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Journal

Key considerations for establishing a
Surgical Training Programme
in the developing world



This issue is dedicated to
**Dr Sriramashetty
Venugopal O.B.E.**
14.05.1933 – 02.03.2018



Indigenous Medicines
and Foods

Heat Stroke in the UK
Did we not see it coming?!

Chronic Cough
in Children

Cannabis:
The wonder drug

**Locum GP or
Salaried GP:**
Expenses Claims



The Journal of The British International Doctors' Association
Issue No.3, Volume 24. October 2018

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bida Journal Editorial

We are proud to dedicate this edition to the late Dr. S Venugopal. He was one of our founding members of the Overseas Doctors Association (ODA) together with Dr. S Chatterjee, Dr. K Admani, Dr. F Hashmi and Dr. A Sayeed. This is an opportunity to pay tribute to them.

It was the advice of Dr. Venugopal which has stood the test of time. He had said, "Get involved". This simple message has strong connotations. He went on to say, "Unless you take leadership yourselves, you cannot provide the kind of service the ethnic minorities need". It was at the national ODA conference in 1990 when Dr Venugopal gave a graphic description of the culture shock experienced by those who, like himself, came to the UK in the early 1950s. It was he who, together with the other founder members, being doctors, stood up as natural community leaders. This leadership has brought the British International Doctors Association (BIDA) to achieve recognition and representation for International Medical graduates in all walks of medico-political fields in the NHS.

We are very pleased with the outcome of Dr Bawa Garba's case. BIDA should be proud of its involvement in this case. Dr. Cicely Cunningham of the Doctors' Association, UK, quite rightly says, "What we need instead is a just culture, which seeks to address the rawness of families' grief as well as the hurt of the staff, who are involved when tragedy strikes". A just culture seeks to learn from events and apply this learning to bring about change.

The Editorial Committee wishes to congratulate Dr. P Singh and his colleagues for presenting a great framework for establishing a surgical training programme in the developing world. We agree that sharing skills in our global community is paramount to driving improvement. It works both ways, benefitting our trainees as well as the surgeons and local trainees of the developing world centre. There are other global foundations like the "World Orthopaedic Concern" and the "AO Alliance Foundation" in the field of trauma and Orthopaedics, where consultants and trainees visit centres in low and middle income countries (LMIC) to teach and train, but these short visits are not part of recognised training. We would support their conclusion that funded fellowships for trainees would ensure continuous input and training within the programme.



Mr. Amit Sinha
FRCS (Trauma & Ortho)
Co-Editor, BIDA Journal.
Consultant Orthopaedic Surgeon.



Dr. Ashish Dhawan
MD, MRCP
Co-Editor, BIDA Journal.
Consultant Cardiologist &
Cardiac Electro Physiologist,
Wigan Royal Infirmary

The Royal Colleges and the deaneries must listen to their trainees.

The article on "Chronic cough in children" by Dr Aditi Sinha is a must read for all GPs and paediatric trainees. It is a comprehensive article in all aspects. There is current information on "Medical uses of Cannabis". I am surprised why it has taken so many years for the UK Health Dept. to wake up to this fact. The other warning bells are about "Heat related issues". The NHS website enquiries have gone up manifold: 73,300 in 2017 to 1.5 million in the past 3 months of this year. Bob Ward from the Grantham Research Institute on Climate Change is of the opinion that "every death from heat related issue should be a public enquiry". A change in climate should bring a major change in our culture.

The tips given by Prof. Brigden in "Competency based interviews" are invaluable and most useful for preparation in the current format for interviews. In fact, similar thought processes should be used in the preparation of your CV or the Grid application for higher training.

The article on "Indigenous Medicine" by Dr Dhuni Soren outlines the intricate details of how Santals practice their medicine. They believe "that a disease-free life is possible if there is congenial relationship between Human beings, Nature and Supernatural being". Dr Soren is a well-known figure and is held in high regard amongst us as well in his native place. His work was praised and published recently in a national newspaper of India, "Prabhat Khabar".

I am sure you would enjoy this edition. What is most important is to remain proud of your association with BIDA and encourage your younger doctors in the family to become members. It is only in this way that we can encourage our young and energetic members to "Get involved" and maintain the ethos as promoted by Dr S Venugopal.

Best wishes

Ashish Dhawan & Amit Sinha

Co-Editors, BIDA Journal

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bida Journal

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Instructions for Authors

The BIDA Journal is a peer-reviewed journal. We welcome original articles from physicians and surgeons from any part of the world. These include review articles, scientific articles, case reports, audits and letters to the Editor. Each submission would be peer-reviewed and then discussed by the members of the Editorial committee at a meeting prior to publication and then either accepted for publication or rejected by the Editor.

Proofs of the edited paper are emailed to the corresponding author for correction and to respond to any queries from the Editor. Once the article is published the authors would receive a free PDF version of the journal. The printed copy would be sent to the author if requested for.

Manuscript guidelines

1. Review articles do not have a word limit but all other submissions would have a limit of 4,000 words or less.
2. We only accept papers that have 5 authors or less. Please list only those authors who have positively contributed to the article.
3. Papers should be divided into headings, which are relevant to whether it is a review article, scientific article or case support etc.
4. The conclusion should be clear and relevant to the work described in the article. Do not repeat the introduction.
5. References in the text should include only those that are important and have been studied in full by the authors.
6. It is expected that each article should have a take home message wherever relevant. Please write a brief text or learning points, which could be considered to be put in a box as a take home message to explain the relevance of the article.

References:

1. References should only be used for published work.
2. They should be presented using the Vancouver system by super script numbers in the order of the appearance and not in alphabetical order.
3. The list of the references at the end of the text should be with details and punctuation as follows.

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Phillips AM, Williams DJ. Ultrasound and the diagnosis of metabolic disorders. *J Metabolic dis* 2013;95-B:1 - 5.

Book reference:

Watson-Jones R. *Fractures and joint injuries.* Vol. 2. Fourth ed. Edinburgh: Churchill-Livingstone, 1955:744-5.

Chapter in a Book:

Wilson RA, Frank VH. Complications of implant use. In: Epps CH Jr, ed. *Complications in ENT surgery* Vol.1. Philadelphia: JB Lippincott Company, 1978:99 - 129.

Web reference:

International commission on radiological protection. <http://icrp.org> (date last accessed 20 September 2009).

Abstract reference:

Sinha L. DVT in Shoulder surgery (abstract). BOA Congress, 2011.



Figures

Please include as many figures as it is relevant to the article but you must ensure that you split the figures into separate images, as they will need to be uploaded individually. Each figure would require a short description. For x-rays, please ensure that you state the view used for that radiograph. The figures should be numbered as 1, 2 and 3 separately.

Tables

We do accept as many tables as it is relevant to the article. Each table should have a short descriptive heading or legend. Tables must not duplicate information already in the text.

Acknowledgements

These should be made onto a separate page at the end of the text.

Submission

Once you have read the guidelines and are ready to submit your article please ensure all elements are included in the same document. They are to be sent to the BIDA office or the Editor. The email address is as follows:

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1. On a separate page with the articles heading please include the details of all the authors, their designation and their place of work.
2. The author who submits the article must include his/her email address for further correspondence.
3. Once the article is accepted then it is the Editor who would be asking for photographs of each individual author, which will be uploaded and printed with the article in the journal. Please ensure that these photographs are in a high-resolution (minimum 240dpi) JPEG format.

Letters to the Editor:

We do welcome letters to the Editors on matters of general medical concern, the NHS or about any recently published article. To submit letters please write directly to the BIDA office or the Editor - all letters should be under 300 words.

BIDA office or the Editor - all letters should be under 300 words.

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Conflict of interest

A conflict of interest statement (if applicable) should be submitted by the author/authors to the Editor for any article, which is accepted for publication. This statement would have no bearing on a decision whether to publish or not to publish.

Amit Sinha FRCS (Tr & Orth)

Ashish Dhawan FRCP

Co-Editors, BIDA Journal.

14.09.2018



13th BIDA International Scientific Conference

Monday 22nd October 2018

- 09.00 am to 09.30 am** *Registration*
- 09.30 am to 09.40 am *Welcome - Dr Ashish Dhawan, Convenor, 13th BIDA International Scientific Congress*
- 09.40 am to 10.00 am *Introduction of BIDA - Dr Birendra Kumar Sinha, President, BIDA*
- 10.00 am to 10.20 am *Challenges facing the NHS Dr Chandra Kanneganti, Chairman, BIDA*
- 10.20 am to 10.30 am *Introduction of Scientific Congress - Dr Sanjay Arya, Chairman, BIDA Scientific Committee*

Session 1: Session Chairs: Dr Surendra Kumar and Dr Shashank Chatterjee

- 10.30 am to 10.50 am *Clinical Dilemmas: Can somebody help me, please? Mr Amit Sinha Consultant Orthopaedic Surgeon, Spire Yale Hospital, Wrexham.*
- 10.50 am to 11.10 am *The challenging ace of General Practice Dr Shikha Pitalia General Practitioner, Director SSP Health.*
- 11.10 am to 11.30 am** *Coffee / Tea*
- 11.30 am to 11.50 pm *Polypharmacy in the Elderly Dr Birendra Jha Associate Specialist, Care of the Elderly Dept., Upton Hospital, Slough.*
- 11.50 pm to 12.10 pm *HIV and the Primary Care Physician Dr Ashish Sukthankar Consultant in Genitourinary Medicine, Manchester Royal Infirmary, Manchester University Hospitals NHS Foundation Trust.*
- 12.10 pm to 12.30 pm *ICU Survivors in the Community Dr Sayeed Ahmed Consultant Anaesthesia & Intensive Care Unit Wrightington, Wigan & Leigh NHS Foundation Trust.*
- 12.30 pm to 13.00 pm *Questions / Answers*
- 13.00 pm to 14.00 pm** *Lunch*

Session 2: Session Chairs: Dr Alka Trivedi and Dr Leena Saxena

- 14.00 pm to 14.20 pm *Effective detection, intervention and the role of Primary Care and community Peripheral Arterial Disease clinic Dr Anita Sharma General Practitioner & GPwSI Gynaecology Clinical Director for Vascular at Oldham CCG*
- 14.20 pm to 14.40 pm *Primary and Secondary Care Interface - the Challenges Dr Veena Jha General Practitioner*
- 14.40 pm to 15.00 pm *Easily Missed and Pitfalls in Paediatrics Dr Shaila Sukthankar Consultant Paediatrician, Royal Manchester Children's Hospital, Manchester University Hospitals NHS Foundation Trust.*
- 15.00 pm to 15.20 pm *Management of Heavy Menstrual Bleeding Dr Anita Sanghi Consultant Obstetrician and Gynaecologist Divisional Director Women's & Children, Royal London Hospital, Whitechapel Caldicott Guardian Barts Health NHS Trust*
- 15.20 pm to 15.40 pm *Management of Anxiety disorders Dr Pamadeth Shobha Consultant Psychiatrist, Kent Institute of Medicine and Surgery, Maidstone. Royal College MRCPsych Examiner & Consultants Appraiser*
- 15.20 pm to 15.40 pm *Questions / Answers*
- 15.40 pm to 15.50 pm *Close of Day 1 - Dr Leena Saxena, Deputy Convenor, 13th BIDA International Scientific Congress*

