07/20]
5. B. Goldacre et. al, OpenSAFELY: factors associated with COVID-19-related hospital death in the linked electronic health records of 17 million adult NHS patients, https://www.medrxiv.org/content/10.1101/2020.05.06.20092999v1#disqus_thread, [accessed 20/07/20]
6. Ethnicity facts and figures, Overcrowded households, https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest#by-eth-

nicity [accessed 20/07/20]
7. B. Goldacre et. al, OpenSAFELY: factors associated with COVID-19-related hospital death in the linked electronic health records of 17 million adult NHS patients, https://www.medrxiv.org/content/10.1101/2020.05.06.20092999v1#disqus_thread, [accessed 20/07/20]
8. Ethnicity facts and figures, NHS workforce, https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#:~:text=out%20of%20staff%20whose%20ethnicity,Chinese%20ethnic%20group%20(0.6%25) [accessed 20/07/20]
9. Ethnicity facts and figures, Population of England and Wales, https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest#by-ethnicity [accessed 20/07/20]
10. NHS, NHS Workforce Race Equality Standard 2019, https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf [accessed 20/07/20]
11. Chakravorty et. al, Self-reported Occupational Risk for COVID-19 in Hospital Doctors from Black Asian & Minority Ethnic Communities in UK, The Physician, volume 6(1)
12. Royal College of Psychiatrists, Mental health units facing 'care home style crisis' without better protection from COVID-19, https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/04/21/mental-health-units-facing-care-home-style-crisis-without-better-protection-from-covid-19 [accessed 20/07/20]
13. Keith Cooper, British Medical Association, BAME doctors hit worse by lack of PPE, https://www.bma.org.uk/news-and-opinion/bame-doctors-hit-worse-by-lack-of-ppe [accessed 20/07/20]
14. Chakravorty et. al, 2020, An Online Survey of Healthcare Professionals in the COVID-19 Pandemic in the UK, http://sushrutajnl.net/index.php/sushruta/article/view/34 [accessed 20/07/20]
15. Blackburn et. al, 2020, Impact of COVID-19 on UK Foundation Doctors: Training and Safety. https://doi.org/10.21203/rs.3.rs-30834/v1 [accessed 21/08/2020]
16. General Medical Council, Key stats from the medical register, https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report [accessed 20/07/20]
17. NHS England (2020). Redeploying your secondary care medical workforce safely. Available at: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Redeploying-your-secondary-care-medical-workforce-safely_26-March.pdf
18. Blance-Colino et. al, Surgical Training During and After COVID-19, Annals of Surgery:July 2020-Volume272-Issue1 – p e24-e26
19. Dekker et. al, How has the COVID-19 pandemic affected junior doctor training? A survey analysis. Available at https://www.researchgate.net/publication/342205707_How_has_the_COVID-19_pandemic_affected_junior_doctor_training_A_survey_analysis [accessed on 20/08/2020]
20. Dattani et. al, (2020), The impact of COVID-19 on the future of orthopaedic training in the UK, DOI : 10.1080/17453674.2020.1795790
21. Villamizar et. al, Enhancement in virtual learning cannot substitute for hands-on training in cardiothoracic surgery, Journal of Cardiac Surgery https://doi.org/10.1111/jocs.14956 [Published on 13/08/2020]
22. Khan et. al, Impact of the COVID-19 pandemic on core surgical training. Scott Med J. 2020 Aug 9:36933020949217. doi: 10.1177/0036933020949217
23. General Medical Council, Fair to refer?, https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer [accessed 20/07/20]
24. Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf [accessed 20/07/20]

CONFERENCE REPORT

Covid-19: Disparities and Lessons Learned

BAPIO midyear virtual conference 2020

ORGANISING COMMITTEE
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Article Information

Abstract
The first virtual mid-year conference organised by the British Association of Physicians of Indian Origin (BAPIO) was held on the 19 September 2020 hosted by the BAPIO North-West regional chapter. The conference digital platform used was Gurukul Education (https://gurukuleducation.online/). There were 736 registrations and 178 attended through the virtual conference hall and 803 attended the live streaming viewing facility. The conference was focused on aspects of Covid-19, from the current status in the UK and India, public health aspects of the pandemic, vulnerability of Black, Asian and Minority Ethnic (BAME) population, initiatives taken to reduce the impact on general practice or mental health services and routine non-Covid care. Strategies on reduction of risk in the workplace, formal risk assessments, promotion of a healthy lifestyle and wider societal education initiatives were incorporated. The need for ongoing research in differential adverse outcomes in BAME population was evident, as well as in prevention measures such as vaccination.

Keywords; Covid-19, health inequalities, BAME,

Introduction

There was a preconference Hatha Yoga workshop by Hemalatha Dadi who took the participants through an awareness session including the basics of yoga, as practiced by the Isha Foundation1, setting a relaxing atmosphere for the rest of the conference. The conference participants were welcomed by the Chair of the British Association of Physicians of Indian Origin (BAPIO) JS Bamrah followed by a traditional Indian lighting of lamp by Ramesh Mehta, President of BAPIO. In his introduction, Ramesh Mehta described the challenges faced by Black, Asian and minority ethnic (BAME) healthcare workers during the Covid-19 pandemic and praised the efforts of BAPIO Institute for Health
Research (BIHR) for their engagement with the frontline BAME healthcare workers. He recognised the work of BAPIO in engaging with various stakeholders in ensuring the safety of the frontline healthcare workforce and the new efforts to address the differential attainment (DA) in medical professions. He announced the formation of British Indian Nurses Association (BINA) and its official launch on 20 Nov 2020, during the BAPIO Annual Conference 2020.

Indo-UK response to Covid-19

Keynote speeches
Andy Burnham, the elected Mayor of Greater Manchester, in his keynote speech, acknowledged the impact of Covid-19 on the BAME population and paid respect to frontline warriors, who had lost their lives

during the pandemic. He reiterated that Manchester was working closely with the Health Secretary in sharing the lessons learned from Manchester, in the use of digital technology and isolation measures, for the benefit of the rest of the UK. He praised the Devolution health and social care model in Manchester2 and its contribution during the pandemic in managing the demand for personal protection equipment (PPE) and human resources across Manchester. He reflected on his experience of the 'Manchester – India partnership", 3 which was working to support healthcare initiatives in India and recognised BAPIO for its contribution to healthcare in the UK.

Sir Simon Stevens, the Chief Executive of the UK National Health Service (NHS), delivered a video message thanking all the frontline staff for their efforts in fighting the Covid-19 pandemic. He acknowledged the deep-seated inequalities and injustice in the UK healthcare system, which the Covid-19 pandemic had exposed. He praised the efforts of BAPIO in helping the healthcare professionals of Indian origin.

Public Health, Inequalities & Risk

The session chaired by Parag Singhal and Parveen Sharma, heard from Professor Kevin Fenton, who shared the public health recommendations following his review on the impact of COVID-19 on the British population.4 He explained that the risk of Covid-19 is strongly associated with age, male gender, deprivation, South Asian origin (Bangladeshi have 1.5 to 1.9 times higher risk), poor socio-economic status, presence of long term medical conditions and the type of occupation. He appealed to key stakeholders for provide targeted advice to their staff during risk assessments and the need to develop a culturally competent system for all institutions. He also mentioned that the Equalities minister Kemi Badenoch, has announced the remit of the newly constituted Commission for race and ethnic disparities5 will be investigating all aspects of inequalities in the UK society.

Covid-19 in India

Professor Anupam Sibal gave an overview of the Indian scenario during the pandemic, where approximately 75% of the healthcare is delivered through private/ independent providers and recognised the partnership with the public sectors. Currently, in India, more than one million Covid-19 tests are performed, every day. He mentioned the ongoing trials for two indigenous vaccines and participation in international trials. He mentioned ongoing treatment trials with Hydroxycholorquine and Remdesivir.6 He recognised that the overall COVID-19 mortality rate was indeed comparatively very low in India.7 He mentioned that India was the second-largest manufacturer of PPE.8

Professor Sir Michael Marmot opened his session by acknowledging that Covid-19 has shone the limelight on, and amplified the inequality on BAME populations, who had a higher risk as well as mortality. He included factors such as age, gender, type of occupation (frontline), poor housing affected BAME population more, compared to their white counterparts. He urged the nation to address ingrained structural and systemic racism, and to implement his recommendations in "building back a better society with sustainable equality in health". 9,10

One minute's silence. Ramesh Mehta asked delegates to remember all those who had lost their lives fighting the pandemic and helping make the NHS sustainable.

Health Care Workforce and Covid-19

In the session chaired by Neena Modi and Jagtar Singh, Habib Naqvi explained the role of new Race and Health Observatory in the NHS.11 He acknowledged that systemic issues of inequality existed in the society, and that efforts to address these issues were often very fragmented. The Race and Health Observatory's role was to commission high quality, innovative research on disparities and formulate strategic policy recommendations, in addition to facilitating the implementation of solutions.

