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working from home and
getting into Med Sc

SUSHRUTA

A JOURNAL OF HEALTHCARE POLICY & OPINIONS SINCE 2007



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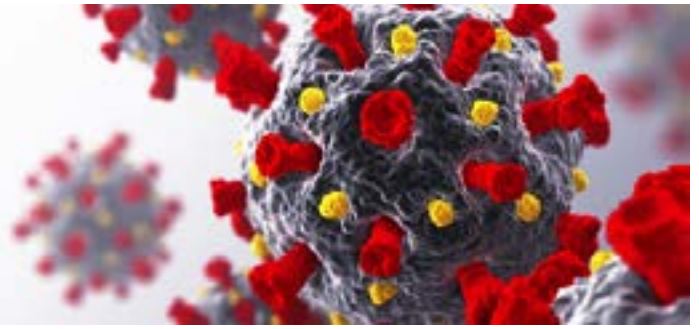
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COVID-19

AN UPDATE ON THE
NOVEL CORONAVIRUS
SARS-COV-2 *PANDEMIC***Subarna Chakravorty PhD FRCPATH MRCPCH**

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In an unprecedented show of scientific solidarity and collaboration across the globe, research on the novel SARS-CoV-2 (COVID-19) virus has progressed at a pace that could almost match the virus's relentless movement through communities. This has been a pandemic like no other. Whilst it is hard to speculate how the world will emerge at the end of this, there is little doubt that scientists are trying to rise up to its challenge in a way that has never been seen before. As of the 21st of March 2020, the National Library of Medicine research repository has a collection of nearly 1000 articles on Covid-19, a novel virus whose genome was sequenced less than 12 weeks ago.^{1,2} Almost all these articles were published in February and March 2020, reflecting the explosion of global research activity on this virus.

Scientists, physicians, epidemiologists and countless other professional groups are currently engaged in active Covid-19 research. Output of such research is being editorially fast-tracked to ensure maximum dissemination and impact.³ At the time of this article going to press, the clinicaltrials.gov website has 125 registered clinical trials on COVID-19 treatment, on human subjects, of which 57 trials are currently recruiting.⁴

The internet and social media have facilitated real-time updates on the identification, treatment and outcome of infection in countries all over the world. Political leaders and policy makers are relying on such information to influence human behaviour and contain the infection within populations. In the midst of all this, there is an equally robust and potentially highly dangerous epidemic of high-profile misinformation, outright lies, speculation, conspiracy theories and pseudo-science attempting to derail important scientific advances for political or financial gain.

It is not surprising that the average reader of medical literature might find it confusing and overwhelming to keep

track of credible Covid-19 research. Many science writers and science publishing houses have identified this gap and are attempting to keep the public informed of research from established research groups. This article attempts to give the reader an overview of Covid-19 research and signpost them to credible repositories of rigorously curated information of this pandemic.

Epidemiology:

Daily updates on new cases and deaths are available from the websites of the Centers for Disease Control and Prevention, (<https://www.cdc.gov/>), the European Centre for Disease Prevention and Control (<https://www.ecdc.europa.eu/en>) and the World Health Organisation (WHO) (<https://www.who.int/>). A carefully curated repository of data derived from the European CDC and other resources are available at <https://ourworldindata.org/>. The National Health Service in the UK have several useful and well researched information sources. A dashboard of daily cases in the⁴ UK nations, including the number of patients who are recovered, is updated by Public Health England (PHE) and can be accessed here. PHE is also providing guidance to the public on self-isolation, information for businesses, employment and financial support, and information public goods and services (<https://www.gov.uk/coronavirus>).

Pandemic modelling and social policy:

This has been a controversial issue where scientific evidence and political interest comes into conflict. On the 30th of January 2020, the Governor General of the WHO, Dr Tedros Ghebreyesus declared the Covid-19 disease outbreak a 'public health emergency of international concern' and implored all nation states to consolidate crisis management teams and cooperate with the United Nations' international systems-wide management programme to prepare and respond to the pandemic⁵. Subsequently, the UK has been criticised for its public

policy to manage the pandemic by emphasising on contact tracing and containment, defying WHO guidance by delaying social distancing measures and limiting the availability of testing. The UK government has claimed that its social policy is informed by pandemic modelling by a group of experts from Imperial College London. The Imperial paper can be found here- it predicts social isolation models and virus spread trajectories based on the group's previous experience in epidemic modelling and data from the Wuhan Province in China and North Italy. Unfortunately, the social isolation policy stated in the paper was not implemented for at least 2 crucial weeks in March 2020, which would certainly have contributed to the rising case numbers ⁶. Countries of interest to the reader might include China⁷, South Korea ⁸, USA (cdc.gov) and India (<https://www.mohfw.gov.in/>) and the latest WHO reports (23/3/20) indicates that the virus has now spread to 185 countries, with Southern Europe being its current epicentre.

Despite WHO guidance, public policy appears to vary widely between countries, for example South Korea has invested in widespread population screening and case isolation, and this has paid dividends in curbing the rate at which new cases were being reported earlier in the month. The policy of 'find, isolate, test, treat' proposed by Dr Thedros Ghebreyesus is being adapted by countries in varying degrees of rigour. Initial data appears to support that all four measures are needed for curbing the exponential rise in cases, as demonstrated by the South Korean programme of Covid-19 control ⁹. The importance

of social distancing is further supported by modelling that has demonstrated that prior to the lockdown imposed in Wuhan Province on 23/1/20, 55% of people who were being infected by each person remained undetected, and due to their greater numbers and widespread mobility, undocumented/ undetected infections were the infection source for nearly 80% of infected cases ¹⁰. Thus, the policy of only testing people with history of travel to Europe or China, or those with symptoms only may not be sufficient in halting its spread. Social distancing and widespread testing are crucial steps in limiting its exponential spread.

Clinical data:

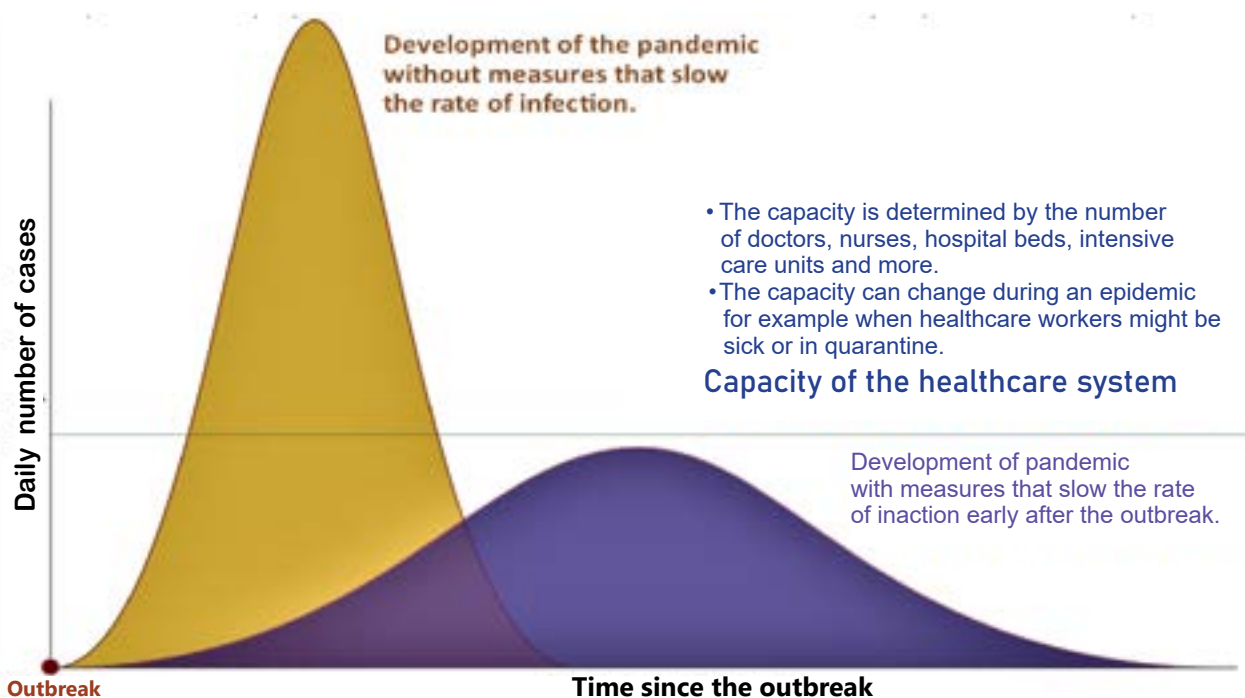
Initial case reports from China and subsequently from Italy has informed the rest of the world on how to prepare for the pandemic. Data indicate that human to human transmission ¹¹ occur via aerosol and fomites ¹² and that age (median age 45-60 years), gender (male > female) and pre-existing conditions (hypertension and diabetes) were important risk factors ¹³. Cough and fever were common symptoms, computerised tomograph of chest showed typical pneumonic features, and lymphopaenia was near universal.

Mortality estimates vary from 1.5 to 3.6% when based on the number of deaths relative to the number of confirmed cases of infection ¹³. However, some experts have argued that this figure is based on the number of deaths relative to the number of confirmed cases of infection on the day of the person's death. They have argued that this was

In the outbreak of an epidemic early counter measures are important



Their intention is to 'flatten the curve': to lower the rate of infection to spread out the epidemic. This way the number of people who are sick at the same time does not exceed the capacity of the healthcare system.



Based on the Centres for Disease Control and Prevention
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not representative of the actual death rate, as many more people are likely to have been infected at the time a person dies of Covid-19 compared to the day when the person was infected. Epidemiological data suggest that the maximum incubation period is 14 days, hence the denominator to calculate death rates should be the number of infected individuals 14 days prior to the day of death. As of 1/3/2020, recalculating death rates using this method resulted in significantly higher values 5.6% (95% confidence interval 5.4–5.8) for China and 15.2% (12.5–17.9) outside of China 14. Additionally, mortality was very high among the minority of patients who had severe disease, and early reports from China indicate 62% critically ill patients and 82% needing mechanical ventilation died¹⁵. In contrast, the disease course in children was significantly mild, and in one case series from Wuhan, only those with underlying conditions (3 out of 172, 1.8%) needed mechanical ventilation, one of whom died. Importantly, majority of children (approximately 60%) had no fever at presentation, and 15% of those who tested positive were asymptomatic¹⁶.

Treatment:

A huge amount of data has been systematically collected and shared by Chinese clinicians to allow planning of effective interventions. Information on human to human transmission, high rates of intra-familial spread, evidence of faecal oral transmission, relatively mild clinical course in children, have all arisen from painstakingly collected clinical data 11 amidst huge operational challenges of managing an epidemic. These have informed policy making internationally. Additionally, host susceptibility data have allowed better resource planning in epidemic preparedness 17. In order to provide targeted treatment to the most at risk of developing severe disease, critical care clinicians have developed clinical risk scoring based on several parameters including age, attendant co-morbidities, lymphocyte count at presentation, respiratory rate among others. This has enabled early recognition and appropriate triage of patients toward continuous or intermittent monitoring, resulting in judicious use of resources and have resulted in improved outcome¹⁸.

A vast number of existing pharmaceutical products are being used and tested in Covid-19. A large number of antiviral agents including ribavirin, oseltamivir and others were empirically given to patients with pneumonia in most centres. A large, randomised controlled trial of the known HIV combination drug lopinavir/ritonavir in 199 hypoxic patients with laboratory- confirmed Covid-19 demonstrated no additional benefit compared to standard supportive care¹⁹. Remdesivir, broad -spectrum antiviral drug with efficacy against Ebola virus has also shown some promise²⁰ and is currently being trialed in human subjects 4. Chloroquine has gained widespread recognition as a potential therapeutic option. Due to its generic production status, low cost and oral availability, it is of significant interest among clinicians and the general public. Both remdesivir and chloroquine have demonstrated in vitro inhibition of SARS-CoV2²¹. An open label, non-random

clinical study using hydroxychloroquine and azithromycin has shown some feasibility of its use in Covid-19²², but well-designed randomised controlled trials are needed before drugs with substantial adverse effects are released for indiscriminate use²³.

Prevention:

A vaccine against the SARS-CoV2 virus is urgently needed to stop its spread in the community and a large number of laboratories around the globe are attempting to produce a vaccine which is both safe and efficacious and several human trials have already started. Whilst a vaccine development is likely to be the only way the epidemic will be finally controlled, it is important to ensure adequate safety checks are in place and sufficient pre-clinical animal testing is undertaken to carefully study host response and adverse effects of these vaccines²⁴.

Important research questions:

- Does the virus result in immune memory sufficient to provide long term protection from reinfection?
- How does virulence change following several passages of human to human transmission?
- How quickly can a reliable serological test be made available to study the true infection rates in affected communities?
- What drugs and vaccines will show promise?
- What new molecules can combat severe host immune response to Covid-19?
- Are there genetically determined modifiers of human susceptibility to virus, host response and response to therapy?
- What are the best strategies to protect healthcare workers caring for COVID-19 patients who have to undertake aerosol -generating procedures?