Tuesday 23rd October 2018

Session 3: Session Chairs: Dr Biro Sinha and Dr Pradeep Sanghi

- 09.00 am to 09.20 am *Management of hip pain in adults in General Practice Mr Mukesh Hemmady Consultant Orthopaedic Surgeon, Wrightington, Wigan & Leigh NHS Foundation Trust*
- 09.20 am to 09.40 am *Managing Shoulder pain in General Practice Dr Uday Kanitkar General Practitioner Undergraduate Tutor and GP ST Trainer, Leyland, Preston*
- 09.40 am to 10.00 am *Knee Replacement for osteoarthritis with Knock Kneed (valgus) deformity Prof Videsh Raut Consultant Orthopaedic Surgeon Wrightington Hospital & Lancashire Teaching Hospital Honorary Professor, Edge Hill University*
- 10.00 am to 10.20 am *A tale of two Plants Dr Vinod Gadiyar Consultant in Anaesthesia and Pain Medicine Bury and Rochdale Care Organisation Northern Care Alliance, Manchester*
- 10.20 pm to 10.40 pm *Questions / Answers*
- 10.40 am to 11.00 am** *Coffee / Tea*

Session 4: Session Chairs: Dr Chandra Kanneganti and Dr Aftab Ahmed

- 11.00 pm to 11.20 pm *Advances in the Management of Heart Failure Dr Ashish Dhawan Consultant Cardiologist Wrightington, Wigan & Leigh NHS Foundation Trust*
- 11.20 pm to 11.40 pm *Artificial route for Enteral nutrition - PEG feeding Dr Ravi Sharma Consultant Gastroenterologist Rochdale Infirmary, Lancashire MMed Programme led in Gastroenterology, Edge Hill University*
- 11.40 pm to 12.00 pm *Sex and the Heart Dr Sanjay Arya Consultant Cardiologist Medical Director, Wrightington, Wigan & Leigh NHS Foundation Trust*
- 12.00 pm to 12.15 pm *Questions / Answers*
- 12.15 pm to 12.20 pm *Vote of Thanks and Close of Conference Dr Vinod Gadiyar, Co-Chairman, BIDA Scientific Committee*
- 12.20 pm to 13.00 pm *Bharatanatyam - Art or Science Dr Swati Raut Artistic Director, Swati Dance Company Principal Teacher, Milap Art School*

Mandarin Oriental Hotel,
Jakarta, Indonesia

Monday 22nd &
Tuesday 23rd
October 2018

BIDA National President's Report



Dr Biru K Sinha
National President, BIDA

Greetings to all BIDA Members,

It is a little over 12 months ago since our new team took over. During this period I have seen much progress in various fields with the help of our officers and active members especially our young and dynamic Chairman Chandra and General Secretary Ashish.

I would like to convey my condolences to the family of Dr Venugopal. We as the BIDA family were immensely saddened to learn of the sad demise of our original founder member.

As we are all aware the recent injustice in the case of Dr Bawa-Garba has shaken the entire medical fraternity in the UK. I am happy that our organization played an important role in raising the issue and getting Dr Bawa-Garba the proper justice she deserved. The turnaround in Government policies on restricted visas to Indian doctors was again a result of vigorous campaigning and BIDA was central in this campaign.

Our next BIDA ARM/AGM is taking place next month near Warrington and we are extremely thankful to Merseyside and Cheshire Division for hosting it and for working very hard towards this important event. The annual event of Presidents Cricket Cup Trophy took place as usual. Dr Raghu Hegde our National Sports Coordinator has done a fantastic job. I congratulate Wigan Division on winning the trophy for the third consecutive year.

I am and so are we all looking forward to our next international congress in Indonesia, which has become an important event in BIDA calendar.

We are currently trying to put our finances in order with the help of our National Treasurer Mr Pranab Sarkar. The strength of any

organization is membership and in coming days we must work hard to attract new and young members to join BIDA.

We recently had a meeting to discuss our retired members as several divisions are having problems with ABPI rules that govern the pharmaceutical companies, and hence I had a detailed chat with APBI regulators and had an official letter about retired members attending the clinical meetings. The summary of the discussion was that if the members were not licenced to practice it would be difficult to justify their attendance in the clinical meetings, which are sponsored by the Pharmaceutical companies. All of us at BIDA realise that our retired members have made immense contributions to our organization, and we wholeheartedly appreciate it. My recommendation would be for divisional officers to organise some social events which can be attended by all BIDA members.

I would like to take this opportunity on behalf of BIDA to thank our BIDA Journal Editorial board, especially the two editors Amit and Ashish for all their hard work all year round to produce a quality journal, which is the face of BIDA.

I'd like to thank our Central Office staff Alison and Mandy for their hard work to keep the office friendly and efficient. Best wishes for the upcoming ARM/AGM and International Congress. Long Live BIDA!

Dr B K Sinha
National President, BIDA

BIDA Women Doctors' Forum Chairperson's Report



Dear members,

The BIDA Woman's Forum meeting was held on Wednesday 25th April 2018. The clinicians presented key action areas to the attendees to make them aware of the holistic approach towards management and also to bring them up to date in the following topics:



Dr Leena Saxena

Chairperson, Women Doctors' Forum, BIDA

Vitamin D update on Prevention & Treatment:

Dr. Sangeeta Naraen (Consultant Physician)

Update on oral contraception pill:

Dr. Nidhi Srivastava (Consultant Obst. & Gynaecology)

Healthy mind, healthy body:

Dr. Alka Trivedi (General Practitioner)

This meeting was very well attended and all speakers presented their subjects expertly, which was followed by interesting discussion about their topics. Update on the various non-clinical therapies for healthy wellbeing including Yoga and laughter Yoga that makes a great way to soothe a person's mind and relieve worries.

Dr Leena Saxena

Women Doctors' Forum Chairperson, BIDA

BIDA National Treasurer's Report



Mr Pranab K Sarkar
National Treasurer, BIDA

Dear Members & Delegates,

It is my privilege to welcome you all to this year's AGM/ARM at the Daresbury Park Hotel, Warrington on 12-14 October 2018 hosted by the Merseyside & Cheshire Division. We are very grateful to Dr Biplab Das and his team for hosting this year's AGM/ARM. I am hoping that delegates from various divisions of BIDA will attend this very important annual event of BIDA in large numbers and strengthen BIDA through their active participation, as members' contributions are vital for the efficient running of the organisation.

This is the first year of my first term in the office as the National Treasurer. I would like to take this opportunity to thank Dr Biru Sinha, my predecessor, for his contributions to the organisation and also giving me valuable insight and advice in managing this important office.

Financially we are in a challenging situation. However, as we are determined to keep our finances in good health, recently it has been necessary to propose a number of measures in order to balance the book. Accordingly, we have proposing to increase our annual subscriptions and reduce a number of subsidies. As I remain determined to ensure that our finances are managed efficiently, I would need your support to implement these difficult, but necessary, decisions in the interest of our organisation. I can assure you that I will remain constantly vigilant on our finances in order to keep a healthy balance.

While we remain focussed on reducing our 'non-essential' expenses, we have agreed to continue to reimburse our ARM delegates by keeping the ARM package cost effective for the

organisation. We will remain committed to support our divisions by maintaining the divisional refunds at its present state. We would continue to support various educational meetings and strategic professional activities with a view to fulfilling our main objective to raise BIDA's profile regionally and nationally by providing financial support from the central funds. We would continue to financially support President's Cup Cricket tournament and our annual national badminton and the table tennis competitions. Despite our difficult financial circumstance, the NEC has given full backing to the publication of BIDA journal, the face of BIDA, which continues to publish quality articles. BIDA EC has also agreed to provide financial support to carry out modernisation of our website with professional advice.

Finally, I am grateful to the members of the EC committee and the Finance committee for their support without which it would have been difficult for me to do my job effectively. I would also like to thank Alison and Mandy for their effort towards efficient financial management in the central office. My special thanks to our Accountant Mr Zahur and his son Ameer of Altman, Smith & Co for helping us to prepare the annual financial report for the year 2017-2018 and also for providing invaluable advices on financial matters.

I wish the Merseyside and Cheshire division a very successful ARM/AGM 2018.

Mr Pranab K Sarkar
National Treasurer, BIDA

BIDA GP Forum Chairperson's Report



Dr Preeti Shukla
G.P. Forum Chairperson, BIDA

Dear members,

This year we saw the profession coming together for Dr Bawa Garba and hashtag #IamHadiza hit the social media to show support. Doctors at the BMA Annual representative's meeting declared that they have no confidence in the GMC. We supported the cause in every way we could by raising the issues in various forums and through our Facebook page and Twitter and promoting the crowd-funding page. This case highlighted that there is an immediate need to move away from blame culture for patient safety. We should promote a learning environment and doctors should be able to report and learn from errors, as is the case with airline industry. Individuals should not be blamed for the systemic failings of an underfunded, under resourced and under staffed system. We look forward to full implementation of the recommendations of the William's review.

Another major development has been the appointment of Dr Nigel Watson to lead the independent review into GP Partnership model to look into how it needs to evolve in the modern NHS. The GP Forward view stated, "GP's are by far the largest branch of British

medicine. A growing and ageing population with complex multiple health conditions means that personal and population orientated primary care is central to any country's health system. As a recent BMJ headline put it - "If general practice fails, the whole NHS fails". We have fed into the review and eagerly await the outcome.

In addition, when Mr Rahul Gandhi, Indian Congress President visited the UK to learn about the nation's healthcare system, and discussed about collaboration between the 2 countries, I stressed the importance of a good primary care system and how it could be developed in India.

I will continue to work on your behalf and raise issues and matters, which affect the profession.

Thank you

Dr Preeti Shukla
G.P. Forum Chairperson, BIDA

OBITUARY

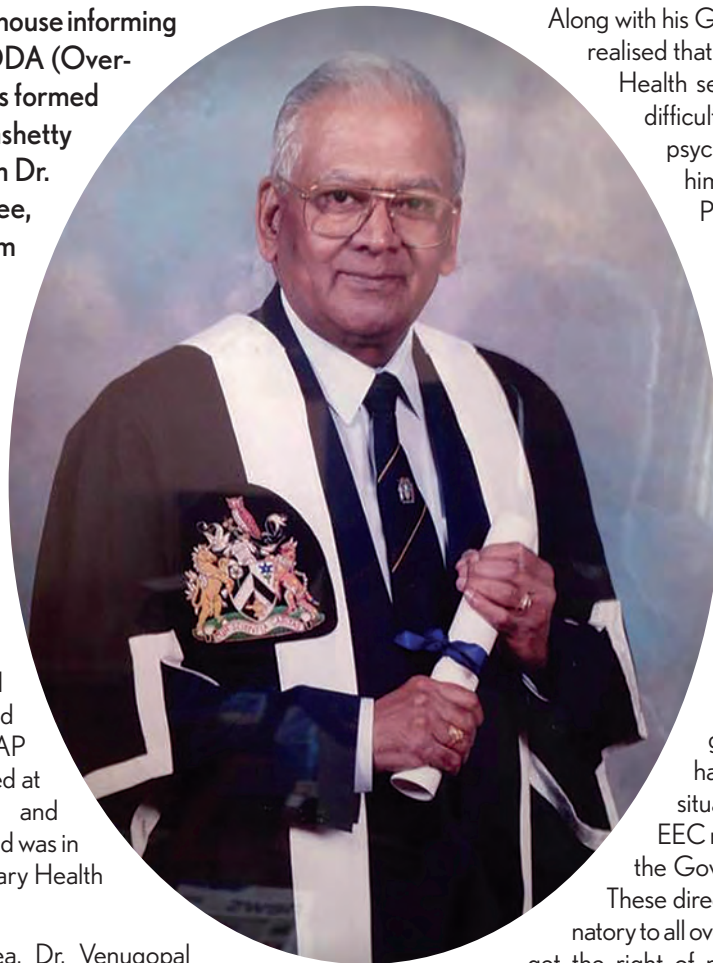
Dr Sriramashetty Venugopal O.B.E. 14th May 1933 – 2nd March 2018

We have a blue-plaque on our house informing the general public that the ODA (Overseas Doctors Association) was formed in our house by Dr. Sriramashetty Venugopal, with the help from Dr. A. Sayeed, Dr. S. S. Chatterjee, Dr. Hashmi and Dr. Karim Admani in the 1970s.