The NHS Chief People's Officer Prerana Issar, thanked the entire healthcare workforce for the fight against Covid-19. She shared her personal experience of facing discrimination and affirmed that she took over the role to address the inequality in the NHS. She described the components of the NHS People Plan12 and acknowledged its importance in the current situation. She insisted on the importance of promoting health and wellbeing of NHS staff, and the need for a meaningful risk assessments for all front line workers. She pleaded to all health care leaders for an effective Freedom to Speak Up system13 and requested everyone to reflect on the challenges faced, and to focus on a new commitment to look after our staff and patients.

Chaand Nagpaul, Chair of the British Medical Association (BMA), discussed the challenges experienced by the medical profession including the increased rates of stress, depression and suicide, compared to the general population. He acknowledge that BAME doctors experienced more bulling and harassment and were reportedly asked to see the patients without adequate PPE. Furthermore, he said that many BAME professionals were not confident to raise the concerns, as they felt that they would not be listened to. BMA has been campaigning for PPE, highlighted the disparities for BAME and international doctors, and the need for Covid-19 testing for all doctors. In addition, he said that the BMA has been successful in securing death in service benefits. He acknowledged the future challenges with the expected second wave, winter pressure and back log of work from the first wave. He requested the system

to implement the lessons learned from the first wave, prioritise and invest in a sustainable medical workforce and pleaded to improve the working culture with a supportive Covid-19 secure environment.

A systems approach to Covid-19

The session chaired by Professor Dame Parveen Kumar and Roshelle Ramkisson, started with a keynote video recording from Soumiya Swaminathan, who presented an overview from the World Health Organisation (WHO) in the pandemic, and her role as the chief scientist for WHO. She reported that the world had witnessed the spirit of global collaboration. She urged for the need for a global behaviour change to limit the further spread of Covid-19. She asserted the need for ensuring the safety of health workers, as they had been disproportionately affected by the pandemic. She mentioned the WHO health worker safety charter (protect health workers, improve mental health, health worker safety policy and patient safety policy).14 She concluded by saying that the governments around the world, need to make tough decisions to combat the Covid-19, and to maintain essential health services.

Nivedita Gupta, senior scientist at Indian Council of Medical Research (ICMR) shared her experiences on the diagnostic capacity for Covid-19 across India. She said that India is trying to upskill and extend the testing facilities to each district in India. Out of 735 districts, 572 districts have Covid-19 testing laboratories. She acknowledged some geographical challenges especially in Ladakh, North East and Andaman Islands. She acknowledged the challenges in private laboratories as accreditation was only optional, and that the prices varied among the private providers. She praised the partnership working arrangements with the aviation sector to assist in transporting the kits and samples as the tests increased from 10/day (in Jan 2020) to 1.15 million/day (Aug 2020).

Aseem Malhotra, Cardiologist explained the serious impact of obesity, hypertension, diabetes, coronary heart disease and chronic obstructive pulmonary disease on patients with Covid-19 . He explained the effect of unhealthy diet, vitamin-D deficiency, and physical inactivity in the population, that is known to increase the risk of Covid-19 morbidity and mortality. He emphasised the increased risk of the association between metabolic syndrome and Covid-19 complications.15 He concluded by asserting the need for healthy eating and regular exercise in the fight against Covid-19.

Research Symposium

This was organised by Samir Shah, Kantappa Gajanan and Rajiv Sethi. The panel of judges consisted of Raj Murali, Roshelle Ramkisson, Kamal Sidhu, Geeta Menon and Ananta Dave. National and international medical students, trainees, Specialist and Associate Specialist (SAS) doctors, researcher students, nurses, allied health professionals presented their research and innovation work in the form of abstracts and virtual posters that were displayed at the conference. There were 49 entries from UK, India, South Africa, Pakistan, Sudan and many other nations making this a truly international event. The top nine abstracts were chosen for oral virtual presentation on the day of the conference. At this conference, there was a new category on narratives and life experiences demonstrating Covid-19 resilience. Awards and certificates were presented to the top three oral presentations, with third award shared between two presenters.

Ethnicity and Covid-19

The session chaired by Professor Ged Byrne and Abrar Hossein, heard from Sanjay Arya, Cardiologist discussing the relationship between BAME ethnicity and disproportionately increased critical care admissions and mortality rates, due to Covid-19 infection (with data from the North-west region). Furthermore, the high incidence of Covid-19 in BAME population was due to presence of other chronic conditions such as cardiovascular diseases, diabetes, hypertension and chronic obstructive pulmonary disease, etc. He said that Covid-19 was a wake-up call for BAME communities and recommended that necessary actions are taken before the second wave.

Manish Pareek from University of Leicester, discussed the UK-REACH study on BAME mortality, which aims to encapsulate various aspects of risk into BAME health care workers, linking data to heath care outcomes to understand the risk of infection, critical care admissions and death by ethnic group, employment etc. He said that the questionnaire covers range of topics including behaviours, work circumstances and discrimination. He appealed to various stakeholders for their support to encourage their BAME healthcare workers to participate in the study.

Professor Anuj Kapilashrami, Senior Lecturer in Global Health Policy, University of Edinburgh, explained the differential risks in relation to race and ethnicity as important markers of infections and health. She mentioned that the disparities are mainly due to genetic reasons, metabolic issues, cultural language barriers, socio economic disadvantage, work and living conditions. Furthermore, she emphasised on the vulnerability of healthcare workers and over representation of BAME in fatalities and infection risks. She also shared her unhappiness in relation to the failure of the public health authorities to tackle the pandemic at the earliest.

T*he pandemic: treatment and prevention*

Session chaired by Kailash Chand and Binita Kane, heard from John Ashton an independent public heath consultant from Liverpool, on protective

measures, social distancing against Covid-19. Prof Ashton opened the session registering his unhappiness on the UK government's efforts to tackle Covid-19 pandemic. He said that the Public Health England (PHE) had failed in registration, notification and effectively protecting the public. He insisted that PHE should provide the needed assurance to the public and rebuild the trust with the communities. He compared the social practices in UK with other countries and explained about the risks in some of our cultural practices. He appealed for coalition across the country instead of blaming and manipulating the data.

Mahendra Patel, University of Bradford, outlined the current research on COVID-19 vaccines in progress across the globe with 142 pre-clinical vaccines, 29 vaccines in phase 1, 18 vaccines in phase 2 and 9 vaccines in phase 3. However no vaccines had been approved till date. He appealed to fight against the myths about vaccines and insisted on following the PHE guidelines on protection were the only measures to reduce spread, until an effective vaccine was available.

Prashant Patel described the seroprevalence of COVID-19 in healthcare workers and its implications. He said that there was an overall 10.8% sero-prevalence, with both genders being equally affected. The study revealed that nurses were more affected and there was a 25% seroprevalence in Afro-Caribbean staff. Sero-prevalence increased with deprivation within BAME groups. Among the medical group, the sero-prevalence was high at 21% among foundation doctors, compared to consultants (7%) with healthcare workers in medical specialities more likely to be affected.

The post-Covid world

This session chaired by Joydeep Grover and Raj Kumar discussed with Professor Christopher Harrison NHS England's National Clinical Director for Cancer and Medical Director (Strategy) for The Christie NHS Foundation Trust in Manchester, the challenges related to normalising clinical services focusing on cancer, which had been significantly affected and a growing number of patients were waiting for diagnosis and treatment. He also explained about the cancer hubs in the Greater Manchester area were engaging directly with patients to avoid any delay in surgery. In addition, he urged on consolidating the learning from Covid-19 and following a comprehensive strategic response.

In a focus on mental health services, Neil Thwaite, Chief Executive of Greater Manchester Mental Health, explained the diversity of services in Greater Manchester. He reflected on various changes that has been made during pandemic period including staff wellbeing, remote working and innovative approaches in various services including substance misuse and prison services. He explained the priorities for the trust in returning to normal and dealing with the back log of interventions, in addition to preparing for the second wave.

Helena McKeown, Chairperson of BMA, discussed the challenges and opportunities for primary care. She asked the stakeholders to embrace the positive changes that happened recently as a response to Covid-19, especially innovations in digital health, and highlighted the need to address inequalities in digital consultations. She appealed for more funding to the health care system and insisted on tackling the inequalities, as well as gaps in the workforce.

Research Prizes

First prize
Lin A, Tokell M, Dave M, Abraham S, Ramkisson R, Mahalingappa S, Pillai S, Matheiken S, Iliani Y, McNally R, and Bamrah JS. Preliminary results on patient satisfaction with Telepsychiatry: A Systematic Review.

Second Prize
Akbar S, McNally S. Recording & Evaluating Affect and Coping during COVID19 in Healthcare-workers & outcomes (REACCH-OUT)

Third Prize
Pervez A., Selvasekar C.R. Retrospective analysis of robotic resections for locally advanced rectal cancer with subset analysis of robotic posterior pelvic exenteration – a single centre experience of 9 years

Gire N, Mohmed N, Caton N, McKeown M, Duxbury J, Naeem F, Chaudhry IB, and Husain N. The Views and Perspectives of Mental Health Professionals in The Development of A Mobile-assessment and Therapy App For Psychosis (Techcare)

Cultural programme

Delegates were entertained Kailash Chand, himself a connoisseur of shayari and ghazals, and the special guest of the evening, Radhika Chopra, famed Indian ghazal singer from New Delhi. This was a fitting finale.