COVID-19 preparedness in the UK

The infection and death rate reports from Italy have served as a sombre reminder to doctors and policy makers in the UK of the seriousness of this pandemic and have helped in the preparedness of institutions, businesses and healthcare providers, occasionally in advance of government decrees 6. It is likely that the UK health system will be severely stretched with rising number of severely affected adults needing critical care. Severe scarcity of resources has forced Italian doctors to deploy rationing methods which may pose significant ethical challenges. It may be necessary to remove such difficult triage decisions away from treating physicians and into the hands to hospital managers with defined criteria for treatment escalation²⁵.

Who to follow on Social Media?

Misinformation and speculation is rife in the current pandemic. Important scientific and policy-related information can be found in social media, and Twitter is an invaluable source for information. The WHO (@WHO)

, CDC (@CDCgov), Public Health England (@PHE_UK) have twitter handles that are worth following for up to date information on policy and data. Several thought leaders have emerged in this pandemic who have worked tirelessly to debunk myths, misinformation and propaganda- follow people like @jpogue1, @devisridhar, @edyong209, @imartincorena, @richardhorton1, @maxcroser, @bhalomanush for insightful analyses.

Conclusion:

It is likely that the Covid-19 pandemic will change the world forever- in ways we work and support each other, the way nation states define its health policies, how NHS responds to the severe constraints in resources- the chinks in the NHS armour are already showing. However, even in these bleak dystopian days, we hear of stories of enormous courage and fortitude, stories which will inspire generations to come and help us rebuild our lives when all this blows over.

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Opinion

From The President's Desk

SUPPORTING OUR STAFF

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The COVID-19 pandemic has turned the normal life upside down. It has become a national crisis. During this extraordinary period of pandemic, our primary focus is the health and wellbeing of patients, members, our staff and loved ones.

We have written to the CMO to express our solidarity during this unprecedented crisis. We stand firmly with the government and support the measures being taken to contain the spread of the disease. Of course there are some worrying issues including provision of PPE and testing of the staff for Corona virus. We have taken up these issues with the authorities.

I am getting messages from our divisions in different parts of the UK that our members are working shoulder to shoulder with rest of the team. We are very proud of the dedication of the NHS staff.

We have raised the issue of health surcharge for overseas workers with the Prime Minister. It now amounts to £4800 per year for family of four. We believe that this surcharge is discriminatory and unfair, as the overseas workers are already paying their due share of National Insurance contributions, superannuation and income tax.

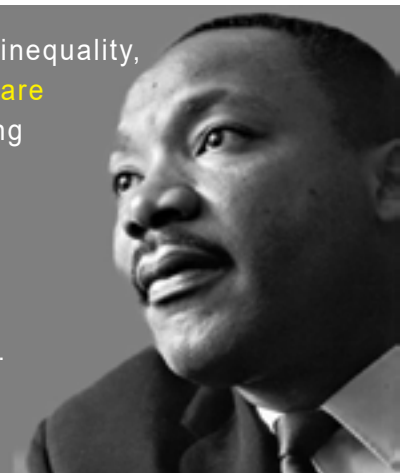
We are pleased with the success we had with GMC granting CCT to CESR-CP holders. Current GMC procedure for IMG trainees who enter postgraduate training programmes at ST3 or ST4 level is that, on completion of their training they are granted a CESR-CP certificate, as opposed to a CCT. In effect, This differential certification seems like second class certification.

Please look after yourselves and family and stay safe.



Of all the forms of inequality,
injustice in healthcare
is the most shocking
and inhumane.

Dr. Martin Luther King, Jr.
March 25, 1966



Editorial

THE GIFT OF LIFE

– SOCIAL AND CULTURAL PERSPECTIVES ON ORGAN DONATION

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Background

There are over 6000 patients waiting for a life-saving organ donation in the UK from figures published by the UK NHS Blood and Transplant Agency in April 2019. The top 4 organs required amongst these are kidney (>4k), liver (407), lungs (338) and heart (290). In the same year, around 4k organ transplants were carried out from 2.5k donors. The number of patients dying while waiting on the active transplant register were approximately 6% for kidneys and up to 22% waiting for heart and lungs. We as a society have a significant mismatch.

While around 31% of people on transplant waiting lists are from black, Asian and minority ethnic (BAME) backgrounds, amongst the 1,600 total deceased organ donors in the UK, only 7.5% were from BAME communities.^{ref} In addition there were 149 people from BAME communities who became living donors, donating a kidney or part of their liver. In the UK there is a high proportion of people from these ethnic backgrounds developing high blood pressure, diabetes and certain forms of hepatitis making them more likely to need a transplant at some point in their lives. Blood and tissue types need to be a match for the transplant to be a success and people from the same ethnic group are more likely to be that match.

Analysis of ethnicity data given when people register their decision to opt out suggests that those who make that choice, are much more likely to be from a BAME background (46% vs 77% choose to give consent).^{ref} The main reasons BAME families gave for declining consent/authorisation for organ donation was that they felt it was against their religious/cultural beliefs or they were unsure whether the patient would have agreed to donation. BAME families are less likely to discuss organ donation and are much more likely to decline to donate.

There are indications that many people are making their decisions based on misinformation, because they are worried about the donation process itself or don't think that their faith or beliefs will be respected. Not knowing what their relative wanted is one of the biggest reasons given by BAME families for saying no to donation when approached by specialist nurses.

With the law changing in England and Scotland in 2020, it is really important that people have the information they need to make the decision that's right for them and their family. This article will explore the religious, social and cultural factors that may be influencing decisions in participating in the 'gift of life' initiative.

Ethical, Religious, Social & Cultural Determinants

There is a global shortage of organs for transplantation but the story is very different between developed and developing countries (45-50 vs <10 per million population). Within developing countries the other major difference is the unusually low numbers of cadaveric vs live donations (>85%).⁽¹⁾ Although there are no overt objections to cadaveric transplants among the major religions of Asia, misperceptions and mistrust with the ethics of procurement and misuse, largely seem to limit consent for organ donation from potential donor families. From an ethical front, more than 80% respondents in a Chinese survey believed that organ transplantation extended life but were reluctant because (74%) believed that "donated organs have not been fairly and appropriately used; the wealthy and celebrities may be favoured"; and 61% agreed that "organ donation laws and regulations were not well developed, and result in unnecessary difficulties."⁽²⁾ Balwani et al in a survey in western India found that majority were (59%) aware of organ donation but believed there is a potential danger of donated organs being misused, abused or misappropriated. About 47%

of aware people said they would consider donating organs, while only 16% said they would definitely donate irrespective of circumstances.⁽³⁾

Following reports of trafficking in human beings (who are used as sources of organs and of patient-tourists from rich countries in 2004), the World Health Organization, called on member states *"To take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to wider problem of international trafficking human tissues and organs"*. The Istanbul Declaration strived to achieve transparency and stricter control on the sale of organs.⁽⁴⁾

As far as is known no major religion formally forbids donation or receipt of organs or is against transplantation from living or deceased donors. There are rare examples of small cohorts/ sections of religious groups where such dictats may have been given. Some orthodox Jews may have religious objections to "opting in." Transplantation from deceased donors may be discouraged by Native Americans, Roma Gypsies, Confucians, Shintoists, and some orthodox Rabbis. Some south Asian Muslim Ulemas (scholars) and Muftis (jurists) may oppose donation from human living and deceased donors because the human body is an "AMANAT" (trusteeship) from God and must not be desecrated following death, but they encourage xenotransplantation. Data from a survey of muslims residing in western countries have shown that the interpretation of religious scriptures and advice of faith leaders were often major barriers to willingness for organ donation.⁽⁵⁾ Others encourage living donation over cadaveric donation. The Catholic Church is against donation from anencephalic donors or after active euthanasia.⁽⁶⁾ Yet there is a faith based non-profit organization, Matnat Chaim ("Gift of Life" in Hebrew), emerging as a major force for arranging living donor kidney transplantation mainly by facilitating altruistic living unrelated donor transplantation.⁽⁷⁾

Cultural Challenges

Inadequate cultural competence and sensitivity when communicating with potential donor families by healthcare professionals may be an important determinant in refusals. Clinicians may not have an understanding of the cultural and religious perspectives of some muslim families of critically ill patients who may be approached about brain death and organ donation.⁽⁸⁾

Misinformation

Where religious misinterpretation hurdles are crossed, misinformation may pose new challenges. While majority of respondents in an orthodox muslim country, (69%) considered organ donation and transplantation acceptable from a religious point of

view, many were reluctant because they believed that one kidney was not enough to survive (50%) or that the remaining kidney may be affected (26%), whereas 15% expressed fear of the operation.⁽⁹⁾

Policy

Over fifty years ago, in the United States of America, the Uniform Anatomical Gift Act (UAGA) was approved by the American Bar Association.⁽¹⁰⁾ The UAGA provided a legal framework on which to base a nationwide organ donation system on the principles of altruism, autonomy, and public trust. The 2006 UAGA amendment reflected the public policy goal of making more organs available for transplantation. However, it transferred the authority over end of life decisions from patients or surrogates to organ procurement organisations, which may be inconsistent with common law and the ethical and legal standards that govern medicine.⁽¹¹⁾

Such a concept of 'presumed consent' is a legislative framework in which citizens must place their name on a national opt-out register; otherwise their consent for donating their organs will be presumed. Changing legislation to a system of presumed consent in order to address the organ shortage has raised ethical concerns.⁽¹²⁾ The Welsh Assembly passed legislation to enable the introduction of presumed consent in 2015. However, there is scant evidence that presumed consent will be effective.⁽¹³⁾ Presumed consent alone is unlikely to explain the variation in organ donation rates between different countries, nor offer a panacea to address the significant mismatch in availability of organs.

Infrastructure

Improvements in transplantation infrastructure in the UK have resulted in a 63% increase in deceased donation since 2007. If, family consent rates could be improved from the current 57% to Spanish levels of 85%, the UK's donation rate could be one of the best in the world.⁽¹³⁾ Lack of adequate infrastructure and resources in developing countries pose a major roadblock for the retrieval and matching of organs, even if consent was available. Huge governmental investment in retrieval hardware and logistics would be necessary.⁽¹⁴⁾ In cash-strapped societies, where minimum standards of health and hygiene are not universally available, there is little appetite for the incredible expenditure required for little gain from a public health perspective. Therefore the only progress is likely in living donors from near relatives or around metropolitan urban localities with private- public partnerships. A metropolis in eastern India, Kolkata, reported its first heart transplants almost simultaneously in public and private facilities in 2018, 24 years after India's first heart transplant was successfully conducted in New Delhi.^{(15) (16)}

The Spanish Plan

Organ transplantation has improved the lives of hundreds of thousands of patients all the world. While progress has been made to increase organ registration and the number of organs transplanted, much more must be done to realize the potential of life-saving therapy without jeopardizing ethical principles. The total organ donation shortage can be met with increase in the conversion rate from eligible deaths, which remain hugely variable across the world.⁽¹⁷⁾ Challenges include an interplay of sociocultural factors, religious beliefs, misinformation, lack of culturally sensitive communication, infrastructure and organisational support.⁽¹⁸⁾

With 40 donors and more than 100 transplant procedures per million population in 2015, Spain holds a privileged position worldwide in providing transplant services to its patient population. The Spanish success derives from a specific organisational approach to ensure the systematic identification of opportunities for organ donation and their transition to actual donation and to promote public support for the donation of organs after death.

The Spanish plan had three specific objectives:

- promoting the identification and early referral of possible organ donors from outside of the intensive care unit to consider elective non-therapeutic intensive care and incorporate the option of organ donation into end-of-life care;
- facilitating the use of organs from expanded criteria and non-standard risk donors; and developing the framework for the practice of donation after circulatory death.⁽¹⁹⁾

Future

A combination of legislation, availability of donors, transplantation system organisation and infrastructure, wealth and investment in health care, as well as underlying public attitudes to and awareness of organ donation and transplantation, may all play a role, although the relative importance of each is not clear.⁽²⁰⁾ Further reviews could investigate the factors likely to modify donor rates but awareness and motivation from all healthcare professionals reaching out to their local community while demonstrating empathy and ethical organ donation is likely to have far-reaching benefits than legislation such as presumed consent which may propagate mistrust in certain societies. BAME leaders have a particularly important role to play in redressing the imbalance in organ donations from their own communities, encouraging open discussions on the benefits within families reducing the proportion of relatives who decline consent on such grounds. The BAPIO seminar on Organ donation in Coventry in February is one of such initiatives to encourage open discussions of religious and cultural determinants.

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ORGAN DONATION LAW AND ITS IMPACT ON BAME COMMUNITIES

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Abstract

Opt out will be introduced in England and Scotland in 2020; building on its success in Wales. BAME issues have moved higher up the agenda and will feature in the new post 2020 Strategy on organ donation and transplantation. BAME communities are taking greater leadership roles in engaging with their communities with the establishment of the Community Investment Scheme and the Living Transplant Initiative. Organisation such as the NBTA and BAPIO are involved in influencing future strategies and policies.