Dr. Venugopal was born on 14th May 1933 at Nalgonda, Andhra Pradesh (AP). His father, Sri Satyanarayan, was headmaster of a primary school. His primary and secondary education was at Nalagonda High School. He completed his Bachelor of Science Degree at Osmania University. After his degree he joined Osmania Medical College Hyderabad, AP. He was awarded MBBS in 1958. Having completed his housemanship, he joined the AP State Medical services and worked at Gandhi Hospital, Warrangal and subsequently at Parkal Hospital and was in charge of the neighbouring Primary Health Care centres.

At Parkal, a very deprived area, Dr. Venugopal provided a yeoman service to the population of Parkal and surrounding areas. He later joined Medical Service of Singareni Collieries and realised that apart from miners there were no services for the civilian population in coal mining areas. Along with his work at the hospital to provide medical care for coal miners, he also looked after the health of the civilian population. During his service at Singareni Collieries he took a gap year to study DRMD at Madras University. This led to the specialised qualification as a qualified radiologist. There was limited scope at the collieries hospitals in Radiology; hence Dr. Venugopal decided to go to the UK for further studies in this specialty.

On arrival in the UK in 1965, Dr. Venugopal started his career as a Senior House Officer (SHO) in Paediatrics, Grimsby. He moved to Birmingham having been appointed as a Registrar in Radiology in Selly Oak Hospital. During his holidays he started working in General Practice in Aston, which was a deprived area, where many of the Indian immigrant population lived. In the early sixties, medical care for this Indian population was very difficult to get since many English GP had problems with communication and understanding the cultural values of Indians. This prompted Dr. Venugopal to establish his own practice to help fellow compatriots providing a culturally sensitive medical care. He started with one patient, and grew his practice to over four thousand patients. This was a great challenge in the early sixties and gave immense satisfaction in serving our own community in a foreign land.



Along with his General Practice, Dr. Venugopal also realised that there were no appropriate Mental Health services for Indians and it was very difficult to provide treatments by English psychiatrists. Dr. Venugopal trained himself as a Hospital practitioner in Psychiatry and with the cooperation of Hospital Authorities and colleagues started a trans-cultural approach to provide Mental Health Service to our population. This was the First Trans-cultural unit in the UK.

During his work in the UK, Dr. Venugopal realised that Indian Doctors who had been invited to the UK in the late sixties to support Hospitals in the NHS, were not given appropriate appointments for their training and were used as a 'pair of hands'. Many of our young graduates were unable to accomplish higher post-graduate qualifications for which they had come to the UK. This inequitable situation was unacceptable. In 1974, EEC medical directives were accepted by the Government of the UK and the BMA.

These directives were restrictive and discriminatory to all overseas-qualified doctors who did not get the right of movement, as their basic medical qualifications were not obtained in one of the member states of the EEC. This was indeed overt racial discrimination for the vast number of doctors who were supporting the NHS in the UK. Many overseas doctors had already acquired UK higher qualifications and many of them were British citizens. Dr. Venugopal took this issue to the BMA, who were not really concerned and remained indifferent to their overseas colleagues. This attitude prompted Dr. Venugopal to convene the first meeting on the 11th May 1975, to organise and launch the Overseas Doctors Association (ODA) in the UK as a representative body of all overseas doctors working in the NHS.

The ODA was immediately recognised by the UK Government. The Department of Health and the Royal Medical Colleges, GMC, and CRE started a dialogue to understand the discrimination faced by overseas doctors in issues of training, promotions and job opportunities. ODA opened all the venues to redress the issues faced by overseas doctors. It is an established association still representing overseas doctors. The ODA has now been rebranded as the BIDA, to encourage second generation of Indian medical graduates qualified in the UK to join as members.

There was a special concern, that the GMC was totally unrepresentative of the Medical workforce in the UK. There were never any overseas-qualified doctors elected or nominated onto this august body. ODA lobbied parliament on this issue and a new medical act was passed so that the method of electing GMC members by the



whole profession on a single transferable vote system came into effect.

Due to Dr. Venugopal's leadership, efforts, dedication and hard work, for the first time in 1979, a few overseas doctors were elected on to the GMC. Dr. Venugopal distinguishably served on the GMC until 1999. Along with his colleagues on the GMC, Dr. Venugopal initiated the recognition of qualifications of many overseas medical colleges for the purpose of registration with the GMC. The GMC introduced the PLAB examination to ensure the quality and linguistic abilities of overseas doctors to be able to work in the NHS. Many overseas doctors found it difficult to come to the UK to take this examination, and support themselves for many months since the pass rate of the PLAB examination was very low.

Many overseas doctors who did not get through the PLAB ended up working as waiters or as petrol pump attendants. This was a very de-humanising experience for a qualified doctor. With lobbying and discussion at GMC committee levels, Dr. Venugopal and supporters convinced the GMC to hold the first part of the PLAB examination in the overseas doctors' own countries. This helped many doctors to come to the UK, after successfully completing Part1 of the PLAB examination.

Along with the medical-political activity, Dr. Venugopal was also taking an active role in the social fabric and problems of the Indian community in Birmingham. In 1972, a situation where young Indian girls were leaving home due to arranged marriages to boys from India. It was basically a communication problem and a generation gap between parents and their children. This was partly due to the fact that their parents were still holding onto their rural beliefs and value systems whereas young educated Indian girls did not share their parents' aspirations and norms. This created a major problem in the Indian community and the local social services were not able to deal with this problem. Dr. Venugopal volunteered and organised local community leaders to sort out this problem by creating the 'Link' House project to help runaway Indian girls to place of safe refuge and conciliate their problem with their parents. This was the first kind of a successful project which was used a model for other areas of the UK.

During his practice, Dr. Venugopal realised that infant mortality in the Indian population was high compared to the indigenous population. Many Indian pregnant women did not take up the antenatal care and maternity services. Many Indian women who came from rural

backgrounds continued with old Indian practices. Dr. Venugopal persuaded the Minister of Health to launch the Mother and Baby campaign to highlight the importance of antenatal care and hospital confinement, as house conditions of Indians was inadequate and poor for home confinements. It also came to Dr. Venugopal's notice, and was supported by research studies that the incidence of Rickets was high in Indian infants. Dr. Venugopal persuaded the Department of Health (DOH) to launch the Rickets campaign. This led to the marked improvement in health of Indian children.

As Chairman and president of the ODA, Dr. Venugopal organised many charitable events to support local charities in the UK. When the disaster in Bhopal happened in 1984, he organised and sent medical supplies and donations to the Chief Minister fund to help the victims of the disaster. He visited Bhopal to assess the situation and offer further assistance.

Dr. Venugopal was a member of the Rotary Club of Aston. He had organised many eye camps in India with the assistance of other club members. After the Tsunami disaster of 2004, Dr. Venugopal and Aston Rotary club raised 80 Lakhs of rupees and helped the regeneration programme, supplying permanent boats for fisherman in Cuddalore, Tamil Nadu. Dr. Venugopal and the Club supplied thousands of pounds of emergency medical drugs. Dr. Venugopal has served the Aston Rotary Club as president, and he has been elected as the 'Paul Harris' Fellow in recognition of his services.

In the last four decades, Dr. Venugopal has identified himself as a true British doctor of Indian Origin in maintaining a high standard of care for his patients and taking a full active part in Medical politics and social deliberations in the UK to help fellow Indian compatriots.

In recognition for his service to the community and medical care Her Majesty the Queen with the Excellent Order of the British Empire honoured him in 1992.

Arun Venugopal



Remembering Dr S. Venugopal

It is a great pleasure and privilege to remember our great friend, the late Dr. S.Venugopal, O.B.E. with whom I had a long association.

I first met him in early 1976, after I had joined as Consultant Geriatrician at Manor Hospital, Walsall on 15th September 1975. Dr. Venugopal was a General Practitioner in Aston, Birmingham. He was in the process of promoting the Overseas Doctors' Association (ODA), which was formed and launched on 11th May 1975, with the collaboration of a few doctors from Indian Sub-continent:

Dr. S.S. Chatterjee, Consultant Chest Physician in Manchester; Dr. Admani, Consultant Geriatrician at Sheffield; Dr. A. Sayeed, General Practitioner at Leicester; and Dr. F. Hashmi, Consultant Psychiatrist at Birmingham.

At the very first meeting, I got the feeling that here was a man with great vision for the welfare of doctors from Overseas and the Immigrant Community's health at large. I got an impression that he was quite assertive and a great communicator. I was quite impressed at the very first meeting where he highlighted the background for the formation of ODA and I readily agreed to join this movement by forming a Division of ODA at Walsall and became actively involved with the various projects of ODA at National level.

Doctors from the Indian Sub-Continent were encouraged in late 1960's to enter U.K. and work for the NHS. Gradually it was becoming apparent that overseas doctors were being used as pair of hands to fill up the jobs which local boys and girls were unwilling to do, e.g. Psychiatry, Geriatrics, Casualty, General Practice in deprived areas etc. They were suffering discrimination in Postgraduate training in their desired field of practice as well as getting appropriate jobs and promotions in their desired fields of their choice.

Dr. Venugopal came to the U.K. in 1965 after doing State Medical jobs in Andhra Pradesh, India and with a Diploma in Radiology, but after a few years of Hospital jobs in U.K. he decided to make his career in General Practice. In his own field of General Practice, Dr. Venugopal realised the plight of immigrant population from the Indian Sub-Continent in and around Birmingham, so far as medical services were concerned because English G.Ps had problems of communication with the local Asian population and they also had lack of understanding of their cultural values.

With the formation of ODA, which was formally recognised by the Dept. of Health, G.M.C. and BMA, communication at various levels were becoming more streamlined. Plight of Overseas doctors did improve to a great extent.

He also realised that Mental Health Services for Immigrant Population was not appropriate. He himself got training in Psychiatry as a Hospital Practitioner and started a Transcultural approach to provide Mental Health Services to

that section of the population. A Transcultural Psychiatric Unit was established in Birmingham and gradually became a recognised way of practice all over U.K. in one form or another.

Dr. Venugopal continued to serve the ODA, as Chairman & President for several years. He was also quite actively involved with the BMA. He did not stop there. To further the cause of overseas doctors and fight against discrimination, it was felt that Overseas doctors must be represented in General Medical Council and in 1979 a few overseas doctors were elected to the G.M.C.

In addition to his services to Medical fraternity he had also contributed in various social problems of the Immigrant community around Birmingham. One of the major problems among the Indian girls was with arranged marriages to boys from India. This was causing a great deal of disharmony and girls running away from their parental homes and getting into all sorts of problems. Local social services were finding it difficult to cope with. Dr. Venugopal took up the challenge and with the cooperation of Local Community leaders created a Link House Project to help these runaway Indian girls to find a safe place to live and reconcile.