Bibliography

1. Yoga Programs-Inner Transformation-Yoga Center @ ISHA Foundation. Accessed October 25, 2020. http://www.ishafoundation.org/?global
2. Greater Manchester Health & Social Care Partnership | Devolution. GMHSC. Accessed October 25, 2020. https://www.gmhsc.org.uk/
3. Manchester India Partnership - Invest in Manchester. Accessed October 25, 2020. https://www.investinmanchester.com/about-us/manchester-india-partnership
4. Review into factors impacting health outcomes from COVID-19. GOV.UK. Accessed October 25, 2020. https://www.gov.uk/government/news/review-into-factors-impacting-health-outcomes-from-covid-19
5. Commission on Race and Ethnic Disparities. GOV.UK. Accessed October 25, 2020. https://www.gov.uk/government/organisations/commission-on-race-and-ethnic-disparities
6. Indian trials on multiple Covid-19 drugs make

progress, have Aatmanirbhar Bharat tilt. Hindustan Times. Published October 21, 2020. Accessed October 25, 2020. https://www.hindustantimes.com/health/indian-trials-on-multiple-covid-19-drugs-make-progress-have-atmanirbhar-bharat-tilt/story-NK0owrrrsYrAgqHvrK2a9I.html
7. COVID-19: Why India's mortality rate is lower than the global average - lifestyle. Accessed October 25, 2020. https://www.mid-day.com/articles/it-pays-to-be-indian-for-once/23034284
8. DelhiMay 25 ITWDN, May 25 2020UPDATED:, Ist 2020 21:44. 60 days, 56-fold growth: India now second largest PPE manufacturer. India Today. Accessed October 25, 2020. https://www.indiatoday.in/india/story/60-days-56-fold-growth-india-now-second-largest-ppe-manufacturer-1681648-2020-05-25
9. Health Equity in England: The Marmot Review 10 Years On. The Health Foundation. Accessed October 25, 2020. https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
10. Marmot Review report – 'Fair Society, Healthy Lives | Local Government Association. Accessed October 25, 2020. https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives
11. NHS England and NHS Confederation launch Expert Research Centre On Health Inequalities. Accessed October 25, 2020. http://www.nhsconfed.org/news/2020/05/race health observatory
12. NHS England » We are the NHS: People Plan for 2020/2021 – action for us all. Accessed September 28, 2020. https://www.england.nhs.uk/ournhspeople/
13. Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards | NHS Improvement. Accessed October 25, 2020. https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/
14. Sign up to the Charter - Health Worker Safety. Accessed October 25, 2020. https://www.who.int/campaigns/world-patient-safety-day/sign-up-to-the-charter---health-worker-safety
15. Malhotra A, Kamepalli RK, Bamrah JS. Perspective: Poor metabolic health is a major issue for increased COVID-19 mortality in BAME groups. phy. 2020;6(2). doi:10.38192/1.6.2.4

Perspective

The Landscape of Differential Attainment in Medicine in the UK- A Student's View

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Differential attainment (DA) is the unexplained variation in results in assessment, training and recruitment outcomes, based on factors other than academic ability such as age, gender, ethnicity. This phenomenon is recognized often in candidates from a variety of backgrounds and in all levels of education, careers or professions when compared to their white peers. This unfortunate fact is well recognized in both the medical school curriculum and beyond in the UK. International medical graduates (IMGs) including those from European Economic Area are more likely to fail postgraduate assessments and have poorer outcomes in recruitment (1).

Bamrah and Chand writing in the Guardian, reiterated that, 'the NHS could not have survived without the commitment of immigrants from the Indian subcontinent, Africa and the Caribbean, the majority of whom were lured from their countries with the promise of prosperous careers. Once here, many have had to live in deprivation and work in jobs that do not match their skills.' (2)

Medicine is also a popular choice for Black Asian and Minority Ethnic (BAME) students who have been born and brought up in the UK. (3) Research has shown that the causes of differences in attainment are not usually individual factors but likely to be systemic. (4) A study aiming to look into perceived causes of DA amongst trainees uncovered some unsettling findings, which will need systemic reform to resolve (5).

Firstly, in their perception of their relationships with senior colleagues, BAME UK graduates and IMGs were less likely to receive support in stressful clinical and non-clinical situations and were less likely to feel their seniors had confidence in them or their abilities. The authors suggest that one of the most important determinants of career success is sponsorship by senior colleagues, therefore BAME doctors may be significantly disadvantaged. (6) Cultural differences and lack of networks or mutually beneficial relationships with peers were recognised (5) and UK BAME and IMGs often faced separation from family. Due to this lack of a social support network outside of work, they tend to experience more stress, anxiety or burnout.

Often those in senior supportive roles, feel unnerved when unfamiliar with an IMGs previous training, which leads to lack of confidence in their ability and missed opportunities for progression. Whilst studies have often failed to identify frequent instances of racial discrimination in education or training, there were many instances of subtle bias in training and or recruitment. BAME candidates often felt 'othered' by their Caucasian trainers and perceived that they were being judged on how well they may fit in socially. Often leading to hindrance in successful progression or fairness in academic assessments. (5)

Often social and cultural stereotypes exist about medical students being heavily pressured and tutored to secure competitive places in Medical School by families. A study published in the British Medical Journal demonstrated concordance in the perceptions that "typical" Asian clinical medical students were over-reliant on theory, poor at communication, lacking in engagement or motivation during clinical teaching. (7) Such harmful perceptions and stereotypes can hinder the progress of ambitious students and make them feel undervalued eventually leading to earlier burnout.

BAME graduates of UK medical schools have worse outcomes during recruitment for foundation, specialty training, and even consultant posts. They are more likely to fail examinations and progress more slowly through training, even when exam failure has been accounted for. (8) A systematic review and meta-analysis of ethnicity and academic performance indicated that non-white candidates underperformed compared to white peers in all undergraduate and postgraduate assessments, including those that were machine-marked. (9)

This is demonstrated regularly in the summative assessment for the membership of the Royal College of General Practitioners (MRCGP). The pass rate of the Aptitude and Knowledge Test (AKT) exam for white doctors was 26% higher than their BAME peers. In the Clinical Skills Assessment (CSA), the pass rate for white candidates was 11% higher than UK-educated BAME graduates and 51% higher than IMG. Organisations representing BAME candidates have been encouraging academic organisations to be aware of these inequalities and to implement reform. (10)

Research suggests that the causes of DA are complex, often embedded in a variety of social, economic, cultural, linguistic and racial systemic bias. The sands are slowly shifting, as implicit bias, micro-aggressions and misconceptions are being recognized and challenged rather than tolerated. A number of medical schools have recently begun to look into issues DA, asking for students' opinions and conducting extensive interviews to elucidate causes and reasons that can be altered through institutional change. The General Medical Council in the UK, is developing tools to recognise DA, interventions to address this inequality and pilot schemes to help organisations. The Health Education in Englad (HEE) is creating 'protective processes' to proactively deal with poor relationships with seniors and tackle the impact this has on learner confidence as well as performance.

DA has existed for years within medicine in the UK and is widespread. DA must therefore be recognised as a systemic rather than individual problem. A survey of system leaders found a level of inherent pessimism in effecting change, sensitivities around issues related to race and lack of a coherent and strategic approach to this issue. Most interventions were found to be typically local or specialty-specific, were not aimed at BAME UKGs or coproduced with them and remained untested or unevaluated.' (11)

More research is needed into

- the causes, and
- effectiveness of interventions in the learning environ ment
- addressing culture,
- educational governance and leadership,
- in the development of curricula and
- Formative and summative assessments
- Mentorship and role models to
- improve the trainer-trainee relationship,

A holistic approach and recognising diversity is key. In order to build a fairer training system, it is important that we review and act on existing inequality through organisational change.

Woolf et al write:

'Medicine is one of the most ethnically diverse professions. To ensure that we can all benefit from this diversity, we need to act now to reduce prejudice and unconscious bias, increase equality of opportunity during medical training, and dismantle the additional unfair barriers.' (4)

References

1. Rimmer A. The state of UK medical education and practice: report from the GMC. BMJ. 2016;i5983.
2. Bamrah J, Chand K. The best birthday present for the NHS? An end to its institutional racism [Internet]. the Guardian. 2020 [cited 19 July 2020]. Available from: https://www.theguardian.com/society/2020/jul/03/best-birthday-present-nhs-end-institutional-racism
3. [Internet]. 2020 [cited 19 July 2020]. Available from: https://www.hesa.ac.uk/free-statistics
4. Woolf, K. Fair training pathways: understanding differential attainment in medicine [Internet]. Improving medical education and practice across the UK. 2020 [cited 19 July 2020]. Available from: https://gmcuk.wordpress.com/2016/07/21/fair-training-pathways-understanding-differential-attainment-in-medicine/
5. Woolf K, Rich A, Viney R, Needleman S, Griffin A. Perceived causes of differential attainment in UK postgraduate medical training: a national qualitative study. BMJ Open. 2016;6(11):e013429
6. Ng, T., Eby, l., Sorensen, K., Feldman, D. Predictors of objective and subjective career success: a meta-analysis. Personnel Psychology. 2005;58(2):367-408.
7. Woolf K. Ethnic stereotypes and the underachievement of UK medical students from ethnic minorities: qualitative study. BMJ. 2008;337(sep01 2):a1470-a1470
8. Woolf K. Differential attainment in medical education and training. BMJ. 2020;:m339
9. Woolf K, Potts H, McManus I. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ. 2011;342(mar08 1):d901-d901
10. RCGP threatened with court action again over BME bias [Internet]. Pulse Today. 2020 [cited 19 July 2020]. Available from: http://www.pulsetoday.co.uk/news/all-news/rcgp-threatened-with-court-action-again-over-bme-bias/20038827.article#:~:text=The%20background%20to%20the%20case,differential%20attainment%20in%20the%20exam
11. Woolf K, Viney R, Rich A, Jayaweera H, Griffin A. Organisational perspectives on addressing differential attainment in postgraduate medical education: a qualitative study in the UK. BMJ Open. 2018;8(3):e021314

Letter to the Editor

For Fairness, Kindness & Justice

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My story is the same as many other. I came to the UK about 25 years ago. I have worked hard to make progress, learn the different ways of a new country, learn to love it's culture, people and weather. I have given my heart and hard work to the NHS and feel proud of what we do and the values of this country. I always remind myself not to live in the past but to live in the present, not to hate anyone for past injustices but work to promote community cohesion, good natured togetherness and harmony.