Introduction

Organ transplantation is the gold standard treatment for patients with end organ failure, as it is not only cost effective, but also results in better outcomes in terms of quality of life and longevity^(1,2). However, the course of action of transplantation starts with the donation of organ(s) by the donor, living or dead. The process of obtaining and recording consent for organ donation from the donor or the family of the donor is called the 'consent'. Consent is the ethical cornerstone of all medical procedures and is required by law. National authorities define and regulate the process of obtaining and recording consent for organ donation⁽³⁾. The reason for the paramount importance of consent is due to the declaration of human rights by the United Nations, which states that, 'all human beings are born free and are equal in dignity and rights'⁽⁴⁾. This declaration underpins the ethics of donation and transplantation.

Consent

There are different types of consent laws for organ donation. The explicit

consent or opting in is where organs are removed from the deceased individuals, following the consent obtained from them to donate the organs/tissues for transplantation or in some cases for research, sometime during their lifetime. This is usually recorded on a donor card, driver's license, Boots' advantage card, online or filed in Organ Donation Registry (ODR). Presumed consent or opting out is when organs and tissues are removed from the body of a deceased individual for transplantation or research purposes, UNLESS the person had categorically expressed their objection to donation whilst alive.

There are further subtypes of consent⁽⁵⁾. Hard opt out is where families do not have a say, example Austria. In Singapore, for all communities other than Muslims the law is similar to Austria. However, all Muslims are considered opted out unless stated otherwise. In Belgium and Spain, it is a soft opt out policy, where family's wish matters. However, in Belgium, unless the family initiates the discussion to stop the donation, organs can be removed; whereas in Spain, the family will be consulted before proceeding to

donation. Where the donation proceeds regardless of the families wishes, provided the individual had consented to donation whilst living is called the hard opt in. In soft opt in, though the individual has provided consent to donate, the family can withdraw. This is the system which currently exists in the U.K. Apart from the above, there is also a mandated choice where all individuals should register for either opt in or out, whilst living.



patients died whilst waiting to receive a transplant ⁽⁶⁾. To understand how to increase the number of patients getting transplanted, a taskforce was created, which included representatives from legal, ethical, medical, surgical and nursing professionals as well as patients and public. On reviewing the available evidence, they concluded that the barriers to organ donation were the processes involved in donor identification and referral, donor co-ordination and organ retrieval arrangements ⁽⁵⁾. They did not find any convincing evidence that opt out would deliver significant increases in the number of donated organs ⁽⁷⁾. However, there was another review planned in five years.

The review in 2013, showed that as a consequence of the Taskforce 2008, more donors were identified and referred and people donating organs after death increased by 57% with transplant rates increasing by 30.5%. This was made possible by the formation of a centrally employed team of specialist nurses of organ donation (SNOD), who co-ordinated all donation activities. In addition, organ retrieval became a dedicated national service commissioned by the National Health Service, Blood and Transplant (NHSBT). Nevertheless, the Taskforce 2013, proposed an increase of consent rate in excess of 80% by 2020, in addition to aiming for increases in deceased donation, transplant and organ utilisation rates ⁽⁸⁾.

However, the single most important objective of the strategy was to increase consent to organ donation from people from all parts of society.

New Legislation

Thus, the new legislation, the opt out law or the Keira and Max's Law, in recognition of all the campaigning Max Johnson and his family have done whilst Max was waiting for a heart transplant and continue to do so, came into being. Max's gift of life came from a young nine-year old girl called Keira Ball, who tragically passed away following a road traffic accident ⁽⁹⁾. This soft opt out law like in Spain will be in place from 20 May 2020 in England and from autumn 2020 in Scotland. Wales has changed to this law since December 2015.

Out of the forty three percent of the families who refused to allow donation,

66% were from BAME population. Though the donor identification and referral rates by the SNODs was similar in both potential white and BAME organ donors, the consent rate last year was 42% for BAME and 71% for white donor families. The main reason given by the BAME families were that donation was against their religious and cultural beliefs and they were unsure whether the deceased person would have agreed to donation if they were alive ⁽¹⁰⁾.

BAME Communities

In general, white patients wait less time for an organ transplant than BAME patients, with the exception of pancreas and non-urgent adult hearts. BAME patients tend to wait the longest. From 2007 to 2016, the median waiting time for a kidney transplant has come down from 1047 to 640 days for white, 1330 to 830 days for Asian and 1363 to 965 days for black patients. There has been an increase in the transplant rate for BAME patients from 892 to 1148 in the last five years. Though there has been an increase in the number of BAME deceased organ donors over the same period from 80 to 121, the number of BAME living donors has remained at 140-160 per year ⁽¹⁰⁾. Thus, it does not account for the concomitant increase in the transplant rate. One of the reasons for the increased transplants in the BAME group, especially kidneys, is the change in the allocation policy of organs which has significantly reduced the waiting time between white and BAME groups ⁽¹¹⁾. The other significant reason is that the more than 80% of transplant donors to the BAME patients are from white donors.

Currently, BAME represent 11% of the population, but 31% of those on the waiting list with only 7% of donors. Last year 21 per cent of people who died while waiting for an organ to be donated were from BAME groups. BAME communities have a higher incidence of hypertension and diabetes; both of which are predominant causes of end stage renal failure. Similarly, chronic viral hepatitis and non-alcoholic hepatitis are more common in BAME patients. Thus, BAME patients are more likely to need a transplant due to increased incidence of end stage organ disease. A good blood group and tissue type match between donor and recipients, especially in kidney transplants, have a much better long-

term graft and patient survival ⁽¹²⁻¹⁴⁾. This is more likely if the donor and the recipient are from the same ethnicity.

Though the evidence is not strong ⁽¹⁵⁻¹⁹⁾, change in law is anticipated to increase the number of transplants by around 700 per year in five years' time. It is recognised that we need to take a strategic approach to tackling the BAME challenges and one of the key themes of the post 2020 national strategy on donation and transplantation being developed at present will most likely be "Diversity and Inclusion". If the decision to opt out of donation has not been expressed, it will be considered that the individual has consented to donate organs. Thus, it is important that BAME individuals are not only aware of this changing law but also spread the message within their communities about enabling the gift of life to patients and families through organ donation. NHSBT are working with the National BAME Transplant Alliance (NBTA) on the most effective way of spreading the message.

It is widely acknowledged that the reach is far better if the message to the BAME groups is given by individuals from the same ethnicity. This has therefore led to schemes which empower local BAME community groups to take leadership in engaging on organ donation with their targeted communities. The Living Transplant Initiative (LTI) ⁽²⁰⁾ and the Community Investment Scheme (CIS) are now well established. Currently there are 26 separate CIS projects ⁽²¹⁾ and five large LTI projects, funded by NHSBT. This approach needs to be developed further so that it involves all major BAME communities and covers all areas with significant BAME population.

In summary, we are currently going through an exciting period in relation to organ donation and transplantation in the UK. Opt out will be introduced



in England and Scotland in 2020; building on its success in Wales. BAME issues have moved higher up the agenda and will feature in the new post 2020 Strategy on organ donation and transplantation. BAME communities are taking greater leadership roles in engaging with their communities with the establishment of the Community Investment Scheme and the Living Transplant Initiative. Organisation such as the NBTA and BAPIO are involved in influencing future strategies and policies. Clearly, we need to ensure that the Governments provide sufficient additional resources so that we can transform organ donation and transplantation in the UK, especially amongst the BAME communities.

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YOUR COUNTRY NEEDS YOU THE BRITISH EFFORT DURING THE WARS AND THE COVID-19 PANDEMIC

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Introduction

We as a nation are going through unprecedented times with the COVID-19 global pandemic. In the UK, we are yet to reach a peak and it appears that the current situation will continue for months to come. Tough decisions are being made, sacrifices are in place and the greatest hindrance to social interaction is in force considering that man at the end of the day thrives in social interaction.

Emmanuelle Macron has recently said, “Nous sommes en guerre” (“we are at war”) regarding the situation in his country. Matt Hancock, our own health minister has alluded the current epidemic sweeping across the country to the hardships faced by the British public during the 2 great wars in the 20th century. Can the situation existing during the British war efforts of 1914-1918 and 1939-1945 be compared to the existing situation during the Covid 19 pandemic? This article tries to find an answer to this question and examines the similarities and the dissimilarities of this nation reacting in every possible way imaginable to the different situations.

The collective national effort

Both the wars and the current epidemic have generated what can be called a collective national effort. Mobilisation in military terms implies that the armed forces are stood on high alert and ordered to engage the enemy. However, there is a bigger part to mobilisation during wars that include the civilian war effort. This is when the whole nation engaged in the war comes together to stand as one in the crises. The British during the wars, inspired by charismatic leaderships in home soil understood that the whole nation will have to participate in the war effort to help the soldiers fighting in the front, help the economy in whatever capacity that an individual citizen can help with and overall maintain morals in very difficult times.

The COVID-19 effort has generated a similar feeling of collective national effort. The fundamental difference with the effort during the wars is that the wars were mostly fought outside of the country's borders. With the exception

of the Blitz in 1940 and sporadic V1 bomb and V2 missile attack towards the end of the war, this country was largely unscathed from the devastation in Europe, the actual theatre of war. Yet the civilian population rose as one. Covid 19 effort is more complex as this effort is directed to combat an enemy in home soil and consequently demands more engagement and commitment than what the British citizens had to put up with during the wars.

Another important difference is the issue of social engagement. The home front war effort encouraged more interaction with each other to promote a sense of camaraderie and uplift civilian morale. The current viral epidemic encourages just the opposite. Man detaching itself from its neighbour, in the complex evolution of social fabric is almost incompatible with life. And that is what we will have to adhere to. Social distancing and social isolation can be detrimental to man's wellbeing especially among the socially vulnerable and it only remains to be seen as to how long this continues. Man is resilient enough to manage short temporary periods of isolation but who knows what will happen to this rather delicate and sensitive but essential attribute if it continues in the longer term.

The third important difference is the mind-set of the people in the country during the wars and in the present situation. The public during the wars knew that they had been putting up to fight a highly visible enemy who were the aggressors flouting human rights. This enemy can attack home any time if they are not defeated and try to establish a new world order of domination. The public during the present times know that they are fighting an invisible enemy who is attacking every second and leaving behind devastation in human lives in its wake but the current world order will not change. Infrastructures unlike in the aftermath of the wars will be preserved, human rights will be preserved and the country will be unscathed from physical damage. The citizens would mourn the death of their soldiers outside the country during the wars and would live themselves but they will mourn the death of their own neighbours in the current crisis and there is no assurance that they will not lose their own lives. This mind set is much more morally challenging and depressing than the mind set during the wars.

Since the past two generations had not seen the war, it would be impossible for us to appreciate what it was really like in those times. My personal opinion is that whilst rationing, air raid shelters and the fear of being injured or maimed were severe, they brought man closer to each other individually. The present situation is not letting that happen at an individual level. There was a predicted inevitability during the wars – either you win or you lose; however, in the current situation, there is supreme uncertainty and nothing is inevitable. Uncertainty in any form is far more challenging to face than a decisive future.

The economy

During the wars and the present crisis, the effect on the economy of the country is significant. In the former, private sector employment decreased to be redeployed to the war effort and a significant proportion of a healthy work force was injured or killed. The majority of the economy was diverted towards the war effort that led to a boom in manufacturing arms, ammunitions and sundries for the war with a significant drop in unemployment especially when conscription to the war effort started after the Blitz. Agricultural production increased by at least 35% and the nation was well fed by the introduction of rationing. In addition to this, much of the food grain to feed soldiers was supplied by the colonies especially India. In 1941, the GDP was more than 20% of what it was in 1938. Britain acquired a large reserve in foreign exchange due to the generous loans by both USA and Canada. Industrial infrastructure was reasonably well preserved and escaped physical devastation as the war was not fought on British soil. Since this country depended on imports to keep her factories running, this did suffer a blow in the initial period due to sinking of convoys by German U boats in the Atlantic, however, this was effectively countered by the Royal and the US Navy. So overall, Britain as a nation was financially secure and sufficient from the economic point of view. As a result, after the war, the recovery was quick.

The contrast with the current situation is stark. Here, private sector work is taking a nose dive with preservation of the work force. The economy is so hard hit with lock down and social isolation, that there is a serious chance of recession once the crisis is over. Jobs are being lost, businesses are packing up and the hospitality and the travel industry are fighting hard to survive. Some manufacturing is continuing and diverted to the collective effort to make ventilators for the health effort but overall since manufacturing needs people in a closed space to implement, it is bleeding every day. To top it all off, unlike in the war effort, there is no foreign aid coming as the countries that helped us so generously during the wars are themselves affected and there are no colonies any more. Imports are continuing but with the days passing by, a complete shut down of international borders is also predicted. The future is rather uncertain as to what the long term effects will be like on the economy of the world, let alone this country. This is unprecedented and far more serious than during the war.

The lock down and the common man

“Bombs, blackouts, air-raid shelters, sirens and rationing were real impositions, compared with the inconvenience of washing your hands”, said a war veteran. There were curfews in force and movement was restricted. However, the

population was not asked to keep a distance.