Infant Mortality rate amongst the Indian Immigrant Community was higher than the indigenous population. Indian pregnant women were reluctant to attend Ante-Natal Clinics. Dr. Venugopal persuaded the Ministry of Health to launch a Mother & Baby Campaign, which highlighted the importance of Ante-Natal Care and hospital confinement. Rickets campaign was also started on his initiative by the Dept. of Health to prevent the rising prevalence of Ricketts in Indian children.

He was an active Rotarian too and with the International Committee of Rotary International he had led various charitable projects in Tamil Nadu.

Thus, overall through the years that I had known Dr. Venugopal I must say he was a perfect human being, kind hearted and a great leader in his field of Medical Practice as well as in the welfare of doctors from the Indian Sub-Continent and the Community at large. His services were duly recognised by Her Majesty the Queen and was honoured with the Excellent Order of British Empire (OBE) in 1992.

His demise has certainly left a big void in the Society at large, and my prayers are always with him and may his soul rest in peace.

"Om Shanti"

Dr Shivendra Sinha

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Key considerations for establishing

A Surgical Training Programme

in the developing world

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Introduction

The need for safe and accessible surgery should be a fundamental part of any healthcare system, and demand is particularly high in the developing world. Supporting this is 'The Lancet Commission on Global Surgery' who aim to incorporate comprehensive surgical care internationally and improve the global health agenda⁽¹⁾. Designing a successful surgical programme in the developing world throws up challenges related to local demand, infrastructure, funding, personnel, education, healthcare standards, and future proofing. 'Success' can be defined as "the ability to initiate a robust and sustainable improvement in surgical healthcare to as wide a population as possible in a self-propagating manner." We will address the key considerations here.



Local Knowledge

Healthcare professionals on the ground are best placed to identify areas for improvement and what infrastructure is already in place. Gathering information on population requirements will streamline subsequent surgical programmes. For example, an emphasis on basic trauma surgery in war torn regions such as Darfur, Sudan, may be more useful to the local population than congenital cleft lip and palate surgery.

Infrastructure & Funding

Once an appropriate surgical agenda has been chosen, liaising with local governments and health ministries can provide assistance with finance, regulations and infrastructure. Utilising charity aid to establish a programme can be beneficial but there is a risk of the service breaking down if funding is diverted to a more pressing crisis; relying on charity support is temperamental as funding is difficult to predict. Government involvement in a training programme is therefore key to ensuring sustainability. 'Interplast Turkiye' is a charity-government organisation, which carries out humanitarian missions around the world for craniofacial reconstructive surgery. Between 2009-2014, 6 missions were organised between 'Interplast Turkiye' and the Uzbekistan government providing 529 operations⁽²⁾.

Where local government input is minimal, charities have a more significant role. 'Interface Uganda' is a charity focused on reconstructive training in Uganda. Given the country's vast size and poor infrastructure, 'Interface Uganda' provides transport for patients to visit reconstructive centres where visiting teams can operate in a safe environment. Without this, injuries that would otherwise have been easily correctable become increasingly debilitating as they are often left untreated for prolonged periods.

Gathering Equipment

Surgeons in the developing world are often restricted by a lack of the resources that would allow their skills to be best utilized. The provision of appropriate equipment is therefore necessary and funding can be obtained via charitable means. 'Interface Uganda' have established an intelligent recycling route whereby UK hospital equipment which cannot be reused due to strict infection control protocols are collected by the charity, sterilised and transported to hospitals in the developing world. To minimise the reliance on charity, establishing a paired system between hospitals in the developing and developed world would be more sustainable.

Provisions for pre- & post-op care

Stringent pre-operative protocols in the UK exist to ensure patients are safely prepared for surgery. Although the same protocols may not be available in developing countries, it is imperative that a standard is maintained. This involves ensuring trained nurses; follow-up appointments and emergency equipment are available. Collaboration with local hospitals and laboratories can provide timely investigations and improve peri-operative care. 'Operation Smile' was the first international agency to adopt the 'WHO Surgical Safety Saves Lives Campaign' including the 'WHO Safety Checklist', which has reduced mortality and morbidity globally^(3,4) and resulted in the formation of 'Operation Smile's Global Standards of Care'⁽⁵⁾. Adopting these principles will ensure a commitment to safety when setting up other surgical programmes.

Key considerations for establishing a **Surgical Training Programme** in the developing world (Continued)



The MDT

A comprehensive surgical programme involves a range of healthcare professionals. 'Interplast' are an international plastic surgery charity who focus on creating sustainable reconstructive training programmes around the Asian Pacific. They organise for trained surgeons and allied healthcare professionals to local hospitals where they help train local nurses; occupational, speech, language and hand therapists; physiotherapists; anaesthetists; and surgeons, all of whom are crucial in forming a robust reconstructive team. Since the foundation of 'Interplast' in 1969 by Dr. Donald Laub, 40,000 consultations and 25,000 surgeries have occurred in over 25 countries through 750 programmes, demonstrating the reliability of this model and how teaching is retained in practice.

The MDT is critical in determining the criteria by which certain patients will be operated on. In resource deprived areas there is by definition a far larger number of patients that require surgery than can be scheduled. There needs to be strict inclusion and exclusion criteria so that cases deemed most necessary are prioritized⁽⁶⁾.

With a variety of healthcare professionals from around the world comes variation in expertise. To ensure standardisation there must be evidence of accreditation from their national representative bodies as well as evaluation during their volunteering to verify credentials.

Teaching & Education

Sharing skills in our global community is paramount to driving

improvement. One way of imparting surgical skills is through funded training sabbaticals for local surgeons to developed world hospitals. Although useful, this is often an artificial environment very different to the on-the-ground surgery where resources, equipment and staffing are sparser. Additionally, this process deprives the developing region of a surgeon for that period of time. Alternatively, senior surgeons from developed world hospitals could visit developing world surgeons and teach in the target environment. In keeping with this training model is 'Operation Smile' who have organised for surgeons to perform cleft lip, palate and facial reconstructive surgery in the developing world since 1982⁽⁷⁾ and in 2006 partnered with local Ethiopian hospitals to establish sustainable training programmes to ensure operations continued after departure.

A training programme in the developing world also provides opportunities for surgical trainees from the developed world to develop their skills in a very different environment, and funded fellowships for trainees would ensure continuous input and training within the programme⁽⁸⁾. However, in the UK these fellowships often involve taking time out of training, thereby restricting the number of trainees willing to do so.

The American Council of Academic Plastic Surgeons has acknowledged such international fellowships with accreditation in their residency programme, with 41% of plastic surgery training programmes in America having a formal global health educational component, thereby addressing the desperate need for international collaboration⁽⁹⁾. There has been criticism that such fellowships traverse





an ethical line between providing valuable services with operating without appropriate supervision and depriving local trainees of opportunities, but integration in to international training programmes would result in the establishment of best practice guidelines and standards.

Improving education will increase awareness of accident management⁽¹⁰⁾ and encourage individuals to enter the surgical training programme as healthcare professionals. Involving the local population and providing the means for them to help themselves is a powerful driver in maintaining surgeons in the long run. For example the 'Barefoot Doctors' programme in China has significantly reduced death rate and improved nutritional status and environmental sanitation since its establishment by the World Health Organisation (WHO) in 1950s. Adding a reconstructive element to this global programme would benefit from the influence and infrastructure provided by the WHO.

The creation of sustainable, permanent surgical centres allows for high volume research and is educationally beneficially globally⁽¹¹⁾.

Continuous Development

Continuous professional development for local surgeons is required to ensure maintenance of their skills. Funded training fellowships to developed world hospitals is one possibility. 'Interface Uganda' for example, has funded trainee surgeons from Sudan to train in micro-surgery in world famous institutes in Taiwan. This demonstrates how through international collaboration, surgery programmes in developing countries can progress to more advanced techniques.

Retention & Future Collaboration

To maintain a sustainable training programme it is important to retain the professionals who have been trained in it. They are an invaluable resource who are free to move as they wish. The drive, therefore, to stay and continue to contribute to the training programme must come from within. Seeing the improvements they are making is a powerful motivator. Being able to display and discuss their work on an international platform ensures a positive feedback cycle; this is often facilitated by grants for developing world surgeons from conferences, and

improves international collaboration.

I have highlighted my key considerations for establishing a surgical programme in the developing world. I have chosen to focus my thoughts on countries with low levels of income, with poor healthcare infrastructure and a large population of patients in need. We must not, however, be blind to the fact that in many 'developed' countries there are regions where access to reconstructive healthcare is limited. The principles I have outlined here can be utilised globally.

As advances in surgical innovation progress, we must be sure to bring these techniques to the developing world to ensure future proofing of our programme. There has been a paradigm shift from service delivery alone to local empowerment and the creation of self-sustaining programmes⁽¹²⁾. The global burden of surgery is significant, and with an increased awareness of this comes an increased responsibility to initiate change.

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Chronic Cough in Children



Dr Aditi Sinha
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Introduction

Cough is an important normal protective reflex mechanism involved in primary pulmonary defense. It enhances clearance of secretions and protects against aspiration. Prolonged or recurrent cough however can become a significant clinical problem for a large number of children. Coughing may affect 30% of children at any given time⁽¹⁾ and can be further subdivided depending on the duration of the cough symptom (see table 1). Most occur in healthy children and are secondary to acute respiratory tract infections, which usually resolve in 1-3 weeks. Some children however may have serious underlying disease, which need to be identified by ensuring a thorough history and examination is undertaken, coupled with appropriate investigations. Furthermore, chronic cough can significantly impact on quality of life of both the child and family. It can affect the child's sleep and school attendance as well as cause significant parental anxiety and distress⁽¹⁾.

Cough	Forced expulsive manoeuvre against a closed glottis associated with a characteristic sound
Acute cough	Recent onset cough <3 weeks
Prolonged acute cough	Cough lasting > 3 weeks which is progressive and may warrant further investigation
Recurrent cough	>2 cough episodes per year lasting more than 14 days
Chronic cough	A non-resolving daily cough >4-8 weeks but there is no exact consensus on the duration

Table 1: Cough definitions (1)

Aetiology

Most chronic cough is divided into 5 broad aetiological categories:

- Normal child
- Upper airway disease e.g. postnasal drip
- Asthma
- Serious underlying illness - e.g. cystic fibrosis, tuberculosis
- Psychogenic

There are a wide variety of more specific underlying conditions (see table 2), which may also need to be considered as part of your differential diagnoses.

History and Examination

Initial assessment should commence with a detailed history, which may immediately identify the cause of the cough. A specific cough history would focus on:

- Age of onset and duration of cough to differentiate between acute, chronic or recurrent cough
- Nature of cough - wet or dry
- Quality of cough - barking, wheezing, whooping
- Alleviating or triggering factors - related to feeding
- Associated symptoms - exercise tolerance, choking
- Activities of daily living - amount of sleep disturbance / school absence
- Exposure to smoke or other aero-irritants
- Response to prior therapy - e.g. previous use of bronchodilators

Infections	Viral respiratory tract infection Post infectious illness (mycoplasma, pertussis, chlamydia) Tuberculosis
Atopic Conditions	Asthma Allergic rhinitis
Chronic Suppurative Lung disease	Cystic fibrosis (CF) Primary ciliary dyskinesia (PCD) Immune deficiencies Prolonged bacterial bronchitis Bronchiectasis
Inhaled foreign body	
Airway lesions	Compression - lymph node, vascular ring Airway malacia
Upper airway disease	Upper airway cough syndrome (postnasal drip) Adenotonsillar hypertrophy Rhinosinusitis or rhinitis Nasal polyps
Recurrent aspiration	Gastroesophageal reflux disease (GORD) Neuromuscular disease Tracheoesophageal fistula
Interstitial lung disease	
Other	Environmental exposure to smoke or chemical irritants Psychogenic cough Cardiac disease Medication related (ACE inhibitor)

Table 2: Conditions causing chronic cough[1]

- Disappearance when sleeping would point more to psychogenic cough

Certain children are at a higher risk of recurrent pneumonia and chronic airway disease from aspiration and retention of secretions therefore a detailed past medical history is important (see box 1).