I have tried to be a force for good, training doctors who have come after me, promoting excellence and getting everyone to be mindful of our NHS's limited resources. Like so many I have aspired to deliver great care to the wonderful people of this country. There has only been one grief that has persisted over the last 25 years. There has been one recurring theme that has caused feelings of guilt, inadequacy, regret and remorse. And that is that I have not been there for my wonderful parents as they aged, became less well and suffered loneliness and sadness.

I have tried my very best to compensate. Every year for the past 10 years I have travelled both for emergencies and electively making multiple trips each year at cost to personal health and my family here. I have had to return and then catch up on my work and on call duties. My parents are not enamoured by the UK. They do not wish to be here. They only wish the comfort and love and security of being with their child in their final years. My dad is 87 years old and has chronic kidney disease. He is the main carer for my mother who is 80, but fragile and frail with severe osteoporosis. They live on their own with a help coming once a day. With Covid-19, the help has been coming once or twice a week. Are they managing? Depends on what we mean by managing. We have tried 24/7 carers but this is an unregulated sector and such carers cannot give love, companionship or genuine caring. Caring for our parents and ensuring they don't suffer is emotional need. It is one of the things that make us human. .

I am nearing retirement. I have space in my house and in my heart for my parents. I do not need to depend on the system here to look after them. Do I still need to prove they are on the street and unable to eat or dress themselves? Do I need to prove they are in penury? Do I need to prove there is no person there who can serve their needs in the final years? To most of us the answer would be clear. For most there is nothing more to say.

Yet these are the current adult dependent relative (ADR) visa rules, amended in 2012. They don't have a human face and are applied with no emotional considerations. This is wrong. I know there will be thousands more who are in the same situation. I believe this is a important cause and we can make the government see the distress caused and do what is needed

On Nurses, Mental Health & Caring for our Carers

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Abstract

The COVID-19 pandemic has stretched the resources of healthcare systems across the world, as professionals work to treat the public with the scant evidence available. This has resulted in the loss of many essential workers' lives, with the loss of over 119 healthcare workers' lives in the UK as of April of this year. Adding the loss of colleagues to the many difficulties associated with working in healthcare, and the increased risk to their lives and the lives of their loved ones will undoubtedly compound the burnout already felt by nurses on a daily basis The author uses her own personal experiences to explore the themes brought up in current research, as well as looking at suggestions of how to support nurses and allied health professionals both in the immediacy and in the long term.

Keywords
Covid-19, healthcare professionals, pandemic, nurses

Compartmentalising is a wonderful thing. Outside of helping people, one of my favourite things about nursing is having the capacity to leave work things at work and home things at home. Some patients will stay with you even as you take off your uniform for the night, but there is a strange comfort in knowing that there's nothing you can do at home about the patient at work. You depend on the strength and training on the colleague you handed over to, and you trust that when you get to work the next day your patient will have had the same standard of care you gave them the shift prior. Doing what's best for your patient on shift and going home knowing you've done what you could is a big part of the pride of being a nurse. Now that I'm a research nurse, things look a little different but that pride in doing the best that you can for your patients is still there.

At first when the pandemic hit, nothing changed in my nursing care. It felt like we were all holding our breath, watching as the wave slowly travelled west towards us. We heard about our colleagues overseas handling the immense pressure their healthcare services were under and we braced for impact. Everyone I know began to prepare. We kissed our friends and family goodbye, we started looking at other accommodation. People with underlying health problems had long discussions with their managers about working safely… or not at all. Those of us who had hung up our uniforms began to take them down again. We watched. And we waited.

And then the tidal wave hit and we were pulled out to sea. Fighting to save lives the best way we could. In my department's case it meant rushing out protocols to look for a cure, a treatment, some kind of medicine, some magic pill, some sort of poultice to put on the wound that COVID-19 had created. My background is in paediatrics; many of the people I trained with were upskilled to Adult intensive care so that we could be uprooted and sent to the wards, to work with medicines we had never used in doses we had never had to calculate before. My adult-trained friends were already in the fray – we were there to bolster numbers. My friends in the community went from home care to swabbing would-be patients. We were all uprooted, we were all asked to swim. So we paddled with all our might.

This is already difficult to compartmentalise. It is hard to escape a pandemic. At work we were surrounded by it on all sides, but the outside world was no better. Hourly updates on the pandemic, headlines being shared on social media, family and friends asking for our opinions because they were scared, so, so scared. But what happens when your closest ones are affected?
My father died of COVID-19 on April 5th of this year.

He was one of many. So many in fact, that there was a backlog when we wanted to register the death and we had to wait for 5 days while the hospital tried to deal with the constant influx of patients. Suddenly the pandemic wasn't just at work, and wasn't just on social media and the news. Suddenly it was in my home, in my family.

I was no longer swimming, I was drowning. The pandemic was in my nose, mouth and lungs and all around me. I couldn't see past it, because there was nothing beyond it. I suddenly had intimate knowledge of both sides of the situation – as the staff member and the family member. I went from giving out the bereavement pamphlets to receiving them. Despite not being able to spend time with my dad in his final hours, I knew what they would look like. He would have been made comfortable, the difficult decision to DNAR (Do Not Attempt Resuscitation) having been made months ago during his last health scare. A nurse would have been with him, and also a doctor, making sure he wasn't suffering to the best of their abilities. He may have been scared or in pain, or he may have been confused and unaware. This I do not know, for I could not be at his side myself. I can only hope that his passing was peaceful.

Death, like this pandemic is all-consuming. Your world is rocked, your identity is questioned. I am a nurse and yet I could not heal my father. I am grateful for the time I spent with him, grateful for the little things. But I couldn't help but think that I should have done more. The reality is of course, that I couldn't.
Over 100 NHS workers have died during this pandemic as of writing (1). I find myself wondering about their co-workers, those who are working during the pandemic, whose lives have been infiltrated until every crack has been filled with coronavirus. Their work life, their social media feeds and now their friendships. I wonder how many of my colleagues have lost a family member like I have, who no longer can call home a place of solitude where they can control the intake of grief this situation has caused. It must feel like survivor's guilt, for this is how it feels to me. Research papers have already been released looking into the mental health of staff following the pandemic (2). As countries begin to heal, resurface from being underwater, they are reporting on those who have had to work through the storm. China, who was first hit (and for a long time, worst hit) (3) highlighted how more vulnerable HCWs to anxiety and depression. Research into the effects of stress has also come from Germany, who are looking to relax their travel rules (4). Here in the UK, our chief medical officer has warned about burnout in hospital staff (5). But what can we do? What lifeboats can we send to rescue the drowning, those without life vests who must swim nevertheless? How do we save our lifeguards?

In 2018 the Office for National Statistics reported on concerning rates of suicide amongst nurses (6). Between 2011 and 2017, over 300 nurses have taken their lives, making them 23% more likely to do so than the rest of the population. A Health Education England report has highlighted that nurses, particularly female nurses, are most at risk of committing suicide when compared to other healthcare professions (7). Dame Donna Kinnair, the Chief Executive of the RCN, has pointed out the increasing pressures on nursing staff, and that many employers are ignoring nurses' cry for help (8). But all of this is of course information prior to the pandemic. How much worse will the next set of statistics be? What will this pandemic leave behind?