Compare this to the current situation. Let’s talk about a 30 year old man in March 2020 who in 2070 will reminisce thus: “ Staying at home, unable to visit my elderly parents, possibility of losing my job, superstores empty of provisions, children can’t go to school and the uncertainty of whether I will be struck down by the bug and die were the realities on the ground compared to bombs and blackouts that brought you closer”.

It must be borne in mind that a society consumes only if it produces. During the war effort, people put in on an average 60 hours per week of work to sustain production leading to consumption. This is impossible in the current climate when in spite of the digital revolution and the luxury of working from home simply cannot replace hard and physical hands-on activities. That is why there is a serious risk of the fabric of economy crumbling down. The government is doing its best to help by sanctioning billions of pounds to support citizens who cannot work due to the social isolation but obviously sustainability is an issue. Karl Marx in 1868 said : ‘Every child knows a nation which ceased to work, I will not say for a year, but even for a few weeks, would perish.’

Civilian casualties during the wars were circa 85,000 and unless contained, civilian casualties predicted during the Covid crisis are circa 500,000, and with government measures circa 25,000. So as a killer, the virus is more deadly than the wars. Moreover, the people killed during the war were the young healthy population whereas the population losing their lives are the elderly and vulnerable population in the majority in the present crisis.

A lesson learnt from wars was that over a period of time, government imposed measures did not sustain and people will go about on their jobs at the risk of being punished. Conscription and evacuation were prime examples. That is why the current government understandably is doing this gradually and already there has been defiance against social isolation in the parks and the beaches.

Politics and leadership

It needs to be remembered that a war is fought for political reasons. When more and more countries become involved it achieves a ‘world’ or global proportions but even then at least from the geopolitical point of view, much of the world is spared. The current pandemic is global and has spread to every corner of the world. This is a fundamental difference with serious implications.

Management of trans-country borders during the war within one side (let’s say the Allies or the Axis) allowed free movement of people. There was no closure and indeed a significant proportion of émigré or temporary governments from Europe were set up in the UK during the Second World War because there was unrestricted entry. This meant that people did have a choice of moving from one unsafe place to a safe one. This is next to impossible in the present viral pandemic. Borders are shut and people have to stay put where they are. Evacuation is not an option.

Cross country financial and material aid during the wars was implemented with great success and kept many countries

functioning. This situation is not possible in the current climate as all countries are geared to combat their own epidemics.

Leadership needs to be decisive. David Lloyd George provided this during the First World War and Winston Churchill during the second. These leaders were ahead of their times. Lloyd George appointed world experts in economy and finance to run the economy and mobilised a huge volunteer force. Churchill motivated the public with his stirring speeches at a time when Britain was alone and the rest of Europe reeling under the Nazi juggernaut. Morals were kept high.

The UK government although slow to react to the corona pandemic has now taken some decisive steps and the Chancellor of the Exchequer has announced a very sympathetic and considerate package for the citizens at a risk of financial hardships. However, in the wake of the December elections, and with the fallout of Brexit still in the political discourse, the country is as divided as ever. It will be interesting to see if this pandemic will bring the country closer together, or exacerbate this divide. It is important to note, however, the real sense of community spirit and care has blossomed from this crisis.

The aftermath of the wars led to profound global political changes as well. A new world order was established, political boundaries were redrawn, countries became free from the colonial yoke and the geopolitical scenario changed completely. Human fundamental rights and freedom were re-evaluated and the guilty punished – the whole concept of war crime arraignment was something new and exceptional. After the dust settles with the current pandemic, the world will remain what it was from the geopolitical point of view.

Health

It goes without saying that when a nation is threatened with crises like wars or an epidemic, civilian and public health suffers. There was no national health service during the wars and the patient profile was dominated by war casualties from trauma or otherwise. The general population could have suffered mental health problems but their physical

health profiles did not differ much from peacetime ones. Nevertheless health services were stretched even with the establishment of several dedicated military hospitals. It was clearly identified that the current provisions were simply not enough to face another similar situation and thus the NHS was born.

We are facing a different situation now. We have the NHS, which is one of the best health services in the world but we are at serious risk of getting swamped by the epidemic. Covid morbidity is rising exponentially and there are not enough provisions to care for the very ill. We are seeing a similar situation in Europe and it only reinforces the idea that a natural disaster can be far more intense than a man made one.

Conclusions

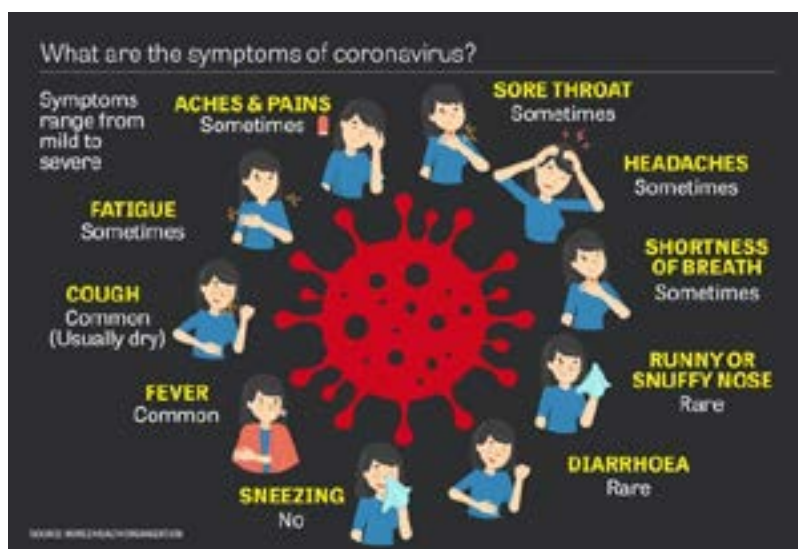
Both the wars and the Covid epidemic have generated a collective effort to combat against these and stand together. That is the only similarity. The war effort is significantly different from the present effort as this article has shown, in terms of the mind-set, the social distancing, the effects of a lock down, the main differences in people's lives, the economy and the predictability for a normal future. There is one positive aspect of these calamities and that is the blossoming of humanity. Man stands shoulder to shoulder with one another like never before, lending a helping hand regardless of inequalities, classes, genders, race or creed. Man is tempered by millennia of survival and civilisation and is resilient enough to withstand any adversity. And I am sure that phoenix will rise from the ashes.

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MEDICS & MIGRATION -IMPACT ON MENTAL HEALTH

Medics, migration and mental illness

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Introduction

It is a well-known factor that migrants to another country have a higher preponderance of developing mental illness when they arrive to settle in their adopted country. The reasons for these are manifold. It is possible that some of these individuals will already have pre-existing mental illness which is triggered off in a foreign land, but there are other factors which are known to be causative, such as stress of migration, isolation, job issues, etc. The article examines the effects that migration has specifically on the mental health of doctors, as well as the consequences of developing mental illness.

Migration and the NHS

The fact of the matter is that the National Health Service (NHS) has been a benefactor of medical migration over many decades. Indeed, during times of staff shortages, the NHS has relied on countries such as India, Pakistan, Sri Lanka and Bangladesh to fill posts in hospital and general practice¹. European Union doctors have also made very significant contributions. By the 1960's nearly half the junior doctor and non-consultant posts were filled by overseas graduates². Today, almost 36% of registered medical practitioners have their primary medical qualification from a non-UK country and for the first time, between 2018-2019 more new registrants are trained overseas, than in the UK. The commonest registered surnames on the GMC register are, in order of popularity, Khan, Patel and Smith giving us an idea on the workforce configuration of doctors in the UK. The UK's response to its own crisis in recruitment and retention continued to rely on international recruitment to fill its vacancies despite the fact that the numbers of medical school places have increased by 50% since the year 2000³.

With migration come a number of challenges. Most doctors leave their native countries to seek better opportunities for themselves and/or their families, or in some instances to escape unsafe conditions (refugees). There are three stages to the migratory process⁴. At the pre-migration stage individuals decide to migrate and plan the move. Stage two involves the necessary psychological and social steps in the process of migration itself and the physical transition from one place to another, and the third stage is the post-

migratory stage when the individuals deal with the social and cultural integration in the new society, requiring them to adopt new values and adapt to their new environment. Their next generation will have some similar experiences in terms of cultural identity and stress, even though they are technically not migrants.

Migrant diaries, letters and articles in medical journals have often captured recollections of traumatic transitions of migrant doctors from old to new worlds: the tribulations of bureaucracy, the pain of parting, and the discrimination many of them feel in their adopted new homeland. In most cases the difficulties were short-lived or manageable, but occasionally they were catalysts for mental breakdown. Those lucky enough to secure high achieving jobs might escape the ravages of these stresses, while for those who are less fortunate, qualitative research demonstrates that they will end up in what are regarded as 'second rate jobs where there are fewer learning opportunities and advancements in careers and more of an element of service delivery, which shatters their dreams and expectations. Most migrants who arrive at trainee doctor level are ill prepared for making that transition; whilst they are likely to be well equipped in the practice of medicine, the adaptation to a different culture, preparedness for postgraduate examinations and a culture of tighter regulation are matters that many of them struggle to grapple with. Medical migrants might also come with no more than a few pound Sterling in their pockets so they may have underestimated the cost of living, expenses on regulatory and essential requirements such as visas, health surcharge, subscription fees for medical defence, trade union and royal college organisations, professional courses and examinations, add to the stresses they are likely to experience.

Racism and Migrants

The recent high profile cases of a Scottish doctor⁵ and a senior surgeon⁶ in the North West have thrown sharply into focus how discrimination by patients can undermine the NHS, and also affect those doctors who are the subjects of such behaviours. In both those instances, involving in a first generation Indian General Practitioner and a second generation Indian hospital surgeon, two caucasian patients had demanded that they see a 'white' doctor. These doctors

are brave to speak out. However, this is a common occurrence for many Black and Ethnic Minority (BME) health staff, underreported for various reasons – ranging from not feeling confident to do so, feeling that no one would listen or act, while many feel recrimination from being branded racists. Although we would be regarded as having been successful in our respective careers that span almost eight decades between us, it hasn't always been plain sailing for us. We have each experienced discrimination, whether that is in exams, interviews or selection to jobs. And there have been seemingly well meaning colleagues who have made remarks that would be considered to discriminatory today. The stress of this, on top of everything else, is unimaginable.

Imperatives for tackling mental illness in medics

The emotional burden of migration to a foreign country is the main contributor to health problems in some of these individuals. Unlike migrants from the general population, medical migrants are unlikely to have pre-existing mental illness and so there are ethical and economical imperatives to ensure that these factors are understood and remedied at the earliest opportunity. Research has shown that availability of career and training opportunities, adequacy of supervision, contract type, salary, satisfaction with life in the host country, and acquiring citizenship are associated with a positive experience for these doctors.

It is well within the gift of employing authorities and statutory organisations to make a better effort in ensuring

that these factors are earnestly tackled. Not doing so comes at a considerable cost not just to the NHS but to the individual doctor and their families as the consequences of stress and depression are substantial, from loss of income, re-employment issues, visas restrictions, stigma of mental health, and at its worst, suicide of the affected doctor.

Conclusions

The contributions of migrant doctors to the NHS are well known and widely acknowledged. However, if these doctors are to feel valued than employing authorities and regulators must do more in order to support them and so that they can continue to work efficiently and productively.

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Healthcare Workforce

Millennials– The Missing Piece in the NHS Workforce Puzzle?

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KEYWORDS

Junior doctors, millennials, workforce crisis, NHS, flexibility, career support, mentorship

ABSTRACT

UK healthcare is in the throes of a workforce crisis. There are 10,000 fewer doctors and over 50,000 fewer nurses than are required to run a safe and sustainable service. Multiple factors from removal of nursing bursaries, introduction of university fees, poor working conditions, under-resourcing of healthcare services, unmanageable workloads, learned helplessness of clinical risk and a culture of incivility or blame is driving the workforce of the future away from NHS. Several governmental agencies, arm's length bodies and trade unions have been grappling with this challenge.