Neuromuscular disease
Chest wall deformities and reduced function of abdominal wall musculature
Tracheo-bronchomalacia (floppy airways)
Laryngeal disorders
Tracheostomy

Box 1: Conditions associated with ineffective cough

In addition to history, physical examination should focus on cardio-respiratory and ear, nose and throat (ENT). Attempts should be made to witness the cough during the consultation, ideally spontaneously or via asking the child to perform a voluntary cough manoeuvre. Auscultation of the chest should aim to identify abnormal breath sounds (crackles and crepitations, wheeze, bronchial breathing) as well as asymmetry of these signs.

The growth of the child should also be documented and charted as a drop in growth centiles may indicate failure to thrive, a marker for more serious pathology. A chronic wet cough plus an abnormal respiratory examination is also strongly suggestive of underlying disease⁽¹⁾. Other red flags and worrying features include:

- Neonatal onset of the cough
- Cough started & persists after choking episode

- Cough occurs during or after feeding
- Relentlessly progressive cough
- Cardiac abnormalities
- Chest wall deformity
- Immune deficiency
- Feeding difficulties
- Haemoptysis
- Neurodevelopmental abnormality
- General ill health or recurrent pneumonia
- Finger clubbing

Investigations

Even in the absence of concerning features baseline investigations including sputum culture, chest x-ray (CXR) and spirometry are appropriate 1st line investigations for chronic cough:

1. Microbiological samples – sputum, cough swab, per-nasal swab for pertussis/mycoplasma and nasopharyngeal aspirate for viruses can be easily taken during the clinical consultation to identify infection as a possible cause for
2. CXR – an abnormality is strongly suggestive of underlying pathology and guides further investigation. It can also lend support to other more specific diagnosis (see table 3).
3. Spirometry – although dependent on the age of the child (>7 years), checking values such as forced vital capacity (FVC), forced expiratory volume (FEV1) and bronchodilator testing can determine obstructive or restrictive lung disease (see figure 1) as well as bronchodilator reversibility, which will help to narrow down the possible diagnosis.

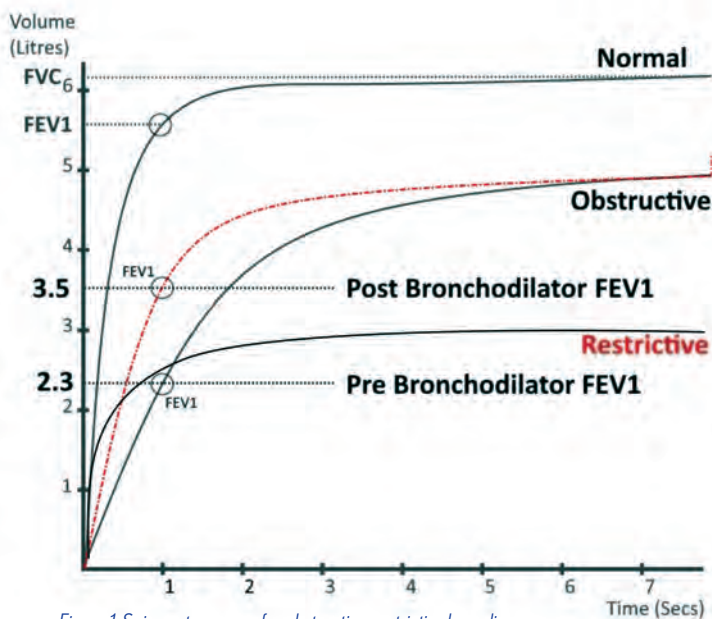


Figure 1: Spirometry curves for obstructive, restrictive lung disease and bronchodilator reversibility (2)

Specific investigations for chronic cough are directed by initial assessment during history and examination combined with results of the 1st line investigations if undertaken. Referral for paediatric opinion should be considered at this stage. Clues to specific pathology can be identified by certain clinical features and therefore investigated appropriately (see table 3). A diagnostic algorithm to guide clinicians can also be used (see figure 2).

Clinical features	Possible diagnosis	Investigations
Sudden onset cough	Inhaled foreign body	Bronchoscopy
Barking cough	Airway malacia	Bronchoscopy
Paroxysmal cough with classic inspiratory 'whoop'	Pertussis syndrome	Respiratory secretions for pertussis, mycoplasma, chlamydia
Wheeze, atopy, exertional dyspnoea, hyperinflation	Asthma	Spirometry (+/- bronchodilator reversibility)
Rhinitis, allergic salute, throat clearing	Allergic rhinitis	Trial of antihistamine, nasal spray, allergy testing
Choking with feeds, chesty post feeds, neurodevelopmental concern	Recurrent aspiration, GORD	CXR, pH/impedence tests, barium swallow, video fluoroscopy, bronchoscopy
Wet cough, poor growth, malabsorption, nasal polyps, clubbing, purulent sputum	CF, PCD, Bronchiectasis	CXR, sweat test, HRCT, nasal brushings, bronchoscopy
Wet cough, recurrent severe/unusual infections	Immune deficiency	Immune function tests
Progressive cough, weight loss, night sweats, fever, haemoptysis	TB	CXR, Mantoux, sputum or gastric aspirate for culture, gamma-interferon
Dry cough and shortness of breath	Interstitial lung disease	CXR, spirometry, HRCT, lung biopsy
Exertional dyspnoea, hypoxaemia, abnormal cardiac exam	Cardiac disease	CXR, ECG, ECHO, cardiology referral
Facial pain, pressure, purulent discharge and chronic nasal obstruction	Sinusitis	Image of sinuses, empirical trial of antibiotics
Honking cough, disappears during sleep	Psychogenic	CXR, spirometry, void over investigation

Table 2: Conditions causing chronic cough[1]. CF: cystic fibrosis, PCD: primary ciliary dyskinesia, GORD: gastroesophageal reflux disease, CXR: chest x-ray, ECG: electrocardiogram, ECHO: echocardiogram, HRCT: high resolution computerised tomography, TB: tuberculosis

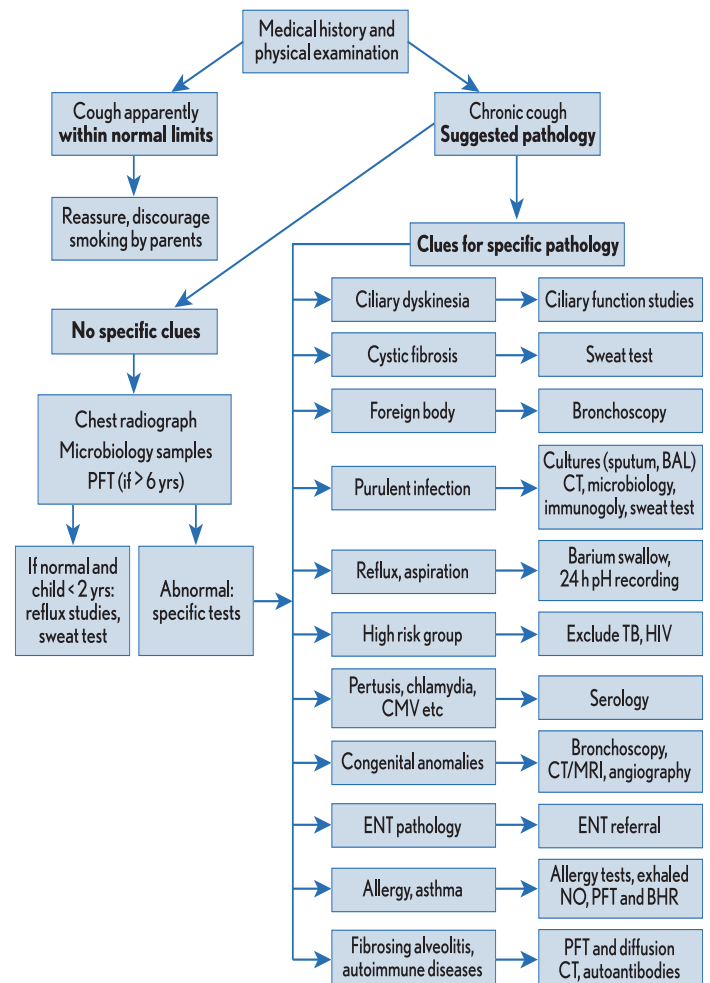


Figure 2: Diagnostic algorithm for use in children with chronic cough. Adapted from[3]. PFT: pulmonary function tests, BAL: broncho-alveolar lavage, CT: computerised tomography, TB: tuberculosis, HIV: human immunodeficiency virus, MRI: magnetic resonance imaging, ENT: ear, nose and throat, CMV: cytomegalovirus, NO: nitric oxide, BHR: Bronchial hyperresponsiveness.

Management

Management of chronic cough can depend on the nature of the cough:

Dry Cough

After thorough assessment to exclude red flags or concerning features, in an otherwise healthy child with a chronic dry cough it can be appropriate to adopt watchful waiting as 70% of cases will resolve spontaneously⁽⁴⁾. It is imperative that parental anxieties and expectations are addressed so that families are reassured about the diagnosis. Over the counter cough medications are not advised and should be discouraged. Furthermore smoking cessation advice must be provided to families and frank discussions had in relation to the effect of smoke as a risk factor for chronic cough.

During repeat follow up and re-assessment of the child it is important to review the history and examination again, as signs and symptoms of an underlying pathology may present over time and are important not to miss. A trial of inhaled corticosteroid therapy (ICS) e.g. Clenil Modulite has been suggested⁽⁴⁾. It should be prescribed for 8 weeks and once the medication is stopped, the child should be reassessed with regards to their symptoms. The recurrence of cough once the ICS stopped is highly suggestive of asthma however a high proportion of children will improve spontaneously so initial response to ICS can be misleading. Therefore a diagnosis of asthma if made must be revisited and ICS therapy continued only if symptoms dictate. If there is no improvement in the cough post trial of ICS referral to paediatrics or paediatric respiratory specialists may be required for further assessment if still ongoing concerns.

Empirical treatment for GORD with proton pump inhibitors are currently NOT recommended as they do not improve cough and are associated with increase respiratory infections⁽⁵⁾ therefore should only be used if clinical features of GORD are present or evidenced by investigations.



Wet Cough

In chronic wet cough with no other concerning features on history and examination, protracted bacterial bronchitis (PBB) should be considered. It is caused by chronic infection of the conducting airways and has been found to account for 40% of cases of chronic wet cough⁽⁶⁾. The highest incidence is in preschool children and because this condition is under-diagnosed and undertreated it can progress to bronchiectasis in a few cases, which highlights the importance promptly managing this condition. PBB is a clinical diagnosis defined by a chronic wet cough for > 4 weeks which responds to antibiotics⁽¹⁾. 2-3 weeks of Co-amoxiclav a broad spectrum antibiotic which eradicates the bacterial biofilm, is appropriate 1st line management as Haemophilus influenzae and Streptococcus pneumoniae are the main causative organisms⁽⁶⁾. A second course of antibiotics can be considered if the cough persists and no other concerns or red flags are present. However children who fail to respond should be referred to a paediatric respiratory specialist for further assessment.

