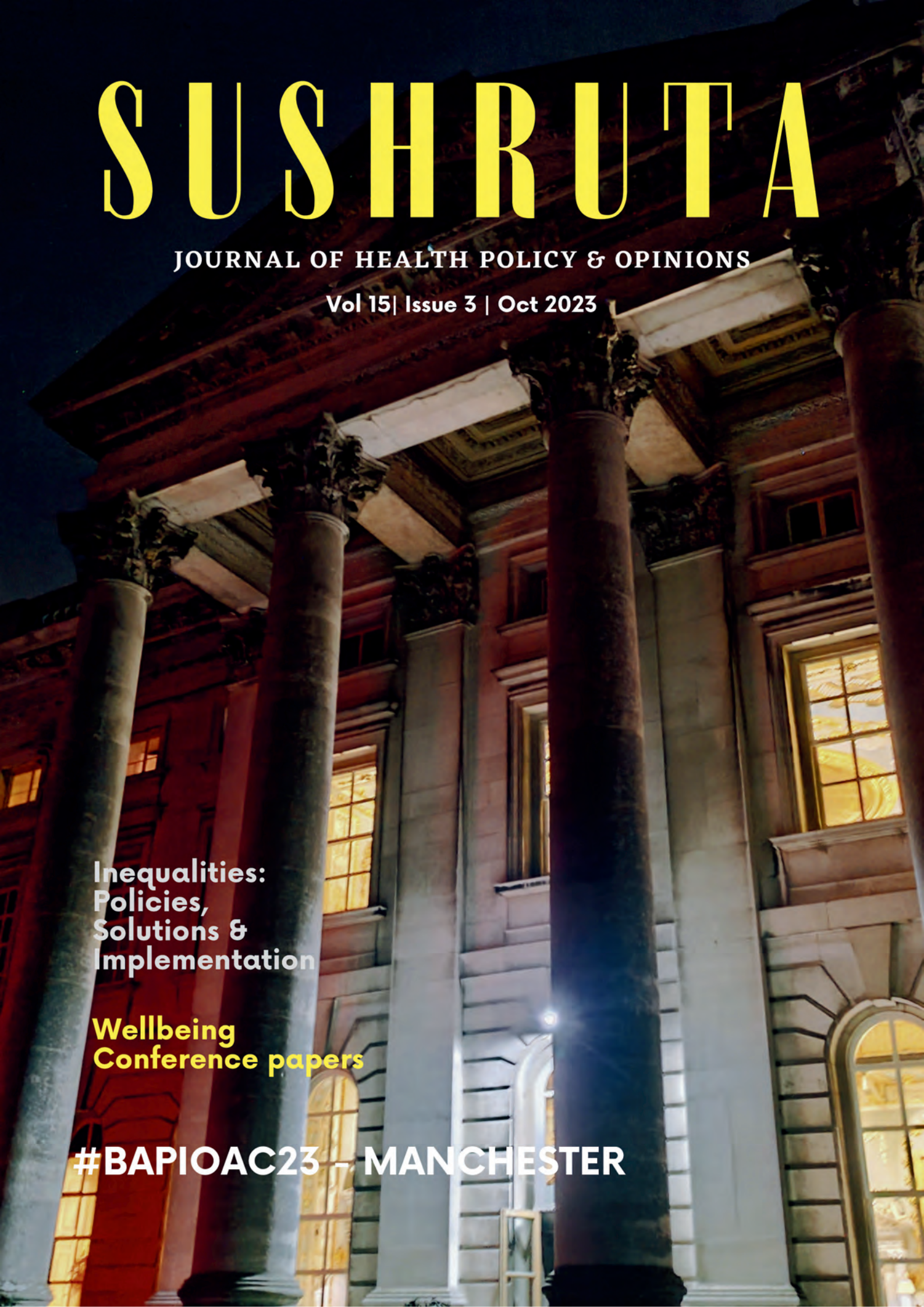

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BAPIO – Journey beyond 25

I look forward to welcoming you to the BAPIO Annual Conference at the iconic Old Trafford Cricket Ground, especially in the background of the ICC ODI World Cup being played in India.

We had an amazingly successful conference here in 2017 and this will be equally good if not better. BAPIO Conferences have evolved into an important national event in the UK medical calendar. BAPIO is recognised as an important partner in the healthcare sector and in our opinion the national level is respected.

BAPIO was born in 1996 with the objective of promoting professional Excellence by standing up to unfairness and injustice. Fast forward 26 years, and we are proud that we have walked the talk! We have been collaborative, constructive as well challenging if required. Over time we are gradually breaking the glass ceiling but of course, there is still a long way to go.

Ramesh Mehta CBE
President, BAPIO

Since Covid, we have published 3 important documents to support the EDI issues. The first project was on Tackling Differential Attainment of International Medical Graduates 'Bridging the Gap'. This was one year's hard work with contributions from 150 professionals. This is the first of its type of evidence-based document about changing the face of challenges that require intervention to make equity in medical careers a reality. This project has been widely appreciated.

The second project was to create a document that defines the gold standard for dignity in the workplace. 'The Dignity at Work Standards' was created with the help of over 50 stakeholders. The NHSE has now provided funds to pilot these standards in 3 hospital Trusts.

The third and equally important document was the charter for 'Locally Employed Doctors', the most neglected breed of doctors.

Our two academic Journals, The Physician and the Sushruta are gaining global recognition under the supervision of a highly talented editor in chief Prof Indranil Chakravorty, and team of BAPIO Institute for Health Research (BIHR).

The BAPIO Training Academy (BTA) has been highly successful in developing several International Fellowship programs thus supporting quality medical education for overseas doctors as well as supporting the UK medical and nursing workforce shortages. It has also launched a high-level Indo-UK Healthcare Alliance under the leadership of Prof. Parag Singhal to promote collaborations between the two countries.

The Medical Defence Sheild (MDS) continues to provide excellent support to doctors in difficulty with an excellent success rate at the MPTS hearing. It is close to making a major announcement in the near future. Please keep your fingers crossed!

British Indian Nurses Association (BINA), an 'arm's length body' of BAPIO. Is creating a major impact in the NHS by raising the EDI issues but also collaborating with the establishment. It is admired for providing pastoral care to newly arrived nurses from India and at the same time supporting the existing Indian nurses. I am pleased to note that some of the BINA members have won national awards and have made a significant presence in the media.

We continue to reach out to NHS Trusts to develop partnerships to assist with the EDI agenda but also provide support with recruitment, retention, and pastoral care for the staff. I am pleased to report that we have signed MOUs with Norfolk Norwich University Hospitals Trust, University Hospitals of Leicester, Bedfordshire Hospitals University Trust, George Eliot Hospital NHS Trust, Kings Lynn NHS Trust, and University Hospitals Sussex NHS Foundation Trust.

We are proud of our close links with the NHSE, GMC, AoMRC, and many Royal Colleges. This enables us to discuss the issues of relevance to our members and find solutions in informal way. We are also pleased with our close associations with various ethnic minority doctors' organisations. We have played a major role in the formation of a federation of these associations.

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With our 13 national divisions and 10 speciality forums in addition to the five arms-length bodies, BAPIO has developed a huge network of like-minded people who are supporting each other and assisting each other's career progression.

I hope you have seen the BAPIO documentaries and the song commissioned to celebrate our silver jubilee. These are now available on BAPIO YouTube and on our website www.bapio.co.uk

Finally, I am delighted to announce that we have been successful in our application to the charity commission for charity status. We are going through a transformation stage and further details will be finalised shortly I hope you take the opportunity during the conference to meet many national leaders as well as make new friends from different parts of the country

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The Case of Nurse Letby: Systems Failure in Safeguarding Patients

Indranil Chakravorty MBE

The case of nurse Lucy Letby killing innocent babies in a neonatal unit has yet again shaken the confidence of society in healthcare professionals and forced many professionals themselves to reflect on what impact this may have on their practice. Like in wider society, there are professionals who cause harm to others deliberately, and in some cases demonstrate attributes of serial killers.

This is not new and sadly is highly unlikely to be ever eradicated. What has shaken the healthcare professions more, is the abject failure of leadership to heed concerns raised (whistleblowing) and actions that may be considered collusive or protectionism, towards Nurse Letby, who apparently did not have the 'face of a killer'.

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INDRANIL CHAKRAVORTY

'Letby was the epitome of ordinary. She appeared conventional in every way.'[1]

It appears that established systems for raising concerns were blatantly defeated by the actions of leaders. There is also an additional concern that the 'conventional' profile of the perpetrator may have played a role in how the leaders reacted to protect her. There are contrasts being drawn by analysts to cases where professionals with different personal attributes (protected characteristics such as colour, race, religion) were treated differently, both while raising concerns or when concerns were raised about them. This case highlights the other elephant in the room, the differential treatment of people in society, as well as in healthcare based on their race or protected characteristics.

What can the profession and society learn from this and similar gruesome incidents? How should leadership accountability be established? What recourse do patients and professionals have to expect their concerns to be taken seriously before harm occurs? What is the implication of the proposed 'Martha's rule' to healthcare?

Keywords
Whistleblowing, Martha's Rule, Raising concerns,

Background

Rogue professionals who cause deliberate harm to patients under their care and sometimes do so with impunity, remaining undetected over time, avoiding established systems of protection, shake the confidence of society - the crucial tenet on which healthcare relies. Such heinous acts shake the resolve of the overwhelming majority of professionals who uphold their Hippocratic Oath and serve with dedication and compassion. Several high-profile cases underscore the gravity of this issue and illuminate the proactive steps taken by society and regulators to mitigate the risks and protect the public.

One of the most notorious cases is that of Harold Shipman, an English general practitioner, who was responsible for the deaths of at least 218 patients over decades.[2] This chilling case sent shockwaves through the medical community and society at large, revealing the potential for unimaginable harm when a rogue healthcare professional goes unchecked.[3] Regulators were forced to reevaluate their oversight mechanisms to prevent such atrocities from occurring again.[4]

'...all doctors, and not general practitioners alone, share responsibility for creating the circumstances that enabled Shipman to be so successful a killer. We must accept that responsibility, and embark on a process of professional renewal in which the principle of patient-centredness is given greater force by the addition of the idea of the patient as the source of control.' Richard Baker, JRSM

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In response to such incidents, governments and regulatory bodies around the world have undertaken comprehensive reforms. Mandatory background checks, thorough screening processes, and enhanced reporting systems have been implemented to identify potential red flags early. Moreover, mandatory peer evaluations and regular performance assessments now ensure continuous monitoring of professionals' conduct and competence. However, more needs to be done as it is becoming recognised by a series of reviews that professional misconduct has a greater chance of occurring when there are design faults and operational failings at different levels from the individual to the organisation and finally in wider society. 5

The case of nurse Charles Cullen in the United States6 further fueled the urgency for reform. His calculated administration of lethal doses of medications to patients in multiple hospitals raised concerns about cross-institutional accountability and the sharing of critical information. As a result, new inter-institutional databases were established to facilitate the exchange of data and information, aiding regulators in tracking a healthcare professional's history across different healthcare facilities.

Why is it difficult to detect when deliberate harm occurs in a healthcare setting?

There are several factors including the complexity of decision-making which is both collaborative and distributive in most settings, and that patients or their families often receive inadequate information or are unempowered.

Collaboration has been standard practice ever since the specialisation of the medical profession began requiring a shared cognitive approach to diagnosis and treatment.7 The shared goal—correctly diagnosing and properly treating patients—has become such an overly complex process that it can only be achieved by splitting the medical professions into specialisations and bringing them back in a multidisciplinary team (MDT) decision-making matrix. However, there are inherent weaknesses in this system, such as patients have little to contribute directly to the MDT process in most settings and are only presented with a heavily redacted, sanitised version of the complexity of decisions. Often patients are not provided the evidence supporting the decisions, nor the tools to understand the implications.8

Healthcare systems depend on the assumption of good self-governance of such MDT processes, and the integrity of individual clinicians to provide an evidence-based diagnosis or treatment. There are recognised weaknesses in such systems such as power imbalance, communication, paucity of facts presented and other human factors including differential empowerment of members. Decisions in primary care or community settings are based on individual observations and are rarely subject to the rigour of an MDT-hence potentially remain vulnerable to the actions of rogue professionals, such as Dr. Shipman.

The introduction of advanced data analytics and artificial intelligence may offer a role in bolstering decision-making, providing transparency in outcomes for individuals, teams or institutions - thus offering a level of protection for the public.9

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These technologies can enable the identification of unusual patterns and behaviours, facilitating early intervention before significant harm occurs.[10]

Patient or Family Empowerment

Martha Mills died in 2021 a few days short of her 14th birthday, just after an August bank holiday weekend. She had been on a paediatric ward at King's College Hospital in London, one of three national centres for the care of children with pancreatic trauma, after injuring her pancreas in a bicycle accident. She was showing signs of sepsis, and her parents raised this possibility with staff, but by the time she was transferred to paediatric intensive care days later it was too late. [11] The proposed implementation of 'Martha's Rule' offers patients, families or next of kin the opportunity of raising concerns directly and independently demanding a clinical review.

A similar measure, called Ryan's rule,[12] had been introduced in Queensland. It was named after Ryan Saunders, who died in 2007 from an undiagnosed streptococcal infection, which led to toxic shock syndrome. When Ryan's parents were worried he was getting worse, they did not feel their concerns were acted on in time. Ryan's rule allows a next of kin to demand a clinical review (not technically a second opinion) if they remain unsatisfied with the current review or the speed with which clinicians may be acting on their concerns. An evaluation of the use of Ryan's rule activations in Australia demonstrated that communication issues were central to more than half the activations, 35% of cases required no clinical intervention.

While clinicians doubted the appropriateness of activators' use of the escalation tool, 15% of patients were transferred to receive a higher level of care.[13] Whether this transfer to higher care would lead to better outcomes and cervical is yet to be seen.

In the UK, there are systems for escalation using evidence-based early warning scores based on clinical parameters, many organisations have critical care outreach teams to attend to clinical escalations with agreed timelines and minimum standards of seniority required. Patients and next-of-kin have access to a liaison service for raising concerns which is independent of the managing clinical team. Patients also have a right to demand a second opinion if there is a disagreement or lack of trust in the clinical decisions. In extreme cases, there are systems for judicial review of clinical decisions.

However, the automatic right to a second clinical review, when patients, next of kin or carers (as proposed in Martha's rule) have concerns or are dissatisfied with the level of care, is new. In the review of activation of Ryan's rule, clinicians labelled activations as a 'complaint' as opposed to a 'concern' and reasoned that a 'complaint' did not justify a full review of the consumer's perspective for the activation. While the vast majority of clinicians would understand and accommodate or themselves seek a second clinical opinion in cases of uncertainty or complexity - the automatic activation of a mandatory clinical review by next of kin may lead to confusion, disruption of patient-professional relationships, trust and pose challenges in the provision of senior opinion makers in out-of-hours situations.

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Measures of effectiveness of the implementation of Ryan's Rule have mainly focused on policy and process without first understanding barriers or facilitators through engagement with stakeholders and environmental assessment. There is also a need to assess the impact on families, particularly within a diverse cultural mix. Without a systematic evidence-informed knowledge translation approach, progress in implementing family-initiated deterioration of condition processes is more about appearance and optics – ticking the box – than genuine engagement with families.14 It would thus be prudent through a period of consultation and piloting to understand the positive and negative impact of such an introduction.

Raising Concerns

Whistleblowing refers to when a worker makes a disclosure of information which they reasonably believe shows wrongdoing or someone covering up wrongdoing and is entitled to protections, through the Public Interest Disclosure Act 1998 (PIDA). Whistleblowing has a tortured history in the NHS although it has been recognised as making an important contribution to patient safety. Institutions remain largely unsupportive of whistleblowing, with many staff fearful about the consequences of going outside official channels to bring unsafe care to light. 15–17 In his summary, Sir Robert Francis wrote,

'Speaking up is essential in any sector where safety is an issue. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up identified in this Review will persist and flourish.'18

Although, whistleblower protection laws19 have been strengthened, encouraging healthcare staff to report suspicions without fear of retribution. In many countries, whistleblower protection laws fail to meet international standards and fall significantly short of best practices. Lacking strong legal protections, employees who report potential wrongdoing to their managers or to regulators can face dismissal, harassment and other forms of retribution and the wrongdoing may continue with impunity, as was illustrated by Nurse Letby's case. 20 Whereas most governmental whistleblowing agencies have investigative tasks, a comparative study found that in Belgium and in the Netherlands, worryingly investigations are done within the same department.21 Other agencies have separated these tasks to avoid conflict of interest or because different expertise is claimed to be needed for both.

Institutional Accountability & Silencing

What was illustrated in the case of nurse Letby was the abject collusion or failure of the institutional leadership in responding to concerns raised through whistleblowing, repeatedly and attempts to threaten or silence the whistleblowers. In studies with whistleblowers, many reported being ignored, threatened, harassed or not given any feedback on the actions taken, thus discouraging them from further reporting. 22 Silencing can be the hidden exercise of power, using institutional mechanisms, communication hierarchies and informal rules to control channels of communication and information flows.

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By distracting from or delaying redress of malpractice and undermining employees' right to recognise and report wrongdoing by minimising, wrongdoing is normalised and responsibility to take action is avoided. 23 Sometimes whistle-blowers can become the focus and victim of raising concerns and speaking up24 and may be persecuted by powerful organisations- such cases were illustrated by the handling of junior doctor Chris Day25, cardiologist Usha Prasad26 in London and another Coventry cardiologist Raj Mattu27 to name a few where NHS Trusts have persecuted whistleblowers at great public expense and devastating consequences to the whistleblowers. An NHS England review into the behaviour of high-profile senior leaders who took over a Midlands trust concluded that the interim chief executive "behaved poorly and inappropriately" while its chair was "complicit with" and failed to address problems 28 highlighted by paediatrician David Drew. 29,30

Retribution & Differential Treatment

It is well recognised that differential treatment of individuals and groups of people (although deemed illegal) exists in society, including within institutions based on protected or unprotected (such as immigration status) characteristics. Institutional bias such as racism leads to structural disadvantage which is persistent and often such practices drive disparities in employment, recruitment, and education. Discrimination or bias can be expressed through bullying and harassment,31 perceptions of job performance32 and rewards, poor work-life balance, and experiences of harmful interpersonal interactions.33

So it is unsurprising that such differential treatment may also be a factor in how whistleblowers are treated, and has an adverse impact on employee confidence in leaders and their ability to effectively address and mitigate concerns raised.34

Does retaliation against a whistleblower qualify as discrimination or an infringement of freedom of expression?

In France, whistleblowing legislation has built whistleblower protection on the model of discrimination. The transposition of the European Directive 2019/1937 of 23 October 2019 on the protection of persons who report breaches of EU law, reinforced by domestic case law, shifted the balance towards freedom of expression. Standing between discrimination and freedom of expression, the protection of whistleblowers is in urgent need of conceptual clarification.35 Retaliation towards internal whistleblowers can in turn negatively relate to relationships with the leaders and decisions to blow the whistle again, using external channels. Following the events at Mid Staffordshire NHS Foundation Trust, Sir Robert Francis found that staff had tried to speak up about their concerns, but that they had been ignored, or victimised as a result. This experience was not confined to Mid Staffordshire and the Freedom to Speak Up report recommended the appointment of freedom to speak up guardians in NHS trusts and foundation trusts and a national guardian to lead this network, undertake case reviews and provide support and challenge to the system.36 An internal review of the NHS Freedom to Speak Up (FTSU) Guardian role in 2022, demonstrated that there was a decline in the confidence to speak up, especially in frontline or community services and overall. 37

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There is also the issue of persistent inconsistencies in the way in which regulatory agencies handle concerns, based on protected characteristics of the individuals involved. 38

In the case of Nurse Letby, numerous instances of whistleblowing were ignored, and silenced with the threat of adverse consequences for those raising concerns, demonstrating an abject failure of leadership and concerns that the profile of the perpetrator when compared to those raising concerns may be a factor.

Conclusion

The menace posed by rogue healthcare professionals demands unwavering vigilance and adaptability from the industry and its stakeholders. Through the implementation of stringent vetting processes, cross-institutional data sharing, and the integration of advanced technologies, a renewed commitment to patient safety is needed. By learning from the mistakes of the past, we can move forward with the shared goal of ensuring that the trust placed in healthcare professionals is well-founded and that the care provided remains a beacon of hope and healing.

The world had taken a step back from when Time Magazine declared it to be the year of "Whistleblowers" in 2002.39 Even if the best legislation is in place, the status of a whistleblower will inevitably receive a hard blow. While employers can't retaliate directly, there is no check on unfair appraisal and deliberate over-burdening.

There is a lack of protection due to the restrictive nature of the definition of a whistleblower and the complicated process of "whistleblowing" that dissuades whistleblowers from coming forward. 40 The UN Whistleblower Policy 2017, addresses similar issues but faces the same pitfall of a restricted approach. It defines reports and cooperation as "protected activities" if they are made as soon as possible, in good faith and not later than six years and rarely may be extended to individuals who report through external mechanisms.41 Herein lies the weakness, when protection is rarely offered for external reporting such as through Monitor in UK Healthservice.42

Stringent regulations and reforms in healthcare systems have contributed to saving lives and preventing harm caused by rogue healthcare professionals. While these measures cannot eliminate the risk of rogue healthcare professionals, they have undoubtedly contributed to minimizing the potential for harm and protecting patients. By learning from past cases and implementing proactive reforms, healthcare systems have taken significant steps towards ensuring patient safety and maintaining the integrity of the profession.

There is also evidence to suggest that whistleblowers from minority backgrounds may experience differential treatment compared to their white counterparts.

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Addressing these disparities requires a multi-faceted approach that involves creating inclusive and supportive organisational cultures, promoting diversity in leadership, ensuring fair treatment and protection for all whistleblowers, and raising awareness about the importance of whistleblowing regardless of one's background. It's essential to recognise that achieving equality in treatment for whistleblowers from minority backgrounds is a critical aspect of ensuring ethical conduct and accountability within organisations.

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IQBAL SINGH CBE

GMCUK-REVIEW RECOMMENDATIONS PAVE THE WAY

IMPROVING THE WORKING LIVES OF BME DOCTORS

In November 2022, the General Medical Council (GMC) published an independent review of its fitness to practice processes and the handling of the case of locum general practitioner Dr Manjula Arora. She was suspended for a period of one month in relation to a laptop request having been found to be 'dishonest in obtaining a laptop when in fact the Trust had recorded her interest in asking for a work laptop'. The consternation was instant and palpable. The medical profession found it difficult to understand how a request for a laptop had passed through different stages of the fitness to practice process (FtP) resulting in a sanction of a suspension to her license to practice. The profession was left in a state of shock resulting in a loss of trust for the GMC. This also threatened to undermine support from Black and Minority Ethnic (BME) organisations and the medical profession for the GMC's plans to eradicate a legacy of racial discrimination.

The review made recommendations in four areas.

1. Professional curiosity and local resolution first
2. The need for cultural competency and diversity intelligence
3. Embedding compassion in all dealings by the GMC and Medical Practitioner Tribunal Service (MPTS).
4. Providing support for doctors before, during and after the complaints process.

The review concluded that understanding cultural competence is essential for the delivery of 21st-century fair, compassionate and proportionate medical regulation. For the first time ever the review led to some groundbreaking actions. The GMC for the first time apologised to a doctor, a move never seen before and for the first time the GMC did not contest the appeal and allowed the sanctions to be set aside.

The review concluded that it could not say that the doctor had not been treated differently because of her ethnicity, and it recommended that instead of trying to reassure itself that there was no bias in the systems, the organisation should.

'recognise that no organisation can be genuinely free from bias. It is therefore vital that bias is proactively sought out rather than looking for reassurance that it doesn't exist.'

It also made recommendations around improvements to the GMC's approach to data collection and data monitoring and that they should embed cultural competence, diversity intelligence and compassion into all of its processes. The GMC accepted all of the recommendations and findings and Chief Executive Charlie Massey said,

"I welcome the report by Professor Singh and Martin Forde. Their examination of this case has been detailed, searching and constructive and I am grateful for their expertise and insight. The GMC accepts all of these recommendations without reservation. It is clear that there were decisions that we did not get right and for those I have apologised to Dr Arora. We share the aspirations of the review's co-chairs that modern regulation should contribute to a better health system which is compassionate, fair and supportive and the recommendations in this review will help us to achieve these aims."

Medical leaders hailed the review as groundbreaking and had the potential to change the working lives of a generation of BME doctors. The Arora laptop case must become a GMC never event warns the doctor leading the review "Understanding cultural competence is essential for the delivery of compassionate, fair and proportionate regulations.

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Local Resolution

Regulators should ensure that appropriate local resolution becomes the norm first and they should not measure their success by the number of complaints that they receive or handle but by how they create a culture of learning sharing and prevention and improve standards with opportunities for support and remediation.

Compassion

Compassion, dignity and respect are the fundamental principles and the bedrock upon which healthcare and social care systems of the 21st century should be built. The GMC and the MPTS have made commitments to these values however, it is important that these are actually implemented throughout the stage of the regulatory process including at tribunals. Tribunals should not be adversarial and doctors must be treated with dignity and respect as the damage caused by cross-examinations to the mental health and well-being of doctors can last well beyond the tribunal hearing.