I am choosing to use my pain as a call to action. The nursing force will need to heal after this, physically, emotionally, mentally, spiritually. The compassion fatigue we will suffer from may overwhelm a lot of us; it is not enough to expect resilience. We must do more to protect our colleagues, or else they will leave the profession altogether.
At present, the RCN is offering counselling services (9), and every trust has access to counselling via occupational health. The wait times may be shorter than asking staff to access mental health support through the community services. One suggestion would be to deal with some of the challenges early through immediate care, with a long-term strategy down the line (10). To that end, the British Psychological Society has released guidelines on the psychological needs of healthcare staff, and includes principles to be used during the 'active phase', such as visible leadership and normalising the psychological response to the situation, as well as during the 'recovery phase', in which staff have time to reflect and may need support processing the situation (11). Many trusts have psychological teams that manage debriefing sessions with ITU teams; perhaps this is something that should be conducted with all nurses that have to work through the pandemic, particularly nurses who are working in areas of high exposure (12). I am personally curious and concerned about the mental health of those who have had to graduate early, come out of retirement or work in fields they had not trained in before, such as in intensive care or with adult patients. In fact, more research into the effects of being uprooted in this situation would point us in the right direction as to what we as a nursing body will need to heal from this experience. Usually, nurses experience a period of preceptorship, where one is eased into the profession. How can you ease into a new job when we're all have had to jump into a situation where we do not know how deep the deep end truly is… or will be? Research on those voices will amplify them, and can better prepare us for the next time, if and when there is one of course.

Who cares for the carers? Who saves a lifeguard when they are drowning? I think a cultural shift towards viewing nurses not just as heroes or sacrifices, but as people who have hopes and dreams and fears and concerns who need real, tangible support not just today but every day would really move the conversation around nurse health forward. When the water level is high already, and a tsunami hits, it feels like there is no escape. We need lifeboats. We need to care.

References

1. Cook T, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from covid-19 analysed. HSJ. 2020; 22. https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article (accessed 26 June 2020)

2. Walton M, Murray E, Christian MD. Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. EHJ: Acute Cardiovascular Care. 2020. https://doi.org/10.1177/2048872620922795

3. Spoorthy MS. Mental health problems faced by healthcare workers due to the COVID-19 pandemic- a review. Asian J Psychiatry. 2020. https://doi.org/10.1016/j.ajp.2020.102119

4. Bohlken J, Schömig F, Lemke MR, Pumberger M, Riedel-Heller SG. COVID-19 Pandemic: Stress Experience of Healthcare Workers - A Short Current Review. Psychiatrische Praxis. 2020; 47(4). Psychiatric Practice 2020; 47 (04): 190-197 DOI: 10.1055 /a-1159-5551

5. Haynes L. Pandemic will trigger significant mental health impact on NHS staff, warns deputy CMO. [Online] 2020 [cited 2020 May 28. Available from: https://www.gponline.com/pandemic-will-trigger-significant-mental-health-impact-nhs-staff-warns-deputy-cmo/article/1682414

6. Office for National Statistics. Suicide deaths among nurses aged 20 to 64 years, deaths registered in England and Wales between 2011 and 2017. ; 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/009209suicidedeathsamongnursesaged20to64yearsdeathsregisteredinenglandandwalesbetween2011and2017

7. NHS Health Education England. NHS Staff and Learners' Wellbeing Commission. ; 2019. https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf

8. Mitchell G. Figures spark call for inquiry into 'alarming' levels of nurse suicide. [Online].; 2019 [cited 2020 May 28. Available from: https://www.nursingtimes.net/news/workforce/figures-spark-call-for-inquiry-into-alarming-levels-of-nurse-suicide-29-04-2019/.

9. Royal College of Nurses. Counselling Service. [Online]. [cited 2020 May 28. Available from: https://www.rcn.org.uk/get-help/member-support-services/counselling-service.

10. Greenberg N, Docherty M, Gnanapragsam S, Wessely S. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. BMJ 2020;368 doi: https://doi.org/10.1136/bmj.m1211

11. The British Psychological Society. The psychological needs of healthcare staff as a result of the Coronavirus pandemic. [Online].; 2020 [cited 2020 May 28. Available from: https://www.bps.org.uk/news-and-policy/psychological-needs-healthcare-staff-result-coronavirus-pandemic.

12. Open Science Framework. Live meta-analysis: Mental Health of Clinical Staff Working in High Exposure Compared to Low Exposure Roles in High-Risk Epidemic and Pandemic Health Emergencies (last updated 2020.05.12). [Online].; 2020 [cited 2020 May. Available from: https://osf.io/yrbvz/

essay

A Student's Perspective: What Can I Do About Climate Change?

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We've all heard about the climate crisis, but it can be hard to shake off a feeling of distance. It can feel limited to splintering sea ice in the distant poles, or the vanishing of distant species, all leading to a dystopian, distant future. Climate change is not distant. It is already changing each of our lives, and will only continue to do so. As a young person, a world in crisis is the only world I have ever known – and it will be up to my generation to take responsibility for it. In this article I will discuss the personal effects climate change has on us now and in the future – and why the efforts of young people are especially important.

Health is one of the most personal ways climate change is affecting us. A French study conducted after the country's 2019 heatwave that reached a record-breaking 46°C, showed that heatwaves that serious are 10 times more frequent today than 100 years ago.1,2 The World Health Organisation (WHO) estimates 250,000 excess annual deaths from 2030 to 2050 from climate-change related issues.3 These include an increase in heat-related health conditions, as well as diseases such as malaria and dengue fever, due to larger areas of the world's climate becoming habitable to the insects that transmit these diseases.

There is also a potential for a surge in mental health issues. Research by the American Public Health Association suggests that 25 – 50% of people facing an extreme weather event have negative mental health effects. 3,4 It is not just those who directly experience these events whose mental health is at risk, however. Eco-anxiety, which refers to a fear of environmental damage, is a growing issue, with a 2018 Yale survey finding that 59% of Americans feel 'helpless' about climate change. 5,6

Climate change is also having an impact on an essential part of our lives – food. As our greenhouse emissions and their associated temperature increases grow, more and more of the food we treasure will become unsustainable. Seafood is becoming scarcer as a result of ocean acidification caused by CO2 emissions, as well as rising ocean temperatures. A study looking at the maximum amount of fish that could be sustainably caught in 1930 vs. 2010 found a 4.1% overall decrease. 7 Though seemingly small, this makes up for 1.4 million metric tons less of fish. The threat to our diets extends across the board: whether it is worldwide crops, vegetable yields or even coffee, you do not need to live in an area at risk of natural disasters for the impact of climate change to affect your daily life.

The immense and personal importance of climate change is clear. But the question remains: why is my contribution as a student important? Perhaps the simplest answer is that my generation will live to see the worst effects. As the environmental impacts of the human behaviour of the past centuries grow, the current students' contribution will matter more and more.

Secondly, mine is the generation that has always lived in the looming shadow of this crisis. Since events such as the Haiti earthquakes in 2010, all the way to the Australian wildfires in 2020, it has been especially difficult in the last few decades to ignore that the number of climate related natural disasters has tripled in the past 30 years. 8

Next, the student generation's youth makes them key in the climate movement. Large industry leaders and governments are pressed to protect profit and voters when discussing climate change with the public, but students need no such filter. Perhaps that contributed to the movements of activists like Greta Thunberg, who launched the 2018 School Strike for Climate 9, involving 1.6 million students in 125 countries, or Licypriya Kangujam, who founded the Child Movement to protest for climate change laws in India at just six years old. 10

Young activists across the globe can connect to the larger climate movement through social media, and this may make young people's role even more crucial. Social media is the tool that can connect people together in worldwide campaigns such as the #climatestrike in May 2019, and the fact that the majority of social media platforms are used more by young

people makes their role in these campaigns even more powerful. 11

Furthermore, the reason why young people are so important might be that younger people care more about climate change. Considering that young people are the ones who will be around to see its effects the longest, it's not hard to believe that 70% of people between the ages 18 to 34 are worried about climate change, comparing to 56% aged 55 or older. 12

So, whether it's due to awareness, responsibility or willingness to act, students play an essential role in dealing with climate change. But what can I, as a student, actually do to help? Not having control over energy use choices, a job in research or industry, or being able to vote might make it seem like my only choice is to sit and wait for the years to tick by.

In fact, the complete opposite is true. There are a massive number of things young people can and should do. For instance, you could start with something as simple as signing a petition. Greenpeace's 2014 petition to stop the oil company Shell from drilling in the Alaskan Arctic started with a petition of over 5 million signatures, and was a key factor that contributed to the project being abandoned. 13 Current petitions include Friends of the Earth pushing the government to commit to 100% renewable energy 14, the WWF asking for climate action to be made a priority 15, and the Climate Coalition requesting more green space and climate justice to be considered. 16

You could also send a letter, email, or even have a phone call with your local Member of Parliament about what they think about the climate change crisis, and what your local council is doing to reduce its effects. Just letting them know that you're concerned is a help – hearing that constituents care can make them more engaged as well. Luckily, there's a lot of support available about the best approach.

And, perhaps most simply, you can educate yourself and everyone around you. The more we open our eyes to the issues surrounding climate change, the more passionate we become, and with passion comes action. The information out there is almost endless, but a good place to start is to remind yourself of the basic science surrounding global warming. 17-20 After that, there's digging into all the things we're doing to our planet, whether it's in the textiles industry, from food waste, energy, or travel. And most importantly, the solutions. 21-23

So, climate change is happening now – and it's much more personal than we might ever have predicted. But the responsibility, the power to change the way things are, is just as personal – especially for young people.