Chronic cough is common presenting complaint in childhood and although a large proportion spontaneously resolve, cough can be a potential indicator of serious underlying disease. Early recognition via detailed history and examination with a focus to identify clues to guide investigation of a specific diagnosis is therefore key. Managing these children appropriately will ensure increased cough resolution, reduce parental anxiety and lead to improved quality of life for both the patient and their family.

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4th Northern Laparoscopic and Robotic Video Symposium

Friday 5th October 2018 at

South Tees Institute of Learning, Research and Innovation,
James Cook University Hospital Marton Road, Middlesbrough, TS4 3BW

Convenors: Mr Anil Reddy & Mr Y.K.S. Viswanath

PROGRAMME:

8:30 to 8:50: Registration

8:50 to 9:00: Welcome: Mr Y.K.S. Viswanath / Mr Anil Reddy

Early Morning Session

9:00 to 9:30: **Advanced Laparoscopic Bariatric Surgery** Mr Sam Dresner

9:30 to 10:00: **Revisonal Bariatric Surgery – A Dutch Perspective** Mr Misha.D.P.Luyer

10:00 to 10:30: **Laparoscopic partial fundoplication / Hiatal hernia repair** Mr Y.K.S. Viswanath

10:30 to 10:50: Coffee Break

Late Morning Session

10:50 to 11:20: **Minimal access oesophagectomy; Dutch experience and lessons learned** Mr Misha D.P. Luyer *Eindhoven*

11:20 to 11:50: **TATME** Mr Mark Katory *Gateshead*

11:50 to 12:20: **Robotic colon-rectal surgery** Mr Selvasekhar *Manchester*

12:20 to 13:00: Lunch

Early Afternoon Session

13:00 to 13:30: **Robotic colon-rectal surgery** Mr Madan Jha

13:30 to 13:50: **Robotic / laparoscopic hepatobiliary and pancreatic surgery** Mr Jeremy French *Newcastle*

13:50 to 14:20: **Laparoscopic gastrectomy, principles, dissection and reconstruction in Laparoscopic UGI Surgery** Mr Bruno Sgromo *Oxford*

14:20 to 14:40: **Laparoscopic component separation / abdominal reconstruction surgery** Mr Hugh Gallagher *Newcastle*

14:40 to 15:10: **SILS / Laparoscopic Colorectal Resection** Mr D. Garg

15:10 to 15:30: Coffee Break

Late Afternoon Session

15:30 to 15:35: Mr Dexter Simon *ALSGBI President*

15:35 to 15:40: Mr Yousuf Aaswaj *Lap-pass training and certification*

15:40 to 15:45: Mr Jeremy Williams *ALSGBI Membership*

Video Trainee Presentations

15:50 to 16:30: **SIX Registrar / MCh fellow presentations (6 minutes each)**

16:30 to 16:45: **Feedback / Conclusion / Certificates**

Close

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4. Mr Y.K.S. Viswanath
5. Mr Andy Gilliam
6. Mr Venkat Kanakala
7. Mr Venkat Shanmugam



Heat Stroke:

Did we not see it coming?

Introduction

The Guardian reported on the 3rd of August, "Deaths rose 650 above average during UK heat wave – with older people most at risk." This is quite alarming. Are these statistics true? The data from the Office of the National statistics states that during the period of the heat wave in June and July this year number of deaths registered were 633 more than the same period over the previous 5 years. One must note that even higher levels of excess deaths are seen in the colder months, but the year-to-year variation is lower in the summer months. These statistics do need further analysis. However, one statistic is certain that the heat waves are here to stay and will come every summer.

There have been reports from the Royal College of Emergency Medicine representatives that "The heat wave will have been associated with a number of excess deaths in particular putting at risk the frail elderly with heart or kidney problems." Some trusts have reported increased emergency admissions, often for respiratory problems and conditions made worse by dehydration. Dr. Isobel Braithwaite, of the public health charity, Medact said, "This fits in with current scientific evidence, which clearly shows that long periods of very warm weather can harm people's health, particularly at extremes of age and in people with other pre-existing health problems".

Will this happen every summer? Are we in the UK prepared for this? Are our hospitals and care homes designed to look after our elderly patients in these hot weather conditions. The heat also puts NHS staff themselves under pressure. Are their working conditions appropriate? There are a lot more questions that require planning but one fact is clear that the UK is "woefully unprepared" for these deadly heat waves. The Environmental Audit Committee has published similar warnings. A cross-party committee of MPs published a report on the 27th July, which stated that the government had ignored warnings from its official climate change adviser, and that without action heat-related deaths will triple to 7,000 a year by the 2040s.

How do we recognise this condition?

Heat Stroke occurs if the body temperature rises to 104 F (40 C) or higher as a result of prolonged exposure to or physical exertion in high temperatures. The signs and symptoms are:

1. Dehydration leads to altered mental state: In the early stages of heat exhaustion it may cause fatigue, dizziness, muscle cramps, confusion and headaches. In late stages, it may lead to agitation, slurred speech, irritability, delirium and coma. In young children it could present with seizures.
2. Sweating is altered in heatstroke brought on by hot weather. Skin will feel hot and dry to the touch. In heatstroke brought on by strenuous exercise, skin may feel dry or slightly moist. In the latter, there would be excessive sweating.
3. Nausea and vomiting.
4. Throbbing headache.
5. Increased shallow breathing and increased heart rate.

Risk Factors

1. Heat waves
2. High humidity in hot weather: A relative humidity of 60% or more hampers sweat evaporation, which hinders your body's ability to cool itself.
3. Heat Island Effect: If one lives in an urban area, as most of us do then one may be especially prone to develop heat exhaustion during a prolonged heat wave, particularly if there are stagnant atmospheric conditions and poor air quality. In what is known as the "heat island effect," asphalt and concrete store heat



during the day and only gradually release it at night, resulting in higher nighttime temperatures.

4. Exertion in hot weather: This may affect military recruits, sportsmen (long distance runners, football players), manual workers if they do not continuously hydrate themselves in these weather conditions
5. Sudden exposure to hot weather. This could happen during an early-summer heat wave or travel to a hotter climate.
6. Drugs: diuretics (alters sodium and water balance), beta blockers (blocks sympathomimetic effects), Vasoconstrictors Stimulants for ADHD, Illegal stimulants (Cocaine & Amphetamines).
7. Alcohol: This alters the body's ability to regulate its temperature.
8. Heart and/or lung disease
9. Extremes of age with multiple medical co-morbidities.

Complications

Untreated heat stroke leads to rapid deterioration causing seizures, rhabdomyolysis, kidney failure, coma and death.

Prevention

1. Hydration is the key to prevention. Therefore, one must **drink plenty of fluids**. Staying hydrated will help body sweat and maintain a normal body temperature.

A general recommendation for those doing moderate- to-high-intensity exercise is to drink 500ml of fluid two to three hours before exercise, and consider adding another 250ml of water or sports drink right before exercise. During exercise, you should consume another 250ml of water every 20 minutes, even if you don't feel thirsty. Also, drink another 250ml within a half hour after exercise.

2. One must **wear loose fitting clothing**. This allows the body to cool properly.
3. **Protect against sunburn**. This affects the body's ability to cool itself. It is important to protect outdoors with a wide-brimmed hat and sunglasses. It is highly recommended to use a broad spectrum sunscreen with an SPF of at least 15 generously. One must reapply every two hours – or more often if you're swimming or sweating.
4. **Avoid strenuous activity in hot weather**. One must try to schedule exercise or physical activities for cooler parts of the day, such as early morning or evening.
5. **Take extra precautions with certain medications or have a history of heart or lung problems**. Medications can affect your body's ability to stay hydrated and dissipate heat.
6. **Never leave anyone in a parked car**. This is a common cause of heat-related deaths in children. When parked in the sun, the temperature in the car can rise 20 degrees F (more than 6.7 C) in 10 minutes.
7. **Get acclimatised to the hot weather**. One must limit time spent working or exercising in heat until you're conditioned to it.



Mr. Amit Sinha
FRCS (Trauma & Ortho)
Co-Editor, BIDA Journal.
Consultant Orthopaedic Surgeon.

Treatment (Early signs of Heat Exhaustion)

1. Rehydration: Drink plenty of fluids (water and sports drinks – lucozade). Sugary and alcoholic drinks are to be avoided.
2. Go to someplace cool and with shades or a place with air conditioning, such as the mall, movie theatre or the public library.
3. If you're outdoors and not near shelter, soaking in a cool pond or stream can help bring your temperature down. Take a cool shower or bath as soon as possible.
4. Use of cool water spray or using damp sheets and a fan is another practical way to cool down.

Treatment (Heat Stroke)

It is essential to recognise the cardinal signs of this condition, often feeling very hot, agitated and confused with a raised pulse rate.

1. Immediately ring up for emergency medical help.
2. Others should take steps to cool the individual off while waiting for emergency help to arrive. This is done by shifting to a cool place with shades and spraying water or covering with damp cloth and using a fan.
3. One must not drink any fluids while waiting for the ambulance. There is a risk that the individual may aspirate the fluid.
4. Once in hospital, the heatstroke treatment centres on cooling the body to a normal temperature to prevent or reduce damage to your brain and vital organs. The diagnosis is established by the history and a rise of rectal temp to 40 C.
5. Any of these steps could be taken:
 - A bath of cold or ice water is the most effective way of quickly lowering the core body temperature.
 - The other technique uses evaporation cooling method. Cool water is misted on the body while warm air is fanned over, causing the water to evaporate and cool the skin.
 - Another method is to wrap up in a special cooling blanket and apply ice packs to the groin, neck, back and armpits to lower the temperature.
6. Shivering and seizures could be controlled by using a muscle relaxant, such as benzodiazepine.
7. Appropriate blood tests (FBC, U&Es, Urine tests, CK) are done to check for electrolyte imbalance, kidney function and to rule out the onset of rhabdomyolysis.

We now know that the frequency and intensity of heat waves is set to increase significantly over the coming decades because of climate change. The UK government needs to address the potential dangers associated with heat waves and educate the public. The government has to seriously consider a change in building regulations and planning policies to ensure homes, hospitals, nursing care homes and schools and other similar facilities are able to deal with extreme heat.

References:

- The Guardian 3rd August 2018
- Heat exhaustion and Stroke - NHS (www.nhs.uk)
- Climate change, Health impacts and opportunities: A survey & discussion of the IPCC Working Group II Report Environment Audit Committee News 26th July 2018

Cannabis:

The wonder drug

Facts:

- Cannabis plants contain more than 100 cannabinoids and many terpenes and flavonoids etc.
- The two most studied are:
THC (Tetrahydrocannabinol) - the "recreational high" is scheduled and illegal in the UK
CBD (Cannabidiol) counteracts the psychoactive effect of THC. It is legally available as a nutritional supplement in the UK.
- There are 40 other countries and 29 US states where medicinal use of cannabis is legal
- The earliest recorded use of cannabis has been documented in China in 4000BC
- In the UK, cannabis was made illegal in 1928
- Cannabis remains a Schedule 1 drug under the Misuse of Drugs Regulations 2001 (no legitimate use or medicinal value)

Evidence of efficacy

- Chronic pain in arthritis, neuropathic conditions and cancer
- Spasticity in MS
- Drug resistant childhood epilepsy (recent case of Alfie Dingley), Epilepsy in Dravet and Lennox-Gastaut syndromes
- Nausea and Vomiting in Chemotherapy. Cannabinoids are very effective.
- Post traumatic stress disorder
- Management of agitation in dementia
- Anxiety & Sleep disorders
- Fibromyalgia
- Motor symptoms of Parkinson's Disease.
- Stimulation of appetite following chemotherapy.
- Glaucoma
- Tourette's syndrome

Formulations available in the UK

- Nabiximol (Sativex): A natural product as 1:1 ratio of THC:CBD. Available as a mucosal spray for resistant spasticity in MS
- Nabilone (Casamet): A synthetic cannabinoid used for chemotherapy-induced nausea and vomiting.
- Epidiolex (Pure CBD): Licensed in the US. Seizures associated with Lennox-Gastaut and Ravet syndromes.