The whole process is viewed as being a highly negative experience where doctors are shown little compassion and respect. The impact on their physical and mental health may have long-term consequences resulting in difficulties in their ability to re-enter the workforce successfully.

Support

Covid-19 had a devastating impact on all communities as well as a generational challenge for the whole of the medical and healthcare workforce. It had a huge disproportionate impact on BME doctors, many of whom lost their lives. We need to value their contributions and commitment.

The current challenges of post-recovery and current circumstances make it even more important that support is right at the forefront of the work of the NHS and regulators.

Going through an FtP hearing can be extremely traumatic even for doctors who might be totally cleared of any wrongdoing, with 70% of doctors reporting an effect on their mental health and well-being in a Medical Protection Society (MPS) survey.1

Language and culture

The medical workforce in the UK comprises large numbers of doctors who trained outside of the UK and English is not their first language. Therefore, even though they can communicate sufficiently well enough to be able to hold conversations and write in English there is still the likelihood of misunderstandings and miscommunication. The doctors' cultural background determines their attitudes and behaviours and influences their views and opinions, especially regarding what is considered acceptable and normal. In addition to culture, the language conventions might be very different. Language is part of a culture, and a person's culture is also part of the language they use to speak and express themselves. The two are inextricably linked especially the non-verbal means of communication.

Doctors are referred to the GMC either for concerns about their clinical performance their attitudes or behaviours, or issues around communication. Sanctions in the case of impairment consider such things as expressions of apology and remorse, demonstrating insight, and showing evidence of remediation.

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Doctors from minority ethnic backgrounds tend to get higher sanctions as panels infer that they might not have shown insight or expressed an apology, when in fact we are clear that the expression has different meanings in different cultures. At the heart of improving regulation, in a case with no issues of clinical performance or patient safety, all examiners, assessors, and decision-makers should have some degree of cultural awareness and sensitivity and have access to experts and advice on cultural competence and diversity intelligence. The sanctions guidance and sanctions themselves need to recognise and take a greater account of the changing demographics of the medical workforce and show sensitivity to the interpretation of values, cross cultures, and communication through the lens of cultural competence and diversity intelligence.

Therefore training around issues of cultural competence, cultural sensitivity, and diversity intelligence should be embedded into all aspects of the fitness to practice processes. Whether that be in the initial stages at the local level, in both NHS and Provider Trusts or after referral to the GMC, it must then continue throughout the whole of the fitness to practise pathway. A panel comprising experts whose expertise is in cultural competence should be available to provide oversight and guidance for those individuals who might be deemed as having charges that are centred around issues of culture or language.

Conclusion

Since the review was published there has been widespread support for and welcome of the recommendations and a feeling that implementing these has the potential to change the face of medical regulation. However, there is understandable scepticism about whether these recommendations will be implemented in full.

The GMC has accepted and committed to implement them and it is important that this is monitored and evaluated with regular progress communicated to stakeholders. We recognise that the GMC is making some positive contributions towards improving race equality. The review recognises that the GMC cannot achieve these goals in isolation, but needs support and partnership to help highlight what needs to be done. There has been a long wait for the UK government to produce legislative reform of health professional regulators. The authors believe that local regulation will help to make regulation more timely and avoid the stress of having to go through the tribunal process. Until then the GMC and the wider health service must engender a culture of curiosity in how it fulfils its statutory duties and treats those doctors who come into its orbit and for now use its influence to follow through on these commitments.

Key Recommendations

- The implementation of all recommendations of the Singh and Forde review should be monitored, evaluated and communicated to all stakeholders.
- The NHS should develop a culture of local resolution first, with those involved trained in professionalism and handling concerns.
- Comprehensive induction for international medical graduates should include patient safety and professionalism, and help to integrate them into the NHS and communities.
- Organisations serving diverse workforces should proactively address bias and have expert advice on cultural competence and diversity intelligence.
- Compassion, dignity and respect are pivotal values, and should be embedded into all pathways of the GMC and MPTS

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Making it to the Registers

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Immigration policies, medical professional regulations, and fitness to practise requirements pose several challenges to overseas-trained health professionals in the UK. These challenges pertain not only to the entry of such workers onto the medical registers, but also extend to securing employment, career advancement, and workplace experiences. For example, research findings indicate that international medical graduates or doctors with primary medical qualifications from outside the UK are subject to less favourable evaluations in recruitment, assessments, and career progression compared to UK medical graduates.[i]

The limited prospects of securing positions often compel many overseas-trained and qualified professionals to accept roles in less desirable locations, geographical areas, and less attractive specialities.[ii] Visa and immigration requirements and restrictions on remaining in the UK further exacerbate the uncertainties and financial challenges faced by overseas-trained professionals.

The project Making it to the Registers: Documenting Migrant Carers' Experiences of Registration and Fitness to Practise aims to offer an account of some of the lived experiences of migrant and refugee health professionals in the UK. The project focuses on how nurses and doctors trained overseas experience the challenging process of obtaining professional registration in the UK.

Making it to the Registers will collaborate with cultural institutions such as the Leeds Playhouse and the Yarn digital community archives platform, to produce, share, and preserve a variety of unheard voices and original insights by migrant health professionals on their experiences of registration in the UK. These experiences will be presented in a variety of formats, including:

- A digital archive of community stories documenting the experiences of overseas-trained health professionals,
- A digitised collection of objects that signify registration to overseas-trained healthcare professionals, curated by Brotherton Special Collections, University of Leeds,
- A youth theatre production at the Leeds Playhouse, which is the UK's first Theatre of Sanctuary, based on the theme of international movement of healthcare workers, and
- An oral history archive of the twenty-five years of activity of our project partner, the British Association of Physicians of Indian Origin (BAPIO), on behalf of overseas-trained healthcare professionals, including litigation, campaigning, and lobbying with public bodies.

Through these different streams, our project aims to contribute to academic, policy, and public understandings of how the regulatory tools of the medical professions are experienced by overseas-trained healthcare workers and the activists who support them. By doing so, the project will provide insights for the reform of professional regulation more broadly.

BAPIO is an ideal project partner in this endeavour. BAPIO has been supporting international medical graduates since 1996, monitoring, highlighting, and addressing the difficulties faced by doctors and advocating for positive systems to support healthcare workers. It actively promotes the diversity, equality, and inclusion of all healthcare professionals and has carried out several campaigns against discrimination in education, training, and career progression of overseas-trained health professionals.

The initial phase of the project will involve archival research to understand how professional regulators and institutional bodies historically have influenced, regulated, and enacted the entry of migrant healthcare workers to the UK medical workforce for the past 80 years, going back to the time of the Second World War. This will be followed by the interview phase, during which we will meet with overseas-trained health professionals who have moved to the UK to investigate their experiences of navigating the UK medical regulatory requirements.

if you have historical papers/documents that represent your experiences of medical registration in the UK and would like to share them. please contact us at makingregisters@leeds.ac.uk.

Funded by the Arts and Humanities Research Council (AHRC), Making it to the Registers is a collaboration between the University of Leeds and the University of Bedfordshire. The project team includes Professor Marie-Andrée Jacob (Principal Investigator, University of Leeds), Professor Nasreen Ali (Co-Investigator, University of Bedfordshire), Dr Priyasha Saksena (Co-Investigator, University of Leeds), Dr Amrita Limbu (Research Fellow, University of Leeds), and Dr Bismillah Sehar (Senior Research Fellow, University of Bedfordshire).

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Legal

Regulation *of* Apology in Healthcare

Learning from GMC V Dr Pandian 2023

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Abstract

The MTPS case involving Dr Nithya Santhanalakshmi Shunmugavel Pandian has sparked significant debate within the medical profession, particularly regarding the disciplinary process and its implications for international medical graduates, gender dynamics, and attitudes towards complaints. A noteworthy factor contributing to the strong reactions in GMC v Pandian is the 2014 implementation of a statutory duty on healthcare providers to be open and honest when medical harm occurs. This legal duty of candour complements existing ethical and professional obligations to maintain transparency and openness with colleagues and patients. This article reflects on the intriguing role of apologies, both inside and outside legal and disciplinary proceedings.

It is acknowledged that healthcare professionals often hesitate to issue apologies due to concerns about potential legal liabilities or substantial claims. In response to this challenge, legislators have introduced apology laws, creating 'safe spaces' where healthcare providers can apologise without necessarily admitting liability. Paradoxically, however, research suggests that these regulatory measures may discourage apologies and hinder honest communication regarding medical harm. Furthermore, incorporating apologies into legal frameworks may unintentionally strip apologies of their inherently humane and uncertain nature.

Keywords
Apology, healthcare regulation, GMC

Introduction

The recent case of the UK General Medical Council v Dr. Pandian in 2023 has sparked debates on the intricate relationship between apologies in healthcare, professional conduct, and medical ethics. The case, which revolves around allegations of professional misconduct against Dr Pandian, a junior doctor, and International Medical Graduate, provides the opportunity to reflect on the role of apologies and their complicated implications in the context of disciplinary proceedings. This article considers the nuances of the case to explore the ethical, social and legal dimensions of apologies in healthcare and reflects on the broader implications of the increased regulation of apologies for the medical profession.

GMC v Dr Pandian

On 5 May 2023, the Medical Practitioners Tribunal found Dr Pandian guilty of professional misconduct, on the balance of probabilities; on 10 May 2023 found her fitness to practice being impaired due to misconduct; and on 11 May 2023 suspended her for two months from the medical register. The allegations revolved around Dr. Pandian's having failed to carry out a physical examination on a patient and falsely recording that she carried out such an examination (Pandian MPT 11 May 2023). 1

In its determination, the Medical Practitioners Tribunal referred to prior internal proceedings at the Kettering General Hospital Trust and to Dr Pandian's legal representatives' letter to her employer, which included an apology.

The apology letter stated:
"1 - This is my routine practice that I always introduce myself before I meet a patient and I believe I did the same when I met Patient A. 2 - This is also my routine practice to document in the notes after I have completed my examination of a patient. After seeing Patient A's notes, I believe that I performed the abdominal examination and documented it in the medical notes. However, if Patient A feels that I documented this without examination then I sincerely apologise for all the distress that Patient A went through because of this." (letter of 13 Dec 2019, cited in MPT, 5 May 2023 para. 48).

During the MPT hearings, the General Medical Council (GMC) argued that Dr. P's apology "would only make sense if Dr. Pandian had not examined the patient," stating that the apology suggested an admission of guilt. However, the MPTS did not accept the GMC's interpretation, but considered Dr Pandian's clarification in her witness statement:

"I wish to make it clear that when I apologised to Patient A in my response to the initial complaint that was made to the Trust, my intention was to apologise for the distress caused to Patient A. I was not accepting any wrongdoing. I would not add a note to the patient record unless I had completed the examination. However, if the patient believed that I had done so this may have caused some distress for which I apologised." (MPTS 5 May 2023, para 49.)

The Tribunal also noted from Dr Pandian's testimony that "she had sought advice from a consultant colleague who had advised that the normal process in these circumstances was to apologise for the distress caused to the patient." (para 51).

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Whilst the MPT did not interpret Dr Pandian's apology as an admission, the GMC's attempt to use it as evidence of misconduct raises questions about the role of apologies in the conduct of healthcare and investigations of patient complaints.

Apologies, insight, and transparency

The case raises significant questions about the role of apologies and their use as evidence in patient complaints and disciplinary proceedings. It features the delicate balance between openness, accountability, and the implications of admitting to an error.
Dr Pandian's Rule 7 response to the internal complaint included, along with her apology letter, "denial of the allegations, and details of remediation, reflection and several testimonials." A letter to the GMC contained the following statements:

"Whilst Dr Pandian's practice is to document in the notes what has been done and recall that this would have been her practice on this day, there may, of course, be the possibility that on this occasion her high standards slipped due to extenuating circumstances, including workload and being on autopilot." [...] "she appreciates that there is a potential possibility that her standard in maintaining good record keeping may have fallen short during this consultation. Dr Pandian accepts that if this did occur, it was a genuine error on her part and that it would have not been her intention to note inaccurate notes or in any way be dishonest." (MPT para 52)

Furthermore, the case refers to Dr. Pandian's reflection discussed during her annual appraisal (MPT para 55). These statements, and disposition to reveal her vulnerability, following the advice of legal representatives, resurfaced during the hearing, potentially to her detriment.

It is inherently human for one's high standards to occasionally slip due to extenuating circumstances or being on autopilot. And yet Dr Pandian insisted during the hearing in her oral evidence, was asked whether she does slip up, that she never does (MPT para 53). Reading the Tribunal's determination holistically, it appears that Dr P struggled to balance the demands of transparency and defensiveness. Her initial transparency was turned against her by the GMC, which suggested her apology implied guilt. In response, she distanced herself from the legal language of her initial response letter and adopted a more defensive attitude. This shift worked against her, the denial of any possibility of error making her appear less open to acknowledging the vulnerability inherent to all doctors. Consequently, her conduct was perceived as problematic by the MPT.
Considering all evidence, including note-taking protocols; the small time between examination and documentation; the examination form template; and applying the balance of probabilities, the MPT determined that Dr Pandian had not conducted a physical examination of Patient A (MPT Para 66). Furthermore, the MPT determined that Dr. Pandian knew that she had not examined when she documented otherwise (MPT para. 67. The MPT also saw Dr. Pandian's claim that she never makes mistakes as unrealistic and determined Dr Pandian's demonstrated a lack of insight (MPT Para 137).

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Insight in this context can involve communication; probity; being honest about mistakes when things go wrong; and consulting with more senior colleagues. Dr Pandian had demonstrated these qualities; she apologised as advised, completed a battery of professional development courses, did ethics and probity training, and engaged in self-reflection and workplace-based assessments. One can query whether, in the circumstances, these various forms of review helped with patient safety and improved meaningful communication.

Confronted during proceedings with her apology possibly implying guilt, Dr. Pandian asserted that she does not make mistakes. Despite all her training and reflection, she insisted on her infallibility, and this led to the perception of insufficient insight and unrealistic views.

The MPT was of the view that Dr Pandian's reflection on her conduct was too general and did not address the specifics of her misconduct (MPT para 110). The GMC's suggestion that an apology could imply guilt, in this case, sparked much discontent among doctors because it seems to conflict with its advice on 'Openness and honesty when things go wrong'.2 The case has sparked other concerns among doctors. The case raises an array of concerns, including issues related to the differential treatment of international medical graduates and minority ethnic doctors in fitness to practice procedures; the function of note-taking and record keeping in medical practice; the increasing and often uneven emphasis on subjective 'soft' and 'communication skills;' and gendered and hierarchical structures endemic to the profession.

It is noteworthy that in this account of a sub-optimal care episode at Kettering Hospital, a junior doctor is foregrounded instead of more senior colleagues. The sole focus is on Dr. Pandian, while her consultant supervisor, who also did not examine the patient on that day, remains unexamined.

The dissection of minute details of Dr. Pandian's professional life and self-reflection on her practice stands in stark contrast with the resounding silence around the practice, supervision, and advisory role of her senior colleagues.

As a side note, it's worth mentioning that the case also serves as a reminder of an unfortunate history of medical dismissal of women's health complaints as the product of anxiety. One encouraging aspect of the MPT decision is the little weight it attributed to the fact that no harm came to the patient. Having concluded that the physical examination did not take place, the tribunal noted that the patient might have had a health problem which could have been detected during the examination and that Dr. P was not to know otherwise. Considering the broad reverberations of the case, it's essential to focus on the GMC's proposed role of an apology, what this might say about apologies and admissions of error in healthcare, and how the GMC will treat apologies in fitness to practice proceedings.

Apologies in Healthcare

To understand the role of apologies in healthcare fully, we must consider the broader context. This context includes the function of apologies in legal and non-legal settings. Apologies in the medical field have evolved significantly over the years.

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In How to Do Things with Words, British philosopher of language J. L. Austin delves into the apology as a 'performative utterance.' 'It indicates that the issuing of the utterance is the performing of an action'. 3 Apology, in this context, is often described as a 'speech act' that is, an act that accomplishes its purpose once it is communicated.

Traditionally, the speech acts of apology belonged to the realm of private interactions, while the law was the domain used to resolve institutional and professional interactions. Professionals were often discouraged from expressing apologies as it might elicit legal liability, and lawsuits or massive settlements. The theory of legal formalism has created this dichotomy, under which the apology is seen in opposition to the law and therefore neither encouraged nor enforceable by it.4 This dichotomy does not translate into apologies being inept or fruitless. This version of apology could transform relationships through a 'script', e.g. an acknowledgement of a wrong, followed by a response. However, this exchange occurred between parties and was not dealt with by law. Whilst we live in an age when public displays of apology and contrition feature regularly in the media, apology is still often framed as such, as a 'private act,' not being externalised and dealt with via legal regulation.

Under this formal, and impoverished, conception of law, the legal process is only relevant when relationships are alienated, making apologies unnecessary. However, richer, and more contextual understandings of law (such as those put forward by legal realists), instead conceive formal and informal law as 'radiating' through relationships5 and influencing behaviours including apologies.

The concept of apologising does not feature massively in historical medical ethics texts. It is completely absent from the Hippocratic Oath. Nineteenth-century medical ethics paternalism stipulated not to discourage patients, and to avoid negative thoughts: The American Medical Association's first Code of Ethics from 1847 recommended physicians to be watchful of their words and behaviours, and "avoid all things which tend to discourage the patient and to depress his spirits".6

Modern medicine has undergone profound transformations, including the scintillation of medical knowledge, with its emphasis on detailed documentation of both successes and errors. The professional commitment to learn from mistakes and reduce failure through peer-to-peer sharing and learning, and intra-professional openness has been amply documented by historians. 7–10 Sociologist Charles Bosk7 has studied how errors were treated by colleagues and mentors in an American hospital. Technical mistakes were seen as inevitable and easily forgiven by peers, and junior doctors were encouraged to share them and learn from them without fear of sanction. However, normative errors, such as dishonesty, were much less easily forgiven. In contrast to relative openness between peers, there has been a historical aversion to similar levels of candour towards patients.11 Due to fragile health, or diminished cognitive abilities, patients were shielded from the experts' acknowledgement of errors. '

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Apologising for mistakes is considered part of this transformation and the improvement of healthcare relationships. The use of apologies has developed from being an ad hoc and exceptional way to deal with inter-relationships and disputes to being gradually institutionalised and translated into concrete normative guidance, such as Good Medical Practice, the NHS Resolution guidance, and the statutory duty of candour. Through this, it transforms from being an anomaly to gradually becoming a normative act well integrated into daily professional practice. Writing in the context of public health context Alberstein and Davidovitch4 point out that at the normalisation stage, problems of loss of faith in apologies and co-optation can emerge.

This transformation of apology into a more systematic component of ethical and professional conduct has challenged the traditional opposition between apology and law. Furthermore, contemporary ethical perspectives see apologies positively from both deontological and utilitarian standpoints. Apologies are conceived as a moral duty, the right thing to do. They are also motivated by utility concerns, as they are believed to enhance the overall quality of patient care and safety.12 Contemporary principalist biomedical ethics 13 support truth-telling including error disclosure based on principles like respect for autonomy, non-malfeasance, and beneficence. Consideration for patient autonomy suggests patients have a right to make informed healthcare decisions, which necessitates knowledge of events affecting their health.

Acknowledgement of harmful errors helps patients avoid related future injury, aligning with non-malfeasance, and improving their future health, demonstrating beneficence. In addition, the acknowledgement of errors by clinicians aligns with the principles of truth-telling and respect for persons.14 The UK Supreme Court case Montgomery v Lanarkshire Health Board15 UKSC 11 has reinforced the importance of ongoing, engaged dialogue between patients and clinicians.

Contemporary regulation of apologies

Contemporary apology laws aim to enable and encourage apologies by shielding healthcare providers from their legal consequences. These laws make healthcare providers' apologies to patients inadmissible in future potential malpractice or disciplinary claims. The idea is that by removing the legal threat of apologies, healthcare providers will be more transparent about their work including their mistakes, thus improving communication with patients and relatedly, patient experience. In turn, better communication is believed to reduce complaints by patients and their families, litigation, and references to the professional regulator, aligning with the utilitarian principles mentioned above.

However, these current approaches highlight the individualistic perspectives on medical apologies and overlook the history of collective, cultural, and organisational aspects of public health apology, which can enrich our understanding of clinical apology.4 Public health concerns tend to emphasise prevention and future-oriented thinking.

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Apologies by organisations, public bodies and nation-states in public health contexts are looking into the future, aiming to prevent harmful conduct from recurring. In addition, public apologies are often symbolic acts, essential to implement social healing and rehabilitation. Drawing analogies from public health contexts can enlarge the meaning of apology beyond efficiency concerns and anxiety over dispute settlement and admission of professional misconduct, touching upon broader notions of professional conduct and public accountability.

Regulating and bureaucratising apology

Regulated apologies, which aim to deactivate legal consequences and promote amicable resolutions, may appear as a win-win proposition at the outset. However, delving deeper into the realm of regulated and bureaucratic apologies reveals a more nuanced perspective.

Under a regulatory framework, apologies can transform into mere formalities and resemble a 'box ticking exercise' aiming to fulfil a bureaucratic function. Apologies can be 'performative' in a different way than J.L. Austin had suggested: they can become performative in the sense that those who make them can show they have been made.16 The words can be carefully selected by lawyers to ensure that the apology does not do too much, say too much, or reveal too much. 16,17 A person could apologise for a wrong in a way that precisely frees them from the effect of committing that wrong.

The latter addresses frontally the institutional value of apology and apology's suitability for the professions and professionalism. In adversarial contexts, advice and counselling can aspire to support doctors asking for advice, but it can also be motivated "by the need to maintain the good name of the collective – the profession as a whole" 18 and can therefore be envisaged as "a form of internal, informal, social control within medicine." The multiple purposes of apologies underscore the need to disentangle apology from its role as a legal resource and foreground the relational nature of apologies.

Apology as a relational act

Understanding apologies as relational acts underscores the importance of making moments of complaint and response more meaningful and less adversarial. Apologies are never standalone utterances; they are always intimately bound to the web of relationships that precede and follow them. Apologies exist within a broader context of doctor-patient care and historical experiences with the healthcare system. Several factors come into play, such as the identity and experiences of the apologizer and the receiver of the apology, as well as the historical context of medical injustices in certain communities. Berlinger's ethics of forgiveness highlight that disclosure and apology require more than knowledge of professional norms; they require relinquishing control and placing the reins in the hands of those at the receiving end of the apology.14 Disclosing and apologising put clinicians somehow at the mercy of those who suffered medical harm. This act of apology in no way obligates patients and families to forgive those responsible for the harm inflicted. This is a risky endeavour, demanding vulnerability, and humility.

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To translate this framework into practice, the principles of public health prevention and policymaking must be integrated into the process of apology for medical errors. This entails the active participation of all affected parties to construct a meaningful apology. In turn, apology training must not focus on a one-size-fits-all textbook approach to be followed universally. Apology awareness ought to reach beyond ordinary abstract conceptualisation and legal considerations. Whilst the focus has so far been on utterances of apology, interlocutors such as nurses, patients themselves, and their family members ought to be depicted and heard too. Apology, as Berlinger suggests, is a 'total response' that necessitates the engagement of others. Whilst this total response is risky, uncertain, and challenging, it requires virtuous action genuinely and necessarily.

Conclusion:

GMC v Dr Pandian 2023 prompts a critical examination of the role of apologies in healthcare, and their treatment during disciplinary proceedings. It draws attention to the need for healthcare professionals to navigate the complex terrain of transparency, accountability, and legal implications carefully. This case can catalyze discussions on how apologies are perceived and utilised in healthcare, and more speculatively, an opportunity to reconsider the broader implications of apologies for the medical profession and the conduct of care.

The evolving landscape of medical ethics, which now places a greater emphasis on truth-telling, patient-centred care, and open communication, calls for a nuanced understanding of the role of apologies in healthcare.

The regulatory framework has deactivated some of the legal risks of apologies for healthcare professionals, but in doing so it has not necessarily encouraged more honesty in doctor-patient relationships. Regulating apologies may have bureaucratised apologies and stripped them of their inherently relational and uncertain nature.

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Sir Al Ansley-Green Kt

Putting Compassion Back into Care

Focus on Minority Ethnic Families Experiencing Dementia

Abstract

Public services are stressed by soaring demand, inadequate capacity, staff burnout and low morale with strikes reflecting profound unhappiness. With so many difficulties, the fundamental need for compassion in public services has been eroded, with adverse consequences for patients and their families or carers. The need for compassion is not only an individual's humanitarian and professional responsibility but one that should be given high priority by organisations, educational institutions, and professional bodies. The care of patients with dementia and support for families or carers provides a perfect example of such disparities and their devastating impact.

The implications for families affected by dementia in minority ethnic or marginalised communities are considered alongside the need for a 'paradigm shift' to patient-centred, 'needs-based' services to improve outcomes. This article explores and attempts to extrapolate the relevance of personal experience to those in minority ethnic or marginalised communities on whom there is limited information and those who have little voice or advocacy.[1] There is a distinct role for charitable and third-sector organisations with a deeper understanding of the cultural context to demonstrate leadership in moving policy and resources to address such societal and service disparities.

What Is Compassion?

