bida Journal

The Journal of
The British International Doctors' Association
Issue No.1, Volume 26 February 2020

A desire for fair and just culture across the medical profession

Ayurvedic Medicine
Origins, Philosophy & Effectiveness

Falls in the Elderly
A review of the common risk factors: Thinking beyond syncope

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Sereflo is part of Cipla's UK respiratory portfolio.

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pMDI = pressurised metered dose inhaler.

Sereflo®

(salmeterol/fluticasone propionate)

Sereflo® Metered Dose Inhaler (salmeterol xinafoate/fluticasone propionate)
Prescribing Information
Please consult the full Summary of Product Characteristics (SmPC) before prescribing
Sereflo 25 microgram (µg) salmeterol xinafoate /125 µg or 250 µg fluticasone propionate per actuation pressurised inhalation, suspension. For both dose strengths the equivalent delivered dose per actuation is 21 µg of salmeterol and the delivered fluticasone propionate is 110 µg, for 125 µg dose strength and 220 µg, for 250 µg dose strength.
INDICATIONS: For use in adults with asthma 18 years of age and older only. Sereflo is indicated in the regular treatment of patients with moderate to severe asthma where use of a combination product (long-acting β_2 agonist and inhaled corticosteroid) is appropriate:
- patients not adequately controlled on a lower strength corticosteroid combination product or
- patients already adequately controlled on an inhaled corticosteroid in a mid or high strength and a long-acting β_2 agonist.

POSOLOGY AND ADMINISTRATION: Patients should be instructed in the proper use of their inhaler (see SmPC and patient information leaflet). Recommended doses in adults 18 years and older - Two inhalations of 25µg salmeterol and 125 µg or 250 µg fluticasone propionate twice daily. A short-term trial of salmeterol and fluticasone propionate may be considered as initial maintenance therapy in adults with moderate persistent asthma for whom rapid control of asthma is essential. In these cases, the recommended initial dose is two inhalations of 25 µg salmeterol and 50 µg fluticasone propionate twice daily. **Note:** Sereflo is not available in a lower strength product containing salmeterol 25 µg and fluticasone propionate 50 µg. Therefore, when initiating therapy, or when it is appropriate to titrate down to a dose below 125 µg, an alternative fixed-dose combination of salmeterol and fluticasone propionate containing a lower dose of the inhaled corticosteroid is required. *Use of a spacer device;* where required in those with difficulties in coordinating actuation of the inhaler with inspiration of breath, it is recommended ONLY for higher strength Sereflo containing salmeterol 25 µg and fluticasone propionate 250 µg. Patients should continue to use the same make of spacer device (Volumatic or the AeroChamber Plus) as switching between spacer devices can result in changes in the dose delivered to the lungs. **See the SmPC for further information on initiation, titration down and spacer use.**
CONTRAINDICATIONS: Hypersensitivity to either of the active substances or to any of the excipients.
SPECIAL WARNINGS AND PRECAUTIONS: Sereflo should not be used to treat acute asthma symptoms for which a fast- and short-acting bronchodilator is required. Patients should be advised to have their inhaler for relief in an acute asthma attack available at all times. Patients should not be initiated on Sereflo during an exacerbation, or significantly worsening or acutely deteriorating asthma. Serious asthma-related adverse events and exacerbations may occur with Sereflo. Patients should continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation. Treatment should not be stopped abruptly due to risk of exacerbation. Therapy should be down-titrated under physician supervision. All inhaled medication containing corticosteroids should be administered with caution in patients with active or quiescent pulmonary tuberculosis and fungal, viral or other infections of the airway. Salmeterol and fluticasone propionate should be used with caution in patients with severe cardiovascular disorders or heart rhythm abnormalities and in patients with diabetes mellitus, thyrotoxicosis, uncorrected hypokalaemia or predisposition to low levels of serum potassium. Prescribers should also be aware of risk of adrenal suppression and acute adrenal crisis which may occur in patients on prolonged treatment with high doses of inhaled corticosteroids. Systemic effects may occur with any inhaled corticosteroid and it is important therefore, that the patient is reviewed regularly and the dose of inhaled corticosteroid is reduced to the lowest dose at which effective control of asthma is maintained. **Drug Interactions:** Concomitant use should be avoided with; non-selective and selective β blockers, ritonavir and other potent/moderate CYP3A inhibitors, unless potential benefit outweighs the risk. Particular caution is advised in acute severe asthma as this effect may be potentiated by concomitant treatment with xanthine derivatives, steroids and diuretics. **See the SmPC for further information on contraindications and precautions.**
PREGNANCY AND LACTATION: Balance risks against benefits.
UNDESIRABLE EFFECTS: Adverse events which have been associated with salmeterol/fluticasone propionate include: *very common*; nasopharyngitis and headache; *common;* candidiasis of the mouth and throat, pneumonia, bronchitis, hypokalaemia, throat irritation, hoarseness/dysphonia, sinusitis, contusions, muscle cramps, traumatic fractures, arthralgia and myalgia. **For other adverse events please consult the full SmPC.**
MARKETING AUTHORISATION HOLDER & PL NUMBERs: Cipla (EU) Ltd. Dixcart House, Addlestone Road, Bourne Business Park, Addlestone, Surrey KT15 2LE. PL 36390/0237 and PL 36390/0238. **Legal category:** POM. **NHS Cost** 25 µg/125 µg 1x 120 dose MDI £14.99 and 25 µg/250 µg 1x 120 doses MDI £19.99. **Date of last revision:** December 2018.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellowcard in the Google Play or Apple App Store. Adverse events should also be reported to Cipla (EU) Ltd on 0203 684 7710, drugsafety@cipla.com