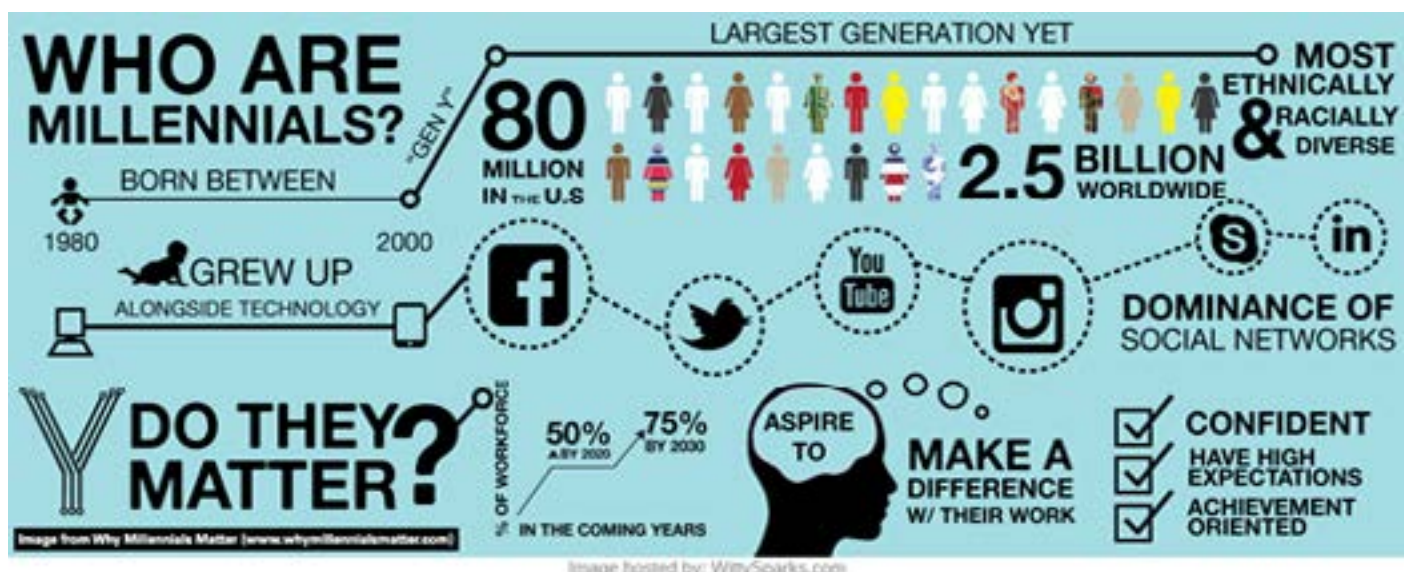
A few solutions have been recommended under the new contract for junior doctors, reintroduction of support for nurses and expansion of medical school places, but some are yet to be implemented. NHS leaders continue to support blue-sky thinking in terms of workforce innovations but tend to drag their feet when it comes to adoption. This reluctance by senior clinicians, managers and policy makers may be related to a lack of understanding of the values that drive the millennial generation that most younger healthcare workforce belong to.

This article will explore the challenges and solutions from a generational perspective and offer an insight to guide future decision-making.

INTRODUCTION

I'm scared, I'm exhausted, and I hate being a doctor.¹

Over half of junior doctors in the United Kingdom (UK) do not continue their training straight after Foundation years, choosing a career break, flexibility in work schedules, in less than full time positions or switch specialities.^{2, 3} Thus leading to an expanding crisis in the safe staffing of hospital rotas.⁴ Despite the considered re-design of medical training pathways, since the time of the Calman review⁵ postgraduate training is failing to persuade a significant proportion of junior doctors to commit to higher specialty training. Those in specialty training are delaying their transition into consultant posts, hence a large number of unfilled consultant vacancies persist, with notable geographical variation. As the healthcare workforce numbers are heavily regulated, the impact of this unpredictability on those remaining is huge,



with an unsustainable burden of work falling onto the middle grade or senior doctors and nurses, whose recruitment is also becoming more challenging.⁶

Added to this, the demand on primary, emergency or secondary care services is growing with an ageing population with complex health and social care needs. The UK public value the National Health Service (NHS) above all other issues in deciding the future governments, hence it has long been used as a campaigning tool in the agendas of political leaders.⁷ There is a promise from successive governments of a better resourced, efficient, sustainable and safe NHS. However, the ground reality appears to be quite different. In the eyes of the junior doctors and nurses, the future of the NHS is seen as uncertain, and many of our doctors perceive working in the NHS as a sacrifice to the stability of their personal lives, their autonomy, health and well-being.

This article will explore the complex reasons behind these issues from the dual perspectives of a junior doctor (mid-way through higher specialist training), drawing on the narrative of peers who have left our workforce with a senior clinician and educator. We present here a wealth of knowledge gathered over several interviews, career conversations, mentor-mentee relationships to help understand the reasons behind the current workforce crisis. The authors offer recommendations for organisations in helping to turn this haemorrhaging of this complex workforce.

What determines junior doctors' career choices? Numerous surveys identify the factors that junior doctors consider when making career choices. Here is a sample in Table 1;

Organisational Factors – Working Conditions and Industrial Action

Junior doctors are regularly faced with the choice of moving home or commuting long distances whilst they rotate through clinical placements. Relationships with friends and family are difficult to maintain. The induction process is often inadequate, rotas under-staffed, managers less sympathetic to their conditions, education and training opportunities sub-optimal, culture hostile, and medical information technology (IT) systems across the UK are described as shambolic.⁸

'I have personally moved house 9 times in the last 10 years of my training due to clinical placements in far-flung hospitals'

The question uppermost in the minds of junior doctors was 'Is there any meaning to our role as doctors, if we can't do what is required to keep our patients safe?' The goodwill and dedication amongst the medical and nursing staff which had cushioned the impact of an increasing demand versus reducing resources on the NHS, was lost. Greater numbers of doctors are leaving fixed training posts for locum positions and the flexibility they offer, and to practice in Australia and Canada, with optimism for respect and a work life balance.

The long drawn out contract negotiations (2012-2016), the subsequent breakdown of trust between UK government and junior doctors led to in 2016, for the first time in 40 years, industrial action. Junior doctors walked out to protest the proposal of an imposition of a 7-day service without adequate investment in services or remuneration, transformation in working conditions or a safe working

environment.⁹ The deal finally agreed brought a £90 million investment for Junior Doctors over four years.¹⁰ The deal included improvements in rest and safety entitlements, contracted less than full time (LTFT) rostering guidance, exception reporting for all Annual Review of Competency Progression (ARCP) or portfolio requirements and guaranteed annual pay uplift of 2% each year for the next four years. Amongst these organisational factors, the Academy of Medical Royal Colleges (AoMRC), General Medical Council (GMC) and Health Education England (HEE) have also made recommendations for robust educational supervision, career support, mentorship, flexibility and less than full time training, as well as supported return to practice under the scope of "improving junior doctors working lives" initiative¹¹.

Supportive Environment

The case of Hadiza Bawa-Garba cast the NHS workforce crisis in a harsh light.¹² The challenges of inadequate hospital staffing, compromised patient safety, institutional culture of bullying and blame were at the forefront of cases brought to public attention. These cases have empowered junior doctors to raise concerns about civility of interactions in the workplace and inaccessibility of senior support. Junior doctors often feel unable to share the responsibility or risks of their unsustainable workload with senior colleagues. The formal supervision of doctors who may be unfamiliar with organisational or departmental processes remains suboptimal. Junior doctors regularly face uncertainty about their roles, ways to escalate concerns and seeking support. Many doctors have only recently become aware of their Trust whistleblowing policies, following the landmark case of Dr Chris Day, an Intensive Care trainee who was discredited for raising safety concerns.¹³ In practice, doctors doing their best in challenging circumstances are often expected to accept full professional accountability, and relationships with hospital and NHS managers are often strained. The attitudes of those who formally share this accountability prevent the implementation of the provisions agreed in the JDC negotiations at a local level. Foundation trainees hesitate to report patient safety issues, working beyond rostered hours and missing educational opportunities. On occasions, those who do raise their concerns in person, are offered vague feedback such as they should consider 'improving their efficiency and time management skills'. This form of discouragement from organisational leaders is a reflection of attitudes that are slow to change.

Individual Factors

Training programmes offering a 'CHOICE OF CLINICAL PLACEMENTS AND FLEXIBILITY' are more attractive to junior doctors. The suggestion from the UK Government to 'conscript' newly trained doctors to the NHS for 4 years unless they repay part of their training costs has reinforced the widely held perception that UK medical training system remains inflexible and even coercive. The NHS is the fifth largest employer in the world, and is valued as a DIVERSE WORKING ENVIRONMENT, with overseas doctors making up 25% of the workforce. In 2018, more international graduates registered with the GMC than UK graduates, and the NHS relies on the ability to readily recruit doctors from abroad. These doctors make a large contribution to the NHS, sharing their skills and knowledge, however governmental policies threaten their security of roles, impose increased costs for

visas and access to NHS, restrictions on their families and hurdles in accessing specialist training and skills.

Junior doctors value job security after years of investment of time and incurring huge debts, yet are faced with uncertainty about the future of their careers, dependent on passing postgraduate exams, fulfilling demanding training requirements and annual revalidation criteria, as well as making a positive impression on their supervisors, whose mentoring they rely on. Doctors are more likely to apply for training programmes which foster better work life balance, and an encouraging and supportive environment. Female doctors, and those with young children often face discrimination for their perceived lack of commitment in less than full time posts, which are severely limited in availability. They often favour careers in General Practice due to the perceived predictability of workload, flexibility or work life balance it offers.¹⁴

Although medicine overall remains a competitive career choice at undergraduate level, prospective candidates considering it may carry significant personal financial burdens, and the rising tuition fees and student debt may be a factor in the decline in applications. Socio-economically disadvantaged applicants often continue to work part time, alongside their undergraduate medical training, whilst worrying that they are unable to dedicate their time to demonstrate 'commitment to speciality', which is strongly favoured amongst recruiters and often correlates with success in postgraduate training applications. Perversely, the demands of a career in medicine has an adverse impact on health and wellbeing. Medical training is associated with increased mental illness, work life imbalance and lack of job satisfaction. Female gender and younger age often are predictors of burnout in junior doctors. In particular, there remains a recruitment and retention crisis in Emergency and Acute Medicine, General Practice and Psychiatry, with increasing demand on these specialties.

Although HEE, Care Quality Commission (CQC) and GMC attach considerable value to league tables about the quality of services including education, most junior doctors make

decisions about their training based on advice from their mentors and peers. This 'INFLUENCER CULTURE', which is rooted in the experience, supervision and encouragement from senior colleagues acting as role models and mentors, has a larger impact on career choice than any formal reports of training surveys, which are less accessible and wholly irrelevant in practice.¹⁵

Many junior doctors' career choices are strongly motivated by geographical reasons, with doctors prioritising proximity to friends and family, who provide a network of social support. One of the major challenges of the NHS is to attract doctors to accept positions in undersubscribed geographical areas. London has historically been oversubscribed and remains highly competitive, whereas unfilled vacancies persist in rural or less socioeconomically advantaged areas. The policy to redistribute training numbers from metropolitan cities to rural locations, in order to encourage junior doctors to develop local networks is unlikely to be successful. Cities are valued for their vibrant and dynamic culture, diversity, ease of travel, accessibility of recreational activities and overall lifestyle flexibility. The competitive nature of recruitment in major cities, particularly London, reinforces a sense of achievement and sought-after opportunity, amongst successful applicants.

What are the Solutions?

Junior doctors are misunderstood millennials^{16,17} and belong to a different generation to their seniors. The values that determine their life choices are markedly different. Senior policy leaders and experts in human resources are clearly failing to understand or speak the language of this group of highly articulate individuals, who happen to know exactly what they wish for. What they wish for, is quite simply, not what is on offer. With a better understanding of the values and motivations for the current millennial junior doctors' generation, NHS and HEE will need to adopt practices and systems which matches the aspirations of this workforce if they are to remain as proactive members of UK healthcare.

Individual Factors affecting choices



To understand what motivates and drives the career choices for junior doctors, one will need to refer to their generational values.¹⁸ Most junior doctors belong to the Generation Y and future doctors to Generation Z. It is imperative therefore, that policy makers and NHS leaders pay heed to their generational values. Researchers and popular media use the early 1980s as starting birth years and the mid-1990s to early 2000s as ending birth years, with 1981 to 1996 a widely accepted definition.

Millennials value choice and flexibility. The ability to choose their specialties, clinical placements and teams. The onetime suggestion from the UK government to 'conscript' ¹⁹ newly trained doctors to the NHS for 4 years unless they repay part of the cost of the £220,000 to train them had serious repercussions. This was suggested as a way to stem the tide of young doctors leaving the country for jobs in the antipodes. The key to keeping doctors in the country is to develop the right training environment for them, to be supported and valued rather than being coerced.

Millennials value diversity and are not afraid to embrace cultural differences openly. One of the previous government proposals was to charge overseas medical students the full cost of their training. This may be counterproductive and reduce international students interest in coming to England. There has been considerable correspondence about the large contribution that foreign doctors have made to the NHS. Overseas doctors currently make up 25% of the workforce and in 2018, there were a greater number of international medical graduates registering with the GMC than UK graduates. They have added to the exchange of ideas, skill sets and knowledge between countries. This study formed part of a larger General Medical Council-funded study about the fairness of postgraduate medical training, which aimed to investigate the fairness of postgraduate training and the possible factors influencing differential attainment concerning International Medical Graduates (IMG) and Black and Minority Ethnic Graduates (BAME),²⁰ and was conducted during the junior doctor contract dispute in late 2015.

Millennials value security. Junior doctors are at a vulnerable phase of their career and their lives. Anxiety and uncertainty are common sentiments as their jobs are without security and their future in the profession is dependent on passing postgraduate exams, displaying clinical efficiency, and making a suitable impression on their supervisors. Support, mentoring, encouragement, and mutual trust are key components in a good postgraduate training programme.