'Putting yourself in the shoes of others and doing something about it!' 2

Compassion is described in the context of health care as being comprised of virtues (honesty, kindness, helpful, non-judgment) and actions (smile, touch, care, support, flexibility) aimed at relieving the suffering of patients. 3 This is different to empathy (putting yourself in the shoes of others), sympathy (feelings of pity for someone else's misfortune), love (feelings of affection for someone) and kindness (being helpful and caring about others). These five key virtues (ESCL&K) need to be the basic principles of behaviour in public services led by a focus on compassion. Compassion is not necessarily a simple process; indeed, many compassionate acts require knowing what the other values, connecting with them, and responding in a way that is meaningful for that person. It is not about what we choose to do for other people, but what we choose to do together with them. Sharing personal information with patients and admitting mistakes are key methods for identifying common ground.4 It thus implies a level of reciprocity and interdependence, and compassionate care can, therefore, be defined as a relational activity. 5

Providing compassionate care is a key constitutional value of the UK National Health Service (NHS) and there has been an increased commitment to ensure this is delivered in patient interactions. However, there is a lack of a consistent definition and understanding among professionals. Current conceptualisations of compassion do not privilege the voice of service users, despite them being key stakeholders within the NHS. Additionally, the literature lacks ethnically diverse perspectives, although ethnically minoritised individuals experience more negative outcomes within the health system.6

In addition to lower socioeconomic status, factors, including bias, stereotyping, racism, gender, limited prevailing language proficiency and immigration status are crucial determinants of care and impact on compassion.7 There are deficiencies in access to the whole spectrum of care from primary to hospital-based healthcare and social services experienced by minoritised populations8 and greater efforts are needed to improve professionals' skills regarding minority populations.9

There is a need for in-depth cross-cultural and psychosocial literacy on the part of healthcare providers. Trust, mutual respect, and understanding on the part of the caregiver and patient are crucial to optimising therapeutic outcomes. Compassionate care can only be fostered and supported in a dynamic, well-resourced, and nurturing environment. This involves organisations or services recognising and respecting the individuality of service users and providing care according to their needs. Removing "power imbalances" in the way services use judgements, control and language is essential.

Case history

Having seen the realities of the patient's experience in the health and care systems (as my wife of 57 years succumbed over three years from vascular dementia in a memory care home). During this time, she developed kidney cancer requiring surgery; I was told that despite her complete dependency on me as her registered carer with Lasting Power of Attorney, I would not be allowed to be with her in the hospital during her admission. I had to leave her at the door unsupported despite self-isolating for two weeks and being shown to be Covid test negative. Eventually, I was allowed to prove that by being a carer (not a visitor), I added value to the team looking after her.

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I asked the nursing staff, especially the most junior and the nursing assistants what they felt about the restriction of access. It was apparent from their observations shared confidentially with me that managerial compliance had overridden basic humanity.

My wife deteriorated quickly, being forced to admit her to a memory care home at the point of care 'burnout'. [10] We found a rare care home with an owner determined to build homes to the standard his own mother would require, were she to need residential care. After nine months of loving care, she fell fracturing her hip. I was instructed by medical staff to admit her to the hospital forthwith for her hip to be pinned under surgery. We experienced the inevitable wait in an overburdened emergency department that has become the norm now. Should she have been considered fit enough for surgery, she would have needed a high-dependency bed, (at a time when all such facilities were saturated with patients with COVID-19) before a difficult rehabilitation back to a life of severe dementia.

I saw this protocolised decision to be cruel and demanded palliative care to allow her to die in dignity, according to her previously expressed wish- never to be admitted to the hospital again. I was told nobody had ever refused this surgery but a compassionate GP overseeing the home agreed and triggered our community nurses to set up a diamorphine drip to relieve her pain and distress. She died quietly three days later. Care home staff sat with us, they held our hands and wept as she died. They came to her funeral to celebrate what she had meant to them through her contented demeanour.

Compassionate Care

In family conferences organised by Congenital Hyperinsulinism International (CHI), I asked the >200 families of babies born with this devastating illness whether they had received compassionate care in the children's hospitals to which they had been admitted.[11] Individual doctors and nurses were remembered for their care, but not one family felt that compassion was embedded in the institution as a fundamental principle. In recent years, there has been a growing recognition in the UK of the importance of compassion in healthcare, both for patients and for staff. Compassionate care leads to better patient outcomes, increased patient satisfaction, and improved staff morale.

Despite this, my experiences show that there is a mismatch between theory and rhetoric and the realities of frontline service delivery, this issue is compounded for those who are marginalised by society. Hence, I decided to investigate the experience of patients and families of those with dementia from minority backgrounds.

Patient care is an extremely difficult and challenging activity. Institutions need to recognise how compassion is informed by the availability of adequate resources and the robustness of organisational structures and processes. Why even under the best of circumstances, there will be some challenging interactions or mismatch of expectations and agendas with patients or their distressed families. In such fractious interactions, healthcare professionals must not neglect their own physical and emotional health as they assiduously address the formidable challenges of providing equitable health care.

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Caregivers should be encouraged to seek help and support from family, friends, and professional colleagues without hesitation. [7] The impact of COVID-19, staff shortages and lack of time is undoubtedly true, but in my view should not be excuses for poor behaviour or inadequate institutional resources.

Ethnic disparities in access to end-of-life care reflect disparities in access to many kinds of care. Barriers to optimum end-of-life care for minority patients include insensitivity to cultural differences in attitudes toward death and end-of-life care and understandable mistrust of the healthcare system due to the history of bias in medicine.[12] In addition to individual and relationship factors that impact on compassionate care practice, there are organisational factors that impact on the clinical environment and team; and leadership factors that hinder or enable a compassionate care culture. There are several enabling factors that enhance a culture conducive to providing compassionate care. These include leaders who act as positive role models, good relationships between team members and a focus on staff wellbeing.[13]

We need a cultural transformation with a cascade of actions:

- Humanity - Humanise your patient. Every care organisation should promote patient-centred care and seek their active participation in the design, development, and delivery of care services.
- Central Operating Principle - Compassion should be the central operating principle in NHS and care settings and must determine the allocation of resources. We should consider not only the compassionate qualities of individual practitioners but also the overall design of healthcare systems.[14]
- Accountability - Hold one's institutions accountable for providing culturally and linguistically competent care. Accountability against defined metrics should be led by the CEO in institutions and inspected by the Care Quality Commission and regulatory bodies.
- Educational Interventions - The earlier and better focus is required on compassion for recruitment and teaching programmes for all grades of professionals and healthcare staff.
- Levelling up - Substantial changes are needed in health education policy and funding to ensure caregivers from marginalised communities are encouraged to join the workforce, so organisations can continue to have access to a diverse, high-quality health professional workforce which is necessary to maintain the health of an increasingly diverse nation. [15]
- Co-development & Partnership - The views of patients and families should be sought regularly.
- Raising Concerns - A willingness to encourage staff at all levels to expose poor practices alongside celebrating excellent care. Maintaining systems for confidential reporting, protection for whistle-blowers and psychological safety.
- Tackling Bias - Counteracting unconscious bias requires awareness, introspection, authenticity, humility, compassion, communication, and a willingness to act. Tools such as the Implicit Association Test should be essential for all staff training. Advocate that the affiliated institution's analyses of patient satisfaction and outcome include cultural group data and that the results lead to concrete action.

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A 'needs-based approach to services

Importantly, there is a need for a re-framing of how we view and categorise family caregivers and understand their needs. This involves recognising that some groups of caregivers may be particularly vulnerable to caregiver burden or other negative health outcomes in addition to barriers to accessing needed support. It is important to understand the often invisible work of, and hidden burdens experienced by family caregivers. Their effort, understanding, and compassion enable so many dying individuals to live out their final days with dignity. It is thus imperative for us to recognise the extraordinary effort that is made every day by family caregivers who care for dying individuals with dedication and ensure that they are provided with all the means necessary to carry out this valuable work. 19

South Asian Dementia Pathway

- An example is the scale of the challenges faced by South Asian communities is spelt out in the work from Bradford University: People from South Asian communities are at greater risk of developing dementia but are less likely to access all points of the care pathway – and more likely to present in crisis and/or at a later stage. They are more likely to face barriers including a late or missed diagnosis, reduced access to treatments, and inappropriate or inadequate support coupled with problems caused by language barriers. They often rely on local, community-led organisations for support. The number of people from South Asian communities with dementia is expected to increase sevenfold by 2051, due in part to inequalities in service provision and the increased risk of other health factors associated with dementia.

For white British people, the rise is expected to be more modest – doubling over the same time. Combatting the current one-size-fits-all model, the South Asian Dementia Pathway Toolkit (ADaPT) aims to provide more accessible, tailored resources enabling services to provide more culturally appropriate care. Designed to address the uphill struggle that many people from South Asian backgrounds face, the toolkit includes short films, animations, awareness-raising materials, assessments, and post-diagnostic support – all of which have been culturally and linguistically adapted for people from South Asian communities. 20

A 'Paradigm shift' in the design of services

Caregivers often encounter environments and situations that utilise methods of force as a component of clinical care. These include emergency care, critical care, and psychiatry. The frequency of forced care varies by cultural context, patient demographics, and clinician. 21 Immigrants are twice more likely to be restrained than native persons, indicating potential clinician bias or at least significant challenges in clinicians' application of alternative care practices in the care of minority patients. 22 There are many commonalities in the challenges facing dementia services in the UK generally (let alone in South Asian families) with those for children's services. 23 Without considering diversity, patterns in vulnerability and inequity are overlooked, and thus continually reinforced in health policy.19

A 'paradigm shift 'is needed based on understanding the needs of the person, the families, and the staff at each milestone in the journey from dementia to end-of-life care.

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Several educational interventions need to be considered including de-escalation training and crisis management skills, person-centred care approaches, and compassionate care approaches—to support development across clinical care settings. Minimisation of the need for forced care and the implementation of compassionate force in treatment requires thoughtful and comprehensive educational plans.21

I suggest that this 'needs-based journey' is useful in defining a more 'holistic' approach to services and further study is needed to validate this proposal, especially in the different cultural groups within marginalised communities.

Conclusions

Caring for "our fellow humans" is a wonderful and gratifying privilege. The healthcare profession enables individuals through a lifelong learning process to be competent caregivers. With this privilege comes tremendous responsibility.7 Compassionate care is essential for every healthcare professional and institution to embrace but this is not possible without adequate resources, training and allowing patients and their carers to have an equal voice.

Dementia care is an area where the impact of compassionate care plays out to its full potential. It is likely to become the dominating condition driving services in the immediate and long-term future.24 Attention to possible bias and careful consideration of the appropriateness of power balance in interactions, especially in members of minority and marginalized groups, is essential. 21 There is incontrovertible evidence that the experiences and outcomes for such people and families in marginalised communities are far worse than those for majority communities.

Addressing these challenges demands research, education, and political action. Clinical outcomes are correlated with the degree of patient's perception of empathy and compassion from their providers. 25 There is a need for compassion in services, and a new practical approach to the design of services based on assessing the needs (and not the professional bunkers) of the person, the family and of staff at each milestone in the journey through birth to the end-of-life care.

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SARASWATI HOSDURGA

IMPACT OF A SOCIAL MEDIA GROUP ON HEALTH & WELL-BEING OF HEALTHCARE PROFESSIONALS

"RESULTS OF A WELL-NET SURVEY"

SARASWATI HOSDURGA

Abstract

Healthcare professionals report workplace stress, burnout and a high prevalence of physical and mental health conditions which may have an impact on their performance and affect outcomes for patients. These include hypertension, diabetes, obesity, anxiety, and depression. As illustrated during the differential outcomes observed during the COVID-19 pandemic, health can be further worsened by social isolation, and incivility in the workplace and impact those from minority backgrounds or with protected characteristics.

Social media groups such as Whats App, Facebook and others offer a safe space for psychological support, peer motivation and flexibility of access to health and wellbeing resources. The British Association of Physicians of Indian Origin spearheaded the formation of a voluntary Well-Net group focussing on health and wellbeing activities in February 2021, which was open to professionals, their friends, and families.

The results of a survey undertaken among the members of such a Well-Net group demonstrated that the combination of peer motivation and flexible access to health and wellbeing support activities improves physical, and mental health and reduces stress levels. A healthy workforce will perform better and lead to safer outcomes for patients. The results make the case for targeted investment in flexible provision for health and wellbeing activities for healthcare professionals, both by employers and voluntary organisations.

Introduction

Medical professionals including doctors carry high-risk factors that lead to impaired well-being and are prone to long-term health conditions due to the nature of their work. Burnout, emotional, and mental health conditions are very common in health care professionals.1 During the pandemic, healthcare professionals' health and well-being hit an all-time low due to stressful working conditions, isolation, and a lack of social support systems. 2

The British Association of Physicians of Indian Origin (BAPIO) is a voluntary organisation which was established in 1998. BAPIO Health and Wellbeing Forum and the 'Well-net' What's App group were formed during the pandemic in Feb 2021 to support members during the pandemic. The group welcomed doctors, nurses and their family and friends as the well-being of the people around a person does impact one's own health and well-being. Having appropriate social support systems and networks has a positive impact on health and well-being.3

The forum organised various well-being activities. They were carried out regularly, weekly, monthly and sometimes on an ad hoc basis. The theme of the activities planned provided an opportunity to change behaviours and influence lifestyle factors such as diet, nutrition, hydration, and activities including yoga, walking, dance fitness, as well as peer support and sleep.

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Aims

We planned to evaluate the effectiveness of the services offered, to understand health needs and to what extent the resources were utilised by members, via a Well-Net survey.

These included -

- Demographics
- Current health status
- Personal reasons for taking part in self-care activities.
- Details about the type, timings, and place of self-care activities
- Impact on health and wellbeing.

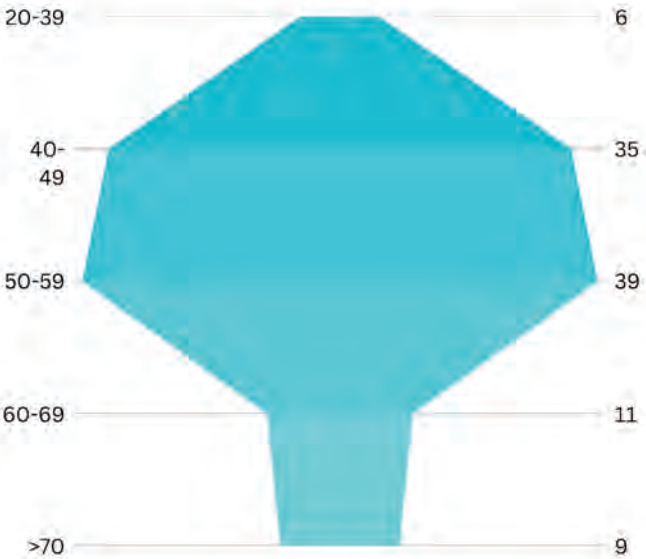
Methods

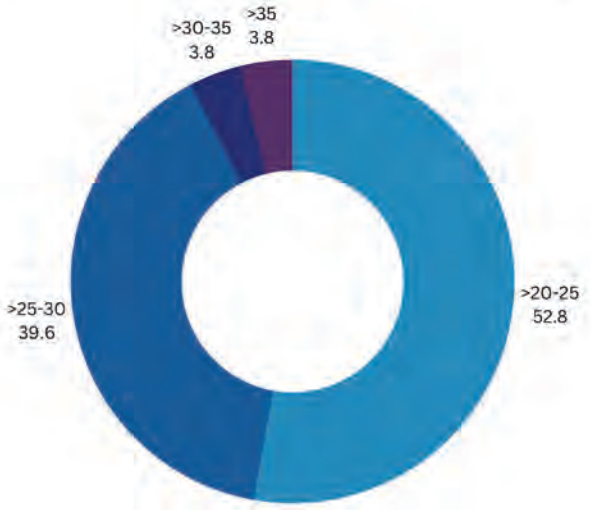
An online anonymous questionnaire was designed using an online Google form with 10 questions with options to choose more than one response in some of the questions and a section for free text comments. The questionnaire was distributed to adult members of the Whats App® group consisting of 102 members in Oct 2022. The survey was open for 2 months. Demographic data, aims of participation and outcome measures to understand the well-being provisions accessed within and outside the workplace were collected. By completing the questionnaires, members consented to data analysis and publications. All data collected was anonymous.

Results

There were 54 complete responses received. The responders included 76% doctors, 15% nurses, and 9% were from family or friends of healthcare professionals.

Demographics
Most of the respondents were between 40-60 years, fig 1. BMI distribution (fig 2) shows majority in the normal to obese range.





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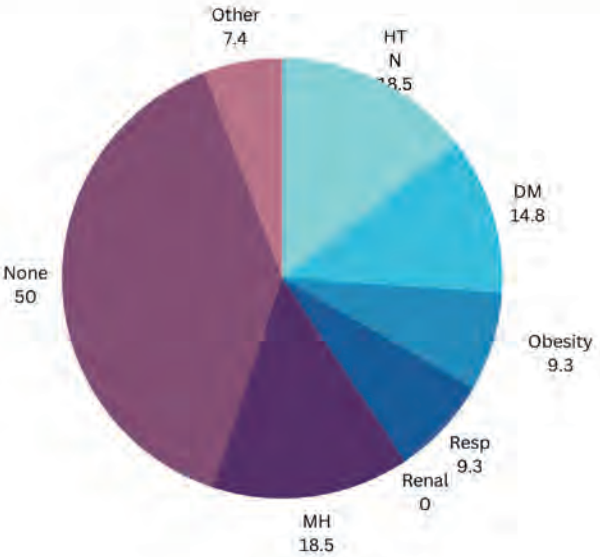
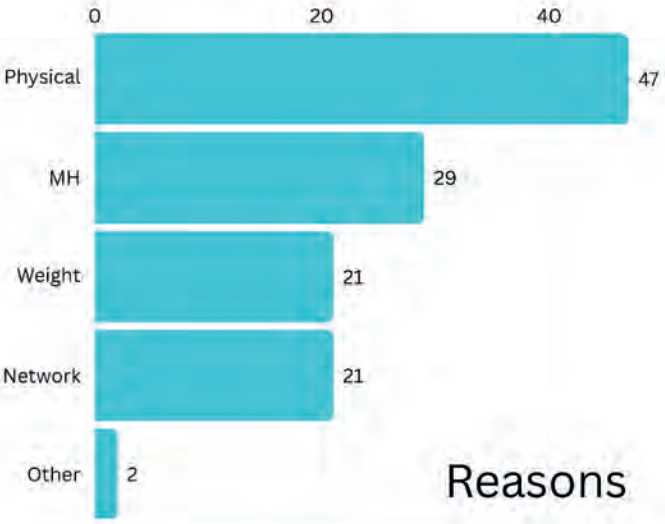
Current Health Status

Almost 50% of the respondents reported being in good health with no known underlying health conditions. The others reported one or more physical or mental health problems. Hypertension (18.5%) was the most common health condition, followed by diabetes and anxiety (14.8 %), obesity and respiratory conditions (9.3%) and depression (3.7%), figure 3.



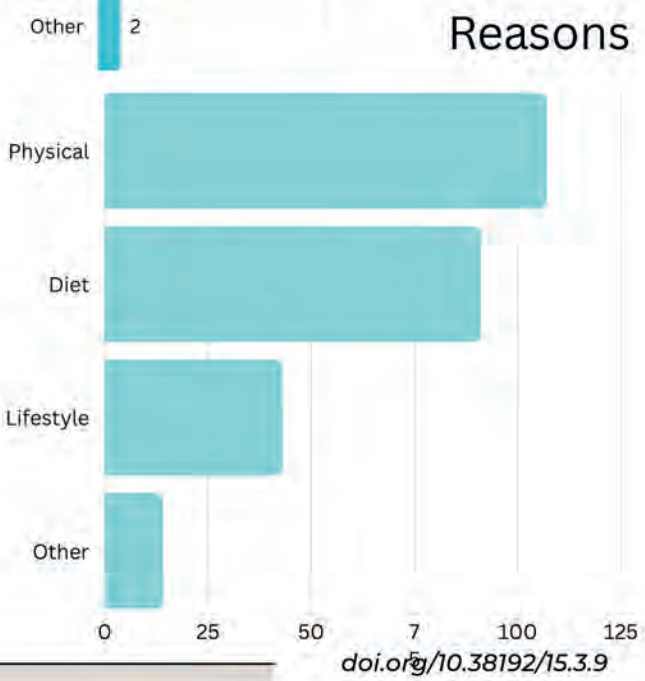
Reasons for participating in wellbeing activities

Most of the respondents joined with an aspiration to improve their physical health or fitness (87%), and mental health (53%) or to lose weight (38.9%). Almost 38.9% participated to improve their social connectedness, and networking, build friendships and combat loneliness, figure 4.



Type of the activities

Walking, a balanced diet and yoga were popular activities incorporated into their daily routines by half of the respondents. A few engaged in vigorous activities like cycling and running, (figure 5)



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Timing of the activities

Very few (14.8%) respondents accessed wellbeing resources during working hours, and 61.1 % accessed resources in the evenings or over the weekends (61%).

Place of the activities

Only 18.5% access support services at their workplace, whereas 75.9% access at home. The majority (74.1%) accessed activities virtually, while 25.9% used gymnasium or leisure centres.

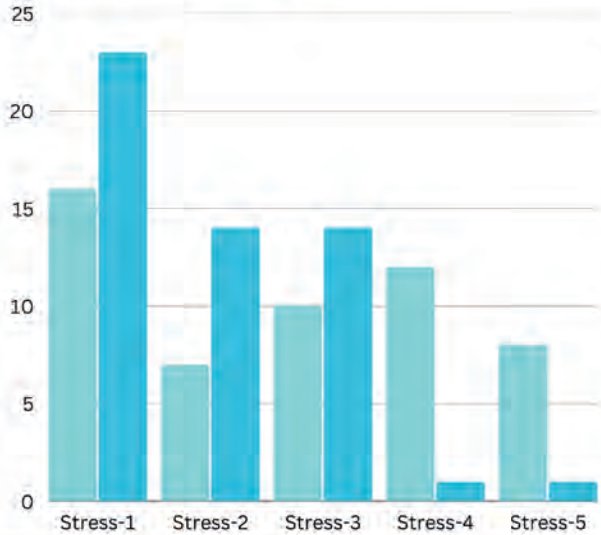
Effectiveness

Weight loss

Over the period of the Well-Net group activities, approximately 1.5 % lost between 7-10 kilograms, 11.1% lost 5-6 kgs, 20% lost 3-4 kgs and 35.2 % lost 1-2 kgs. Around 29.6% of the respondents didn't lose any weight.

Stress

After engaging in self-care activities, the number of respondents in highly stressed categories (grades 4 and 5) reduced significantly. The numbers from grade 4 and grade 5 dropped to 1.9% from 23 % and 15 % respectively.



Discussion

In the Well-Net survey of healthcare professionals who were members of the BAPIO Health & Wellbeing WhatsApp group, around 75% were in the middle-age range of 40-60 years, with nearly 50% being either overweight, obese or extremely obese. Around 50% of respondents had a health condition, including hypertension, diabetes, and anxiety. Most reported high levels of stress.

The health and well-being of healthcare professionals is a global health priority as most of the healthcare provision and aspirations of universal health depend critically on having a healthy and viable workforce.4 Work pressure, poor sleep, lack of access to healthy food or lack of time to incorporate physical activities within a busy lifestyle are known contributory factors to hypertension, diabetes, obesity, and emotional and mental health conditions of healthcare professionals. Anxiety, depression, post-traumatic stress, and poor psychological well-being are far too prevalent in this cohort. 5 The Well-being of healthcare professionals is known to directly impact patient care, and there is evidence for the benefits of promoting mental well-being and healthy working conditions 6 but often such guidance does not explicitly recommend specific measures to improve physical well-being nor the impact of peer support on diet, physical activity, social isolation, or psychological wellbeing. Most of the respondents in the Well-Net survey accessed self-care activities either after work or at weekends. Therefore, whilst the provision of workplace resources is important, doing it in a peer-supported way outside of working hours – seemed to be more convenient, particularly online or at home.

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Some organisations invest in wellbeing resources during working hours, but it does not appear to be convenient or preferred so may not be utilised by many.
In our survey, activities supported via the What's App group had positive benefits with desired weight loss and reduced stress and appear to have helped to build strong community support. Members felt happier seen in the free text comments and requested to continue these support services. It also reduced their stress levels and loneliness which had a positive emotional impact. 7
Limitations of this survey included the lack of a baseline survey at the time of formation of the Well-Net group in Feb 2021. This survey was done 19 months after coaching and guidance on diet, physical activity, yoga, and emotional well-being activities were delivered during that period. Nevertheless, this survey shows self-reported improvement in outcomes such as weight loss, reduced stress levels and loneliness, and a sense of belonging as well as happiness.

Implications for the future

In the UK, organisations such as the National Health Service should allocate resources for health and well-being which are flexible, accessible and in a format that may be utilised by staff at their convenience. Our survey results highlight that the convenient timings are likely to be after work, at home and online. Currently, many resources are offered mainly during working hours and are focussed on psychological well-being rather than holistic physical health and wellbeing.8 Organisations and their leaders should prioritise workforce well-being and create supportive working conditions and policies that also offer equality, diversity, and well-being- which is likely to lead to efficiency and better outcomes. 10,11

There is evidence that healthcare professionals from minority backgrounds tended not to access resources provided by their employers unless these were culturally tailored. 12 This is in line with our survey results where this cohort practised their self-care in social hours engaging themselves with their culturally favourable social network and support systems, outside the workplace.

