Correspondence

The recruitment legacy of COVID-19

With increasing thought being put into COVID-19 and the implications for psychiatric care in the months and years to come, it would be remiss to not consider the potential impact this could have on recruitment to the specialty.

Recruitment in psychiatry is a national, if not global problem, and has been for some time. Although frequently highlighted, there has been limited work clarifying the reasons behind the problem, which in turn has led to muted and potentially ineffective responses. This could all now be amplified by the COVID-19 crisis.

We know that foundation doctors already have very low exposure to psychiatry placements and teaching; the proportion of psychiatry teaching time has been found to be as low as 2.3% relative to surgical and medical specialties seeing 44.1%. We also know that there is a significant correlation between trainees having a foundation placement in psychiatry and going on to apply for specialty training.[1] This has been replicated in targeted studies with a surprisingly high 45% of psychiatric specialists found to not have even considered the specialty before their foundation years.[2]

So, it is not an understatement that the current foundation year trainees are to be drastically affected. Not only have rotations been paused, but huge numbers have been redeployed. Already, the invaluable experiences of an entire cohort have been curtailed, with more likely to follow. Additionally, national exams have been cancelled; the impact of this and the choices made thereafter may even lead to very immediate-term shortages and unknown ramifications.

This is before we even consider those that will shortly follow them through, the medical students. The proportionally enormous amount of time lost directly affects many of the clearly identified factors attracting students to the field such as placement and elective exposure.[3] There have recently been some targeted strategies implemented by the Royal College of Psychiatry to try and improve recruitment – especially the 'Choose Psychiatry' campaign – these outreach programmes might serve to be a much-needed lifeline more than ever before. Psychiatric societies within universities might be the great untapped resource that prevail the shutdown and educational restrictions.[4] Could they, in turn, be a vital commodity?

There is a growing recognition that although it may appear to be minutiae relative to the scale of a global pandemic, COVID-19 could have a profound effect on the career progressions of a generation of doctors.[5] Only by addressing this early and actively can we mitigate potential disaster for years to come.

Rajaei K. Sharma, Medical Student, University of Exeter, UK; email: rajaei.sharma@nhs.net; **Bhupinder Sharma**, Consultant, Royal Marsden Hospital, UK NICE Expert Advisor Centre for Guidelines Development, UK; **Harriet L. Ogle**, Medical Student, University of Exeter, UK

Declaration of interest

None.

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Highlighting some of the challenges COVID-19 has posed to the European Convention on Human Rights

The European Convention on Human Rights (ECHR) came into force in 1953 to guarantee specific rights and freedoms for people in countries that belong to the Council of Europe and to protect their human rights and prohibit unfair and harmful practices.[1]

COVID-19 took the world by storm and invaded all aspects of humanity. The 'normal approach' we had to life and issues relating to everyday living changed. New norms/ways of thinking as well as laws[2] emerged to tackle the sweeping public health crisis with consequent implications for accepted rights and freedoms under the ECHR.

Governments' world over (including Europe) variously imposed lockdown measures to limit the spread of the disease and subsequently introduced schemes to alleviate the financial difficulties imposed on their populace and pioneered schemes such as volunteer services to help the less able with shopping, collecting medication from pharmacies etc, to lessen the hardship(s) imposed by lockdown measures.

The powers available to public authorities under Article 5 (1)(e) of the ECHR to lawfully detain people for the prevention of the spreading of infectious diseases were imposed by governments across Europe with the consequence that health and law enforcement agencies acquired powers to confine otherwise healthy individuals to their homes and to isolate and screen individuals suspected to have contracted COVID-19 using powers under Article 5(1)(b) of the ECHR.[3]

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The promotion of powers under Article 5(1)(e) of the ECHR did not seem to have been extended to the promotion of provisions of Article 5(4) of the same convention, which allows for everyone deprived of their liberty by arrest or detention to be entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court and their release ordered if the detention is not lawful.

The exigencies of COVID-19 especially in the early stages meant that health resources were diverted to combat/contain the pandemic with the consequent effect that the care of some individuals were delayed and, in some instances, cancelled, for example clinics and operations, possibly leading to death as an indirect consequence of COVID-19 and interference with Article 2 rights of these individuals.

There were concerns about issues relating to the blanket approach taken to writing 'DNAR' (do not resuscitate) on the notes of older adults and people with intellectual disabilities without proper consultation[4] in disregard of their Article 8 rights.[5]

There were also problems with the supply and availability of personal protective equipment[6] to health and care professionals, with consequence on the human rights of workers[7] to be protected from toxic exposures at work.[8]

There were concerns that the exigencies of the pandemic had the potential to cause doctors to consider factors such as the availability and capacity of current resources[9] when making decisions about whether to continue life-saving treatment on an individual with a potential scenario where an individual could be deprived of continued treatment, consequently interfering with their Article 2 rights.[10]

A Court of Protection judgment[11] considered the interface between the right to private and family life (Article 8), right to liberty and security (Article 5) and right to life (Article 2) among others, and drew out the primacy of absolute rights under ECHR such as Article 2 rights over qualified and limited rights (Article 8 and Article 5 rights, respectively).

Patient consultation via telephone and video calls has grown in popularity and acceptance[12] with possible implications for Article 8 rights of patients. The effect of the lockdown on the physical and mental health of the populace as well as mortality rates, including suicides will become apparent as time goes on.

Time will tell with regard to whether the exigencies of COVID-19 had an impact on the speed of hospital discharge as well as the care of people in care homes and the care and survival of the less able and whether this interfered with their Article 2, Article 3 and Article 8 rights.[13]

Although there is the possibility under Article 15 of the ECHR for governments, in time of war or other public emergency threatening the life of the nation, to temporarily derogate from their obligation to secure certain rights and freedoms under the Convention,[14] some of the measures put in place to tackle the exigencies of COVID-19 will endure long after the pandemic has abated in the UK – otherwise we would have learnt nothing from the pandemic and forgotten nothing. There is therefore the need, going forward, to carefully calibrate the fine balance between public health needs and safety with human rights.

The understanding is that the European Charter of Fundamental Rights that brings together the fundamental rights of everyone living in the European Union, including the rights protected by the ECHR (as brought into UK law by the Human Rights Act) will stop having effect in the UK after the UK leaves the European Union. The government has however guaranteed UK's continued commitment to 'respect the framework' of the ECHR.[15]

Oluwatoyin A. Sorinmade, Consultant Older Adults Psychiatrist, Interpersonal Therapist, Course Director s12/AC/DoLS Refresher Courses, Oxleas NHS Foundation Trust, UK and Mediator, The Civil Mediation Council, UK; email: oluwatoyin.sorinmade@nhs.net

Declaration of interest

None.

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