Millennials carry significant personal financial burdens. Although medicine remains competitive, rising tuition fees and higher student debt could be a major factor in the decline in applications. For many, student debt can exceed £80,000 (including maintenance) and medical graduates on an average salary are unlikely to repay their SLC (Student Loans Company) debt in full.²¹

Millennials value work-life balance. Rising workloads, worsening morale, the NHS pay cap which has seen doctors' pay fall by up to 17 per cent in recent years, and concerns around work life balance are likely factors contributing to doctors taking time out from training or leaving the NHS

altogether. Postgraduate training is typically characterised by work-life imbalance. Long hours at work were typically supplemented with long commutes, out-of-hours revision and completion of log books and e-portfolio. Work-life imbalance is particularly severe for those with children and especially women who faced a lack of less-than-full-time positions and discriminatory attitudes. Female trainees frequently talked about having to choose a specialty they felt was more conducive to a work-life balance such as General Practice.¹⁴

Millennials value time with friends and family. Trainees regularly are forced to move workplaces which could disrupt their personal lives and sometimes lead to separation from friends and family. This makes it challenging to cope with personal pressures, the stresses of which could then impinge on learning and training, while also leaving trainees with a lack of social support outside work to buffer against the considerable stresses of training. Low morale and harm to well-being result in some trainees feeling dehumanised.³

Millennials value their personal health and wellbeing. It is unsurprising that medical training is associated with mental health problems, with reviews concluding that lack of work-life balance, long hours, lack of job satisfaction, female sex and younger age are important predictors of burnout in doctors. There are significant concerns that already high levels of emotional exhaustion and burnout in doctors^{22,23} will increase as a result of changes to the junior doctor contract in the UK and this will cause trainee doctors to leave the UK to work in other countries, causing significant problems for a health system already suffering a recruitment and retention crisis.

As a group, female doctors have been found to be vulnerable to burnout and studies have highlighted lack of work-life balance as the single most important precipitant of burnout in female doctors. A study from the USA found burnout rates among female doctors increased by 12–15% with each additional 5 hours they worked over the contracted weekly 40 hours and this correlated with women feeling less in control of their working environment.²⁴ The strain of juggling caring responsibilities with challenging job demands impinges more on women because domestic responsibilities more often fall to them.²⁵⁻²⁶

Instead of focusing on healthcare in the traditional sense and treating medical issues as they arise, millennials gravitate towards wellness and prevention. They are also a lot more open to talking about mental health, which is a huge issue for the younger generation. This is down to the big impact that the relentless speed of change and the pressure of social media can have on them. In recent years, meditation and mindfulness have become increasingly popular and this is now becoming a significant industry that's attracting the younger generation.²²

Millennials learn in innovative ways: Young doctors' educational habits are changing rapidly. Doctors in training have to undertake competitive job applications and numerous assessments and examinations, while managing frequent job, role, team and hospital changes. More doctors than ever before are questioning the value of formal structured, unidimensional postgraduate education. Many millennials

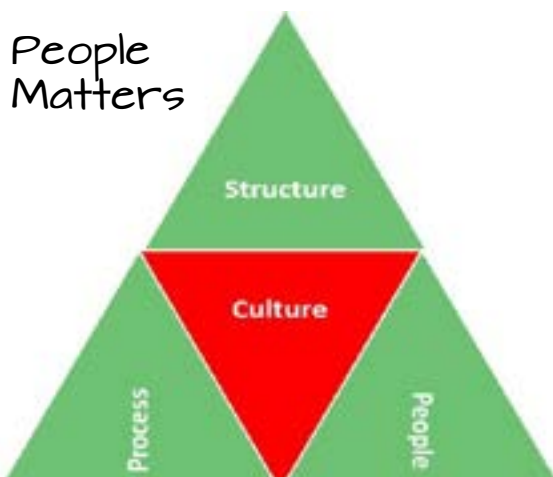
prefer to learn at their own pace. With the proliferation of digital learning resources, which can be very affordable, they can now achieve this. Also, the internet and connectivity has allowed them to reimagine how they work. They are able to experience a different level of productivity, if they are motivated to do so.

Conclusions

The NHS workforce crisis needs innovative solutions.²⁷ Better understanding of the underlying values and motivations of the critically important millennial generation of doctors, nurses and other healthcare workers will help in creating the environment and conditions necessary to attract, retain and motivate the current junior workforce to keep their faith in the health service.

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EMOTIONAL INTELLIGENCE FOR HEALTHCARE

EI IS AN ASSET FOR ALL HEALTHCARE PROFESSIONALS AND CAN IMPROVE OUTCOMES

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What is Emotional Intelligence?

Emotional intelligence is a term popularised by the American Psychologist Daniel Goleman^[1]. It is the ability to recognise, understand and control one's emotions and consider the impact these have on oneself and others around them, particularly in the context of social interaction. Emotional intelligence can therefore allow for the formation of strong friendships, effective leadership abilities, high performing teams, and is usually identified in high achieving individuals^[2].

It is broadly recognised that emotional intelligence is comprised of four main components:

- Self-awareness – this represents one's ability to recognise one's own emotions and responses to a particular situation. This can also extend to recognising one's own strengths and weaknesses, cultural influences, biases, values, and how this impacts and influences others.
- Self-management – refers to the ability to control one's emotional response to a particular situation, allowing for healthy, non-disruptive interactions. In combination with self-awareness, the ability to temper and alter a response in a social setting can prevent escalating negative interactions and allow for healthy relationships to continue.
- Social awareness – refers to the ability to recognise and act on the emotional responses of others in an empathic way. Reacting to these can facilitate communication, enhance relationships and support others. Social awareness can also extend to recognising power dynamics within a team, or organisation.
- Relationship management – indicates the ability to healthily and successfully maintain social relationships, interact with others in a productive way, work in teams, and even lead and inspire those around them.
- Emotional intelligence is linked to intellectual intelligence (IQ), but operates as a separate system^[3]. This was demonstrated by Damasio, who showed that impairment to the prefrontal cortex impairs emotional response

and rational decision making, while leaving intellectual and cognitive function intact^[4]. It is generally felt that IQ is something fixed, determined in development by the interplay of genetics and environment, whereas emotional intelligence is more malleable and can be taught and improved.

Why is Emotional Intelligence Important?

Developing skills in emotional intelligence has numerous benefits. Prati et al describe how a leader with higher emotional intelligence directly correlates to higher team effectiveness^[5]. A leader who can recognise the emotional responses of those around them, navigate how these team-members interact and communicate, and predict responses of those around them, can better motivate that team to perform. A leader with high emotional intelligence can simultaneously create an environment of empowerment and support, resulting in team members who show higher self-motivation, and a conscientious responsibility to want to achieve the best for that team. In business this can mean greater profits, high employee satisfaction and worker retention. It can create teams that innovate, perform highly, and produce high quality work. In medicine this can mean better performing teams that are providing better care for their patients.

Emotional intelligence also plays a key role in dealing with conflict^[6]. Being aware of your own emotions in a situation allows you to control them, identify the best approach based on the perceived needs of others and how your response interplays with their emotions, in order to proceed in a productive manner when working with others. Utilising this approach effectively can often avoid conflict. If there has been conflict, developing high emotional intelligence can allow for greater success at conflict resolution. A study by Başoğlu and Özgür demonstrated the improved outcomes between nurses when the nurse in charge allocated to mediate the conflict, scored higher on their emotional intelligence scales^[7].

A study by Shahid et al^[8] reviewed how developing emotional intelligence may benefit doctors. They reported that inclusion of an educational intervention to help improve emotional intelligence "may improve stress management skills, promote wellness and prevent burnout in resident physicians". With reported levels of burnout amongst doctors increasing, they proposed the benefits of emotional intelligence would be widespread and significant. Recognising your own emotions in response to stressful environments, in this case in a clinical setting, can allow you to develop healthier coping mechanisms and prevent impact on inter-personal relationships and patient care. The study demonstrated significant improvements in emotional intelligence after an educational course, evidencing that this is a skill that can be learned and improved.

A doctor with higher levels of emotional intelligence can lead to improved patient satisfaction. An observational study by Hui-Ching Weng utilised self-surveys across doctors and patients in an out-patient setting and found that doctors with higher emotional intelligence correlated to increased patient satisfaction^[9]. One of the difficult tasks of any patient interaction is reaching a level of understanding with a patient that best allows you to mutually agree an appropriate management plan. We have already discussed how emotional intelligence allows one to regulate their own emotions, control them in their responses, and perceive and react to others' emotions. It makes sense that this would be beneficial when it comes to doing this with a patient, as well as when acting in a team. Conflict resolution skills can also be utilised here with patients and family and allow for far greater outcomes in those with high emotional intelligence.

It has been considered whether emotional intelligence should be included as part of a selection process for doctors, given its numerous and recognised benefits^[10]. Peggy Wagner discussed the potential to not only be able to identify those individuals with sufficient IQ required to manage the theoretical aspects of the profession, but also the emotional intelligence to be able to supplement this. They argue the role of a physician extends beyond book learning to handling difficult patient interactions, working within many different teams, usually with leadership roles, all of which require emotional intelligence. However, they felt that it is not a reliable way to select candidates, and instead, should form part of the educational experience after successful application.

Conclusions

There is an increasingly pressing need for doctors to understand their own emotional reactions to what they experience in their practice. Doctors are exposed to a variety of traumatic situations from distressed patients and relatives to witnessing death. Doctors are human and most, if not all humans, will absorb some of the emotional burden even in their subconscious.

The experience of doctors practicing in the current climate is stressful with increasing regulations aimed at improving quality of care. Therefore, it is not surprising they are often overwhelmed in a tug-of-war between administrators, staff, colleagues and most importantly, patients. With many doctors experiencing burnout, questions arise regarding

their mental health and work-life balance.

Improving emotional intelligence can help doctors become more aware of the burden, allow them to regulate their response and develop healthy coping mechanisms. This can contribute towards improving doctor's overall health. Further to this, recognising the impact of emotion as an individual opens a pathway to respond to these traumatic situations with patients optimally and address personal work-life balance issues.

Indeed, in reality it can be challenging to be both scientifically objective, clinically competent and empathetic towards patients, but what about empathy towards ourselves? Perhaps the current "ideal" image of doctors is that of a clinical, rational, skilful, yet somewhat emotionally detached persona. To be emotionally expressive often is perceived to equate to unprofessionalism. It is these very images which prevent doctors from engaging with their patients emotionally and with their own feelings. Engaging with our own feelings forms the foundation of empathy derived from a level of emotional intelligence.

Doctors should be supported with this emotional burden in the healthcare environment. Empathy and emotional intelligence should not only be expected from doctors but should be actively promoted, assisted and cultivated in the medical profession. Practices like emotional intelligence and mindfulness provide vehicles for realistic long-lasting solutions which will be imperative given the increasing pressures doctors will continue to face. Institutional support and educational intervention has been proven to help and should be utilised at every possible opportunity.

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What can Medical Students do in the Coronavirus Pandemic?

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Introduction

In the last two days, the World Health Organisation (WHO) have characterised the coronavirus (COVID-19) outbreak as a pandemic¹. This is not something to be taken lightly, and in a time when the capacity of the National Health Service (NHS) will be tested, it is important to consider what role medical students can play in the crisis.

Should medical schools be closed?

Pandemic outbreaks represent a unique challenge to medical education. The closure of medical schools or suspension of patient contact will of no doubt be disruptive to education; however, one must consider the risks versus benefits of having medical students on the wards. Some medical schools in the UK are already taking extreme measures. For example, Cambridge University have cancelled their final year clinical examinations². These examinations require face-to-face contacts with patients, so cancellation is understandable given the potential risks associated.

As I write this article, my own institution, the University of Oxford, have announced that all clinical teaching will be suspended until further notice, giving the reason that this will allow clinical tutors to spend the majority of their time treating patients. This seems inevitable as it is unlikely that medical students will be able to receive adequate teaching from hospital staff in the current situation. It will become even more unlikely if the situation in the UK escalates to the level reached in the Hubei province, where entire hospitals were transformed into COVID-19 treatment facilities³.

Looking into the future, it will be difficult to completely halt medical education, as this will seriously impact the competence of the doctors who will join the workforce in the future. That being said, there are some alternative methods of clinical teaching which medical schools could consider. During the severe acute respiratory syndrome (SARS) epidemic in 2003, several medical schools which had barred medical students from patient contact instead used web-based learning and mannequin-based simulation training in order to minimise disruptions to medical education⁴. Given the recent improvements in technologies such as virtual reality, it may become necessary to utilise this type of "patient surrogates" further in the upcoming months.

Should medical students join the NHS workforce?

The UK's Chief Medical Officer Chris Whitty revealed in a statement earlier this month that the government is considering drafting medical students into the workforce, as well as encouraging retired General Practitioners to return^{5,6}. If necessary, final year medical students may be able to take on some of the roles of foundation year one doctors, in order to help shoulder the burden. In previous health crises, similar actions have taken place. For example, during the 1918 influenza pandemic, medical students in the United States of America were fast-tracked through medical school in order to increase the number of healthcare workers available to help on the front line⁷.