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Own Oxygen Mask First

Psychological Strategies for Self-care

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Abstract

Health and self-care are not complicated, they just require some common-sense learning and applying that learning to us. This article discusses the principles of self-care and puts the case forward for paying attention to personal health and well-being as essential for delivering on the aspiration of providing excellent care to patients.

Let's remember, as they say at the start of the flight, to put our own oxygen mask first before helping the person next to us.

Keywords

Healthcare professionals, self-care, patient safety, healthcare efficiency

Introduction

Doctors are dedicated to their patients. The UK General Medical Council (GMC) advises us to 'make the care of your patient your first concern'.1 Medicine is a wonderful calling, and we are privileged to help people with their illnesses and lives. Most doctors are very skilled at (metaphorically) giving oxygen to their patients – but may often be in a state of personal partial hypoxia. To use an analogy: when we drive our cars on an important journey, we make sure the fuel is topped up beforehand. After all, to use irony, there is no convenient place on a major motorway to run out of fuel, break down or worse have an accident.

Continuing this metaphor, doctors learn a great deal about car breakdowns and accidents – but learn relatively little about how to prevent them. We learn a lot about disease and little about the key points in promoting health. We ignore our own fuel gauge and the red lights on the dashboard - because there is a curriculum gap in personal health promotion and prevention of disease.

Why do we not appreciate this?

Well, ask a hundred people in the street how they are, and the answer is 'Fine' (which in my opinion stands for fearful, insecure, neurotic and emotionally imbalanced)– the denial mechanism. Ask a hundred doctors, mothers, managers, or health professionals how they are - and the answer is silence – one's own health is not an item on the to-do list – so gets ignored by being too busy – a strategy of displacement. These two psychological D's (denial and displacement) may lead us into Distress, Despair, Disillusionment, Exhaustion, and maybe Debt, Divorce, Discipline and the big three occupational health issues for doctors – Drink, Drugs and Depression. Tragically Death may also be an outcome.2p8 If we are too busy to reflect, gain insight and look after our own health and inner mindfulness, then we cease to be Reflective Human Beings (RHB) (a core aspect of who we are) balanced with part-time Task-Driven Human Doings – and become full-time TDHDs – losing insight in the process.

Burnout

In Stop Physician Burnout3 Dike Drummond shows us the simple fact that "You can't give out what you haven't got". We need to keep our three energy accounts topped up – the accounts of physical, emotional, and spiritual energy. The result of empty energy accounts is inevitable burnout at some point – described by Christina Maslach as a triad of exhaustion, depersonalisation, and lack of efficacy – or simply exhaustion, compassion fatigue and cynicism, and 'What's the use?'. The pattern in women doctors tends to be all three, whereas men often lack the third, still believing that they are doing good work (despite exhaustion and cynicism)4

Conditioning

Personality conditioning happens in medical training and can sabotage personal health. In 'Stop Physician Burnout' Dike Drummond lists five traits as Workaholic, Superhero, Emotion-free, Lone Ranger and Perfectionist. Initially, these may be useful skill sets – but doctors fail to put them aside when the job is finished (as a mechanic would put down their tools) – they continue to use them, and as Dike says, often become them. He also notes the two 'Prime Directive' attitudes that pervade medicine:

- The patient comes first.
- Never show weakness.

The first directive is recognizable as Displacement, and the second as Denial 2p8 Drummond summarises the factors that contribute to Doctors' Burnout as the stress of practising medicine, the specific stresses to our own work role, the work-life balance including refreshing and recharging our health account, and the conditioning of medical education.

Drummond has a wonderfully direct approach to Burnout Prevention (avoiding the doctors' D's), which reminds us of the 1960s pop song title 'Accentuate the Positive, Eliminate the Negative'.

1. Deal with the inner critic (who otherwise sabotages us)
2. Realize that burnout is not a problem (problems have solutions) – it is a dilemma, which needs managing systematically.
3. Avoid problem-solving traps (Give Up, Play Victim, or Look for the Magic Pill)
4. Change your perspective – doctors are trained to see negatives and so often, in life outside medicine, fail to appreciate positives – focus on the positive

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5. Stop being a superhero, build capability one step at a time
6. Celebrate all your successes – a culture of appreciation and gratitude, both inward and outward makes for a better life.

Hierarchy of Needs

So, we have a problem! Fortunately, the answers are not difficult. Let's look at some basics. If we attend to the base of the pyramid of Maslow's Hierarchy of Needs, then we have a chance to restore health. High-quality refreshing sleep is key. The Association of Anaesthetists take fatigue5 particularly seriously – the rest of us should take note! And hydration and nutrition are vital – how often during the day do we ignore our own bodies' needs? Yet ignoring them automatically evokes the autonomic stress response – let alone the response being triggered by many other potential threats, demands and stressors.

Understanding the Mammalian Autonomic Nervous System is useful pp35-39. All mammals share this 'engine management system' The parasympathetic component relates to being and stillness – Rest, Digest, Chill, Repair, Tend and Befriend when we feel safe, Freeze when unsafe. The sympathetic component relates to Action – Curiosity and Drive when we feel safe, Fight or Flight when unsafe.6 All mammals except humans seem to spend most of the day on parasympathetic calm. Adrenaline (sympathetic) is the stress hormone priming us for action. It gives raised blood pressure, rapid shallow upper chest breathing, excitement changing to anxiety then irritability, dry mouth, sweaty palms, and a target-focused approach.

1. Just changing our breathing pattern back to slow regular calming diaphragmatic breathing can entrain parasympathetic calm, lowered blood pressure, a feeling of inner peace and greater situational awareness. So why would we not do this? Many find it worthwhile to find short moments of calm frequently throughout the day, simply by putting their feet flat on the floor, allowing their spine to be comfortable, and taking three slow regular calming diaphragmatic breaths. Why not give it a try? 2 p146

Psychological Well-being

Turning to psychological well-being, one useful lens on how life works is through an understanding of the Drama Triangle 7,8 The model flows from an understanding of Transactional Analysis9. In TA, there are three ego states: the Parental one where thoughts and behaviour are modelled on parents, the child one where our thoughts, feelings and behaviours can arise from our subconscious to be replayed, and the adult rational sensible responses.

- Parents can be wise and guiding – or bossy, critical and dominating.
- Adult remains secure in sensible responses, whilst.
- child can be free and creative, or whiny and manipulative.

Adult-to-adult relationships share equal power, whilst in parent-child the power is unequal. Polarised, the roles can lead is into the three roles of rescuer, persecutor, and victim.

Every dysfunctional interaction takes place around the drama triangle.

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It involves blocked or distorted communication based on fear, judgment, and insecurity. Whenever you feel disempowered, guilty, stuck, resentful, blamed, helpless, trapped, dependent, misunderstood, bewildered, betrayed, controlled, manipulated, or abused, you are in a drama triangle - which might involve two, three or more people. At the top of the triangle are the one-up positions (parent), while at the bottom is the one-down position (child). Although many people have a familiar position, the roles can rotate with lightning speed, playing all the toxic games of co-dependency. There are no winners in a drama triangle. Everyone loses and feels like a victim - until someone stops playing the game.

The Parental roles are Persecutor (blame everyone else) and Rescuer (make things better), whilst the Child role is Victim (poor me), each of which stems from fears and insecurity. Resolving the drama triangle is lifelong learning for many of us. This is relatively easy once we understand the roles, their weaknesses and how to grow beyond them2pp78-81. An appreciation of the Five Agreements from South American wisdom is also useful 2pp87-90. These are Be Impeccable with your work, Take nothing personally, Make no assumptions, Just do your best, and Be sceptical, but learn to listen.

Coping with Change

The third topic that many find useful is coping with change and loss, using the Emotional Logic system10. Life is about connection and growth. Having a setback or disappointment causes a loss reaction of shock. We try to adjust to the changing circumstances by recognising the loss, trying to prevent the loss, and then either recovering the loss or letting it go.

In the process, we transit the Emotional Stepping Stones towards growth and reconnection. These are shock, Denial, Anger, Guilt, Bargaining, Depression (not the clinical state, but the stepping stone) and Letting Go. An understanding of the useful purposes of each of these, and the system of Emotional Logic can help us grow and mature. In resolving stuck issues, we release energy to help us grow into a healthier state.

In summary, Health and Self Care is not complicated, it just requires some common-sense learning and applying that learning to us. Let's remember, as they say at the start of the flight, to put our own oxygen mask first before helping the person next to us. Good Luck and Go Well!

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Managing Stress and Mental Well-being in NHS Staff

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Abstract
This article focuses on the workplace stress and mental well-being element and considers views on who is responsible for managing stress at work and promoting mental well-being.

Keywords
Healthcare workforce, well-being, recruitment & retention

Introduction

There is a continuous, dynamic, and sometimes fierce debate on the determinants of the workforce crisis in the NHS. A long-term UK Government workforce plan for the NHS has been published. The recently published Parliamentary research briefing "The NHS workforce in England (1) 1 cites the statistics; as of January 2023, there were 1.42 million people working in the NHS in England, including 133,000 FTE (full-time equivalent) hospital doctors and 325,000 FTE nurses along with 35,200 permanent qualified GPs (March 2023). Asian or Asian British doctors account for 33% of the medical workforce compared to only 10% of the working-age UK population, due to the number of internationally qualified medical graduates inducted into the NHS. We also know the workforce (especially nurses) is largely female – around 75%.

Along with the debate of recruiting enough numbers to work in the NHS, is the ongoing conversation about retention of the workforce. Excessive work pressures, comparatively low pay, bullying, and harassment including racism are various reasons for workplace stress cited through NHS Staff surveys2, medical 3 and nursing organisations 4 and could also be contributing to high sickness levels and poor retention rates in the NHS. Workplace stress consequently affects health and well-being which includes physical, mental, and social aspects. The need to manage workplace stress optimally is not only a humanitarian, and ethical issue but also one which affects the quality of patient care and the future of the NHS if it cannot provide a sustainable workforce for growing demand.

Whose responsibility is it anyway?

Most of the responsibility for minimising workplace stress and that it remains manageable as well as promoting well-being rests with the employer. A look at the various surveys over the last few years, even pre-dating the pandemic, demonstrates excessive workload, not being valued at work, bullying and harassment, lack of support when reporting discrimination, lack of adequate career progression, as well as lack of flexible working arrangements. The proportion of staff responding thus in these various surveys is significant too. For example, in a 2021 Royal College of Nursing Survey, 556.8% of respondents said they were considering leaving their current post and cited feeling undervalued and under pressure as the main reasons for this.

The annual General Medical Council (GMC) State of Medical Education and Practice in the UK report 6 states that a quarter of doctors surveyed (25%) were categorised as being at high risk of burnout in 2022, compared with 17% in 2021. The findings are stark indeed; half of doctors (50%) were satisfied in 2022, down from 70% in 2021.1 In 2022, more doctors reported working beyond their rostered hours on a weekly basis (70%, up from 59% in 2021), having difficulty taking breaks each week (68%, up from 49% in 2021), and feeling unable to cope with their workload each week (42%, up from 30% in 2021). This survey targets trainers, non-trainers and trainees and is an important predictor of our capacity to train and supervise the doctors needed for the future.

It is clear from the above that the key factors affecting workplace stress and wellbeing are the direct responsibility of the employer. The ongoing junior doctor and nurses strike around demands for pay restoration and pay in keeping with inflation also demonstrate the role of fair wages on stress and well-being. While issues of pay scales for healthcare staff are not a direct employer responsibility, they need to ensure that staff are paid appropriately for the work they do including overtime and that they are able to progress fairly through the career ranks, which will help ensure that staff are appointed to the right level of seniority for the work they deliver. The NHS has not been doing this consistently as is shown by the results of various surveys referred to above.

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A further indictment of the NHS is that it does not always provide the support that staff need at vulnerable and difficult times. Inflexible rotas and lack of flexible working opportunities have been referred to in the above surveys. Also, recent high-profile cases have shown us that when there is a discriminatory and punitive culture, staff are subjected to disciplinaries or referred to the regulators when speaking up against discrimination or asking for the right tools to do their job. 7

To understand the link between employer responsibility and workplace stress, there is much to learn from those places where staff do feel supported and report a compassionate, kind and just culture. 8 Michael West and the King's Fund 9 work has shown, that in healthcare organisations with the right culture, there are more employees who report joy at work, more productivity and fewer employees reporting stress and burnout. This is also borne out by the top performing Trusts in the NHS staff survey, 10 where there is a link between leadership with the right culture and values and employees feeling more recognised and valued, less likely to be stressed and more likely to continue working in the organisation.

Conclusion:

Workplace stress by its definition is directly related to work and influenced by the culture, conditions, and resources at work. These are firmly within the domain of the employer's duties and accountabilities. It follows that managing stress and mental well-being at work is the responsibility of the employer.

It is within the purview of the employer that they create a culture where employees feel able to ask for help and support when they are facing stress and burnout. Otherwise, we risk making that perennial mistake of blaming individuals for what is a systemic problem, and the vicious cycle will continue.

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Implementing Nutritional Strategies in the Workplace

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Abstract

The lifestyle of a health professional is mired with long hours, undue stress, shift work, poor sleep, inactivity, and unhealthy eating, despite their knowledge and expertise in what habits promote or preserve health. Healthcare workplaces are largely environments with underfunding, poor infrastructure, overcrowding, and limited or no access to health and well-being resources. The British Medical Association published a charter for minimum standards for facilities and preventing fatigue which has recommendations for access to freshly prepared food, extended hours for canteens and healthier options. 1 Most health professionals report high levels of stress and burnout. Burnout is believed to be directly associated with poor patient outcomes and compromised safety. 2 While better rota design, managed workloads, improved infrastructure, physical activity, psychological safety, and dignity at work are important determinants of employee health and well-being – access to a nutritious diet, water and education on healthy habits is a crucial component.

Organisations including the National Health Service have a social responsibility to encourage healthier habits provide access to healthy eating within their premises and even offer incentives, not only to the patients they serve but also to their staff. This article explores the simple interventions that have been shown to be effective- and links to their evidence.

Keywords

Healthy food choices, hospital food, healthcare professionals, healthy eating incentives

Introduction

Why promote healthy eating?
Promoting healthy eating and physical activity in the workplace enhances productivity – a balanced diet helps employees maintain focus, energy, and efficiency throughout their workday. 3 When employees feel physically and mentally healthy, they are more likely to have a positive attitude towards their work and colleagues. 4 A nutritious diet can strengthen the immune system, making employees less prone to illnesses. In addition to physical exercise, a healthy diet may lead to decreased absenteeism and fewer disruptions in work schedules. 5 Organising activities centred around healthy eating, such as group lunches or potlucks featuring nutritious options, can encourage camaraderie and strengthen team bonds.

Healthy dietary patterns were defined in the 2015 Dietary Guidelines Advisory Committee Scientific Report as diets that are high in fruits, vegetables, whole grains, low and non-fat dairy, and lean protein. Other characteristics of healthy dietary patterns are that they are low in saturated fat, trans fat, sodium and added sugars. Encouraging healthy eating habits can help prevent chronic diseases like obesity, diabetes, and heart disease. 6 By supporting employees' well-being, employers demonstrate their care for staff's long-term health and happiness. Practical benchmarks of lost work and performance may help employers assess the financial impact of suboptimal health. Healthier employees tend to have fewer medical expenses, which can lead to lower healthcare costs for both employees and employers. 7

An organisation that promotes healthy habits demonstrates social responsibility and commitment to employee well-being. This can enhance an organisational reputation and attract, as well as retain top talent. 8 The UK Parliamentary Hospital Food Standards Panel recommended that 'every hospital has a responsibility to provide the highest level of care possible for their patients and this, without question, includes the quality and nutritional value of the food that is served and eaten.' It also adds that 'this should include healthier eating for the whole hospital community, especially staff and sustainable procurement of food and catering services.'9

This report reviews the existing literature on healthier nutritional interventions, such as food labelling, catering, vending machines, educational resources, messaging tools, easy availability of water, and engaging champions to model healthy behaviours. The effectiveness, implications, and limitations of these interventions are discussed, along with recommendations for organisations as well as individuals.

At the risk of being named a 'nanny state,' the UK Public Health Agency recommended the Eatwell Guide and principles of healthy eating for those above the age of 5 years. 10

- eat at least five portions of a variety of fruits and vegetables every day.
- Base· meals on potatoes, bread, rice, pasta, or other starchy carbohydrates, and choose wholegrain versions where possible.

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- Have· some dairy or dairy alternatives (such as calcium-fortified soya drinks), and choose lower fat and lower sugar options.
- eat some beans, pulses, fish, eggs, meat, and other proteins. This includes - two portions of fish every week, one of which should be oily. If consuming more than 90g of red or processed meat per day, try to cut down to no more than 70g on average.
- choose unsaturated oils and spreads and eat them in small amounts.
- drink six to eight cups/glasses of fluid every day

Food Labelling

Food labelling is an effective tool for promoting healthier food choices among employees. Research shows that providing clear and easy-to-understand nutrition information on food items can help employees make informed decisions about their food choices, such as provided by NHS Inform. 11,12 There is evidence that food labelling decreases consumer intake of energy by 6.6%, total fat by 10.6%, and other unhealthy dietary options by 13.0%, while increasing vegetable consumption by 13.5%. For the food industry labelling decreased product contents of sodium by 8.9% and artificial trans-fat by 64.3%. No significant impact was identified by label placement or type, duration, labelled product, region, population, voluntary or legislative approaches, combined intervention components, study design, or quality.13 However, the effectiveness of food labelling relies on employee engagement and understanding of the nutrition information provided.

While nutrition knowledge is a prerequisite for label reading behaviour, trust and attitude are also important. Organisations should ensure that employees are educated on how to read and interpret food labels and incorporate this information into their daily food choices.

Catering Initiatives

Hospital catering has two-pronged challenges – on the one hand, most elderly patients suffer from undernutrition or patients with a range of conditions lose their appetite as a result of their illnesses, hence hospitals have to cater to different content and texture of food served to their patients (multisensory flavour experiences)14; while healthy staff have limited access to food from external sources and need to be presented with options which are nutritious but healthy, in a competitive marketplace. Thus, workplace catering services focussed on staff can play a pivotal role in promoting healthier food options. Studies have shown that implementing healthy catering guidelines, such as offering more fruits, vegetables, whole grains, lean proteins, and low-fat dairy products, can improve the overall nutritional quality of meals consumed by employees. 15

Healthier Vending Machines

With most people in employment spending 60% of their waking hours in a work environment – where they will typically consume drinks, snacks and at least one meal – the workplace provides an opportunity to influence positive eating habits. The BMA Facilities charter recommends that between 11 pm and 7 am hospital staff should be offered access to healthy vending machines.

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Vending machines provided 922.2 million products, including snacks and cold drinks, in the UK in 2015. Almost 85% of vending machines are found in the workplace, and commonly in NHS working environments. With the NHS being the UK's biggest employer, healthier vending can offer a significant opportunity to encourage healthy consumption habits amongst NHS staff, as well as patients and visitors. In 2015, only 39% of vended cold drinks in the UK were reported to be "low sugar, diet or water", and 14% of snacks were labelled as "healthier".16 Thus, replacing traditional vending machine offerings with healthier snack options can improve employees' dietary choices. Research suggests that employees are more likely to choose healthier snacks when they are readily available in vending machines. 17 However, healthier vending machine initiatives may face challenges in terms of product availability, cost, and consumer preferences.

Prompts, Educational & Cost Incentives

A simple, theory-based point-of-purchase system of prompts can produce small but significant reductions in the energy content of snack purchases from hospital shops. 18 Providing educational resources, such as healthy cookbooks and sandwich containers, can encourage employees to adopt healthier eating habits. These resources offer practical guidance on preparing nutritious meals and snacks at home, which can contribute to improved overall diet quality. 19 The effectiveness of these resources relies on employees' motivation and willingness to engage with the information provided and there is evidence that cost and healthy incentives can be sustained beyond the period of the offer. 20

Messaging

Communication strategies, such as posters, newsletters, and digital messaging platforms, can raise awareness about the importance of healthy eating and promote positive behaviour change among employees. Research indicates that consistent and engaging messaging can lead to improvements in employees' dietary habits. 21 Organisations should tailor their messaging tools to their specific workplace culture and employee population to maximize effectiveness.

Access to Drinking Water

Providing employees with reusable water bottles or easy access to drinking water can encourage increased water consumption and reduce the intake of sugar-sweetened beverages. Studies have shown that increasing water consumption is positively associated with better weight management and overall health. 22

Engaging Champions

Role modelling health behaviours through engaging champions can foster a supportive environment for healthy eating in the workplace. Champions can be influential employees who advocate for and demonstrate healthy behaviours, inspiring others to follow suit. 23

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Recommendations for Organisations

1. Implement a combination of interventions to address multiple aspects of healthy eating in the workplace.
2. Ensure that interventions are tailored to the specific needs and preferences of employees.

Provide ongoing education and support to help employees engage with and maintain healthy eating behaviours.

3. Monitor and evaluate the success of interventions to identify areas for improvement and adapt strategies accordingly.
4. Share guidelines and details about nutritional values, ingredients, and cooking methods when relevant.
5. Participate in community healthy eating initiatives and promote them through posters, leaflets, intranets, screen savers, payslips, and employee meetings.
6. Offer healthy packed lunch recipes and organize 'taste and try' events.
7. Organise themed healthy eating days or weeks, such as focusing on breakfast, pasta, or fruit.
8. Conduct educational sessions or workshops on nutrition, healthy eating, and cooking for employees.
9. Support employees striving to maintain a healthy diet or lose weight by encouraging the formation of support groups or enrolment in programs like Weight Watchers.
10. Collaborate with external nutrition or dietetics experts to provide seminars on healthy eating and nutrition.

Recommendations for Individuals

1. Engage with workplace interventions and educational resources to improve knowledge and skills related to healthy eating.
2. Seek support from colleagues, friends, and family to maintain motivation and accountability for healthy eating habits.
3. Set realistic goals for improving dietary habits and track progress over time.
4. Prioritise self-care and stress management as these factors can influence dietary choices and overall health.

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Eatwell Guide

Use the Eatwell Guide to help you get a balance of healthier and more sustainable food. It shows how much of what you eat overall should come from each food group.

Check the label on packaged foods

Each serving (150g) contains

Energy	Fat	Saturates	Sugars	Salt
1046kJ 250kcal	3.0g	1.3g	34g	0.9g
	LOW	LOW	HIGH	MED
13%	4%	7%	38%	15%

of an adult's reference intake
Typical values (as sold) per 100g: 697kJ/ 167kcal

Choose foods lower in fat, salt and sugars

Eat at least 5 portions of a variety of fruit and vegetables every day

Fruit and vegetables

Raisins
Chopped tomatoes
Frozen peas

Choose wholegrain or higher fibre versions with less added fat, salt and sugar

Potatoes, bread, rice, pasta and other starchy carbohydrates

Potatoes
Whole grain cereal
Cous Cous
Porridge
Bagels
Whole wheat pasta
Rice
Spaghetti

Beans, pulses, fish, eggs, meat and other proteins

Lentils
Beans lower salt and sugar
Tuna
Lean mince
Plain nuts
Chick peas

Eat more beans and pulses, 2 portions of sustainably sourced fish per week, one of which is oily. Eat less red and processed meat

Dairy and alternatives

Low fat soft cheese
Semi skimmed milk
Soya drink
Plain Low fat yoghurt

Choose lower fat and lower sugar options

Oil & spreads

Choose unsaturated oils and use in small amounts

6-8 a day

Water, lower fat milk, sugar-free drinks including tea and coffee all count.

Limit fruit juice and/or smoothies to a total of 150ml a day.

Sauce
Crisps

Eat less often and in small amounts

Per day 2000kcal 2500kcal = ALL FOOD + ALL DRINKS

Conclusion

Workplace nutritional interventions can play a crucial role in promoting healthy eating habits and reducing the risk of overweight and obesity among employees. Organisations should implement a combination of evidence-based interventions tailored to their specific workplace context and employee population. Individual employees should engage with these interventions and seek support to maintain healthy eating habits and contribute to overall well-being in the workplace.