Bibliography
(all online content accessed 30 June 2020)

1. https://www.worldweatherattribution.org/human-contribution-to-record-breaking-june-2019-heatwave-in-france/
2. https://www.nature.com/articles/s41598-019-46928-9
3. https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health
4. https://www.apha.org/~/media/files/pdf/topics/climate/climate_changes_mental_health.ashx
5. https://ijmhs.biomedcentral.com/articles/10.1186/s13033-018-0210-6
6. https://climatecommunication.yale.edu/publications/climate-change-in-the-american-mind-december-2018/
7. https://www.fisheries.noaa.gov/insight/understanding-our-changing-climate
8. http://climate.org/eco-anxiety-mental-health-impacts-of-environmental-disasters-and-climate-change/
9. https://en.wikipedia.org/wiki/Greta_Thunberg
10. https://www.earthday.org/8-year-old-activist-licypriya-kangujam-demands-climate-action-just-dont-call-her-the-greta-of-india/
11. https://ourworldindata.org/rise-of-social-media#:~:text=In%20general%2C%20young%20people%20are,more%20popular%20among%20younger%20people.
12. https://climatecommunication.yale.edu/publications/do-younger-generations-care-more-about-global-warming/
13. https://www.theguardian.com/business/2015/sep/28/shell-ceases-alaska-arctic-drilling-exploratory-well-oil-gas-disappoints
14. https://act.friendsoftheearth.uk/petition/climate
15. https://www.wwf.org.uk/fight-climate-change
16. https://www.theclimatecoalition.org/declaration
17. https://www.ucsusa.org/climate/science
18. https://www.businessinsider.com/fast-fashion-environmental-impact-pollution-emissions-waste-water-2019-10?r=US&IR=T
19. https://letstalkscience.ca/educational-resources/stem-in-context/environmental-impact-wasted-food
20. https://www.ucsusa.org/resources/hidden-costs-fossil-fuels
21. http://www.thegreenmedium.com/blog/sustainable-travel-guide
22. https://www.scientificamerican.com/article/7-solutions-to-climate-change-happening-now/
23. https://www.hftf.org.uk/

The Coronavirus Collective

How I overcame COVID-19 infection and went on to defeat the surge by working in Intensive Care

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It was the start of the pandemic, and we had very few cases in the UK. I work in Northwick Park Hospital, which was later to become the epicentre of the outbreak in London. In March, I developed a headache, dry cough, fever, and myalgia. I also noticed anosmia, now confirmed as a pathognomic feature of COVID-19.1 I immediately sought help and I received an antigen test. I remember how uncomfortable the test was, especially the nasal aspect.

Three days later, self-isolating at home, I received a phone call – I had tested positive for COVID-19 PCR. My initial feeling was that of shock and surprise – I only knew of one other doctor in the hospital who had tested positive. I wondered how I had acquired it, but I am pretty sure it was nosocomial. I took the diagnosis seriously, measuring my oxygen saturation and temperature regularly at home. GPs from NHS 111 called me every 36 hours. Of course, this was early on in the crisis, little did we know how the situation would unfold.

After one week, I returned to work after clearance by occupational health. Although I was training in rheumatology, I was redeployed to intensive care! Duty called, and the patients needed my help. I did not have a second thought about going to ITU. I was one of 80 "surge" ICU SHOs. 2 I was saddened to see the impact of Covid-19; it reminded me of a war zone type situation that we regularly see on television, with numbers escalating rapidly.
I vividly remember my first day in ICU, which was a converted anaesthetic recovery ward. My role became more apparent: I had to adapt to do whatever was needed, whenever and wherever. I rapidly learned nursing roles included washing of patients, positioning, drawing up medication such as noradrenaline and propofol and documenting ICU charts. One thing is clear from this crisis – I could not have done my job or looked after patients without support from ICU nurses. The rapid rise in patients requiring ICU care meant that we had to transfer out stable patients to other hospitals, including NHS Nightingale.2

My emotions fluctuated daily. It was distressing to see so many patients die from Covid-19 without their loved ones by their side. But I also witnessed the joy of several tracheostomised COVID patients successfully weaned and stepped down to the ward, to be discharged home. End of life care needs to be done well, especially in ITU setting, to provide a dignified death. I was proud of my colleagues who set up an iPad video service to allow families to see their loved ones.

I noticed how the majority of patients I looked after were from BAME groups. Data shows that being a member of black or minority ethnic group (BAME) increases the risk of mortality from covid -19. 3 Ninety five percent of doctors who have died from COVID were BAME. 3 This was alarming to note, but I must state that all times I had full PPE available to me with good training and support, which was reassuring. This experience has changed me forever. I am proud to be a member of the medical profession and the NHS. We became united to fight a common enemy and I saw at first hand the leadership shown by doctors in tackling the surge through service delivery, research and innovation, often beyond the call of duty and at personal risk to themselves and their families.

At around the same time, I received good news that I had been successful in gaining an ST3 training in number in my dream specialty – Rheumatology!

References

1. Lost or changed sense of smell [Internet]. nhs.uk. 2020 [accessed 4 June 2020]. https://www.nhs.uk/conditions/lost-

The Coronavirus Collective

Pros and Cons

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I think that this lockdown has done more good than bad to not only me, but a lot of people I know. It has given us a chance to take a small break, stop and think.

It has made people appreciate the smaller things in life such as taking a walk and breathing in the summer air. It has also made people appreciate things which they would normally despise, such as school!

Lockdown has also helped people to become a bit more educated with what is going on in the world, as we have a lot more free time. With everything going on with the Black Lives Matter movement, I think that it is partially because of quarantine that we have been working so hard for racial equality. We now have lots of free time to take part in protests and signing petitions.

I think lockdown has most definitely changed lots of people for the better, as we have become more aware of the world, how to take care of it and how to take care of each other!

The Coronavirus Collective

A Collection of Thoughts

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Lockdown has allowed me to use my negative experiences, emotional intelligence, my creative and adaptable skills to innovate and make a difference. Dentists were advised by their leaders to stop working immediately when the lockdown came into effect about March 2020.

During lockdown I designed and gave a lecture to colleagues as part of their Continuing Professional Education (CPD) to support dentists and dental care professionals in maintaining and updating knowledge. I spoke about leadership skills and 'How to prevent burnout in staff'. The topic covered tools to help support staff well-being, communication, management of self and others, understanding flexible working, work-life balance? We focussed learning on emotional intelligence.

I learnt how to prepare chicken potato hot pot.
Finally, during lockdown, I took part in my first virtual Corona hackathon- artificial intelligence versus COVID-19 April 2020.(1) I was in the team that won, no mean feat considering that we all met only online.

COVID-19 has changed my life forever.

People are the heartbeat of an organisation. I can only describe my experience and impact by quoting my favourite poem by Maya Angelou:

"I've learned that people will forget what you said. People will forget what you did but people will never forget how you made them FEEL."(2)

My message is 'Please be kind'.

When you are kind to yourself and at peace with yourself, you are able to give happiness to others, value, respect and support them to reach their full potential. This act is like a ripple effect which spreads to make a difference in others.

Fish in the fishy sea
I am a fearful,
oral fish with peg shaped,
incisal, occlusal, mesial and distal teeth
in a salty, flowing, rapid, rolling, foamy blue sea.

Whence shalt help come?
I swim against the tide
in a salty sea full of sharks with sharp teeth, dolphins with conical teeth, sea horses with no teeth, plants and sea anemones beneath.
I cry myself to sleep and no one to turn to.

Whence shalt help come?
Why doesn't anyone understand,
my pain and frustration in this wild,
severely crowded sea with different characters who try to project, overbite, overjet
superiority over poor sticky fissure me.
If you are in a job and your manager dislikes you please run, run, run before your health is destroyed. They will always find someone to replace you but your health cannot be replaced.

1. CoronaHack - AI vs. Covid-19 - Hackathon in London [Internet]. [cited 2020 Jul 18]. Available from: https://www.hackathon.com:443/event/coronahack---ai-vs-covid-19-99337559314
2. Caged Bird Legacy | The Legacy of Dr. Maya Angelou [Internet]. [cited 2020 Jul 18]. Available from: https://www.mayaangelou.com

The Coronavirus Collective

A Perfect Storm

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It was apparently a perfect storm.

A virus, a seeming nonentity with no sign of life, only recognisable by its genetic code, ever-mutating to perfection. It assumes a deadly sequence that wins the top prize for evolution- a successful mission of self-preservation like no other. Inevitably finding its way from wildlife into humanity, learning from the mistakes of its predecessors and mutating to ensure it survives. Nestling in the throat, undetected for days, enough to allow the hapless human to spread it around and then proceed in full throttle to attack its benefactor, till the very last breath is squeezed out of their hypoxic, inflamed and congealed bodies.

The deluge of victims matched the deluge of ideas to combat it - stories of scientific valour and rigour, of international collaboration and back breaking work so doctors learnt what to expect, people learnt how to behave, nations learnt how to prepare. And yet, nothing prepares you for a pandemic. Faced with a killer virus that creeps into unsuspecting victims and spreads like wildfire, people and countries did glorious and despicable things.

Humanity showed itself at its best and its worst. Some countries rattled their sabres to get the lion's share, others decided to defy convention, some others simply sped on rudderless, with self -serving narcissist leaders who should have known better. We heard stories from the East where societies came together with expediency and humility to protect their peoples. We heard stories from the West where learned experts were ignored, lies were propagated, and morgues were overwhelmed.