Side effects

- Recreational cannabis "Skunk": has high THC. Can cause serious mental health problems.
- Products with high THC can cause euphoria, drowsiness, confusion, somnolence, fatigue etc.
- Products with THC linked with psychosis or schizophrenia, particularly in those with a previous history of psychosis.
- Long term use (who start young) risks causing neurocognitive deficits
- Dependency in 9%

Current situation in the UK

- Current recommendation: "Whole class of cannabis based medicinal products be moved out of Schedule 1"
- DHSS (Dept. of Health & Social Care) and MHRA (Medicines & Health products Regulatory Authority) have been asked to define what constitutes a cannabis derived medicinal product.
- Panel has been established for applications to be made for consideration of a special licence
- In the meantime, clinicians will continue to apply to the independent panel on behalf of patients wishing to access these products.

References:

Bridgeman MB et al. Medical Cannabis - History, Pharmacology and implications for Acute care setting. Pharmacy and Therapeutics 2017 Mar;42(3):180-188

Peter Reynolds. Medical Cannabis: The Evidence - The BMJ. 27th Feb 2015



Competency-based

This guide will provide you with a better under

It may be some time since you last had an interview, or you may never have experienced an interview using competencies before.

This guide includes some tips and advice that will help you structure your responses in a What is the difference between traditional and competency-based interviews?

Traditional hiring methods focus on education, qualifications and experience. These traditional methods elicit responses that address credentials, opinions and feelings, but do not prompt the candidate to tell the interviewer about actual performance on the job, or about job experiences and accomplishments in specific situations.

Using traditional methods, the candidate does not have the opportunity to focus on what they actually did in a specific situation or in a previous job, how they did it and in what circumstances they were delivering. This means that traditional interviews don't do a good job in helping to predict how a candidate will behave in specific situations.

Research has shown that competency based interviews represent the highest accuracy found in contemporary interviewing methods. As a result, most recruitment interviews held today are competency based.

What is a competency?

In simple terms, a competency is about the way we do things or the behaviours we use. If you are successful at 'communication' for example, you will do things in a certain way. Competencies describe these behaviours and are the result of a mixture of skills, abilities and knowledge. Once you understand what a competency is, the approach used during a competency based interview becomes clearer. It's a structured way for the interviewer(s) to find examples and evidence of when you demonstrated the range of behaviours that make up a competency.

Why are we using a competency-based selection process? The basic principle underlying a competency based selection process is that the best predictor of future performance is past performance in similar circumstances. More specifically:

- ◆ The more recent the past behaviour, the greater its predictive power

Interviews

standing of what competency-based interviews are, and help you prepare for them.

- ◆ The more longstanding the behaviour, the greater its predictive power. This type of interview focuses on past performance: skills, experience and achievements in order to greatly increase the organisation's ability to predict whether a person will be a strong performer in the role(s) they are applying for.

What will be included in the competency interview?

You will be asked questions to assess how well your experience meets the core competencies for the job. You will be asked to provide examples of what you have done, what you have said and what you have thought and felt in different situations. You may be asked for more than one example. As an example, instead of being asked 'what is good patient care?', you may be asked 'describe a situation when you have provided superior patient care; what were the circumstances? What were your specific actions? What was the result?' The interviewer(s) will take notes during the interviews and probe for further details when required.

What is the interviewer looking for?

You will be assessed against each essential criteria or competency, and asked questions about:

- ◆ past behaviours and performance
- ◆ learning from past behaviours
- ◆ future adaptability to the new post
- ◆ knowledge and understanding of issues in relation to the post.

The interview panel will make two important key comparisons:

- ◆ How do you compare against the requirements of the job?
- ◆ How do you compare against the other candidates?

How do I prepare for the interview?

You should have at least two good examples that best demonstrate your skills, experience and achievements for each of the core competencies specified. For example: Communication, Planning & Organising, Teamwork, Achieving Results, Service Improvement and Expertise (plus Managing People, Decision-making, Influencing and Driving Change). One way of approaching this is to review your current CV,

details of your objectives, performance and development reviews and any other relevant information.

Brainstorm your roles and key responsibilities over the past few years. You could list them or use a mind mapping technique. For each area of your responsibilities, think about your achievements. What did you achieve, what happened as a result of your actions, what were your successes? Finally, look through your roles, responsibilities and achievements and pick those that are good examples of you demonstrating the key competencies required for the role(s) you are applying for.

Your preparation means that you will have a range of scenarios to use. When you are asked a question, stop and think about which of your examples is most appropriate. Think about how you will use it to answer the question that you have been asked.

For each example that you will be describing to the interviewer(s), it is helpful to consider the following **STAR** method:

Situation – What was the situation? What was the background and context?

Task – What specific task did you need to accomplish?

Action – What specifically did you say and do? What were the actions you took?

Result – What were the results of your actions? What was the impact? What did you learn?

Using the STAR method makes it easier for the interviewer(s) to understand your answer. It also helps you remain focused.

How should I structure my answers and what should I avoid?



Prof. David Brigden

CCP Tutor,
School of Medicine,
University of Liverpool
Emeritus Professor
Lifelong Learning,
University of Bolton



You now need to think about the difference between an answer that is okay and an answer that really hits the mark. Think about these general rules which will help you:

DO - Always speak in the first person singular 'I thought / felt / did'

AVOID - Using we instead of I 'we thought / felt / did'

DO - discuss events that have occurred and speak in the past tense: 'The way I handled the situation with the patient was I first established the history...'

AVOID - Using hypothetical or future tense: "What I usually do is..." "What I would do is..."

DO - Focus on what actually happened: "At that time, I responded by..."

AVOID - Being vague... 'in general, I always...'

DO - Be time specific..... 'in August ...'

AVOID - Humour - it can go badly wrong!

DO - Focus on what YOU did

AVOID - Talking about your colleagues and not what you did ...'we, the team ...'

DO - Focus on what actually happened not on what might have happened

Will the final recruitment decision be based entirely on my performance at the interview?

No. While the competency-based interview is an important method of gathering information, it is only part of the selection process. Other sources of information may also be used in order to determine the most suitable candidate to fill the role.

Indigenous Medicines and Foods



Dr Dhuni Soren
Retired GP, Liverpool

Indigenous Medicines

The indigenous medicines have different meaning for different people. The WORLD HEALTH ORGANISATION defines traditional/ indigenous medicine as the sum total of knowledge; skills and practices based on theories, beliefs and experiences indigenous to different cultures, whether explicable or not used in the maintenance of health as well prevention, diagnosis, improvement or treatment of physical and mental illness.

In some Asian and African countries up to 80% of population relies on such medicines. For government of India any system of medicines prevalent before the advent of Allopathy is Indigenous like Arurvedic, Unani, Siddha medicine etc.

According to UNO there are 370 million (37 crores) indigenous people in the world. 70% of them live in South East Asia (Indian sub-continent, Indonesia, Malaysia, Singapore, Myanmar and Thailand). India has the largest Adivasi population and is estimated to be around 100 million (10.42 crores) out of more than a billion population.

This article is based on my personal experience and observation through my long life and little bit of reading. Here we will concentrate on one tribal group called SANTAL. They are mainly found in the Santal Pargana region and are the largest tribal group in the state of Jharkhand. They are also found in the states of Bihar, Assam, West Bengal, Odisha, Tripura and beyond the Indian borders in Nepal and Bangla Desh. Total number of Santals are estimated to be around 1 crore which is nearly 1% of the population of India.

Having lived in harmony with nature for centuries, Santals believe a disease free life is possible if there is congenial relationship between Human beings, Nature and Super natural beings. According to them, the following are the reasons for ill health and social disharmony in their community and villages-

1. Sinful act
2. Infringement of social customs and practices.
3. Displeasure of their ancestors and Bongas (spirits)
4. Witch crafts and evil eyes and
5. Occasional wrath of Maran Buru (Cando Baba) THE GOD

Methods of healing and responsibility

This is shared by a group of people headed by village head (Manjhi Hadam) according to the system of traditional self-governance at the villages. He is supported by Pramanik (Deputy to Manjhi), Naeke (priest), Kudam Naeke, jog Manjhi responsible for young people and rituals of their marriages, Jog Pranik (deputy to Jog Manjhi), Susariya for chata-pata and jatra porob and Godet (village Cryer).

1. Naeke (village priest) is entrusted to look after the propriation of the spirits.
2. Kudam Naeke - responsible for outside spirits.

3. Guru Baba (medicine man) is involved in the act of naturalisation of the effects of society, evil eyes and witchcraft.
4. Ojha - apart from giving medication, he also tries to drive away the disease by magic.
5. Jan guru (the soothsayer) - reveal and identify the witches, nowadays seldom found.

Apart from these professionals, most Santal adult men and women are familiar with home remedies for simple illness and they try these before turning to professional medicine men and others. The Santal way of curing diseases involves combination of both application of herbal medicine and invocation of spirits.

The institution of local healers and ojhas are formed by such practices. The Ojhas-Guru baba- soothsayers, sorceress, exorcists, magicians and experts in herbal medicines. The training of all these professionals is passed on orally to the next generation invariably to their own children or close relations. There were no written books or documents until P. O. Bodding compiled a book "STUDIES IN SANTAL MEDICINE AND CONNECTED FOLKLORE" which was first published in 3 parts between 1925 and 1940 by the Asiatic Society. Since then some Santal writers have tried to write Santal Medicine books. Most important of them is HOROPAHTY by P.P. Hembrom F I S (Rtd) in 1994.

Common procedures of preparing medicines are;

1. Grinding the ingredients on flat stone.
2. New earthenware pots are used at the time of preparation and administration.
3. Unmarried girls are used for preparation of these medicines.
4. Sundays are considered auspicious day for preparing these medicines.



Figure 2: The historic Banyan Tree: Where Adivasi (Santal) people gathered before Santal Hul (Santal Rebellion) of 1855/56 against the British.



Figure 1:
The Annual Harvest Festival of Santals which I joined in during one of my regular visits, playing a traditional musical instrument and dancing with the Adivasi students of a college at Dumka, Jharkhand.

The various methods of healing used by Santals are-

- ◆ Sekao (fomentation)
- ◆ Iskir (Massage)
- ◆ Soso (Marking with juice of mastang nut)
- ◆ Tobak (Marking the affected areas with the red hot tip of sickle)
- ◆ Purging the evil spirits out of body of the patient by Mantras (Bahker).
- ◆ Sucking out the causes of disease
- ◆ Medicinal steam
- ◆ Splint made from certain plants for broken bones
- ◆ Santal medicines prepared from the plants and sometimes mixed with animal products, cereals and pulses, trees, minerals and soil.