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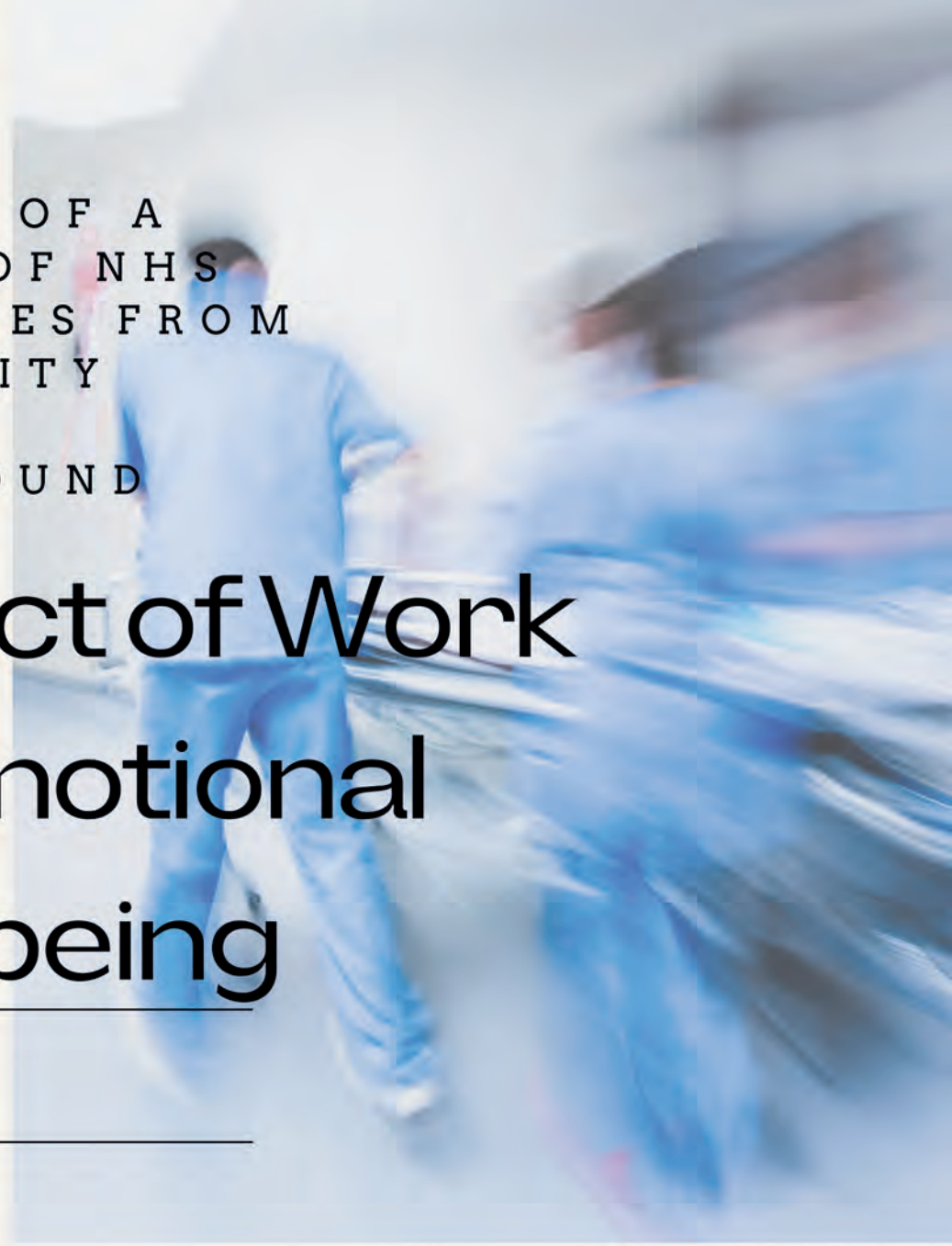

RESULTS OF A SURVEY OF NHS EMPLOYEES FROM A MINORITY ETHNIC BACKGROUND

Impact of Work on Emotional Well-being

RAJEEV GUPTA

Abstract

The healthcare workforce has borne the brunt of the recent COVID-19 pandemic and reports experiencing high levels of stress, work-life conflicts, and incivility which leads to poor recruitment and retention. Despite the high competition rates for entry into university healthcare professional courses, there is a trend of professionals leaving the profession within 2-3 years of qualification. This trend leads to a gross imbalance of carefully crafted workforce prediction numbers and leads to additional stress on those who remain. The impact on the safety and efficacy of healthcare provision is also challenged due to the workforce's unpredictable career intentions. Organisations need to understand the determinants of workforce well-being and develop interventions or incentives that may have a positive impact.

The healthcare model depends on having a happy-productive workforce. The survey undertaken in a Yorkshire NHS Trust provides insight into the emotional well-being of healthcare professionals predominantly from a minority ethnic background. It's clear that there are several positive aspects, including clarity of roles, support from colleagues, and perceived respect. However, there are also areas for improvement, such as managing workload intensity, improving job autonomy, promoting mutual respect, facilitating open communication with line managers, and promoting work-life balance. These findings can inform strategies to improve the work environment and support the emotional well-being of NHS employees.

Introduction

Well-being is a state of positive feeling and meeting one's full potential. It can be measured subjectively and objectively. 1 The hedonistic term 'positive feelings and the eudemonic term 'meeting full potential as a member of society' are inclusive, free from cultural bias and should be included in such a definition. While overlapping with health, wellness, welfare and quality of life, wellbeing is separate from these.

Occupational stressors at work increase the risk for mental health dysfunction. Poor mental well-being is harmful to the individual and can affect professionalism, organisational effectiveness, and public safety. 2 It is recognised that working conditions affect worker's well-being (Occupational well-being), including job demands (role conflict and emotional demands) and job resources (influence at work and social community at work) among other factors. The organisational stressors most often demonstrating consistently significant associations with mental health outcomes included lack of support, demand, job pressure, administrative/organisational pressure, and long working hours. 2 Occupational stress impairs psychosomatic well-being, which includes anxiety, depression, sleep quality, and somatic symptoms. The subdimensions of occupational stress - workload and time pressure, professional and career issues, patient care and interaction, interpersonal relationships and management problems, but not resource and environment problems impact occupational well-being. 3 Doctors' poor rota design and inhumane working hours or work-life conflict are the key contributors to burnout. Ideally, employers want their employees to be happy-productive, yet over half tend to be either unhappy-productive or happy-unproductive- both of which are not desirable. 4

Employees report that "feeling happier at work" is the most important factor promoting their health and well-being. 5 Other factors include a good understanding of the role, being able to manage the role without being physically or mentally stressed, having access to breaks and feeling valued are also important factors. Individual factors (i.e., personal feelings, behaviours, and health) are determinants of an individual's perceived work-life balance, along with the quality and quantity of personal time. 6

It is important for organisations to explore and understand the specific determinants of occupational well-being for their employees on a regular basis and invest in measures that improve conditions working towards a happy-productive employee model. This is ultimately likely to lead to better recruitment and retention as well as patient safety and organisational efficiency.

Methods

Instruments that measure occupational well-being with the greatest number of positively rated measurement properties include the Personal Growth and Development Scale, The University of Tokyo Occupational Mental Health Well-being 24 scale, and the Employee Well-being scale. However, none of these worker well-being instruments meet the criteria for adequate instrument design. 7 We designed an occupational well-being survey of doctors in a Yorkshire NHS Trust. Our survey used an anonymised, online questionnaire (using Google Forms on multiple digital platforms) based on the Management Standards Indicator Tool developed by the Health and Safety Executive (HSE).8 The survey was designed to capture the multifaceted nature of work-related emotional impact on United Kingdom National Health Service (NHS) Trust employees.

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Results

The survey received 570 responses. The length of employment varied between less than 2 years (9.5%), 2-5 years (32.6%) 5-10 years (51.6%) and some more than 10 years. The top three reported ethnicity of the respondents were Indian (49.3%), Pakistani (29.5%) and White British (8.8%).

Most respondents reported being clear about what was expected of them at work (73%), having no concerns at work (73%), and knowing how to get their work done (73%) and did not report having too many demands on them from different quarters (73%).

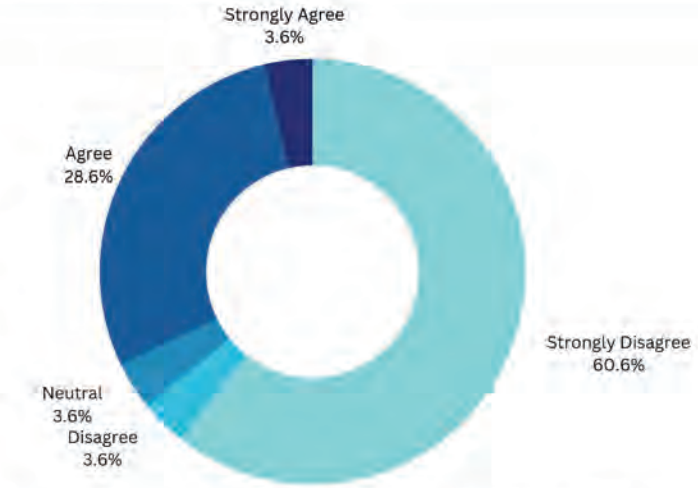
Most respondents did not report facing harassment or rarely (58.2%; 15.4%) and believed that if the work was tough, they would receive help from colleagues (72%).

Respondents reported not having to work more intensely than expected (65%), that they have a choice in what they do at work (65%, fig 9) as well as being clear on their responsibilities (70%) and understanding the aims and objectives of their team or department (77%).

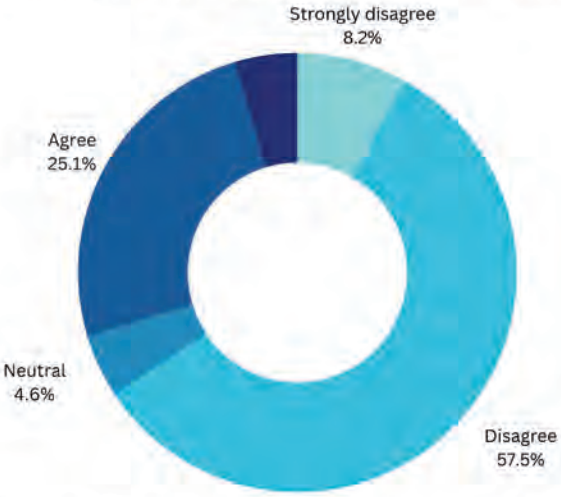
Respondents reported being able to take sufficient breaks (58.1%), being able to talk to their line manager about being upset or annoyed (64.3%), being respected by colleagues (64.8%, fig 14) and being supported for carrying out work that was emotionally demanding (66.9%).

Respondents reported being consulted about change at work (66.3%) and felt that their colleagues were willing to listen to work-related problems (68.1%). They reported feeling warm at work (59.6%). They reported that work did not affect them (65%,) or their families negatively (65.7%).

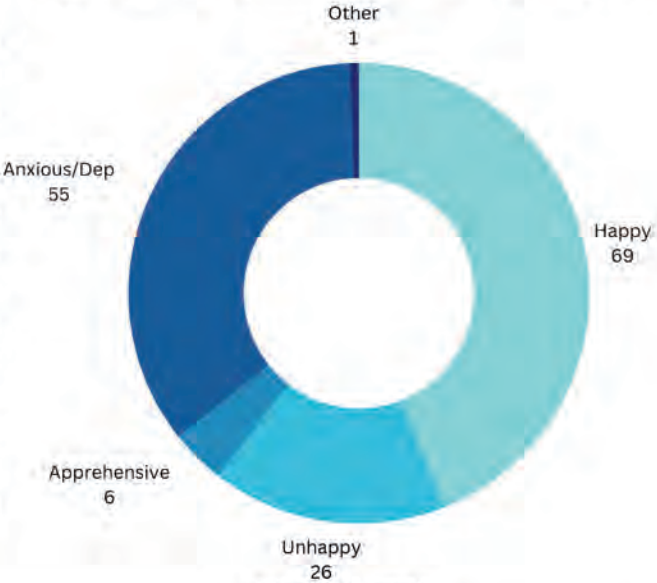
Sixty-nine per cent of respondents felt happy at work, while the remaining were apprehensive, unhappy, anxious, or depressed.



My work has negatively impacted my personal life



My work has negatively impacted my family life



Mood at work

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Discussion

The results from the current survey provide perspective into the emotional well-being and work-related experiences of NHS employees in Yorkshire, a vast proportion of whom were doctors belonging to a minority background. Responses to the questions illuminate how various aspects of the job environment can impact healthcare professionals. Our findings, combined with previous studies, underscore the complexity of the factors contributing to emotional well-being at work.

It is important that employees understand the nature of their work and are clear on what is expected of them. Our findings are in line with findings from a 2019 national NHS staff survey that reported that over 70% of NHS workers felt they knew what was expected from them at work.9

In this survey majority of respondents did not report concerns related to their work, which aligns with the findings by Alarcon that healthcare professionals often exhibit a high level of dedication and commitment to their work 10, despite the presence of underlying issues potentially related to stress, workload, or interpersonal dynamics 11.

Most of the respondents demonstrated confidence in being equipped to deliver their work, which is consistent with reports that healthcare professionals tend to report high levels of expertise and confidence in their abilities 12 and adaptability. 13 The proportion who reported experiencing workplace harassment reflected the persistent reports from NHS staff surveys and Workforce Race and Equality Standards (WRES) proportions. 14 Despite the reports of harassment, most respondents believe that colleagues would lend help if needed, findings are consistent with the literature on teamwork and camaraderie in healthcare settings. 15

Most respondents disagreed with the statement about having to work more intensively than expected. This might reflect the often-demanding nature of healthcare jobs, which could set higher expectations of workload intensity. This finding contrasts with the increasing concern about burnout in healthcare professionals due to high workload demands. 16 In terms of autonomy at work, most respondents felt they had a choice in deciding their tasks, which is associated with higher job satisfaction. 17

A significant proportion agreed that they were unable to take enough breaks. This could contribute to fatigue and burnout and is worth attention. 18 Most respondents felt they received the respect they deserved from their colleagues, indicating a generally positive work environment. 19 Most respondents reported that they could discuss upsetting or annoying work-related matters with their line managers. This is a promising finding, as open communication with superiors can contribute to better job satisfaction and well-being. 20 Almost half of the respondents felt supported through emotionally demanding work, which is vital in healthcare settings where emotional stress is prevalent 21 and agreed that their colleagues were willing to listen to their work-related problems. This is positive, as peer support is known to help mitigate work-related stress. 22

The response to the question about a warm feeling towards the workplace was almost evenly split. This could be indicative of varying levels of job satisfaction, workplace culture, and engagement. 23 Negative emotions about the workplace can impact job satisfaction and productivity, so this warrants further investigation. 24 Many disagreed that work was negatively impacting their personal and family life. This is an encouraging finding, given the known risks of work-life conflict in healthcare professions. However, the sizeable minority who agreed suggests a need for continued efforts to promote work-life balance.

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Limitations

This methodology, despite its limitations, has provided a foundation for understanding the work-related emotional impact on NHS employees. By building upon this study's methodology in future research, we can continue to generate insights into these important issues, driving forward initiatives to improve the working lives of those at the heart of our healthcare system: the employees of the NHS.

Conclusions

The results from this survey provide important insights into the emotional well-being of NHS employees, particularly those from a minority ethnic background. It's clear that there are several positive aspects, including clarity of roles, support from colleagues, and perceived respect. However, there are also areas for improvement, such as managing workload intensity, improving job autonomy, promoting mutual respect, facilitating open communication with line managers, and promoting work-life balance. These findings can inform strategies to improve the work environment and support the emotional well-being of NHS employees.

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INDRANIL CHAKRAVORTY

University Degree of Higher Worth- vis-à-vis Sunak

Background

The value of university degrees in society can be significant and multifaceted. University degrees often serve as a prerequisite for many professional careers. They provide graduates with specialised knowledge and skills that are relevant to their chosen fields, making them essential for certain professions and attractive to employers. Many job listings specifically require a certain level of education, and having a degree can open doors to a wider range of job opportunities.

Individuals with university degrees tend to earn more over their lifetimes compared to those without degrees.[1] This wage premium varies depending on the field of study, but higher education can generally lead to higher-paying jobs and better career advancement opportunities. University education goes beyond just knowledge acquisition. It helps students develop critical thinking, problem-solving, communication, and research skills, among others.[2,3] These skills are valuable in the workplace and everyday life, contributing to personal growth and societal development. In many societies, having a university degree is associated with a certain level of prestige and social status.[4]

The RT Hon Rishi Sunak MP, the first of his kind in the history of the UK, as a minority and from immigrant parents, announced in the same week that his government pushed through the Anti-immigration bill that he will restrict Universities from running courses which are in his vision of 'low worth'. This created unrest among the academic circles, who either took to Twitter to report how they have personally gained and also gainfully contributed to society with the 'lower worth' higher qualifications. There was also the band of social scientists who described how this elitist view is designed to reduce the access to students from multiple deprivation backgrounds to courses such as arts, humanities, and philosophy which are truly then reserved for those from the top of the socio-economic food chain. This argument or viewpoint is not new and nor will it be the last time that such a debate is had in society. This debate about what knowledge or study is considered useful or gainful in society can be described in economic or utilitarian versus philosophical terms.

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Obtaining a degree is often seen as an achievement and a sign of dedication to one's education and future prospects. University education equips individuals with the expertise needed to address complex societal challenges and contribute to the advancement of knowledge in various fields. Graduates may go on to become researchers, innovators, policymakers, or professionals who shape society and its progress. For many people, pursuing higher education is an important life goal. It offers the opportunity to study subjects of interest and passion, leading to personal fulfilment and a sense of accomplishment. Universities provide an environment for students to build social and professional networks. These connections can be invaluable in finding job opportunities, collaborating on projects, and accessing resources throughout one's career. It's important to note that the value of university degrees can vary depending on factors such as the reputation of the institution, the specific field of study, and the individual's dedication to learning and applying knowledge gained during their education.

While degrees can offer numerous advantages, they are not the sole determinant of success, and many successful individuals have achieved their goals without a university degree.[5] Ultimately, the value of a university degree is influenced by the ever-changing dynamics of the job market, societal norms, and individual aspirations.

A growing and maturing society needs its citizens to read the basics of science, mathematics, and technical subjects. This knowledge is gained and handed on purely for an applied purpose. It helps design and run machinery, factories, production lines, hospitals, and so on. One can describe such knowledge as leading to blue-collar jobs or industries.

All modern societies have been through the process of industrialisation and there has been a significant impact of such applied knowledge generation on people's living standards, wealth acquisition, and improvement in health. Britain went through this phase during the period of the Victorian and early Elizabethan era. So Rishi Sunak is right in wanting to go back to the heady days of production in Britain. We have also heard of similar aspirations from his counterpart in the USA and in India with their 'Make in India'[6] or 'Make America Great Again'[7] rhetoric.

Arts and Humanities

What he is missing is that once a certain equilibrium is reached by such societies, and people can turn from toil to thinking - art, humanities, and philosophy flourish.[8] The study of arts and humanities holds significant value in society, even though their benefits might not always be as immediately apparent as more vocational or technical fields. Arts and humanities degrees foster an appreciation for literature, history, philosophy, art, language, and other aspects of culture. They encourage students to explore different perspectives, develop empathy, and better understand the complexities of the human experience. This cultural enrichment contributes to a more well-rounded and informed society. It encourages critical thinking, analysis, and creative problem-solving. Graduates in these fields learn to think critically, question assumptions, and communicate effectively, skills that are highly transferable to various professional settings. They often emphasise effective communication through writing, public speaking, and interpersonal interactions. These skills are valuable in almost every career and are essential for building strong relationships and conveying ideas persuasively.

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They play a vital role in preserving cultural heritage and traditions. Graduates may become educators, archivists, or advocates for cultural preservation, ensuring that societies retain their unique identities and histories.

The study of humanities can help individuals develop emotional intelligence by examining human behaviour, emotions, and societal norms. This understanding can be beneficial in personal relationships and leadership roles. Arts and humanities graduates often adapt to change, find creative solutions, and think outside the box. These qualities are increasingly valued in a rapidly evolving job market where innovation is essential. Many arts and humanities graduates become advocates for social justice, equality, and human rights. They may work in NGOs, public policy, journalism, or advocacy roles, using their knowledge and empathy to address societal challenges. Arts and humanities degrees can intersect with other fields, leading to interdisciplinary knowledge and collaboration. This interdisciplinary approach is becoming more valuable as complex global challenges often require diverse expertise. The arts and cultural sectors contribute significantly to the economy, creating jobs and fostering creative industries. Arts and humanities graduates play a role in supporting and advancing these sectors.

While arts and humanities degrees may not always lead directly to specific job titles, they provide graduates with valuable skills and a broader understanding of the world. Many employers recognize the value of these degrees and seek candidates with strong critical thinking, communication, and problem-solving abilities. Moreover, pursuing a passion for the arts or humanities can lead to personal fulfilment, a strong sense of purpose, and a lifelong love of learning.

This has been described in historical analysis of Greek, Roman, Indus Valley, and Egyptian societies. Even in relatively newer societies (1000 AD onwards) in Europe, America, and Asia we have plenty of examples of philosophy and art flourishing in times of peace and prosperity.[9] Humanity's greatest creations are those that reflect such thinking.

There is a fundamental requisite for the human mind to change from survival to reflection - and that is to be provided a level of creature comfort and sustenance. Even in relatively newer societies (1000 AD onwards) in Europe, America, and Asia, there are numerous examples of philosophy and art flourishing during periods of peace and prosperity, such as Pax Romana, the Italian Renaissance (14th to 17th centuries, Europe) - a period of immense cultural and artistic growth in Italy. Supported by the patronage of wealthy families and city-states, artists like Leonardo da Vinci, Michelangelo, and Raphael created masterpieces in painting, sculpture, and architecture. Philosophers like Machiavelli and Pico della Mirandola also made significant contributions to political and philosophical thought. The Golden Age of Islam (8th to 14th centuries, Middle East and North Africa): During this era, the Islamic world experienced significant advancements in various fields. Scholars like Avicenna (Ibn Sina) and Averroes (Ibn Rushd) made significant contributions to philosophy and Islamic thought, while poets like Rumi and Omar Khayyam produced enduring literary works. [10] Edo Period (17th to 19th centuries, Japan): The Edo period in Japan was characterised by relative peace and stability under the Tokugawa shogunate.[11]

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During this time, traditional Japanese arts, including ukiyo-e woodblock prints, Noh theatre, and haiku poetry, flourished. Bengal Renaissance (19th and early 20th centuries, India): The Bengal Renaissance was a period of intellectual and cultural revival in Bengal, India. It saw the emergence of influential figures like Rabindranath Tagore, who won the Nobel Prize in Literature, and Swami Vivekananda, a philosopher and spiritual leader. 12

These examples demonstrate that periods of peace and prosperity have often been catalysts for intellectual and artistic flourishing in various societies and periods. The stability and resources available during such times have allowed individuals to engage in creative and philosophical pursuits, resulting in lasting contributions to humanity's cultural heritage. Hence the arts have always flourished under patronage. Patronage often came from benevolent leaders who had acquired their power and wealth by using the tools produced by industrial or engineering progress.
So we come full circle. So why is there such an academic uproar among the intelligentsia?

What becomes apparent when one studies the rise and fall of civilisations, is that there is a division in society along the lines of those who can engage in 'higher' intellectual pursuits and therefore retain their position at the helm of society. At the same time, the rest are allowed to continue to strive for their daily bread. When studying the rise and fall of civilizations, it can indeed become apparent that there is often a division in society along the lines of those who can engage in "higher" intellectual pursuits and retain positions of power and influence, while the majority of the population may be primarily focused on meeting their basic needs and livelihoods.

This division is referred to as elitism, social stratification or social hierarchy which perpetuates different classes based on factors like wealth, education, and influence. The elite class, possessing intellectual prowess and power, may enjoy privileges and resources inaccessible to the majority. If the elite class earns their positions through merit and capability, a meritocratic society could argue that the best and brightest are leading and influencing decisions, ultimately benefiting the broader population. However, it also raises questions about inequalities and social injustice. However, societal divisions are not solely determined by intellectual pursuits or privilege alone. Factors like gender, race, ethnicity, and social class can also play significant roles in shaping the structure of a society. The study of the rise and fall of civilizations often reveals complex interactions between various societal factors that contribute to the dynamics of social stratification.

As we continue to learn from history, it is crucial to address inequalities and strive for a more inclusive and equitable society where everyone has the opportunity to pursue intellectual growth, contribute to the betterment of society, and enjoy a fulfilling life. In Indian society from the time of the Vedas, societal hierarchy always placed knowledge (acquired and protected by Brahmins) above power (held by Kshatriyas) and business (practised by Vaidyas) and so on. This caste-based societal structure created a division of labour based on birth, with each varna having a specific role and responsibility. Knowledge, especially religious and philosophical knowledge, was held in high esteem, and the Brahmins were expected to preserve and transmit this knowledge through generations.

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The rigidity of the caste system often prevented social mobility and limited opportunities for individuals to pursue the roles they were most interested in or suited for. Over time, the caste system became associated with discrimination, exploitation, and social divisions. Modern Indian society may appear one of the equal opportunities as described by the longest-written constitution in the world, but in reality, a small proportion of Brahmins and Khatriyas hold and protect ninety per cent of the wealth and power that exists. The rest are allowed to toil for their daily bread and work in the industrial hinterlands.

Society in Communist China is no different as the power is held by those who understand and follow the philosophical principles of Marxism. In a communist system like China, the party's understanding of Marxism and its interpretation of socialist principles play a central role in governance and policy-making. The CPC's leadership implement policies that align with their interpretation of Marxism and their vision of socialism in China.

However, it is important to note that in practice, China's modern political and economic system has evolved significantly from classical Marxist theory. The country has adopted a mixed economy, combining elements of socialism and market-oriented reforms, leading to significant economic growth and development over the past few decades.

Philosophy & Science

Physics often transcends the organic and conceptualizes the unknown. So, philosophy and the quest for 'the unknown' is sometimes described as religion, by some. Philosophers seek to explore the unknown through critical thinking, rational analysis, and contemplation. Philosophy and physics can complement each other.[13] Philosophical inquiries can address foundational questions that lie beyond the scope of physics. For example, philosophy can explore the nature of time, causality, the origin of the universe, and the implications of scientific theories. At the same time, physics can inform philosophical discussions about the nature of reality and our place in the universe.