And yet, for all its grand sweeping reach, the virus is person

al. To me, it started with news from China, stories of stifled voices and whistle-blower deaths. Then came the Italian and Spanish stories of full ITUs, the gasping elderly and infested care homes. And finally, it arrived closer to home. And the stories got worse. The death-collage of smiling faces on TV expanded daily, mostly of men not dissimilar to the one I love. Every morning's goodbye before work felt like it might be the last.

And then, suddenly, I was struck. It came unannounced- no familiar prodrome of known viral illnesses. And while I lay in my sick bed, with drenching sweats, back pain and heavy breath, days passed, more deaths announced, and yet more heart-breaking stories of personal loss emerged.
I have lost 6 weeks of my life to the virus. Nothing more. And for that I am grateful. Grateful that I am allowed to live, grateful that I did not pass it on my more vulnerable husband.

I am saddened by the misery it has brought to billions. I am angered by the ineptitude of callous governments driven by self-interest. I am awed by the selflessness and hard work of countless ordinary citizens risking their lives and carrying on serving against all odds.

And I am hopeful that we will emerge from this with more humility and respect for everything we share our precious planet with.

The Coronavirus Collective

You May Clap But We are Soon Forgotten

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You may clap, but we are forgotten.

Health Secretary, Matt Hancock, has stated that people from Black, Asian or Minority Ethnic (BAME) backgrounds are "disproportionately" dying with coronavirus [1]. The National Health Service (NHS), an organization of extremely diverse staff members, echoes this claim [2, 3]. Where 21% NHS staff are BAME, 63% healthcare workers who have died were BAME; where 44% doctors are BAME, 95% doctors who have died were BAME [4].

Due to emerging evidence, NHS England advised trusts to perform updated risk assessments on BAME staff [5], but nearly 40% BAME doctors had not received these when Public Health England's report emerged last week [6]. Not only are we left with little to alleviate our concerns, but there are simply no solutions once assessed [7], rendering this a purely tick-box exercise.

My personal experience of this risk assessment was just this, through no fault of the individual, department or trust.

1. Do you feel more at risk given the evidence about BAME individuals being more at risk for Covid-19? I was not sure how to answer a question where the answer was already present.
2. Has emerging evidence about BAME risk increased your anxiety or led to other mental health concerns? Surely the question is flawed in itself? Like many of my colleagues, I said no; we're all just as anxious. A solid, politically correct, 'we're all in it together', response.
3. Do you feel more likely to do things you would otherwise be uncomfortable in doing because of your BAME background? Rephrased – are you less likely to say no to doing things at work? Here, I was quick to claim that if this was the case, it would be because of my 'personality'. Thus, I disregarded the cultural elements of our personalities and that as immigrants or children of immigrants, we will always hesitate to say no and avoid doing so. This quality translates to all aspects of life, this nature to please at the expense of yourself.

Ultimately, coronavirus thrive on inequalities [8], which include: socio-economic backgrounds, crowded living, increased genetic predisposition to chronic health conditions [1, 9], and subconsciously chosen 'key worker' professions in the BAME community, likely based on immigration rules that on UK arrival, you offer a 'service'. But let us examine the greatest inequality, where BAME individuals are so conditioned to put themselves second just to be seen as 'the same', in a society which perpetuates this.

Of course, we cannot shield 40% doctors, 20% nurses [10] and all other BAME key workers. However, recommendations could be offered? Or failing that, surely BAME workers should have had a risk assessment by now, carried out by a fellow BAME individual? It is criminal to rob so many colleagues of a forum to express their thoughts and fears, with someone in a similar position. When we make up so much of the key worker body, NHS and otherwise, please do not forget us. We never wanted your claps; we just wanted equality.

References

[1] Butcher, B. & Massey, J. Why are more people from BAME backgrounds dying from coronavirus? BBC News. 2020. Available from: https://www.bbc.co.uk/news/uk-52219070 [Accessed 10th June 2020]
[2] Cook, T., Kursumovic, E. and Lennane, S. Exclusive: deaths of NHS staff from covid-19 analysed. HSJ. 2020. Available from: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article [Accessed 10th June 2020]
[3] Kline, R. NHS Covid 19 and health care worker deaths: questions that need asking. Race Equality Foundation. 2020. Available from: https://raceequality-foundation.org.uk/health-care/nhs-covid-19-and-health-care-worker-deaths-questions-that-need-asking/ [Accessed 10th June 2020]
[4] British Medical Association. COVID-19: the risk to BAME doctors. BMA. 2020. Available from: https://www.bma.org.uk/advice-and-support/covid-19/your-health/covid-19-the-risk-to-bame-doctors [Accessed 10th June 2020]
[5] Bostock, N. All BAME staff must be risk-assessed before seeing patients face-to-face, warns NHS England. Available from: https://www.gponline.com/bame-staff-risk-assessed-seeing-patients-face-to-face-warns-nhs-england/article/1685791 [Accessed 10th June 2020]
[6] Hasan, R. Nearly 40% of BAME doctors still not given coronavirus risk assessments recommended to prevent deaths. ITV News. 2020. Available from: https://www.itv.com/news/2020-06-06/nearly-40-of-bame-doctors-still-not-given-coronavirus-risk-assessments-recommended-to-prevent-deaths/ [Accessed 10th June 2020]
[7] Khunti, K & Pareek, M. Covid-19 in ethnic minority groups: where do we go following PHE's report? BMJ Opinion. 2020. Available from: https://blogs.bmj.com/bmj/2020/06/08/covid-19-in-ethnic-minority-groups-where-do-we-go-following-phes-report/ [Accessed 10th June 2020]
[8] Morgan, E. 'Coronavirus thrives on inequalities': BAME people up to twice as likely to die from Covid-19. ITV News. 2020. Available from: https://www.itv.com/news/2020-06-02/coronavirus-thrives-on-inequalities-and-being-bame-is-major-risk-factor-report-suggests/ [Accessed 10th June 2020]
[9] British Heart Foundation. Why are so many people of ethnic minority background dying from coronavirus – and what does it have to do with heart disease? BHF. 2020. Available from: https://www.bhf.org.uk/informationsupport/heart-matters-magazine/news/behind-the-headlines/coronavirus/coronavirus-and-bame-patients [Accessed 10th June 2020]
[10] NHS Digital. NHS Workforce Statistics – March 2019 (Including supplementary analysis on pay by ethnicity). NHS workforce statistics. Available from: https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#by-ethnicity [Accessed 10th June 2020]

The Coronavirus Collective

Who cares for the carers?

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You travelled thousands of miles from the east, a stranger equipped with nursing skills. You hold a nursing degree, trained from your home land. Grew in a place of comfort, a home that is full of familiarity and warmth. A place where you have walked and talked without being judged. You need not say a word and you are understood. A place called home.

Like many nurses, the decision to become a nurse is influenced by family, so that one day you can travel in search for a better life. Raised in a land where there is year-round sunshine, you ventured in to a place where the season changes four times in a day. The two years became twenty years, despite the multiple opportunities that came by, you stayed. You left home, you forgot the comfort of affluence, having your own driver, the comfort of your chef at home. You took pride on being independent, knowing how to travel through the underground. This is the place, you found home again, a second home. Suddenly work is work no more, you found a purpose,
'it is for the betterment of many', you say.

You carried on developing and growing, the quest for knowledge took you to research. The competency through to running a daily clinical service. The composure and strength to stand as a leader and face adversity. The humility to listen and follow. You are in the world where diversity is advocated, you embraced the culture. You look forward for an afternoon tea, not anymore a coconut drink. You break boundaries, there are million times when you stood up for what you believe in.

You are a nurse, you review patients and not only carrying out doctors' order like it was traditionally done. You train doctors and influence change. You research possible treatments or develop clinical guidelines. You are a nurse and you lead, trained like a scientist or a pilot, the way you talk, move and aim for perfection. There is no room for error. You are a nurse. You are known to care.

Suddenly, you heard of a virus that came from the east. You continue the routine, preparing two weeks ahead of many. You hold your breath, you are used to entering a contagious room with a mask, you see patients with pneumonia every day. You are mask-fit tested and have a flu vaccine every year. You learn to talk with breathless patients, you are comfortable to hear a respiratory patient shout and yell, that he/she cannot breathe. You provide comfort to a distressed patient, check that the airway is patent. You observe a chest that rises and falls, you look at a pursed lip that takes on a blue hue. Your eyes inspecting and observing, that there is a nebuliser by the bedside. An oxygen mask, you are ready anytime and for anything.

But nothing prepared you for what is yet to come.

The whole team were called up, divided and designated in to different roles. You were waiting to be at the bedside, 'this is my area' you say, because you are a nurse. Then, you receive a call, you lead a diverse group of healthcare professionals, from maternity to AIDS (acquired immunodeficiency syndrome). Those who have previously worked with you to deliver research, are now ready to help the clinical teams. Your team receives the support they need.

Now that the surge is past, the research, you had been advocating for in clinical practice, is once again to be fought for. A national executive order that comes a lot later than the critical care order. You are not in the military but it feels like you are. You cannot 'question' the orders nor the sequence. You asked, 'Are we not late? Should we start from the accident and emergency?'