Preventive measures

1. New born babies are given Tobak after fall of umbilical cords on three occasions at the interval of one week
2. Massage with oil mixed with turmeric
3. Soso mark to protect them from evil eyes.

Food of Santals

Historically Santals started their very long journey as Hunters and Gatherers. They lived on whatever animals, birds, fish and other seafood they came across in the environment. They so had various fruits, sags and underground edible roots

During this period, they mainly ate meat and vegetable cooked on open fire after wrapping them by leaves or directly roasting on open fires.

At long last they settled down after clearing forests as agriculturists and working on them for their livelihood and keeping various animals. Their food habits gradually changed and started to eat various products of their cultivation. Maize and rice cooked with plenty of water and to eat with salt, chili and onion and the left over is similarly eaten next day as Dak Mandi. Other products of Agriculture like bajra, Janhe, gundli, kode were cooked and eaten. With developing agriculture products, they started eating various pulses. Cooking methods gradually changed and they started eating simple cooked meals. With time they have nearly reached to the stage of the mainstream community especially in towns where some of educated Santals have made new homes.

Ref. Dr Patnaik, Director Social Sciences & Development Research, Institute Bhubneshwar, Rev, P O Boddling and Horopathy by P P Hembrom F I S Retd.

Did You Know?

The Food Standards Agency warns people not to overcook bread, potatoes and other starchy food as this produces acrylamide (Mallard reaction), which has been linked to cancer. Cooks should aim for a golden yellow colour, not dark brown. "Go for Gold" and say no to burnt toast. (BMJ2017;356:j365)

Don't store raw potatoes in the fridge, as it leads to a process called cold sweetening. This increases the amount of acrylamide produced in the cooking. (BMJ2017;356:j365)

If you are allergic to shrimps then you may be allergic to house dust mites as well. They do look alike. So get yourself tested. If you are tested positive then throw away your house dust (and shrimp) recipes! (Allerg Asthma Clin. Immunol 2017)

Randomised controlled studies on "Diet Drinks" have mixed findings. Some studies show modest weight reductions, while others indicate no effect. The advice is to choose a diet drink rather than a sugary one. (BMJ2017;356;j96)

Locum GP or Salaried GP:

Expenses Claims



Yeamin Haque
Senior Accountant, NLE Chartered
NLE Chartered Certified Accountants
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Locum GP:

At present due to demand and work flexibility, many newly qualified GPs prefer to provide medical services as a Locum GP. They provide their services either as self employed or via Limited companies. Providing medical services is like any other business where advance planning is necessary to run the business efficiently.

We as specialist Medical Accountants are frequently asked by our clients whether it is best to provide the locum service as self employed or via a limited company. Both setups have their pros and cons plus individual personal

circumstances and future plans are different, there is therefore no straight answer to that question. Another common question we are asked by our clients is which expenses can be claimed against the locum income? There are allowable expenses which can be claimed against the locum income no matter whether you are a self employed or provide services through a Limited Company. Every business is different and there is a wide range of expenses that can be claimed depending on the business set up and its requirement, below is a list of some of the most common business expenses:

◆ Travelling Expenses

- ◆ Mobile and Telephone bills
- ◆ Computer Expenses i.e. Internet, software and hardware
- ◆ Professional Use of Home
- ◆ Courses and Conferences
- ◆ Books and Medical Journals
- ◆ Professional Subscriptions e.g. GMC, BMA, MDU etc. memberships
- ◆ Drugs and Medical Instruments
- ◆ Accountancy Fees

◆ Printing, Postage and Stationery

To claim the expenses you have to ensure that all of the expenses are wholly and exclusively for the business. If not, you can only claim the proportion used for the business. For example, if you use your personal mobile phone for business and you pay £150 total for a year and 20% of the calls were for the business, you could claim £30 against your income.

Salaried GP:

Salaried GPs also can claim tax relief if they have incurred and paid for expenses related to the employment. An employee, without submitting a tax return can claim the tax relief through the online form P87 if the expenses they are claiming are less than £2500 for the tax year. Most common expenses salaried GPs claim are Professional Subscriptions i.e. BMA, GMC, MDU and MPS membership cost. The P87 online form also contains a list of other expenses that are eligible for tax relief. The tax relief claim should be made 4 years from the end of the tax year.

As mentioned above, every business is different so please do not hesitate to seek professional advice when making an expenses claim.

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- Locum/ Associates
- Hospital Doctors and Consultants
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Letters *to the Editors*

Dear Co-editors,

Karim Admani OBE; A life to be remembered.

In my June diary occupies a special place for remembering Karim Admani, and his tireless and ceaseless work for the cause of Overseas Doctors Association in the UK.

I had a long association with Karim and a working relationship with the ODA when its offices were at Princess Street, Manchester. It was a long solo drive from Darlington where I was based, but it was always a pleasure to be amongst you all; Hilda Prescott was the administrator, and in the early years lot of hard work had to be undertaken.

Both when dealing with the DHSS (Dept. of Health and Social Security), and when dealing with the ministers, it was invariably Karim's charisma and personal negotiating skills which prevailed.

Karim struck a deal with the then Health Secretary to create a new career grade post for the time-barred junior doctors - the 'Medical Assistant' grade, now called 'Associate Specialist', for doctors who failed to become consultants. This is Karim Admani's principal gift, and the lasting legacy for which he will be remembered.

Karim left us on 18th June 2004, on a very long journey. He died in the Stroke Unit, which he himself had started, at The Royal Hallamshire Hospital, Sheffield; Peace be upon him.

Karim was a Kutch bhai, run of Kutch marshy desert in the State of Gujarat. He moved over to Pakistan after the partition of India, and graduated from Dow Medical College, Karachi, Sind Province. He married a local South Shields lass and gave her a Hindu name "Seema", meaning boundary. His love was boundless for his wife.

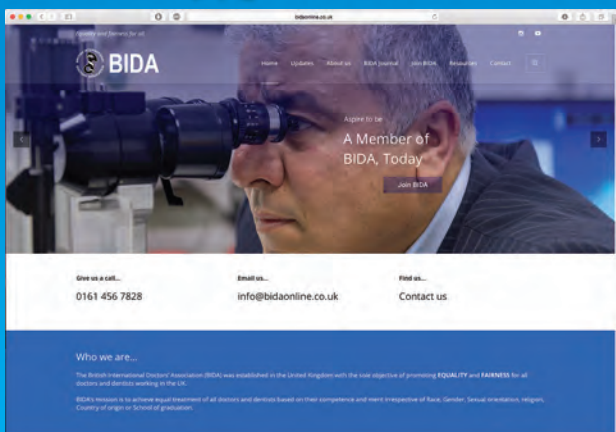
Karim, you will be sorely missed by all your friends and family.

Yours as ever, fondly missed

Professor Yash Pal Suri

Rohtas House, Darlington.

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Dear Mr Sinha and Dr Dhawan,

Dr Madan Mohan Gupta

My family and I would like to express our gratitude to you, the editorial committee of BIDA Journal and the whole BIDA family for dedicating the February issue of the BIDA Journal to my father, Dr Madan Mohan Gupta. All of us, including my mother, were very touched by this very kind gesture.

It is a tough time for us but the support that we have received from friends and family has given us strength to accept our loss. Many of you have also told us how my father touched and made a difference to your lives and this has been of great support to us too.

My father was a founding member of the Overseas Doctors' Association (now BIDA) and was a Past President. He was immensely proud of BIDA and all that it has been able to achieve. The Association has been and continues to be influential in making much needed positive changes for international doctors and the delivery of patient care in the UK. We must never forget this, particularly since there are still injustices in and challenges facing our health care system. There is still much work to do!

Kind regards,

Rajat.

Professor Rajat Gupta

*Consultant Paediatric Neurologist
Birmingham Children's Hospital NHS Foundation Trust*

Congratulations

to

Prof. Iqbal Singh



Professor Singh has recently been appointed to the Health Honours Committee, which advises on nominations for Honours in the New Year and Birthday Honours lists for a period of three years in the first instance. He is Chair of the Global Centre of Excellence in Safety for Older People (CESOP) and has been a leading contributor to healthcare and medical regulation, a founder Commissioner in HealthCare Commission and was council member of the GMC. He is a member of the National Platinum Awards Committee and Medical Vice-chair of Advisory Committee for Clinical Excellence Awards (ACCEA) North West. He led the way for stakeholder engagement. He is also Chair of the GMC BME Doctors' Forum and a member of the Clare Marx Review Working Group.

BIDA President's Cup

Cricket Final 2018

BIDA President cup cricket tournament final took place on Sunday 19th August between defending champions Wigan and Blackburn Divisions at Mawdesley Cricket Club. The match was hosted by Wigan Division.

The match was watched by the BIDA National President Dr. Biru Sinha, Dr. Bachi Sarker and the supporters from both sides. Wigan division batted first and made 134 for 9 in their allocated 30 overs. Their captain Ravi Badge played well for his 29 runs. Blackburn bowled well to restrict Wigan to 134.

In reply, Blackburn started cautiously, made slow progress because of good bowling by the Wigan division. Then the middle-order batsmen made quick runs until Sankesh was brilliantly caught on the boundary line by the 11 year old Aditya Badge. This was followed by a run out of J Raju. Finally, Blackburn was all out for 80 runs.

The BIDA National president Biru Sinha thanked the Wigan division for hosting the final and all players for playing the game with very good spirit. He presented the trophy to the winning captain, Dr. Ravi Badge. The national Sports coordinator Raghu Hegde presented the man of the match award to the 11-year-old Aditya Badge for the brilliant catch, which changed the outcome of the match and scored 12 runs.

Wigan 134 for 9; Blackburn 80 all out; Wigan won by 54 runs
Man of the match - Aditya Badge.

Clockwise, from top left: The participants in the final; Flanked by Dr Bachi Sarker and Dr Raghu Hedge, BIDA President Dr Biru Sinha presents the trophy to Dr Ravi Badge, captain of the victorious Wigan Division team (bottom picture). Main pic: An aerial view of the picturesque Mawdesley Cricket Club.



Report by
Mukesh Hemmady
Consultant Orthopaedic Surgeon

Report by
Raghu Hedge
BIDA National Sports Coordinator



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TOGETHER, WE ARE STRONGER



The **British International Doctors Association (BIDA)** is a professional doctors' association. Its sole objective is promoting **Equality** and **Fairness** for all doctors and dentists working throughout the UK.

BIDA's mission is to achieve equal treatment of all doctors and dentists based on their competence and merit, irrespective of their race, gender, sexual orientation, religion, country of origin or school of graduation.

If you believe in this mission and would like to be part of this endeavour, join us!

- ◆ You will make professional contacts, gaining the opportunity to network with people who can impact your profession, and giving you access to new opportunities, friends and information.
- ◆ In addition to being part of a group of like-minded professionals, and having the recognition of your peers, specific member benefits include:
 - Attending BIDA-organised international, national and regional conferences, seminars, meetings and many other educational and social activities
 - Constant access to pastoral support
 - Nominations for excellence awards
 - BIDA Journal, our Scientific journal, complete with news, interviews and much more.



If you are interested in joining BIDA, or would simply like to know more about us, please either write to **BIDA, ODA House, 316A Buxton Road, Great Moor, Stockport, SK2 7DD** or e-mail us at bida@btconnect.com, or contact us through our website at the address below.

We look forward to hearing from you!



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