First year clinical medical students like myself are faced with a unique dilemma. Our relatively limited clinical exposure and skills restricts our ability to make a meaningful contribution on the wards. However, being a part of the healthcare community and future members of the NHS front-line, I believe we do have a responsibility to contribute where we can.

Although it is true that even observing ward activities will provide us with valuable lessons, we must be practical when considering how the presence of non-essential staff such as ourselves may increase the risk of virus transmission in hospitals and out in the community. Our reasons for being on the wards would be purely for our own educational benefit, rather than for the immediate care of patients. The General Medical Council's "Good Medical Practice" applies to medical students as well as doctors. Within this document, it states that "the care of your patient is your first concern"⁸. For first year clinical students, this may mean refraining from the wards, as the risks to patients' health may not outweigh the benefits of continuing our clinical education in this manner in the short term.

Medical students have a responsibility to act sensibly and do what we can to minimise our own risk and risk to others in our networks. This includes keeping well informed, maintaining good hygiene, practicing social distancing and self-isolating if necessary. In a time where fake news is rife, conveying clear messages to friends and family online may also be a good idea. In terms of volunteering, there are many non-patient facing roles that medical students can be involved in.

These include helping to run the NHS 111 hotline and driving vans with ventilators to satellite intensive care units. So if you would like to help, then I recommend contacting your medical school to ask what you can do. It is also important to remember that medical schools have a responsibility to ensure that all healthcare professionals (including students) are well-trained in the use of personal protective equipment and have knowledge of infection control measures.

Conclusion

In the WHO pandemic response, the fourth and final stage is "innovate and learn". I believe there is much to be learnt about how to continue medical education in a health crisis. The whole world will be playing catch up during the aftermath of the pandemic, and as medical students, we will have to do the same. Learning how to deliver care in a crisis will help us prepare for pandemics which may arise in the future, at a time when we will make up the majority of the workforce.

Where to find the latest guidance about coronavirus:

1. The Public Health England Website
2. Foreign and Commonwealth Office (FCO) Website
The University of Oxford Coronavirus updates

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Picture: PA

LOVE IN THE TIME OF CHOLERA

HOW DOES EDUCATION AND TRAINING SURVIVE IN THE FACE OF A PANDEMIC?

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Introduction

Gabriel Garcia Marquez created a timeless narrative of love blossoming in the face of malady, of trust and betrayal and eventually decades later, 'true love' flourishing between Fermina and Florentino in the autumn of their lives. There are several similarities one can draw from the Marquez's world of fantasy in Columbia to 2020. One that is wildly infectious, has been a pandemic since 2010, affects millions of people worldwide and causes between 30-130,000 deaths.⁽¹⁾

As the world rushes to find a vaccine for the novel corona virus SARS-CoV2 causing Covid19⁽²⁾, the essential message for containment is still as simple as avoiding contact, social distancing and washing hands frequently with soap-water or sanitising using alcohol gel. John Snow developed his epidemiological techniques of contact tracing and isolation back in 1854, working in London; many of which form the corner stone of current strategies.⁽³⁾ In the first few weeks of the discovery and rapid spread of the novel corona virus, health systems in every country of the world are examining their preparedness. In the United Kingdom, the cash-strapped and workforce-challenged National Health Service which seems to be perpetually in the throes of 'winter crisis' feels unprepared for coping with this new malady. The government is rapidly moving from its prevention to delay strategy. There are calls for inducting medical and nursing students to complement the challenges and rapidly depleting workforce and to return retired healthcare staff back in to duty as a national healthcare emergency is being declared.^(4,5) As of 20 March, all schools are closed indefinitely and all examinations cancelled or postponed.

How does an organisation educate and train healthcare staff during such critical times? What may be negative impact of such lost opportunities? How do organisations take charge of educating the public they serve for high impact actions during such periods? This article explores the evidence from previous pandemics and draws on what methods might be suitable for organisations to adopt.

In recent years, there has been a heightened focus on the development challenges faced in contexts of protracted crises, however, there is a lack of robust evidence on how

to effectively translate this interest into practice. In the field of educational research, this is further compounded by the comparative lack of academic capacity on to explore 'education in times of crises'.⁽⁶⁾

Enhancing understanding of the role of education and learning in responding to and fashioning novel ways for coping and/or transforming opportunities and outcomes in crisis settings, particularly those in the longer-term and including natural as well as man-made crises.

Building the evidence base of how education and learning take place and are affected during and through crisis situations, including particular attention to the importance of local context and practice in this regard, and what implications this entails for learning and communities.

Investigating how crises particularly affect the education and learning of healthcare staff and their families of hidden populations, marginalised people including girls and women, and populations on the move. Although the World Bank report⁽⁶⁾ on global learning crisis refers to universal education the principles and recommendations are equally applicable in the healthcare setting.

Firstly, there is a need to assess learning, so it can become a measurable goal. In the context of healthcare setting, the imperative of assessing and reporting on outcomes remains critically important. The findings however stark, will help to focus attention on learning, inform policy choices, track progress, and shine a spotlight on areas which may be lagging behind.

Secondly, it is necessary to attract innovative minds into teaching and keep them motivated by targeted teacher training, deploy adaptable technologies that help teachers to teach in the clinical setting preferably during the real-time management of patients and strengthen governance.

Thirdly, there is a dire need to use information and metrics to motivate staff, increase accountability, and create the political will for educational reform. The WHO recommends reaching out to stakeholders, including patients and the

wider community, in all stages of education reform, from design to implementation.

At the Oslo Summit for Education and Development⁽⁷⁾, the report from Overseas Development Institute (ODI) recommended a governance structure including a top-level oversight body that includes the most powerful and influential influencers to assume responsibility of education. In a way, the UK already has an arm's length body, Health Education England (HEE), the deanery in Scotland or the Health Board in Wales to provide a unified and strategic 4 nation approach to healthcare education and strategy. There are national committees working on specialist areas such as Technology enhanced learning, the eLearning for Health to support the adoption of a unified educational regime, norms and platform of support for education of all staff.

Amidst the rapidly evolving global health crisis of COVID-19, the UNESCO held its first virtual meeting on 12 March 2020 where there was consensus on the importance of UNESCO's Futures of Education initiative⁽⁹⁾. Numerous participants in the meeting expressed concerns about inequalities deepening and emphasized the importance of collaboration and solidarity—particularly in ensuring that educational opportunities reach the most vulnerable and marginalised. Within healthcare education and training sector, there are vast inequalities in provision, financial resources and capacity in different countries around the world. Even in the UK, under the watchful eye of General Medical Council's (Quality Assurance Framework)⁽¹⁰⁾ HEE has struggled to provide for parity across the country⁽¹¹⁾. In the face of crisis, it is perhaps inevitable that these inequalities of variable educational and supportive environment will widen. Areas that have struggled to provide for a stable environment and positive approach are at risk of shelving any attempts to improve quality. The consequences are often direct on trainee morale, and indirectly in patient related outcomes.

Yet, while the healthcare leaders are calling for re-purposing of the workforce to face the crisis, providing refresher training to equip many retired / returning healthcare workers⁽¹²⁾ or those that have not been in patient facing roles in the recent past, and increasing specific capacity for intensive care⁽¹³⁾ as appears to be the need of the hour- there is no better time for education and training faculty to innovate and reach for the most radical of solutions.

It has been observed in human history that necessity and frequently war-time provides the catalysts for huge progress in innovations and human inventiveness. It could be said that the time we are living in now is the third of the world wars. Only this time, the enemy is to be invisible, measured in microns and spreads rapidly through human contact. We have seen countries across the world take sweeping measures to contain public contact. The ability of instantaneous information flow across the digitally connected world population has allowed countries across the globe to learn from each other and move rapidly. Within days we have seen similar measures being rolled out from countries bordering the pacific to Europe and Africa.

What then are the solutions to provide rapid access to relevant education and training to vast swathes of the workforce while maintaining social distancing. The answer is technology⁽¹⁴⁾. Learning has been switched to the virtual classroom⁽¹⁵⁾

using multiple platforms. Content can be generated from universally available devices (the ubiquitous smartphone, tablets and laptop computers) and delivered to individual learners. The flexibility of place, time and convenience that this universal method of streaming interactive content across the globe allows is mind-boggling. Providers such as Microsoft Teams, Zoom and Google Classroom⁽¹⁶⁾ have seen their usage rise exponentially. Organisations of different sizes and culture have rapidly adapted to delivery of learning through next generation technologies.

As the novel Corona virus spreads across the globe, a revolution is happening in human life. In addition to the change in social culture, a phenomenal expansion is being enacted in education and learning. The artificial barriers are being broken down as universal access to education is being delivered. When the world emerges from this pandemic, human civilisation and along with education would have been transformed forever.

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British Association Of Physicians of Indian Origin

GENERAL ADVICE

- Follow national and trust guidelines but try to pursue a higher and better standard.
- Recommend: High risk colleagues i.e. ID, ICU, ENT, Anesthetists, Ophthalmologists, Resus Teams, A&E, AMU, Respiratory and UGI Endoscopy to be extremely careful in handling patients and to follow highest recommended standards.
- Recommend: staff to wear scrubs or uniforms, left to be washed at the hospital
- Recommend: surgical mask (plus visor for close contact e.g. examining patient) as the standard for suspected and confirmed cases. Unless there are aerosol generating procedures in which case you need an FFP3 fit tested mask.
- Recommend: canceling all elective surgery including cancer and cancer cases to be decided on a case by case basis with postponement as default.
- Recommend: MDTs to go virtual
- Recommend: distancing at the hospital, avoid meetings
- Recommend: healthcare staff to be screened with questions and temperature check and those who fail screening to be sent home
- Recommend: Free parking and free food for staff (Northumbria has already done this)
- Recommend: all staff who are not providing direct service for the day to stay at home (staff health preservation)
- Recommend: All patients arriving in the hospital to be screened for COVID-19.
- Recommend: making an individual judgement around the risk and if deemed high risk then ask for full protective gear. If full protective gear is not available or not being provided, please ring your defence union for further advice.
- Recommend: contact with suspected COVID-19 patients should be minimised. Physical examination of the patient should be avoided if possible.

AN OXFORD MEDICAL STUDENT'S TOP TIPS FOR GETTING INTO MEDICAL SCHOOL

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PART 1: IS MEDICINE FOR YOU?

INTRODUCTION

When I was a child, I wanted to be an astronaut. However, when I realised that this job requires rigorous physical exertion, I changed my ambition to astrobiologist (aliens were definitely my thing). As I explored my love for biology through reading, I discovered that what really interested me was a little closer to home – think planet Earth, think humans. So, at age thirteen I finally decided that I wanted to be a doctor.

Between the ages of fourteen and seventeen I focussed single-mindedly on one thing: gaining a place in medical school at Oxford or Cambridge. I pursued this dream so meticulously that by the end of my school career, I had essentially become a professional at getting into medical school. I'd read all the books, watched all the videos and read all the articles. Without tooting my own trumpet too much, let me play you a piece. This series will tackle the ins and outs of the application process, including topics such as: personal statements, work experience, examinations, interviews and extra-curricular activities.

WHY DO YOU WANT TO STUDY MEDICINE?

Four years into medical school and hearing those seven words still send shivers down my spine. It is the question that all applicants fear. When I was applying to medical school this was one of the most difficult questions I had to prepare for. I remember recording myself saying my answer out loud, then cringing when I heard it back. I also remember thinking that it was so hard to come up with an original answer - surely there are only a few reasons why people want to become doctors? In one of my interviews at Oxford, I was asked a variation of the dreaded question. They asked: "Why should we ask the question: why do you want to study medicine?"

As it happens, this raises an important point. Answering the question: "why medicine?" shouldn't be a performance. After all, you're applying to be a doctor, not an actor. This question should be one that you ask yourself. Getting a place at medical school is not easy. Also, getting through medical school is not easy either. Your time will consist of long hours in the library, laboratory and ward. You may feel like you're working much more than your non-medic friends, and you'll

be held to a different standard too.

The reason I mention all this is not to scare you, but instead to demonstrate a point. The lengthy application process itself is a good test of your desire to study the subject. In my opinion, the most important thing when embarking on the journey to medical school is to figure out if you truly want to do this, and whether that motivation enough to get you through years of hard work. So, how do you do that?

Firstly, it's important to ask yourself whether you know what a doctor actually does, and how the UK medical system works. As much as we may wish that being a doctor is like being on House MD, but sadly that is not the case. In my opinion, the best way to figure this out is by talking to doctors you meet during your work experience about their jobs, watching videos made by medics and reading personal essays. It is important to use your work experience time to actually assess whether you enjoy the working environment, and whether you think you may fit in. Work experience is not just a box ticking exercise, and can actually be very valuable to you.

WHEN IS TOO EARLY TO START PREPARING?

Whenever students or parents ask me this question, I always give the same response. In my opinion, it's never too early to start doing something. It's a lot easier to get off the path to medical school then to get on it at a later date.