Philosophy and spirituality are distinct but not mutually exclusive. While philosophy may explore questions about the existence of a higher power or the nature of the soul, spirituality often involves personal beliefs, experiences, and practices that go beyond purely rational inquiry. Some individuals integrate philosophical reflection with their spiritual beliefs, seeking a deeper understanding of their faith or personal worldview. The relationship between spirituality and physics can be complex and varied. For some individuals, spiritual beliefs may coexist with scientific understanding, and they might find awe and wonder in the mysteries of the cosmos. Others may seek to reconcile their spiritual beliefs with scientific findings, often engaging in dialogue between science and religion. Ultimately, the interactions between philosophy, physics, and spirituality are diverse and can vary from person to person.

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Some individuals may find harmony between these areas of inquiry, while others may see them as distinct and separate aspects of human understanding. The pursuit of knowledge and meaning in each of these domains contributes to our broader understanding of ourselves and the universe we inhabit.

The purpose of this editorial is not to delve into such areas that are lesser known but to reiterate that alongside STEM subjects which may lead to gainful employment, most mature and progressive societies need to provide patronage to the pursuit of arts, humanities and philosophy. The patronage of arts and humanities can play a crucial role in fostering a progressive society. While not the sole factor, it contributes significantly to the cultural, intellectual, and social development of a community. While patronage of arts and humanities is vital for a progressive society, it is essential to strike a balance with other areas of social development, such as education, healthcare, and infrastructure. A holistic approach that values both the practical and cultural aspects of society contributes to a truly progressive and flourishing community. Governments, private organisations, and individuals all have roles to play in supporting and promoting the arts and humanities for the collective benefit of society. That is the true marker of a progressive society and one that is likely to survive the next millennia.

As many of the readers of this journal are health professionals, we understand our role via our education and training to apply the knowledge we have received through apprenticeship. Much of the several years of training we receive is designed to amass a fountainhead of factual knowledge and apply it to processes and protocols to provide care.

Rarely do health professionals get a chance to delve into the acquisition of new knowledge or explore unknown causes of maladies or uncharted treatment options, unless one is privileged to have funded time for research. Even in research and academic circles, there is less opportunity for bench research or undertaking truly novel phase-one trials.

Utilitarianism in Education

Much of our education did not teach us to ask why but merely to accept and apply. That is a fundamental folly of such utilitarianism in education and one that Rishi Sunak's metrics of gainful degrees may not support. The lack of emphasis on critical thinking and questioning in some educational systems can indeed be seen as a fundamental folly of an overly utilitarian approach to education. Utilitarianism in education often prioritises practical skills and immediate applicability of knowledge, which can lead to a neglect of fostering curiosity, analytical thinking, and a deeper understanding of the world.[14] By focusing solely on rote memorisation and practical skills, learners may be discouraged from asking "why" and exploring topics beyond the immediate curriculum. This stifles their natural curiosity and creativity, hindering their ability to think independently and pursue knowledge beyond prescribed boundaries. When learners are taught to accept and apply information without understanding the underlying principles or concepts, they struggle to grasp the broader implications and interconnectedness of knowledge. Understanding "why" something works a certain way is essential for building a strong foundation for further learning.

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Critical thinking is a crucial skill for evaluating information, solving problems, and making informed decisions. If education primarily focuses on accepting and applying information without encouraging critical inquiry, students may lack the ability to analyse, question, and assess the validity of the knowledge they encounter.

A "why" focused education promotes a growth mindset and a willingness to continuously learn and adapt to new challenges. Innovation often arises from questioning the status quo and exploring new possibilities. An education system that emphasises critical thinking and asking "why" nurtures innovative thinking and problem-solving abilities.

It's important to acknowledge that not all educational systems fall into this utilitarian trap, and many educators and institutions actively promote critical thinking and inquiry-based learning. A balanced approach that combines practical skills with critical thinking and creativity can lead to a more well-rounded education and better prepare students for the complexities of the modern world. Encouraging learners to ask "why" and fostering a culture of curiosity can lead to more engaged, motivated, and thoughtful learners.

Original research takes huge investment, opportunity and a safe environment to innovate. Many of us are merely trained operators who apply our craft but do not innovate. It takes a different mindset to be innovative and visionary. However, unless we allow our future generations to be visionary, innovate and accept that there will be many experiments or ideas that will be either considered crazy or fail miserably: no new knowledge will be produced, no progress will be achieved and we will regress as a society.

The history of human civilisation is full of ideas that did not fly and so it should be.[15] Research very rarely leads to significant original achievements that can be monetised, in Sunak terms. But progress is made. Science, Arts and Humanities must coexist, collaborate and codesign ideas to take forward. We must have social science working hand in hand with pure scientists and all should be working with philosophers and historians so we learn from our rich past and what is described as heritage.

The Future Vision for Education

So we should encourage our young minds to be free to choose what they fancy, to fly and accept that falling is also part of learning. Absolutely, encouraging young minds to be free to choose what they fancy, to explore, and to accept that failure is a part of learning is vital for their growth and development. Allowing young minds to pursue their interests and passions fosters intrinsic motivation. When they are genuinely interested in a subject or activity, they are more likely to be engaged and dedicated to learning. Giving children the freedom to explore different subjects and activities enables them to discover their strengths, interests, and talents. It allows them to develop a well-rounded set of skills and knowledge. By accepting that failure is a natural part of the learning process, young minds can develop resilience and the ability to persevere in the face of challenges. This resilience is crucial for their personal and academic growth. When young minds are encouraged to explore freely, they are more likely to think outside the box and develop creative solutions to problems. Embracing their creativity can lead to innovative thinking in various aspects of life.

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Allowing children to make choices and experience the consequences of their decisions can boost their self-confidence and sense of independence. It empowers them to take ownership of their learning journey.

It's important to strike a balance between encouraging freedom and providing guidance and support. Parents, educators, and mentors can play a crucial role in nurturing a learning environment that allows young minds to fly freely while providing a safety net to catch them if they fall. Celebrating both successes and failures as opportunities for growth can instil a positive attitude towards learning and foster a resilient and confident mindset in young individuals. They must be allowed to ask why or why not. They must be given the freedom to For that is where the future success of our society and civilisation lies.

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Abstract

Medicine is a global profession and doctors from the time recorded history began have migrated between different parts of the globe, bringing with them knowledge of different diseases and treatments and culture and language, enriching their adopted lands and building bridges across nations and people. Due to the British Empire reaching across the globe, many countries that were previous dominions and are now part of the Commonwealth, share the legacy of language, culture and the British way of life.

So, institutions of learning in many countries across the globe, use English as a language of instruction and inspire a desire to visit Britain in many impressionable young minds. In the last seven decades, the UK National Health Service has been held in high regard as a magic formula for universal health provision. For a doctor or a nurse in many countries, one of the career aspirations usually involves travelling to and working in the UK NHS. Hence, the UK NHS has over 47% of doctors from 200 countries and around a quarter of its 1.3 million employees have qualified overseas.

This blog narrates the professional trajectory of a doctor qualifying in a medical school in Malaysia to become a consultant psychiatrist in the United Kingdom. The combination of hard work, diligence and an unwavering will to pursue one's passion in mental health, has enabled Sai Achutan to achieve his career objectives.

Multi-cultural Malaysia

Sai is a fourth-generation Malaysian whose ancestors originated in Kerala, India. His upbringing was rich in cultural diversity and strongly emphasised family values. Sai completed his medical degree at the Manipal University in Malaysia in 2012 and developed a fascination with psychiatry during housemanship (equivalent to Foundation year 1 training in the UK). His inclination towards psychiatry was consolidated during his apprenticeship with Professor Ismail Drahman,1 who had qualified in Geriatric Psychiatry during his training in the United Kingdom several decades ago. Malaysia's medical school has options to complete a twinning program with different countries namely the UK, Ireland, India, Indonesia, and many more- as my 2.5 years were spent in Manipal, India. Being multi-lingual, with fluency in English, Malay, Malayalam, Tamil, Sarawakian, and some command of rudimentary Mandarin and Hindi, he found this talent to be helpful in his interactions as a doctor.

The experience of training in a mental health system in Malaysia that closely resembled the UK further strengthened his desire to pursue training in Britain while appreciating the difference in culture and structure of a developing country compared to a developed country. In 2016, he commenced the MRCPsych training programme to attain specialised accreditation in Malaysia, which resembles the training in the UK. In 2017, he undertook a fellowship in Addiction Medicine followed by membership of the Royal College of Psychiatrists having passed the examination in 2018.

Coming to the UK

One of the requirements for working in the UK was the IELTS English examination which Sai considered to be straightforward for him, as a native English speaker. The writing component posed a challenge, which he successfully surmounted by transitioning to the computer-based format and achieving a passing score on his second attempt. This minor setback did not deter him. Initially, he enrolled with a recruitment agency, looking for speciality training roles in NHS hospitals. Although he was successful in interviews, he realised that these NHS speciality training roles were not suitable for him. He decided to opt for the independent mental health sector, which was more aligned with his career choices.

Cultural Integration

Sai really loves Malaysian food – which is a heady fusion of Indian, Malay, and Chinese cuisine. Moving from the hustle and bustle of a busy metropolis in sunny Malaysia to the bucolic countryside of England's West Country was quite the culture shock. While life in Malaysia is hectic, people like to congregate together, while in the UK rural life is more laid back and values individuality. Taunton's old homes and charming countryside were a far cry from the sparkling skyscrapers and neon cityscapes of Malaysia.

The longing for connection with family and friends in Malaysia was somewhat lessened by the easy availability of social media, video-chats and the frequent trips home. The exposure to other cultures and ways of living while growing up in multicultural Malaysia provided the mindset and social skills to communicate well with individuals from all walks of life.

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At first, the British formality (the fabled stiff upper lip) was somewhat difficult to fathom but as rapport was established it became easier.
In his professional experience, he found that the UK placed a higher value on privacy and attention to detail than in Malaysia. The NHS appeared to be bureaucratic and well-governed because of its need to stay within available resources, but he felt that Malaysia's less formal and flexible approach had its advantages. Having lived in Malaysia, where the work was demanding, strenuous, and often unforgiving, he appreciated the UK's focus on work-life balance. While nothing can compare to the delicious food of Malaysia, he found comfort in the slower pace of life.

Independent Sector

Cygnet Health Care expeditiously sent an invitation for a comprehensive interview, including insightful questions about NHS structures, mental health law, mental capacity acts, and processes. He articulated his objective of attaining specialist registration as a Consultant Psychiatrist and was offered a customised position at Cygnet Taunton as a speciality doctor, which he started in September 2019.

He was supported in his quest for specialist registration by Cygnet Healthcare. In December 2019, he submitted his application for Section 12 permission and initiated the process of collecting documentation from Malaysia to support his Certificate of Eligibility of Specialist registration (CESR) portfolio, which aims to establish the comparability of training to that of the United Kingdom. Cygnet provided complete financial support for the equivalence training programme, which was undertaken in collaboration with the Royal College of Psychiatrists.

His supervisor and mentor at Cygnet dedicated two hours per day, to thoroughly examine and evaluate his clinical competence, reflections, and work-based assessments. In 2020, he was promoted to Associate Specialist and later as acting consultant. He had an honorary contract with the National Health Service (NHS), which provided him with community experience enhancing his understanding of the nature of the mental health system in the UK, particularly within the framework of community mental health. Working closely with a clinical psychologist contributed to the improvement of his therapy abilities, and the involvement of an occupational therapist helped refine his skills in behaviour management strategies for his patients.

Post CESR-CCT

Despite the challenges posed by the pandemic in 2020, the utilisation of telehealth has significantly enhanced his professional capabilities. His dedication was recognised with awards for being a model employee and for 'an act of random kindness'. In 2022, he successfully obtained certification on the specialist register as a Consultant Psychiatrist specialising in general adult psychiatry. He also completed the Postgraduate Diploma in Clinical Psychiatry.

While working as Deputy Medical Director at Cygnet Taunton, he led efforts to enhance the quality of care across all domains and the Learning Disability service at Cygnet Taunton achieved Good or Outstanding ratings during inspections. Following his promotion to Medical Director at Cygnet Kewstoke, he implemented several quality improvement initiatives.

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His professional growth included a Diploma in Healthcare Leadership and Management, an MBA in Healthcare Management, and a master's degree in clinical psychiatry. He received nominations for Cygnet national honours in the categories of Medical Educator, Consultant and Leader of the Year, and was named Consultant of the Year in 2022. In 2023, he was shortlisted for the Medical Leader of the Year in recognition of his contributions at Cygnet Kewstoke. He became the Deputy Regional Advisor of Southwest at The Royal College of Psychiatry fostering enhanced collaboration between the independent and NHS sectors.

Ingredients for Success

As a foreign medical school graduate in the UK, he understood that respect, flexibility, and being cognizant of local cultural norms were essential. Making new friends and connecting with the local expat communities was essential to his happiness. Sai considered himself to be fortunate to have had the best of both worlds. He believes that International medical graduates who are open to new ideas while maintaining their cultural origins and their healthcare training bring innovative solutions to the NHS and have a promising future.

No matter where one practices medicine, the ability to approach patients with compassion and an open heart is vital which is not much of a difference from Malaysia, and critical for a cross-cultural psychiatrist. This narrative illustrates the combined contribution of personal dedication, mentorship, support, and dogged diligence in facilitating the success of an overseas medical practitioner in the UK or for that matter any health system. In pursuing the Certificate of Eligibility for Specialist Registration (CESR), success depends on understanding the stipulated criteria and working with mentors to achieve them.

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Working in the NHS: International Doctors' Perspective

Introduction

Working in the UK as a doctor is a dream for many international medics across the globe. Indeed, working in a healthcare service that is free at the point of delivery, and that aims to treat patients and employees equally is the ideal environment for doctors to achieve the promise they make when they take the Hippocratic oath.

As international medical graduates (IMGs) enter the workforce, we are often faced with two parallel experiences, one that includes all the ups and downs that all junior doctors find themselves experiencing while working in the NHS, but also another kind of experience unique to foreign graduates. The data shows that IMGs perform worse in post-graduate medical exams and are more likely to require training extensions in comparison to their UK-born colleagues. Furthermore, IMGs are more likely to receive complaints, with these complaints more likely to lead to sanctions or warnings1.

This essay highlights some of the key challenges and experiences faced by IMGs working in the NHS, shedding light on issues such as rotational working, bullying and harassment, challenges with the training pathway, racism and discrimination, and the support available for IMGs. Ultimately, it underscores the need for improvements in the system to retain the valuable doctors who have long aspired to serve in the National Health Service.

Challenges with rotational working

Getting used to a new system is, obviously, challenging for anyone working in a new job. It must be kept in mind that this challenge is almost continuous as a junior doctor. Even if you get used to the system, what services can be offered, and what guidelines should be followed, those parameters change significantly from one hospital to the next. The nature of a junior doctor's job means we often find ourselves being moved from one hospital to the next, just when we feel comfortable enough in our environment. The nature of the training system has become such that we often have little control over where we get a job. It can be difficult to adapt in a short time for any doctor.

Although it can have its positives, such as learning new techniques, a variety of demographics and diseases, it can have its toll. It is not surprising, therefore, for doctors both local and international to take more gap years out of training, as a locum or doing clinical fellow jobs to stay in the area they want to live in, where their support system is, or until they could get a training job in the area that is desired. This can take years, and it could be disheartening and demotivating, often resulting in junior doctors changing career goals to get the life balance and get the choice to live where they want.

Bullying and harassment

One challenge that some doctors face that is less spoken about is bullying. This is important because the impact of bullying is profound, not only on the victims themselves (leading to feelings of depression, anxiety and burnout) but also is associated with poorer quality of healthcare services and patient care2. It is something experienced by many juniors in their respective fields. However, as doctors can be considered "junior" for a long time in the UK, and as the work environment can be stressful at all levels, the exposure can be subtle and prolonged. When I first started as a doctor, I was encouraged to handle stress with the "stiff upper lip" method by some of my senior colleagues and even penalised when I tried to escalate issues. Many of us fear doing this, as we feel we are at the bottom of a totem pole where it is easy to get blamed. Having supportive supervisors who listen and help address the bullying is essential, and in my experience, an educational supervisor who takes your complaints seriously and is not dismissive can make a great impact on one's experience as a junior doctor. Recognising that being vocal about this issue while feeling safe and not being reprimanded for it is imperative for a healthy working environment. Bullying is a pervasive issue within the NHS, and it is well established that doctors who are from ethnic minorities are more likely to face bullying in comparison to their white peers.3

Challenges with the training pathway

Unfortunately, training is becoming less appealing for many of us due to the shape specialisation is taking in the UK. Specialising is a very important method of career progression for junior doctors.

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With a frozen salary for many years, lack of stability in the area we work in, and having a trajectory to aim for, often can be the sole motivator for doctors. It has become a centralised process that could at times disregard previous experiences we have.

For international medical graduates, it is particularly important, as some may be even consultants back in their country. Applying for those specialities here can feel arbitrary and this makes them change to easier, more attainable specialities. It is important to emphasise the reduced number of training numbers for many specialities and funding, as well as the need for consultants in all specialities in the UK. Training programs themselves are a great method for doctors to ensure safe practice under supervision and attain a certain standard. However, some programs have simply become centred around service provision rather than learning and teaching, with limited opportunities outside of the acute settings. This of course varies from area to area and hospital to hospital. With the pressures of an increasing number of patients and a reduced number of doctors, it is an expected change.

Racism and discrimination

Institutional and covert racism can very much be a type of bullying that both international and national doctors experience, in some instances, daily. One example is when one of my colleagues kept being called by another doctor's name who was from the same ethnicity. When the consultant doing this was confronted, he replied that the two colleagues looked the same and that he could not be bothered to learn both names. Such instances can be considered small, but the accumulation of their occurrence can have a deep impact on an individual who is already under pressure in a highly demanding environment.

Support available for IMGs

Most IMGs struggle to build connections to get observerships so that they can renew their knowledge. There are some charities and programs that can be helpful in helping IMGSs learn English and prepare for exams. Bridges Program in Scotland is an example of an excellent program that helped me and other refugee doctors I know to navigate the system and arrange observer-ships for us.
Another such scheme is the pan-London Professional Support Unit (PSU), which offers a range of schemes to help IMG doctors move safely to working in the NHS, ensuring both patient and doctor safety. The Clinical Apprenticeship Placement Scheme for refugee doctors places post-PLAB refugee doctors in funded supernumerary foundation year 2 posts and provides a targeted educational programme4. Schemes such as these have been shown to be beneficial for increasing the number of IMGs who return to work or join training programs 5. Further targeted support schemes are necessary to support the careers and development of IMGs.

Conclusion

All the above compounded with increasing pressures of seeing more patients, brutal rotas, lack of safe areas and offices for juniors to work in or rest in, and pay issues highlighted by the British Medical Association (BMA) have led to an increased number of doctors with burnout. The problem was amplified by the COVID situation. A survey conducted by the BMA found that two-thirds of doctors reported symptoms of depression, anxiety, stress, and burnout related to or made worse by work. Of these, almost half said their condition was worse after the pandemic6.

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worked on the front line in ITU during the first two large waves of COVID. I saw comradery and hard work that has re-inspired me and made me grateful to be part of this team of people who put in one hundred per cent effort with reducing resources. It truly highlighted why many doctors strive to work here. But the pandemic also revealed that self-care and work-life balance are important, recognition of the importance of a doctor's worth is also important so that they can offer more of themselves and care in return.

In conclusion, creating better training programs, increasing funding for speciality training, taking complaints of bullying and harassment seriously, and providing a stable and supportive work environment are essential steps toward retaining the doctors who have long dreamed of serving in the NHS. By addressing these challenges and supporting IMGs, we can ensure that the NHS continues to provide high-quality care to patients while fostering a welcoming and equitable environment for all doctors, regardless of their country of origin.

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BTA WORKFORCE SOLUTIONS FOR THE NHS

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BTA

BAPIO TRAINING ACADEMY

The National Health Service (NHS) is going through the worst crisis in its history and its services are under unprecedented pressure – bed occupancy, with 19 out of 20 beds occupied, is above 95%1, ambulance response times and waiting times at A & E are at a record level, and the elective waiting list stood at a record 7.2 million in 2023. 2 Even though there has been an increase in recruitment in recent years, 21% more doctors and 16% more nurses, as compared to five years ago, the latest figures indicate that September 2022 recorded the highest number of staff vacancies – 1 in 10 posts were unfilled (9.7% of the workforce). 3 A record number of people resigned in the 12 months leading to 2022- 148,460 or 10.8% of the workforce resigned as compared to 9.1% resignations in the 12 months leading to 2019. Staff burnout, work-life balance, and worsening working conditions since the start of the pandemic are some of the reasons. 4

There is an urgent need for training and recruiting new staff into the NHS and the service is experiencing some of the highest vacancies on record. International medical graduates (IMGs) continue to remain a key part of the NHS medical workforce. United Kingdom (U.K.) medical graduates joining the U.K. medical workforce rose by 2% in the last five years compared to a 121% rise in IMGs. Of the doctors who joined the workforce in 2021, 50% were IMGs and 39% were UK graduates. 5 This highlights that IMGs form a major component of the medical workforce and suggests a future trajectory whereby they will become further embedded within UK healthcare systems.

A long-term approach to ensure a sufficient and skilled workforce in NHS is a challenge that needs to be at the core of the workforce implementation plan. However, even though a sustainable long-term workforce strategy is urgently needed, ethical recruitment of doctors from overseas can partially address the recruitment gap, critical for the delivery of safe patient care.4

BAPIO Training Academy solutions

British Association of Physicians of Indian Origin (BAPIO) is a national voluntary organisation established in 1996 with a commitment to the principle of providing high-quality patient care through the NHS. BAPIO actively promotes the principles of diversity and equality with the aim of "Empowering doctors and dentists to be beacons of leadership and professional excellence." Over the years, the association has grown in stature and influence. It is represented through active divisions covering all the English Regions as well as Scotland, Wales, and Northern Ireland. It is now one of the largest organisations of its type in the country. BAPIO is a non-party political membership organisation, recently registered as a charity. It actively contributes to the cause of promoting access to better health care globally and responds to aid victims of natural disasters in the world.

BAPIO Training Academy (BTA) is an arm's length body of BAPIO, and its strategy is to promote professional and clinical excellence. BTA has led the way in finding innovative solutions to the healthcare sector's workforce crisis in the UK. Its global initiatives to enable skilled doctors to join healthcare organisations across the UK in various sectors help in the identification of talent internationally, upskill health professionals, work through sustainable recruitment processes, include GMC sponsorship and connect to educational programs with professional development. BTA strives for quality through education and training to enable better patient care across specialties. The programs provide continued professional development, medical indemnity, pastoral care, and liaison to streamline the journey.

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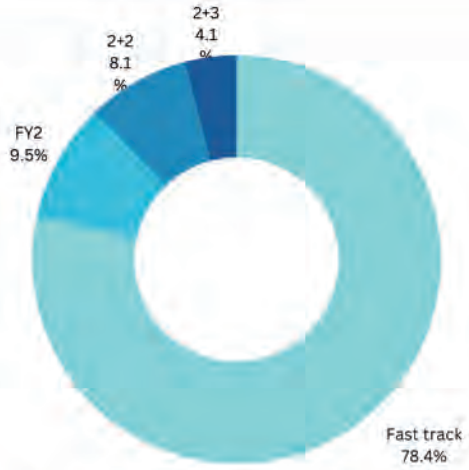
BTA's innovative offers reduce locum spending, identify worldwide talent, and provide an effective solution to workforce needs impacting patient care. BTA model of engagement involves working collaboratively with NHS healthcare services, universities, regulators, politicians' governments and global partners. It is critical to the success and sustainability of healthcare systems. It is this whole system approach that has allowed for the development of innovative workforce initiatives to address workforce crises and improve the provision of quality healthcare services.

Workforce Development

BTA has established partnerships with at least 24 NHS Trusts for the workforce development of doctors, nurses, and allied health professionals. BTA's innovative projects have been recognised and now working with NHS England to support the winter pressure crisis, development of the primary care workforce and wider workforce development initiatives across the country. Through BTA's programs, more than 65 international medical doctors have gained GMC registration and working across NHS healthcare services across various specialties including emergency medicine, paediatrics, OBG, neurology and psychiatry. These doctors are now working in hospitals and units where there are significant gaps. A skilled safe workforce providing care at a point when there are significant healthcare workforce shortages is a massive benefit to safe patient care.

The clinical fellow's program has also enabled NHS organisations to reduce locum spend. The unique 2+2 program wherein doctors complete 2 years of training in their home countries adhering to UK education and training standards followed by 2 years in the NHS healthcare services has started showing results; more than 5 doctors have also started their year 3 in the NHS and at least another 30 are anticipated to commence year 3 in the UK imminently.



This has the potential for significant savings over the next 5 years including clinical excellence and a sustainable healthcare workforce. Additionally, BTA has partnered with Higher Education sectors, and UK and global Universities to address the higher education needs that support developing healthcare professionals fit for the 21st century. The programs have in-built independent quality assurance processes to ensure early identification and swift resolution of any concerns to maintain the highest standards of program delivery.