There are many of them, patients, doctors and nurses alike, in intensive care. Do we have enough research nurses? There are many patients coming in but your fellow specialists were in the intensive care. You took comfort in the support given by your paediatric and midwifery colleagues. They learn fast, they embrace the change. I often wonder what was going on in their heads but the impossible was made possible. There was unity despite the despair. We lost a father, mother, son and daughter.

We are facing a global pandemic, this COVID-19 that came from the east. The only thing that can be seen and not covered by the mask, are your eyes. Your eyes that resembles those from the east. You are not used to this, the face mask you wear at work is amplified, even outside. Many of your race were routinely shouted and jeered at. You find you cannot ignore or tolerate that anymore. There are the same people that you care for, that are now in the streets rushing

and jostling past you to get food and then there is none left for you, at the end of your gruelling shift.

Then, people also care, there was free tea and biscuits, the five-star hotel accommodation, you
would not even dream of booking with your meagre salary, suddenly it is free and you are treated like a VIP. Although it is a lockdown, the the big society does not stop, everyone focuses and for the first time, think and act like one. For the first time, the society has recognised what you do in health care, they call you 'heroes' and clap every Thursday evening. You lost many of our colleagues, you struggled to be heard but you choose to see the positive. This is the only way to cope, you either fight, or dismiss the negative and carry on. You choose the later, dismiss the negative and be positive. Together we are stronger they say.
'Please do not call me a hero', you say.
'I am a nurse delivering my oath and this is what we do, day in and day out. Long before the pandemic.' You existed before the pandemic and you will continue to serve your fellow man beyond. Scientific research on SARS-COV-2 is showing outcomes, there are promising treatment emerging, there is vaccine in development. The big society has come together and it works.

Slowly the lockdown is being eased off. Slowly, they are drifting away. You are left with hundreds to follow-up in the clinic. You continue to stand guard by the entrance to serve those that come with suspected or positive COVID-19. The old and new services are overlapping. The society is going back to the old world, the diversity of life that boosts the economy. No more free tea, biscuits and accommodation. You too, search for a break, a holiday. We find comfort in the material things, dictated by society, an escape from reality. All this happens so fast and suddenly six months have flown past. You go back to the new norm, face a new reality.

Where are they now? They rejoice for the research outcomes, for the services set-up and sustained. You had a break, but you continue to be vigilant. They rejoice and take pride in what you do. You are a research nurse working in the background. The pandemic emphasised your purpose. You fought hard to be heard. They do understand now. Did they ask, if you are fine?

You came from the east where the word stress comes with a stigma. It shows weakness. You are too proud to acknowledge it to yourself, or event admit it exists. You too, don't understand, it is all new to you and wish people could read the signs. You deny it yourself. You are a proud Asian, raised and resilient overcoming the disasters and storms that pass through the 7,641 islands in your home land. But you stayed in your second home longer than in your motherland. Where do you really belong? How will they listen when they don't really know you?

There's no question that the COVID-19 pandemic, the largest global disruption since World War II, is devastating millions of people with unexpected illness, disability, or death, financial ruin, postponed weddings or virtual graduations, and more [1]. COVID-19 during nationwide lockdowns produces acute panic, anxiety, obsessive behaviours, hoarding, paranoia, and depression, and post-traumatic stress disorder (PTSD) in the long run for society as a whole. These have been fuelled by an 'infodemic' spread via different online platforms and social media. Outbursts of racism, stigmatisation, and xenophobia against particular communities is also being widely reported. Nevertheless, frontline healthcare workers are at higher-risk of contracting the disease as well as experiencing adverse psychological outcomes in form of burnout, anxiety, fear of transmitting infection, feeling of incompatibility, depression and PTSD. [2]

Since the outbreak started, the Laura Hyde Foundation has seen an 88% increase in calls to its helpline in search for support [3]. Many non-profit organisations that were formed during the pandemic, responded to calls in support to those affected [4]. Humphries and Jabson, investigated the influence of culture and history of trauma on the specificity of autobiographical memory. The group exposed to high trauma appeared to provide significantly fewer specific autobiographical memories, than the low trauma group. The findings suggest that even in cultures where specificity is not as evident in autobiographical remembering style, trauma exposure appears to further lower the specificity on autobiographical memory [5]. Hence, we forget the impact a traumatic event has on our memory, this may be a survival strategy for humans.

Perhaps we are now beginning to ask the right questions? However, do we always expect to get the right answers. We continue to search. Who cares for the carers? Who supports the leaders? We aim to survive and be resilient in search for post traumatic growth.

References:

1. Behel, J. & Coleman, J. Covid-19 could cause a mental health crisis. It can also spark post-traumatic growth. (Accessed online 19 Jul 2020) https://www.statnews.com/2020/06/22/covid-19-spark-post-traumatic-growth/
2. Dubey S, Biswas P, Ghosh R, et al. Psychosocial impact of COVID-19 [published online ahead of print, 2020 May 27]. Diabetes Metab Syndr. 2020;14(5):779-788. DOI: 10.1016/j.dsx.2020.05.035
3. Gilroy, R. Charity launches clinically supervised well-being service for health staff. Nursing Times. [Accessed online 19 Jul 2020] https://www.nursingtimes.net/news/coronavirus/charity-launches-clinically-supervised-wellbeing-service-for-health-staff-27-05-2020/
4. Filipino Unite [Accessed online 19 Jul 2020] https://filipinounite.com
5. Humphries CA, Jobson L. Short report: Influence of culture and trauma history on autobiographical memory specificity. Memory. 2012;8:915 - 922. https://doi.org/10.1080/09658211.2012.710432

SOUTH ASIAN HEROES

CELEBRATING SOUTH ASIAN HERITAGE – AUG 2020

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The United Kingdom National Health Service (NHS) staff and students have been working tirelessly throughout the pandemic in a multitude of ways, including caring for patients, volunteering their time or being involved in research and education. People of Asian origin make up 29.7% of the NHS medical workforce1. In recognition of South Asian Heritage Month, we asked our readers to nominate health care workers of South Asian origin who have demonstrated their tenacity, innovation and excellence in recent months.

NHS HERO: SONALI DUTTA-KNIGHT
Ninety five percent of the NHS doctors who died from Coronavirus were from Black and Minority Ethnic (BAME) groups. From March, this concerned me. I was just a normal jobbing General Practitioner, wife, mother… would anyone listen? I started discussions through social media. I researched and published articles (notably British Medical Journal Leader). I created the group 'Healthcare Professionals Against Racism' which has over 1000 members. I was invited to advise a group of Members of Parliament in an all-party conference to discuss strategies to protect BAME NHS staff. I'm even now running for the Royal College of General Practitioners Council primarily because I want to raise the voices of all doctors of colour.

NHS HERO: SARISHKA SINGH
The COVID-19 pandemic washed over our medium sized District General Hospital like a tidal wave, filling staff with fear and then receded, leaving us battling exhaustion and depression. As a Foundation Year 1, I did not expect my year to be uprooted like it was. I witnessed my environment suddenly changing and the bustling ward that I had known morphed into a unrecognisable area of sick and dying COVID patients. The months that followed were hellish, but still we rallied against the seemingly never-ending tide of admissions with energy and vigour despite staff shortages, succumbing to the virus ourselves and physical and mental exhaustion.

NHS HERO: VEENA NAIK
I would like to nominate my friend and ex colleague Veena Naik who is a Consultant Anaesthetist at James Paget University Hospital NHS Foundation Trust, Great Yarmouth. Her husband, after undergoing a kidney transplant has recently had to go back to dialysis due to rejection and go back on the transplant waiting list. During the pandemic she had to stay away from him to be able to work for NHS as he would have been at risk. Nominated by Nilanjana Singh.

NHS HERO: MUKESH CHUGH
This picture was taken after 18 hours of dealing with Covid-19 patients on one of the most exhausting nights of my career. Prostration was not due to the number of hours or number of patients; but was due to donning and doffing, getting dehydrated while breathing through the mask and fear of unknown.

NHS HERO: ANITA GHEI
Due to medical risk assessments, my clinical role as a dentist was impacted. Consequently, I was enrolled into restorative and oral surgery telephone triaging. This service provides 'Advice, Analgesia and Antibiotics', ensuring patients meeting the urgent criteria are seen. Triaging allows adaption and development of communication skills in order to assess, differentially diagnose and manage dental problems without seeing the patient. This role has included many challenges: language barriers, decisions associated with shielded patients and restricted services of local anaesthetic clinics only. However, this experience has highlighted the importance of oral health and the need for dental service provision.

NHS HERO: AIYAPPA BIDDANDA
The initial two weeks when Italy went into lockdown the hospital and government were very laid back. This led to the hospitals having no clear plan of action and the initial spread of disease. I was distraught, feeling scared and angry as a night medical registrar where I had to make quick decisions. The lockdown was not as hectic as I expected it to be, but I had to manage staff fears/ safety on my ward with only surgical masks and plastic aprons which left me feeling the same anger towards the hospital management and lack of clear leadership.

REFERENCE
1 NHS workforce - Ethnicity Facts and Figures, <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#by-ethnicity> (2020).

The Coronavirus Collective

Only a Wearer knows where the Mask Pinches

Image – Self Portrait

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