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BRITISH INTERNATIONAL DOCTORS' ASSOCIATION

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bida Journal

Editorial

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

The Work force has reported that in 2019, for the first time, more non-UK graduates joined the medical register than British-trained doctors. BIDA's role to support and mentor and look after the interests of these vast numbers of International Medical graduates has become ever more important.

Claire Light, as Head of Equality, Diversity and Inclusion at the GMC has highlighted the factors, as researched by Dr Doyin Atewologun and Roger Kline's report "Fair to refer?" GMC as our regulator welcomes the recommendations and has taken appropriate steps to engage with IMG doctors.

This edition incudes an excellent article by Dr Phillips and colleagues on "Falls in the Elderly". We tend to forget that these falls can occur in their own environment, which often go unnoticed as, they lead to minimal physical but severe psychological strain. This sets up a vicious cycle of the fear of falling again and reducing their physical activities further. We have 2 articles from Prof Brigden, which imparts ideas and tools to learning, teaching and interaction in a clinical setting.

We should be aware that Complementary medicine plays a huge role in relieving a lot of common ailments in the community. According to a new research funded by the National Institute for Health Research (NIHR) complementary and alternative medicine (CAM) has grown in England. Researchers at the University of Bristol's Centre for Academic Primary Care found that 16% per cent of the population in 2015 were using CAM compared to 12% in 2005. The article on "Ayurvedic Medicine", gives a fascinating account of its journey from the Vedic times to the current period.

The major global issue most of us are concerned about the spread of the Novel Corona Virus (COVID-19). The apprehension remains whether the epidemic would soon be converted into a pandemic. As I write this according to the WHO statistics, the total number of cases is 75,204, of which 924 are outside China. In the past 24 hours no new countries reported cases of the COVID-19 cases.

With the information currently available for the novel coronavirus, WHO advises that measures to limit the risk of exportation or importation of the disease should be implemented, without unnecessary restrictions of international traffic. On 11-12 February, WHO is convening a global research and innovation forum to mobilize international action. We sincerely hope they are able to identify and prioritise research, which contributes to the control of COVID-19.

BIDA requests all its members to attend the sponsored meetings and conferences. The "Tackling Obesity in Childhood" and "Biennial BIDA Oncology Conference 2020' are being organised soon in Manchester. Please encourage your colleagues to attend.

Congratulations to our esteemed members, Dr A Trivedi, Dr B Das and Dr S Pitalia who have achieved recognition with their talents and special contributions.

"You can't beat the waves, but you can learn to surf" (Jon Kabat-Zinn).

Best wishes

Amit Sinha
Editor, BIDA Journal.

Welcome to new BIDA members

Name	Membership No.	Division
Dr S Bisarya	10648	Wigan
Dr N Varma	10649	Wigan
Dr M Mehta	10650	Stoke-on-Trent
Dr L Mehta	10651	Stoke-on-Trent
Dr D Nama	10652	Stoke-on-Trent
Dr A Jain	10653	Wigan
Dr R Jain	10654	Wigan
Dr M N Hossain	10655	London Met
Dr J Shah	10656	Rochdale & Bury
Dr P Jha	10657	Manchester
Dr M M Alsayed Taufeeq	10658	Manchester
Mr D Prakash	10659	Birmingham

The Biennial BIDA National Oncology Conference

Saturday 16th May 2020, 10:00am – 4:00pm

Venue:

The Auditorium, 2nd Floor, Department 17, The Education Centre. The Christie School of Oncology, The Christie NHS Foundation Trust, Wilmslow Road, Manchester M20 4BX.