Clinical excellence with a sound understanding of strategy, resource management, leadership and healthcare management can only further strengthen the workforce capability. The educational programs including university accreditation and continued professional development provide an opportunity for ongoing development for individual doctors, nurses, and allied healthcare professionals to be future senior clinicians. As we tackle waiting lists, resource constraints and workforce gaps, BTA's programs enable a unique offer to deal with the demands crippling organisations across the UK. Feedback from stakeholders and healthcare professionals is positive.

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Staff experiences, resources, and delivery programs have supported significant cost savings for organisations in reducing agency locum spending which then can be spent on patient care or further workforce development. Gains to the organisations include highly skilled medical staff who can meet the needs of various communities and current and future healthcare needs.

These doctors with either postgraduate qualifications or through the in-house 2-year training program (2+2) enter relevant clinical specialities providing high-quality patient care. Estimated locum costs across the NHS are being analysed and are expected to be significantly high savings. This is reflected in partnership with NHSE, 24+ NHS Trusts and other healthcare sectors. Partnership in the UK and globally is increasing at a rapid pace due to BTA's innovative program where clinical excellence and development of a capable and sustainable workforce are at the core of its mission.

BTA program strives to transfer knowledge and skills between the UK and other parts of the globe, mainly South Asia. BTA has contributed to upskilling programs for overseas doctors, nurses, and allied healthcare professionals. BTA's work transcends across borders – nationally and internationally.

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VIPIN ZAMVAR

Proceedings from the BAPIO Scotland Annual Meeting

Diversity, Equality & Inclusion
The first session on diversity, equality and inclusion introduced Ramesh Mehta as the first speaker. Honouring him for his lifetime contribution, Vipin Zamvar said,

"Whether we realise it or not, whether we acknowledge it or not, many of us in the room have benefitted from what Ramesh and BAPIO have done over the last twenty-five years to create a level playing field for all.

He has always spoken out against injustice when he has seen it."

Ramesh Mehta described the various initiatives that BAPIO had taken. These included

- the development of the 'Dignity at Work Standards'1 adopted by NHS England and implemented in different pilot sites in Leicester and London.
- Su Young (Ophthalmology Clinical Fellow) presented her research findings about differential attainment in Ophthalmology in the UK and the initiatives now being taken by the Royal College of Ophthalmology.2

The Scottish Division of the British Association of Physicians of Indian Origin (@BapioScotland) organised the first in-person Annual meeting at the Royal College of Physicians of Edinburgh after the pandemic.

True to South Asian/ Indian tradition, the meeting started with the lighting of the lamp by Professor Andrew Elder, President of the Royal College of Physicians of Edinburgh.Ramesh Mehta CBE, President of BAPIO, explained that darkness signified ignorance and light represents knowledge. This meeting was meant to impart knowledge, exchange ideas, and gain new insights.

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BAPIO SCOTLAND ANNUAL MEETING 2023

- BAPIO led the series of workshops in 2021, 'Bridging the Gap', which spearheaded the holistic re-examination of the evidence leading to DA and the initiatives needed to eradicate it. 3 Imran Liaquat (Neurosurgeon, Edinburgh) reflected using personal experiences on subconscious bias and racism plaguing the NHS workplace.4 Pragnesh Bhatt (Neurosurgeon, Aberdeen)5 spoke about his life story and how attending a BAPIO workshop twenty years ago, organised by the BAPIO North West Division, helped him onto a path that culminated in him becoming a Consultant in Aberdeen. He described how he had been denied a chance to sit the FRCS (Neurosurgery) exams two decades ago and how he had organised the same exam two years ago in Aberdeen. This was a remarkable journey against so many odds.
- Nicola Cotter (Head of General Medical Council, Scotland) discussed the Diversity, Equality and Inclusion initiatives. She described GMC's targets for eliminating disproportionality in fitness to practice referrals.

Innovations

During the 'Innovations in the NHS' session, Santosh Bongale (ED Consultant, Paisley)6 spoke about the initiatives he has developed in his hospital for allowing International Medical Graduates (IMGs) taster placements. These placements allow IMGs to experience NHS work first-hand and settle down to life in the NHS.7 Liesje Turner from Morecambe Bay8 spoke about the BAPIO training academy9 and how it had helped Indian doctors prepare for work in the NHS. This is a win-win situation as it allows Indian doctors who wish to come to the UK to get GMC registration and mentorship from experienced UK doctors, and it also helps NHS hospitals face staff shortages and find it challenging to recruit.

Rajeev Gupta (Pediatrician, Yorkshire) discussed the potential contributions of Ayurveda to the NHS in managing chronic conditions.10 Robert Rea (Innoscot Health)11 spoke about helping clinicians with new ideas to move forward to the next step, protect their ideas with patents and then turn those ideas into commercial success. Barry Alan (Medtronic UK) introduced the Touch Surgery App,12, which allows surgical procedures to be recorded and stored remotely. Surgeons can download these anytime on their phones or laptops and be used for training.

Retirement & Personal Finances

There were two fascinating talks on investments and pensions by Jay Thind and Pree Panchmatia from Thind Wealth Advisory. 13 They provided valuable insights into NHS Pensions and Retirement planning. The delegates offered positive feedback and had several questions for them after the event.

Professor Raj Bhopal CBE 14 spoke about his adventures in the 'Land of Retirement' during COVID-19 and how remaining engaged with healthcare was enjoyable and fruitful. Prof. John Frank talked about the health inequalities by social class in Scotland.15 Ananta Dave (President of the British Indian Psychiatrist Association and CMO Black Country Integrated Care Board)16 gave a compelling lecture on the challenges facing "Women Leaders in the NHS" and why the health service would be more efficient and compassionately led if the gender imbalance was addressed.

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There were 38 abstracts submitted to the meeting. Three were selected for the podium presentation and 7 for the poster presentation. The prize winners were the first prize, Shubham Jain (Aberdeen); the second prize, Fatima Zain (Fife); and the third prize, Helmi Ahmed (Middlesbrough).

At the session on "Celebrating Achievements", Professor Andrew Elder (President of the Royal College of Physicians), Subodh Dave (Dean, Royal College of Psychiatrists), Aman Coonar (President-elect, Society of Cardiothoracic Surgeons of Great Britain and Ireland), and Nitin Gambhir (Lead Dean Director in Scotland) spoke of their journeys from medical school days to the present.

The last session was on recent advances in managing Chronic obstructive pulmonary disease (Ghourab Choudhury, Chest Physician, Edinburgh17) and using Artificial Intelligence in Plastic Surgery (Vidya Mehendale, Plastic Surgeon, Edinburgh University18). Mr Bijay Selvaraj, Consul General of India at the Edinburgh Consulate19, was the Chief Guest.

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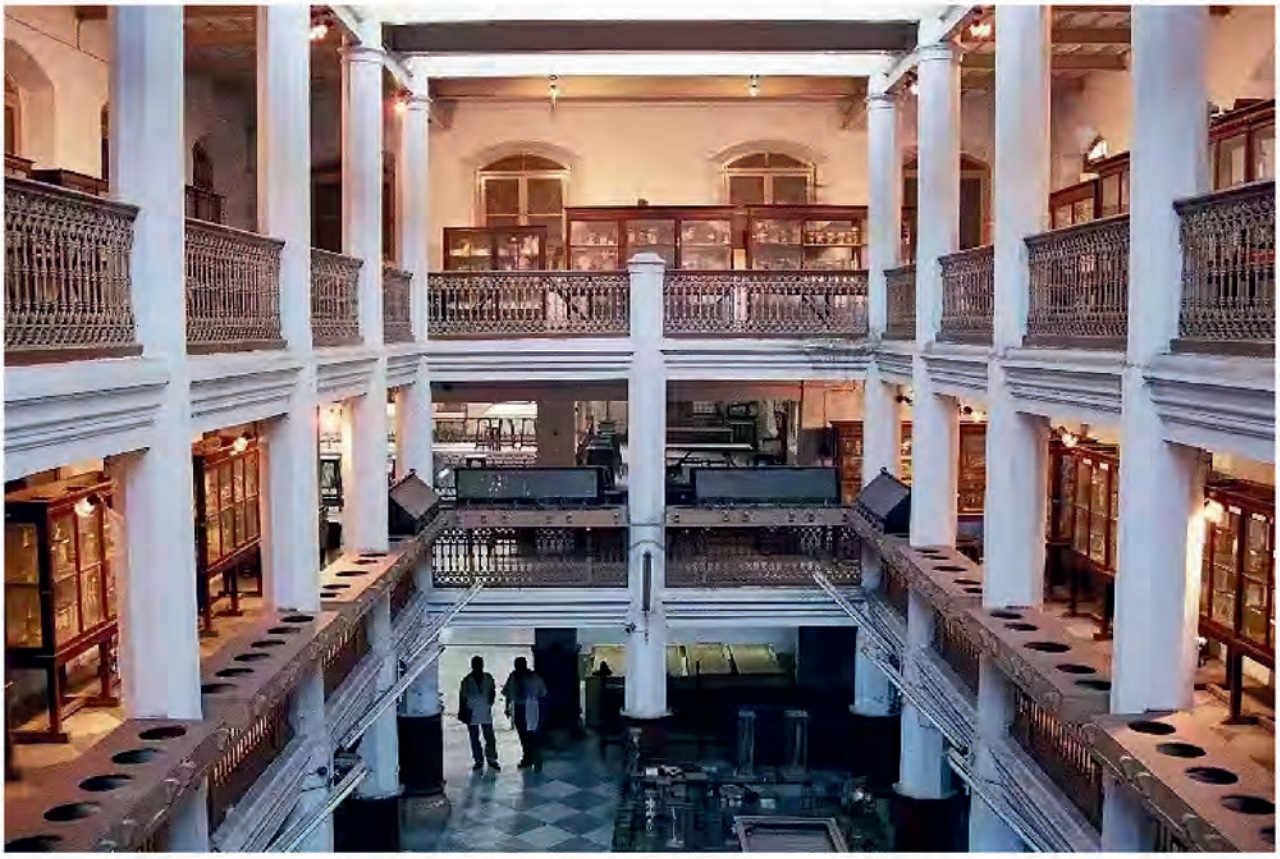
Introduction

An indispensable modality of treating disease in the annals of human medicine is surgery which entails removal of a body part causing disease. Since the dawn of civilisation and man's discovery of tools, surgery has been an integral part of medicine over the ages. However, removal of a live body tissue came with its own complications, most importantly pain. This stretched human endurance to the limit and indeed surgery itself was complicated by significant morbidity and mortality. The trade-off between cure and maim or even death often pushed surgery in the opposite direction.

A need therefore arose to provide painless surgery, i.e., a resection when the patient would be insensitive to pain. The earliest allusion to such a philosophy dates back to Sushruta in 500 BC where opium, alcohol and hemp were used to blunt the pain during surgery. Following this, all over the world, painkillers or drugs influencing sensorium were utilised to the same effect. Hypnotism or mesmerism in susceptible individuals worked to a certain extent. It was not until the Enlightenment period in Europe that chemical gases were identified which had a similar effect.

Advent of Modern Anaesthetic Medicine in India



Contribution of Calcutta Medical College

Soumit Dasgupta

Humphrey Davy in 1799 described two important effects of nitrous oxide which were euphoria and analgesia and recommended its use in surgery for the first time. Even before, a surgeon from London, James Moore observed nerve compression as a method to alleviate pain during amputations that was tried successfully only once by James Hunter, the father of modern surgery. Davy subsequently elaborated nitrous oxide and later Michael Faraday was the first to study ether to numb pain during surgery in 1818. In 1844, Gardner Quincy Colton successfully used nitrous oxide for a dentist Horace Wells in Hartford, Connecticut for a painless tooth extraction.

On 30th September 1846, William Morton, a dentist from Harvard Medical School and Wells' student performed the first painless tooth extraction in a patient with ether. This created a huge interest in the surgical world and led to the first public demonstration of a proper operation under ether anaesthesia on 16th October, the same year where a jaw tumour was removed at the operating theatre of the Massachusetts General Hospital in Boston. The world was ready for a revolution in surgery and no wonder, the technology arrived on the shores of the empire. The very first time that ether was successfully used in Britain was by a dentist James Robinson in 1846 on the 19th of December in Gower Street witnessed by the famous surgeon Robert Liston (Figure 1). Two days later the 21st of December 1846, Liston used the same technique for a painless amputation of UCL. The time was ripe for the use of ether to be disseminated in the empire and who else but the vanguard of Western Medicine in the empire to take up the responsibility, the Calcutta Medical College?

Western Medical Education in India - Calcutta Medical College

The Portuguese were the first to introduce Western medicine into India. The first ever medical school in Southeast Asia with professors from Coimbra University started in 1801 and 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 1823, established L'École de Médicine de Pondicherry that became the JIPMER in independent India. However, these two schools and hospitals did not admit the native populace. The Calcutta Medical College (CMC) as established by the British in 1835 was the first in the whole of Asia to impart Western medical education and hospital services to British and natives alike.

CMC since its inception pioneered several medical landmarks in the Indian context. The first human cadaveric dissection, the first students to sail to London to achieve higher medical training and degrees, the separation of medical jurisprudence from Materia Medica by Henry Mouat for the first time in history, the first intravenous saline administration for cholera by William Brooke O'Shaughnessy, the first time use of cinchona for malaria by Hugh Falconer, the first publication in the Lancet by Henry Goodeve and the recognition of the college by the Royal College of Surgeons, the University College of London and by the Royal Society of Apothecaries were all achieved within 1847 when another first was added as a feather to the cap of glittering achievements.

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Birth of anaesthesia and its evolution in Calcutta Medical College

Astonishingly, within five months from Morton in the USA and three months from Robinson in Britain, the method percolated to the British Empire, CMC adopted the procedure routinely, just one week after the news reached Calcutta. Dr R. O'Shaughnessy, Professor of Surgery, Calcutta Medical College, and cousin of the illustrious William alluded earlier, on the 22nd of March 1847, successfully used ether to remove a jaw tumour. This case was published in The Lancet in 1848 (Figure 2).

BY MR. R. O'SHAUGHNESSY. 269

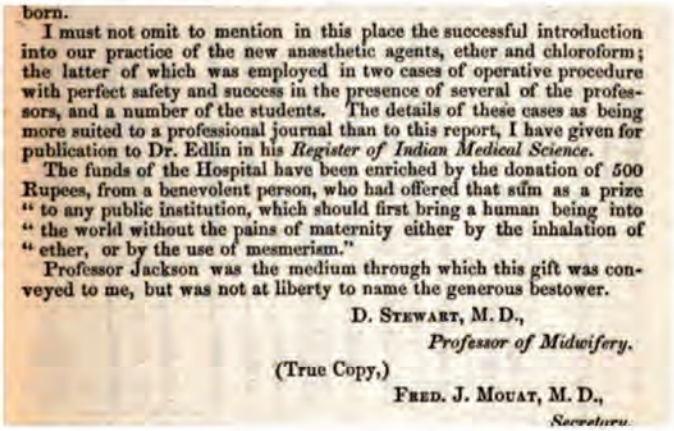
ment the tumour has gone on increasing; it gradually protruded into the mouth, and six months after its first appearance it commenced bleeding copiously once or twice a month, and he says the bleeding was more abundant and more certain to return at the full of the moon than at any other time during the month. This periodical discharge of blood did not produce any salutary alteration, or effect any check on the advancement of this frightful disease; it still continued to increase in pain and bulk till after filling the mouth so as nearly to produce suffocation, it at last (about six weeks ago) protruded from that cavity through the lips, and went on rapidly increasing up to the present day.

He positively says that he never received an injury of any kind in that cheek or jaw, and that he never had a tooth drawn or an unsound one. On his admission into the Dispensary, the tumour presented the following appearance.

An enormous growth completely occupied the left side of the face, rising to a level with the floor of the orbit and extending a long way below the inferior maxilla but unattached to it, occupying the whole of the anterior and left side of the mouth and protruding between the lips, pressing down the lower jaw, so as almost to make the chin touch the throat, and flattening the nose so as to leave no trace of the natural prominence of that organ. Still there was difficulty of swallowing, and the patient seemed to breath without inconvenience through the right nares. That portion of good health, and also the benign character of the tumour, and its freedom from any attachment to the lower jaw, I felt not only warranted but in duty bound to offer to this poor sufferer the only chance now left for him of escaping a lingering and frightful death, which of course was only to be hoped for by his submitting to an operation, and

On the 4th of November 1847, Sir James Simpson, an obstetrician from Edinburgh was experimenting with different chemicals in his laboratory with two other colleagues, when they all fell unconscious after inhaling chloroform. Thankfully, they did not inhale the toxic dose and on regaining consciousness, Simpson immediately saw the potential of using this for painless surgery in obstetrics. He tried it successfully in a very difficult labour on the 8th of November 1847.

Within two months, CMC decided to apply chloroform in surgical practices. The very first obstetric procedure was carried out on 12th January 1848 by Professor J. J. Jackson. The very next year, CMC published its initial experiences with ether and chloroform in the General Record of Public Instruction in 1848 which was disseminated to the rest of the world (Figure 3).



born.

I must not omit to mention in this place the successful introduction into our practice of the new anæsthetic agents, ether and chloroform; the latter of which was employed in two cases of operative procedure with perfect safety and success in the presence of several of the professors, and a number of the students. The details of these cases as being more suited to a professional journal than to this report, I have given for publication to Dr. Edlin in his *Register of Indian Medical Science*.

The funds of the Hospital have been enriched by the donation of 500 Rupees, from a benevolent person, who had offered that sum as a prize "to any public institution, which should first bring a human being into "the world without the pains of maternity either by the inhalation of "ether, or by the use of mesmerism."

Professor Jackson was the medium through which this gift was conveyed to me, but was not at liberty to name the generous bestower.

D. STEWART, M. D.,
Professor of Midwifery.

(True Copy,)
FRED. J. MOUAT, M. D.,
Secretary.

There are some interesting postscripts to the discovery of chloroform. Chloroform as a chemical was not Simpson's discovery. It was discovered in 1831, its chemical structure identified in 1835 and its anaesthetic properties were described by Marie Jean Flourens, the French physiologist before Simpson. Flourens was the first to discover that the semi-circular canals in the vestibular system in the human ear are responsible for balance. The chemical was introduced to Simpson by a Scottish physician turned chemist David Waldie. He devised a way of purifying chloroform from its impurities. He was never recognised by the medical profession and left England out of disappointment and frustration. Where did he go? He arrived in Calcutta and worked as a chemist for Malcolm and Company and then founded his own company Cossipore Chemical Works. This survives to this day as Waldies who specialises in manufacturing lead oxide. He died in Calcutta and was buried in Howrah and continued to supply chloroform to CMC till his retirement.

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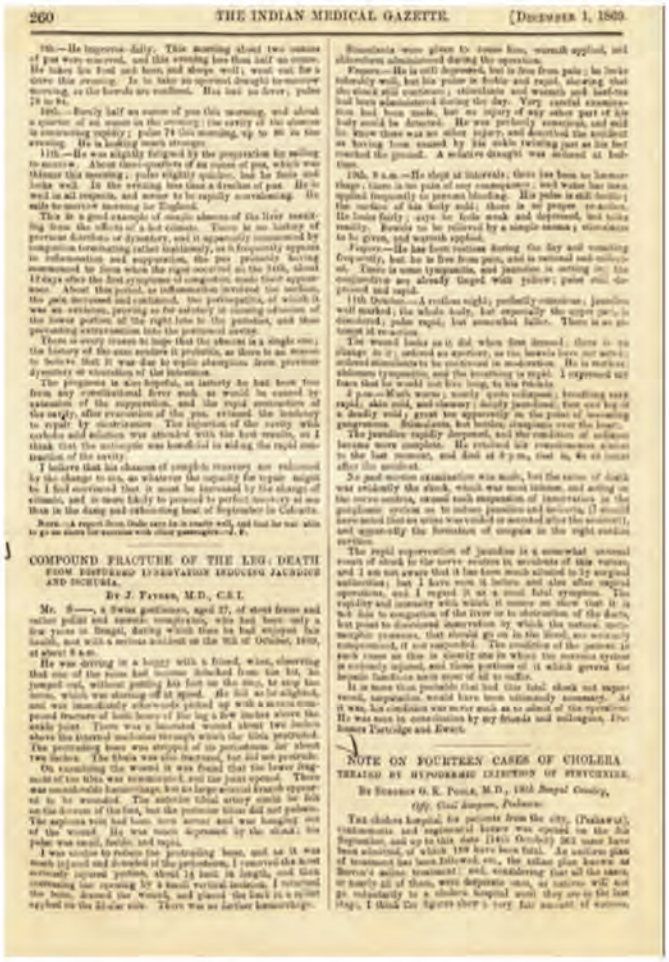
Sir Joseph Fayrer, the physician in residence during the Sepoy Mutiny in Lucknow was the professor director of Surgery in CMC. He debrided and excised pieces of bone from both tibiae in a Swiss gentleman in 1869 with bilateral compound lower leg fractures with chloroform. 24 hours later, the patient expired due to rapid jaundice, hepatic encephalopathy and kidney failure, all features of chloroform toxicity. This could well be the first report of delayed chloroform poisoning (Indian Medical Gazette 1869 – Figure 4).

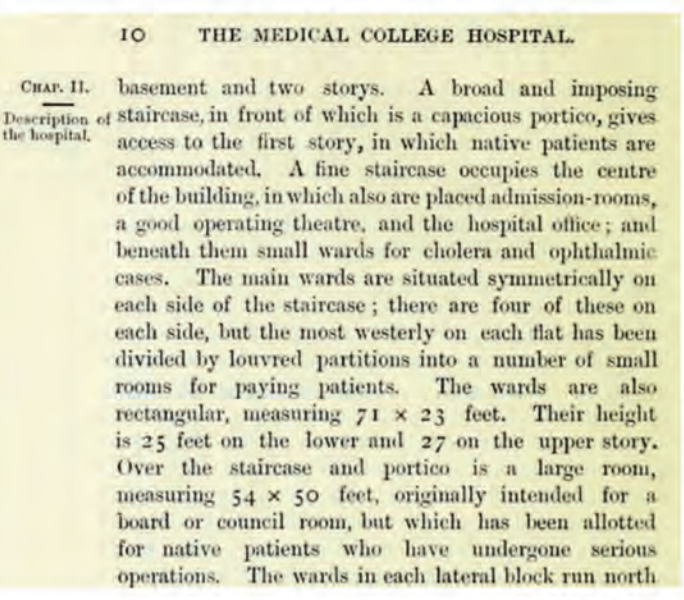
Dr Alexander Crombie of Indian Medical Services and Professor of Materia Medica in CMC had been successfully using morphine for pain relief in a variety of medical conditions. A milestone was created when Professor G D McReddie used a tracheal catheter for the administration of chloroform to remove an osteosarcoma of the jaw in 1880 in CMC with morphine as a premedication administered by Professor Crombie (Indian Medical Gazette 1888). This is the first documented case of endotracheal insufflation anaesthesia and anaesthesia premedication in the world. Reports of two cases appeared in the Indian Medical Gazette in 1881 by Sir Kenneth McLeod, Professor and Head of the Department of Surgery in CMC (Figure 5).



260 THE INDIAN MEDICAL GAZETTE. [DECEMBER 1, 1869.

COMPOUND FRACTURE OF THE LEG: DEATH FROM DIFFUSED INFLAMMATION RESULTING JAUNDICE AND ICHURIA.

By J. FAYRER, M.D., C.S.I.



10 THE MEDICAL COLLEGE HOSPITAL.

CHAP. II. Description of the hospital.

basement and two storys. A broad and imposing staircase, in front of which is a capacious portico, gives access to the first story, in which native patients are accommodated. A fine staircase occupies the centre of the building, in which also are placed admission-rooms, a good operating theatre, and the hospital office; and beneath them small wards for cholera and ophthalmic cases. The main wards are situated symmetrically on each side of the staircase; there are four of these on each side, but the most westerly on each flat has been divided by louvred partitions into a number of small rooms for paying patients. The wards are also rectangular, measuring 71 × 23 feet. Their height is 25 feet on the lower and 27 on the upper story. Over the staircase and portico is a large room, measuring 54 × 50 feet, originally intended for a board or council room, but which has been allotted for native patients who have undergone serious operations. The wards in each lateral block run north

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Sir Kenneth Mcleod introduced Listerism or sanitation methods in CMC, especially in surgical theatres and dramatically controlled infection-induced mortality after surgery. He described the operation theatre that was housed in our MCH building graphically in his seminal textbook, Operative Surgery in the Calcutta Medical College Hospital, published in 1885 (Figure 6).

7. *Osteo cystoma of lower jaw.*—(*a*) Hindu female, æt. 25 Tumour of right side of lower jaw, of two years' duration; jaw divided at symphysis and below coronoid process; mucous membrane stitched with catgut and edges of skin wound brought together by iron wire and horsehair stitches. Drained by caoutchouc tube. Wound healed by first intention; very slight constitutional disturbance. Left hospital 20 days after operation.