Let's say that you are fourteen years old and you decide you want to be a doctor. So, you sign up for some volunteering sessions, you spend a week shadowing some doctors and you read a few science books. Fast forward three years and you decide that medicine is no longer for you. You've not really lost anything having given up some of your time to volunteering, in fact, you've probably gained some life experiences and helped people out in the process. Having read those books will just have helped you become a more well-rounded person, and you're now free to focus on what you really want to do.

Let us now consider the opposite scenario. At age fourteen you aren't really sure about medicine, but at seventeen inspiration has struck and you realise that medicine is your calling. To your dismay, you haven't taken the right A Levels

or managed to do any work experience. Work experience can sometimes take months to organise, and if you're not well connected, you may not have enough time before the application deadline. So, if you think you are even somewhat inclined to medicine, there are some things that you can do to make sure that you're on the right track.

1. Keep up to date with health and science news

It's important to keep well informed, not just for your personal benefit, but for your application too. Having a general understanding of current affairs will be useful for your interviews, your personal statement and even for your Biomedical Admissions Test (BMAT). I recommend building a habit by reading the news at a certain time each day. This is a great habit that you could even maintain into your adult years. When I was in school, I wrote particularly important or interesting news headlines down in a journal, so that I could look back at it during interview preparation.

2. Choose the right A Levels

For the University of Oxford and several other medical schools, it is compulsory to take Chemistry and one other Science A Level. If you are contemplating medicine, it is critical to have these, or else you'll be stuck at the first hurdle. It's my personal view that Biology A Level should also be compulsory for medicine, because in my four years at medical school I have relied a lot more on the knowledge and skills gained during Biology A Level than those I gained from Chemistry. However, the theory is that it is possible to catch up the Biology syllabus in your own time, whereas with Chemistry it may not be.

3. Start volunteering

Not only does a long-term commitment to something this look great on your application, it will also help you to become

more comfortable with interacting with people of different ages, backgrounds and abilities. I recommend reaching out to a local care home or nursery.

4. Hone your extracurricular activities

If you can, try to take on some leadership and teamwork roles at school. This could include joining a sports team, running a club or editing for the school's magazine. It doesn't really matter what activity you do, as long as it is something you enjoy. Leadership and teamwork are qualities that will come in extremely useful when working in a multidisciplinary team in a healthcare environment. Also, managing extracurricular activities on top of your academic demands is good practice for maintaining a work-life balance in university and in the workplace.

5. Read some science and medicine books

Regardless of whether or not you include them in your personal statement, reading around the subject is an important part of the application process. Not only will it give you something to talk about at interviews, but it may also give you an insight into the profession and ignite your interest in a particular topic. There are several good books out there, and many recommended reading lists to browse.

Three books that I recommend are:

- Also Human: The Inner Lives of Doctors by Caroline Elton
- Life at the Extremes: The Science of Survival by Frances Ashcroft
- Bad Science by Ben Goldacre

In part two we will tackle how to: choose a medical school, write a personal statement, ace the admissions tests and make the most out of your work experience.



WORKING FROM HOME

A GUIDE FOR THE BUSY CLINICIAN

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Introduction

In the week since SARS-CoV-2 has been declared a global pandemic, healthcare workers have found themselves in the midst of an unprecedented global health emergency, amongst them are thousands of medical students. As the majority of hospitals suspend clinical placements, many medical schools are turning to distance learning with students "Working From Home" (WFH). For medical students to remain productive whilst both physically and mentally well is of paramount importance so here are 3 key tips to remember when working from home:

1. Set realistic goals
2. Look after yourself
3. Look after others

Set realistic goals

As I write this article, sixth-year medical undergraduates at my institution, Imperial College London, have taken their final year assessments online in a world-first¹ and set a precedent for online examinations at other medical schools. Keeping on top of your academic workload may thus appear important but so will ensuring proper self-care. Structuring regular breaks into your work schedule using techniques such as Pomodoro² (working for 25 minutes, followed by 5-minute break) and Getting Things Done (breaking big projects into smaller actionable items) can boost productivity by maintaining motivation and concentration. An example would be to calculate how many questions from a question bank need to be completed over the coming week and then dividing it into manageable 25-minute sessions. We are lucky to live in the digital age and so working together remains an option: Facetime and Skype to catch up with friends easy as well as more professional services such as Zoom and Microsoft Teams to work with colleagues can provide a level of accountability as well as help with mood.

Look after yourself

Personal goals will vary greatly during this period of uncertainty and from individual to individual. Working from home can blur the line between your personal and

professional life so it is important to set boundaries early on; this can be done both in terms of time and workspace. Try and keep your bedroom as a place to relax and unwind as well as occasionally disconnecting from social media and messaging services. Acknowledge that your mood will fluctuate during this extended period of uncertainty and it is completely normal to feel anxious and worried about what lies ahead. Looking after yourself and others is key to developing emotional resilience. Small things such as simply getting ready and getting dressed in the morning are small victories that are not to be overlooked.

There are a number of electronic resources currently available that have been made free to access to help healthcare workers deal with current levels of stress and anxiety. App stores are full of mindfulness apps, one example is Headspace that is currently offering 3 months of premium access providing guided meditation sessions⁴. In the current lockdown, individuals and household can still go out to exercise once a day and with the NHS recommendation of 150 minutes of moderate intensity activities remaining.

Look after others

Many students will now find themselves at home looking after both older parents and grandparents as well as younger siblings. With schools having been suspended, childcare will be a chief concern to many people. In response to this a number of online communities have sprung up to provide ad-hoc childcare to healthcare staff as they work on the front-line. A network of "National Health Supporters⁵" operating through regional Facebook groups connects volunteers to staff to provide help with childcare as well ancillary task such as shopping and dog-walking. General Practices are also recruiting volunteers to help staff telephone lines as well provide other administrative support.

Those of a medical background living at home with family will undoubtedly become a major source of information over the coming weeks. Whilst it is important to remember the limits of our expertise, the role of fact-checking messages that family members receive on WhatsApp and other forms of social media will be incredibly useful to prevent paranoia and the spread of fake news. Advocating for proper sources

of information such as Public Health England and NHS.UK is also crucial in for proper education.

Conclusion

There is currently no set deadline for self-isolation with timescale of between 3 weeks to 3 months⁶ currently being discussed by the government. In a pandemic not so long ago, it was the heroic efforts of 200 medical students providing round the clock ventilation to over 300 patients⁷. Similar efforts may be required to help reduce the predicted 250,000 casualties to below 20,000 as per the Imperial College London report⁸. Ensuring you remain well in what will may become more of marathon than a race is essential. As medical students, our responsibilities are two-fold; both as diligent citizens and as possible members of the hospital workforce.

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British Association of Physicians of Indian Origin

BAPIO was first to write to CMO expressing solidarity and applauding Govt efforts. Of course, as membership organisation we had to raise concerns felt by members regarding staff testing and PPEs. Further approaches will be made to Sir Simon Stevens to raise further points and concerns communicated to us by our members.



WHO'S STRATEGIC OBJECTIVES

WHO's strategic objectives for this response are to:

- Interrupt human-to-human transmission including reducing secondary infections among close contacts and health care workers, preventing transmission amplification events, and preventing further international spread*;
- Identify, isolate and care for patients early, including providing optimized care for infected patients;
- Identify and reduce transmission from the animal source;
- Address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines;
- Communicate critical risk and event information to all communities and counter misinformation;
- Minimize social and economic impact through multisectoral partnerships.
- *This can be achieved through a combination of public health measures, such as rapid identification, diagnosis and management of the cases, identification and follow up of the contacts, infection prevention and control in health care settings, implementation of health measures for travelers, awareness-raising in the population and risk communication.

CASE DEFINITIONS

WHO periodically updates the [Global Surveillance for human infection with coronavirus disease \(COVID-19\)](#) document which includes case definitions. For easy reference, case definitions are included below.

Suspect case

- A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.
OR
- B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset;
OR
- C. A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

- A. A suspect case for whom testing for the COVID-19 virus is inconclusive.
 - a. Inconclusive being the result of the test reported by the laboratory.
 OR
- B. A suspect case for whom testing could not be performed for any reason.

Confirmed case

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

- Technical guidance for laboratory testing can be found [here](#).

Definition of contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:

1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
2. Direct physical contact with a probable or confirmed case;
3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment¹; OR
4. Other situations as indicated by local risk assessments.

Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after the date on which the sample was taken which led to confirmation.

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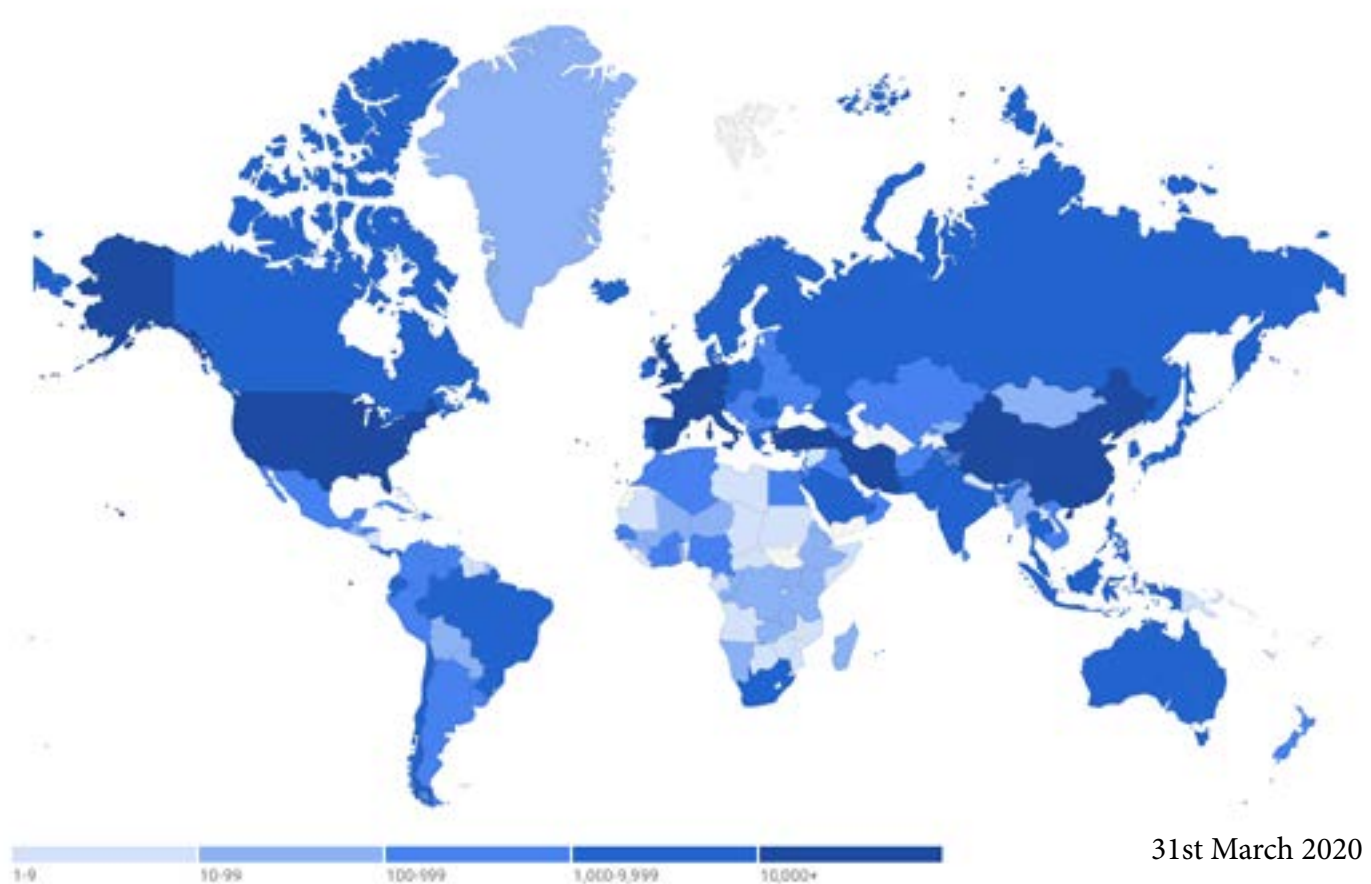
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Coronavirus (COVID-19) map

Updated less than 13 minutes ago



SURVEILLANCE: Countries, territories or areas with reported laboratory-confirmed COVID-19 cases and deaths. Data as of 30 March 2020 (Source: WHO)

	Infected	Death
Spain	78797	6449
Italy	97689	5217
China	2447	3310
Iran	38309	2640
France	39342	2602
United Kingdom	19526	1408
U.S.A	122653	2112
Germany	57298	455
Switzerland	14274	257

Remaining countries have recorded death blow 200

Confirmed UK

Cases	New cases	UK deaths	
22,141	2,619	1,408	
England	Scotland	Wales	NI
18,594	1,563	1,451	533

Data from Public Health England at 9:21 BST 31st Mar 2020

Source link: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200330-sitrep-70-covid-19.pdf?sfvrsn=7e0fe3f8_2





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