(*b*) Hindu male, æt 32. Tumour of two years' duration; as large as a fœtal head; situated on left side. Jaw removed from symphysis to coronoid process; mucous membrane stitched with catgut; drainage tube introduced. Healed partly by first intention; wound inflamed and diffuse cellulitis occurred in its neighbourhood. Patient became insane and remained so for about a week. Left hospital in good health, mental and bodily, in 42 days with the wound

Simultaneously with actual surgery, CMC felt the need to include anaesthesia as a part of the training curriculum for medical students from as early as 1906. Students were required to attend at least 10 operations under anaesthesia. It is to be noted that Great Britain started a programme in anaesthesia for trainees in 1918 and the USA in the 1940s.

Finally, the first Boyle's apparatus was installed in India in CMC in 1935 at a cost of Rs 645 and the first oxygen plant was established in the same year. The first indigenous Boyle's apparatus was manufactured by the IOC in 1950 and the first nitrous oxide plant in 1962, both in Calcutta.

Conclusions

CMC was quick to pick up the latest state-of-the-art cutting-edge medical scientific discoveries immediately after these discoveries, was prolific in publishing results of practical applications and continuously strove to innovate and discover newer techniques. The work in CMC paved the way for other medical facilities all over the Indian subcontinent especially Hyderabad and Bombay to pick up the reins and continue the good work.

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Abstract

Artificial Intelligence (AI) has been utilised in many settings, including in the film industry where it is already changing several aspects of how storylines are conceived (1). Similarly, medical advancements are now seeing a major shift in how AI might influence patient treatments, sometimes controversially so. We explore the transformative role of AI in the field of medicine, highlighting its potential to improve diagnostic accuracy, treatment efficacy, and patient outcomes. We highlight various applications of AI in medical imaging, diagnosis, drug discovery, personalised medicine, decision support systems, prevention, and patient engagement. Furthermore, we discuss the ethical and legal considerations and challenges associated with AI integration in healthcare. Drawing on relevant research and case studies, this paper provides insights into the future implications of AI in medicine.

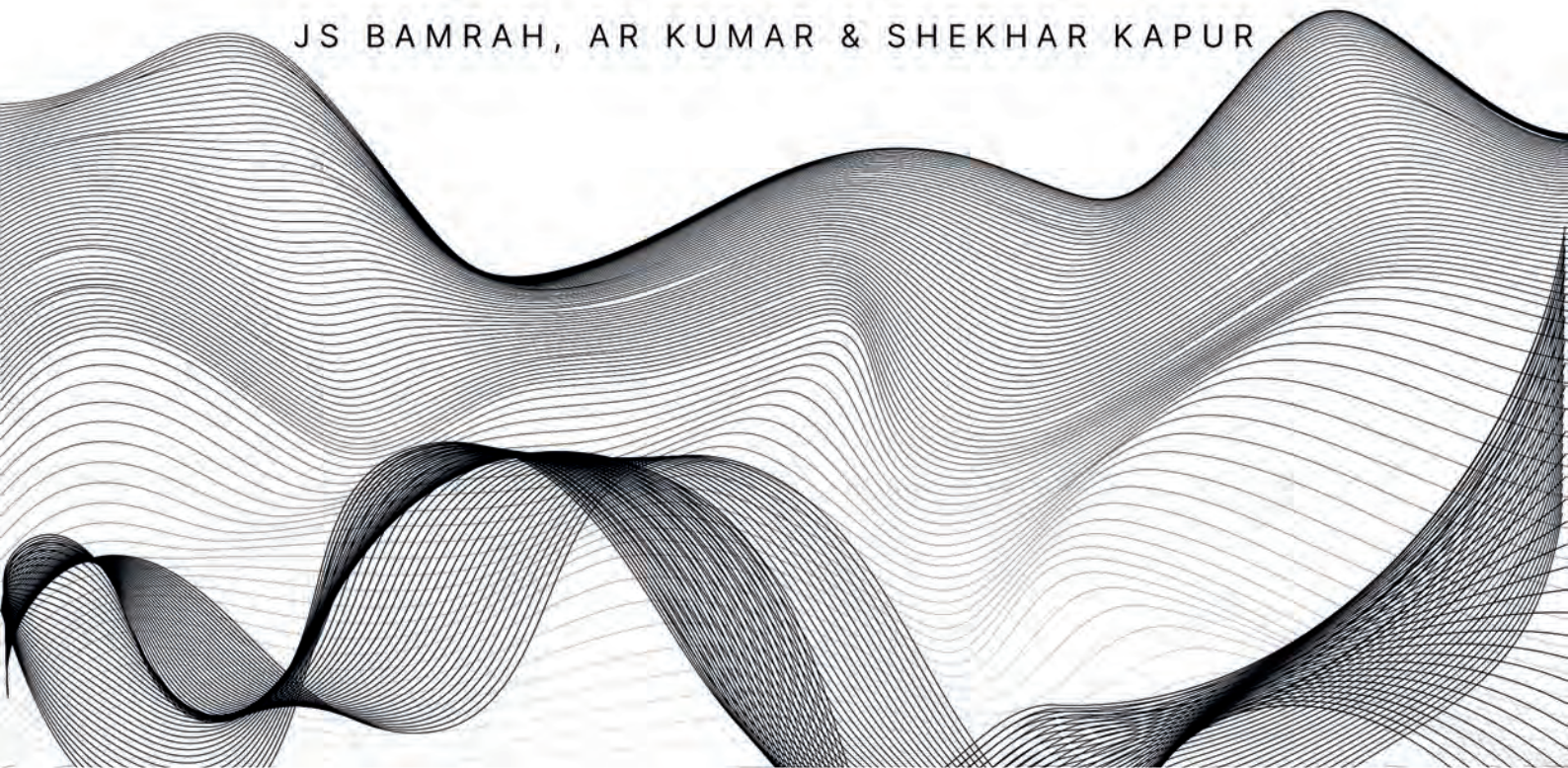
Keywords -artificial intelligence, healthcare,

Introduction

The notion that machines can be developed that will simulate human intelligence has been around for decades, certainly from the 1950's. The field of artificial intelligence research was named and founded as an academic speciality in 1956. The whole concept that had been discussed by the academics was around creating an artificial brain. However, until recently, other than in fictional books and films, the incapability of technology thwarted any attempts to make this a reality. In the 1990s, with the advent of machine learning, a mode that focuses on creating algorithms that can learn from data, the reality of Artificial Intelligence (AI) began to grow green shoots. This shift brought about a new wave of advancements in areas such as speech recognition, computer vision, and natural language processing. Machine learning techniques, such as neural networks (2), became increasingly popular and proved to be powerful tools, providing intricate solutions to complex problems.

ARTIFICIAL INTELLIGECE IN MEDICINE FRIEND OR FOE?

JS BAMRAH, AR KUMAR & SHEKHAR KAPUR



The 21st century saw tremendous progress in AI, fuelled by the availability of vast amounts of data, powerful computers, and advancements in hardware. Breakthroughs in deep learning, a subcategory of machine learning, unlocked new capabilities in image and speech recognition, machine translation, and autonomous vehicles. Many industries were much speedier in adopting AI than medicine, where the risk to patients and much tighter governance and regulatory constraints delayed start-ups. However, AI is now emerging as a powerful tool in various domains, and one of its most promising applications is likely to be in the field of medicine (3, 4). With the ability to analyse huge amounts of data and make an informed analysis for potential decisions, AI has the potential to revolutionise the way medical professionals diagnose, treat, and manage diseases (5, 6).

However, although the integration of AI in medicine holds immense promise for revolutionising healthcare practices, there is potential for it to cause harm too. An example would be an unscrupulous geneticist fundamentally altering the DNA structure of a new-born embryo for aesthetic or gender selection reasons. This brief article aims to provide an overview of the use of AI in medicine, highlighting its benefits, challenges (7), and prospects. We provide an overview of AI and its potential applications in medicine, emphasising its ability to process large volumes of data swiftly and uncover patterns that humans might otherwise miss, with the substantial benefit of combining human and artificial intelligence to resolve medical conundrums which so far have baffled and frustrated many doctors (9). We touch on ethical and legal considerations, without which there would be no safeguards from potential abuse of AI.

Applications of AI in Medicine

Medical Imaging: AI's ability to analyse medical images, such as X-rays, CT scans, and MRIs, has demonstrated significant potential for accurate diagnosis and early disease detection. This subsection discusses the advancements in computer-aided diagnosis, image interpretation, and radiology assistance systems.

One of the areas in which AI has showcased tremendous potential is medical imaging. Radiologists often face challenges in interpreting complex scans, such as X-rays, CT scans, and MRIs. AI algorithms can analyse these images and assist radiologists in the accurate diagnosis and identification of diseases. For instance, deep learning algorithms have shown great promise in detecting early-stage cancers and other abnormalities with high accuracy rates. Such advancements can enhance early detection rates, leading to better patient outcomes.

AI-Assisted Diagnosis and Treatment: AI provides invaluable assistance to healthcare professionals in diagnosing and treating diseases. Machine learning algorithms can analyse patient data, including medical records, genetic profiles, and symptoms, to assist in accurate diagnosis and personalised treatment plans. Moreover, AI can predict drug responses as well as reduce the need for trial and error in treatment selection.

Drug Discovery: AI-driven algorithms and machine learning techniques have expedited the drug discovery process. AI might prove pivotal in identifying novel drug targets, predicting drug efficacy, accelerating virtual screening processes, and optimising drug formulation.

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Personalised Medicine: AI can help personalise treatments by leveraging patient data, genomics, and medical records. AI gives us the prospect of predicting treatment responses, designing patient-specific treatment plans, and identifying potential adverse reactions to medication.

Decision Support Systems: AI-based decision support systems provide healthcare professionals with valuable insights for clinical decision-making. The use of AI in predicting disease progression, recommending optimal treatment pathways, and minimising medical errors gives us a better scope for safe practice. AI-powered virtual health assistants can provide real-time health monitoring and guidance, improving access to care, especially in remote areas. This has already been key and offers significant and exciting potential for the recent developments around "virtual wards" or "virtual hospitals" with AI monitoring of key parameters whilst the patient is at home.

AI for Healthcare Operations: AI is also transforming healthcare operations by improving resource allocation, streamlining workflows, and optimising patient schedules. AI-enabled systems can automate administrative tasks, freeing up healthcare providers' time to focus on patient care. Intelligent algorithms can also predict patient admission rates, optimise patient flow, and predict equipment failure, leading to more efficient healthcare delivery.

AI-enabled Predictive Analytics and Prevention: Effective AI that accesses large public and population health-derived data can forecast disease outbreaks and resource needs, helping healthcare systems prepare for emergencies.

AI can fundamentally alter our approach to prevention and give us more accurate data to elicit predictions about disease, based on epidemiological evidence, and historical patterns, thus ultimately helping us in better ways of preventing disease, including future epidemics and pandemics. AI can make correlations across all the different bodily systems enabling specialists to look beyond their own specialism and understand better what and how their treatment might impact other parts of the body. The complexities of environment, lifestyles and illness might be interpreted in different ways, helped by factoring in traditional methods of treatment, aided where applicable, by evidence-based alternative therapies.

AI-enabled Patient Engagement: AI-driven apps and wearable devices can utilise large cohorts of data and effective algorithms that would provide 24/7 consistent advice on their individualised health needs and thereby also encourage individuals to take proactive steps in managing their health daily.

Ethical Considerations in AI Integration

The field of AI in medicine presents several ethical challenges that need to be addressed (8), such as:
Data privacy and security: Healthcare data can often be fragmented, unstructured, and of varying quality. Integrating data from diverse sources while ensuring accuracy and privacy is a major challenge. AI systems predicate on accessing large and sensitive datasets. This poses a risk to the privacy and security of patient information being breached by unscrupulous users or hackers. Protecting personal health data from unauthorised access or use is crucial to maintaining trust and preventing potential harm.

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Algorithmic bias and equity: AI systems are trained on large datasets that may unintentionally reflect biases present in the data. If these biases are not addressed, they can contribute to and perpetuate inequalities and inequities in healthcare outcomes. It is important to promote fairness and ensure that AI systems do not perpetuate existing biases based on race, gender, or other demographics.

Elucidation, communication, and transparency: Many AI models in medicine, such as deep learning algorithms, can be highly complex and difficult to explain. If patients or healthcare professionals cannot understand how and why specific decisions are being made by AI systems, it can lead to mistrust and hinder acceptance. Ensuring transparency and the ability to elucidate AI algorithms and communicate in a language that the patient can understand is crucial for building trust and accountability. To achieve this, rigorous testing and validation are necessary to ensure AI algorithms are safe, effective, and reliable in real-world clinical settings. It's only after such robust clinical validation will healthcare providers and frontline clinicians feel comfortable about integrating AI processes into their Electronic Health Records, existing workflows and decision mailing processes for their patients.

Accountability and liability: Determining responsibility and accountability when an AI system makes an incorrect or harmful decision can be challenging. There is a need to establish clear guidelines and regulations to assign liability in such cases and ensure that healthcare providers retain ultimate responsibility for patient care.

Human-AI collaboration: AI systems should be developed to support healthcare professionals rather than replace them. Striking the right balance between the roles of human professionals and AI tools is crucial to ensure both accuracy and ethical decision-making.

Legal intricacies and complexities of AI

Similarly, AI in medicine faces several legal challenges as it continues to advance in healthcare, principally:

Data privacy and security: AI systems in healthcare require access to large amounts of sensitive patient data. Ensuring compliance with data protection and privacy regulations, such as the General Data Protection Regulation (GDPR) and Data Protection Act (2018), is crucial. AI algorithms must be designed to protect patient privacy and secure data from unauthorised access or breaches.

Accountability and liability: Determining liability for errors or harm caused by AI systems can be complex. If an AI algorithm makes a diagnosis or treatment recommendation that leads to a negative outcome, who is responsible? Legal frameworks need to be developed to distribute accountability among technology developers, healthcare professionals, and regulatory bodies.

Regulatory oversight: AI systems used in medicine must meet regulatory standards for safety, efficacy, and quality. However, the rapid pace of AI development often exceeds the ability of regulators to keep up. Striking a balance between providing timely access to innovative AI technologies while ensuring patient safety remains a challenge. Indeed, such is the specialist nature of AI that traditional regulatory bodies such as the General Medical Council will be out of their depths and therefore there would be a strong case for a separate authority that would deal with AI matters.

Bias and fairness: AI algorithms are trained on large datasets, which may contain implicit biases. If these biases are not addressed, they may perpetuate or even amplify existing health disparities. Efforts are needed to enhance transparency in AI algorithms, detect and mitigate bias, and ensure fairness in healthcare decision-making.

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Intellectual property and patent issues: AI algorithms and innovations in medicine may raise questions regarding intellectual property rights. Determining patentability and ownership of AI-generated inventions in healthcare can be legally complex and may require adaptations in existing patent laws.

Challenges and Future Implications

The deployment of AI in medicine faces several challenges. Possible limitations of AI include interpretability, algorithm robustness, and the potential for job displacement. Traditional medicine has relied on striking a rapport with patients, modifying doctor-patient interactions according to patients' responses and the doctor's emotional intelligence in ensuring there is appropriate empathy, compassion as well and humour where necessary, all of which are more difficult for AI to overcome, if we are to solely heavily on algorithms and robots to deliver care and treatment. However, there are the potential benefits of AI integration, in terms of improved patient outcomes, reduced healthcare costs, and the role of AI in addressing global health challenges.

Addressing ethical and legal challenges requires collaboration between policymakers, healthcare professionals and providers, technology developers, regulators, legal experts, and society as a whole. Striking the right balance between innovation and the protection of patient rights will be crucial for the responsible and ethical deployment of AI in medicine. By navigating these ethical considerations, we can develop AI solutions that enhance healthcare while upholding patient privacy, fairness, and trust.

However, the current legal and regulatory frameworks surrounding AI in medicine are simply inadequate and are likely to be even more knotty than the disputes caused by doctors who take to social media to promulgate their opinions. As ever, advancements in medicine will outstrip the pace of these considerations but now that the genie is out of the bottle, no amount of effort can, and should, put it back.

Conclusion

AI has been around for more than half a century, previously as an imaginary and fictional entity that appeared in novels and films, but it is now a reality in medicine. There are, nevertheless, challenges to the role of AI in medicine, particularly when it is inculcated into everyday practice with the potential application of AI in every assessment and treatment pathway for patients. There are likely to be key ethical and legal issues surrounding the integration of AI into healthcare. As AI continues to evolve, its impact on medical practices is expected to transform the healthcare landscape, optimising patient care and outcomes if we get it right, but there is potential for harm through misuse or unvalidated use.

Nonetheless, AI in medicine holds great promise for improving healthcare outcomes and transforming the way medicine is practised (10). AI-powered tools can assist medical professionals in early and accurate diagnosis and personalised treatment plans for each patient, optimising healthcare systems and operations on a macro scale, and on a global scale to prevent or restrict harms caused by global diseases. Surmounting and pre-empting these challenges will ensure that we advance research and development, revolutionise healthcare, and make the NHS more efficient, cost-effective, and patient-centred.

Disclosure:

This article was partly generated through an AI search engine.

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Lancaster Cricket Ground

BAPIO NW

bapioac23

Inequalities: Policies, Solutions & Implementation

6-8 Oct'23

NHS Inequalities: Policies, Solutions & Implementation

6 OCT 23 FRIDAY

Welcome - M Coumarassamy — **09:30**

Keynote: D Burton **-** Listening & Learning — **09:35**

SESSION ONE: **EMPOWERING FOR EQUITY**

CHAIRS: M Pallam & S Colfar — **09:45**

- Achieving equity in NW: progress in the last 3 years" - J Hanson
- "Leadership and talent development – N Saini
- "Enhancing equity through fair regulation"– C Dzikiti
- "Inequity in international nursing workforce"– S Shobrany

REFRESHMENT BREAK

SESSION TWO: BRIDGING THE GAP — **10:45**

CHAIRS: A Thomas & M Coumarassamy

- "Harnessing the strengths of international workforce"– O Soriano — **11:00**
- "Challenges and opportunities in social care"– S Tuckwood
- "Actions in Nursing WRES: Progress so far"– J Jean-Jacques
- "Empowering nurses to deliver quality care"– J Ntalumbwa

SESSION THREE: WORKFORCE TRAINING & EDUCATION

CHAIRS: A Shah & D Maheswari

- "The global workforce crisis: who's ahead of the game?" - G Byrne
- G Menon — **12:00**
- P Singhal
- Panel - M Srivastav, S Babu, S Sharma, R Ramkisson

LUNCH

SESSION FOUR: Women's "Unfinished business: Gender Equality"

CHAIRS: P Kumar & S Arya

- "Women in the NHS" -J Srinivas — **13:00**
- "PPP Period Products Pilot" - P Patel & D Devlia
- "Making waves. Sexism in Medical school" - V Omar & G Nair — **14:00**

Guest Lecture - "People, process, culture, tools and tech" — **14:45**

B Bridgewater, CEO, Health Innovation Manchester.

CHAIRS: G Byrne & S Sharma

BREAK — **15:00**

NHS Inequalities: Policies, Solutions & Implementation

6 OCT 23 FRIDAY-II

SESSION FIVE: NHS DIGITAL SESSION **15:15**

CHAIRS: A Khandelwal & T P Kaur

- "Digitise, Connect and Transform"- AR Kumar
- Panel: M O'Keefe, G Thomas

SESSION SIX: Artificial Intelligence Workshop **16:00**

CHAIRS: S Daga & C George

- "Understanding basics of AI" – A Chakravorty
- "Designing, training and testing AI in healthcare" – S Daga
- "Using OpenAI tools" – A Nafees
- Panel: P Coates, S Sridevi

CLOSING REMARKS - S Shah & A Thomas **17:00**

7 OCT 23 SATURDAY

BAPIO Health & Well-being Forum - Members' Suite* **08:00**

Storytelling - L Wijedoru (pre-booked)

WELCOME: JS Bamrah **09:00**

LIGHTING THE LAMP: R Mehta, S Mathew, G Menon, CR Selvasekar

GUEST OF HONOUR: Andy Burnham, Mayor of Greater Manchester

KEYNOTE: A Esmail - "Eradicating discrimination in the NHS Workforce" **09:45**

CHAIRS: R Mehta & U Gordon

Panel: N Thakker, V Sharma, A Sinha

PLENARY SESSION ONE: Social determinants of health **10:15**

CHAIRS: Mala Rao & S Chakravorty

- "Racial disparities in health outcomes – London roadmap" - K Fenton
- Panel: S Karunanithi, H Naqvi, Z Aslanpour

KEYNOTE: "The NHS Long Term Workforce Plan" - N Evans **10:45**

CHAIRS: G Menon & CR Selvasekar

Panel: N Khwaja, M Thakur, M Coumarassamy, S Karuthedath

NHS Inequalities: Policies, Solutions & Implementation

7 OCT 23 SATURDAY-II

PLENARY SESSION THREE: BTA "Delivering NHS workforce" **11:30**

CHAIRS: R Mitchell & S Shah

- "Importance of a skilled workforce" - P Singhal
- Panel: N Evans, P Carver, G Menon

PLENARY SESSION FOUR: General Medical Council **12:15**

CHAIRS: J Dacre & I Singh

- "Making medical regulation equitable" S Gallagher
- Panel: H Shahid, A Khan

BAPIO Health and Wellbeing Forum **12:45**

- Can NHS promote health and wellbeing? S Hosdurga & S Kumar

LUNCH & POSTER VIEWING **13:00**

PARALLEL SESSION - Research & Innovation Competition **14:00**

CHAIRS: I Chakravorty & R Ramkisson

Oral Presentations

Lightning Poster Presentations

(JUDGES - P Kumar, J Dacre, A Elder, R Thakar & TA Chakravorty)

BAPIO GP Forum **14:00**

CHAIRS: K Sidhu & S Chakravorty

- "Challenges and solutions to the general practice crisis" -C Nagpaul
- "Survive to thrive" – T Ulam
- "Safe and sustainable general practice" – K Kasaraneni
- Panel: S Kinra & M Hussain

TOPICAL SESSION: **14:45**

"Long Covid – what do we know, and what can we do about it?"

CHAIRS: B Kane & S Gupta

Panel: A Prasad, M Vadhva, A Khan

BREAK **15:15**

NHS Inequalities: Policies, Solutions & Implementation

7 OCT 23 SATURDAY-III

GUEST LECTURE: "What's a doctor worth to the NHS?" –P Banfield **15:30**

CHAIRS: K Singhal & TA Chakravorty

PLENARY SESSION FOUR: MDS SESSION- Case Studies **15:45**

CHAIRS: S Mathew & N Sadasivam

- J Grover
- S Dodds

BAPIO DEBATE **16:30**

"This house believes that the ACCIA awards should be scrapped"

CHAIRS: M Rao & JS Dua

Speakers: N Shrotri (For) v S Daga (Against)

Panel: S Singh, N Kumar, H Shah, R Jainer

Conference Dinner and Awards Ceremony-Reception Drinks **18:30**

8 OCT 23 SUNDAY

BAPIO Health Walk (weather permitting) **08:00**

BAPIO Meditation Session

Welcome - CR Selvasekar

KEYNOTE– "The changing nature of medicine"-J Dacre **10:00**

CHAIRS: G Menon, L Patel

Panel: A Sultan, N Varapande, A Jagannathan

PLENARY SESSION 1: YDF Challenges facing doctors in training **10:30**

CHAIRS: M Daruwalla & N Natarajan

- Impact of Covid on surgical training – I Maitra
- Junior doctors and Industrial Action - A Banerjee
- Panel: L Patel, T Chakravorty-Gannon, AS Oberoi

BREAK **11:00**

NHS Inequalities: Policies, Solutions & Implementation

8 OCT 23 SUNDAY-II

BAPIO Paediatric Forum **11:15**

CHAIRS: R Jainer & R Gupta

- "Hearing loss & balance in children"- S Dasgupta
- "RCPCH ambassadorial role – U Das
- "Paeds Forum Update" - R Jainer

PLENARY SESSION 2: SAS Recognition and Industrial Action **11:45**

CHAIRS: K Gajanan & B D'Souza

- "Industrial action and challenges ahead for 2024" – U Mohite
- "Advocate role and its value" – G Shanke
- Panel: A Kochhar, S Madhapura

GUEST LECTURE -"RHO's plans for making the NHS a better place" - H Naqvi **12:15**

CHAIRS: R Thakar & J Singh

Panel: B Chawda, M Patel, C Marimouttou

LUNCH **12:45**

PLENARY SESSION 3:Integrated Care Systems – what does the future hold? **13:30**

CHAIRS: R Jain & V Mehra

- Primary care perspective – M Thakur
- Secondary care perspective – A Dave
- Panel: S Bailey, A El Kholy, K Tumurugoti

BAPIO DEBATE: "This house believes that Physician Associates are an asset" **14:30**

CHAIRS: CR Selvasekar

V Zamvar (FOR), V M Hemadri (AGAINST)

Panel: Z Ahmed, B Simon, L Godwin, TP Kaur

Symposium: "Diversity in Dementia Care" **15:30**

In collaboration with the Universities of Bradford, Northampton and Hertfordshire followed by the launch of the project "Improving the Lives of South Asian Families experiencing dementia (ILSAF)"

Leads: R Mehta & J Oyebode

CHAIRS: JS Bamrah

16:30

Vote of Thanks - JS Dua

BTA

BAPIO TRAINING ACADEMY

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Welcome to BAPIO Training Academy (BTA)

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