Themes:

Common oncology topics, interactive discussion, Trainee forum, key note lecture on NHS, GM Cancer, Cancer delivery, GMC and international clinicians opportunities and challenges.

Description and Aim:

This one day conference is aimed at providing general practitioners and practicing hospital clinicians with an educational update on current trends in adult solid cancers. The wide spectrum of topics covered will provide the attendee with a sound understanding of the advances in the management of common adult cancers pertinent to their practice. There will also be a session for oral and poster presentations for medical students and junior clinicians, as well as updates on the current issues in the NHS, discussion on training issues for international healthcare graduates

Fee:

The event is free to attend, but a refundable deposit (£15 for Members and Junior Doctors, £25 for Non-Members) is required to reserve your place.

Registration:

Please deposit the cheque made payable to 'BIDA' and send to:
The British International Doctors' Association,ODA House, 316A Buxton Road, Stockport, Great Moor SK2 7DD.

Please contact BIDA Central Office for more information and registration: Telephone **0161 456 7828**, or by e-mail to **bida@btconnect.com**

For further information and to register, please follow the link:
DA Link for BIDA Oncology Event

Speakers include:

Professor Nirmal Kumar:
Wrightington, Wigan & Leigh NHS Foundation Trust.

Professor Siba Senapati:
Salford Royal NHS Foundation Trust.

Mr C Selvasekar: The Christie NHS Foundation Trust, Manchester.

Dr S Kulkarni: The Christie NHS Foundation Trust, Manchester.

Mr K Gajanan: The Christie NHS Foundation Trust, Manchester.

Mr Rahul Deshpande: Manchester Royal Infirmary, Manchester.

Mr Mike Smith: The Christie NHS Foundation Trust, Manchester.

Details for abstract submission:

(Word count, any specific points and if the abstract submission should be online):
100 words abstract, IMRAD format. Online submission through DA site by 1st May.
There will be an opportunity to display selected posters and on prize podium presentation.

The Christie
School of Oncology

bida National President's report

Dr Birendra Sinha
National President, BIDA

Dear Colleagues,

I'd like to begin by wishing you a happy, healthy and prosperous new year.

2020 is going to be a very busy year for our organisation. As you know, there has been some disruption to the Central Office due to Alison being off on sick leave and some essential building works taking place at the ODA House. I would like to thank you for your patience during these disruptions, which resulted in some EC meetings being cancelled. I am happy to report to you all that Alison is now back full time and contactable on the normal office telephone number during office hours.

We are due to have the BIDA National Elections this year and soon will be appointing our Election Commissioners, who will be conducting the BIDA National Elections. I would encourage every member not only to vote, but also to stand for our National team. On top of this we will soon be notifying members about our Cricket & Badminton Tournaments.

This BIDA International Congress, which was being planned for Vietnam and Cambodia in October of this year, has now been cancelled. This decision has been made due to the increasing spread of the Coronavirus and the uncertainty of the situation in South East Asia.

We are soon having a Study Day on "Childhood Obesity" at Salford Royal Hospital on Tuesday 24th March, and a National Medical Conference on Saturday 16th May focusing on "Oncology" at The Christie Hospital, Manchester.

I know I may be repeating myself, but I would just like to reiterate that membership is key to any strong organisation and I would like to encourage all the Divisional Chairmen and Secretaries to inspire as many new members to join as possible. We do need some fresh young Doctors to join and carry on the good work BIDA has strived to commit to for over 40 years.

I would like to thank Mr Amit Sinha for being the editor of the BIDA Journal. As always, this takes hard work and commitment from both him and the whole of the editorial board. I would like to thank them for giving of their valuable time in making this Journal the huge success it is.

As BIDA National President I often get asked the question 'what does BIDA do for it members?' I thought I would briefly sum up some of the main points for you all:

Our objective is to provide members with Equality and Fairness. In order to do this BIDA is fully engaged with the entire major stakeholders in British Medical politics:

- GPC of BMA
- Consultants committee, BMA
- BME council of GMC
- RCGP, Involved in various GMC committees
- CQC
- BIDA is a nominating body for the ACCEA awards
- BIDA actively organises many successful National Educational Conferences throughout the year such as the Obesity Study Day and the Oncology Conference which are all CPD accredited and free for BIDA members
- BIDA holds frequent local divisional meetings / events
- BIDA also organises International Congresses on a regular basis and also holds annual Cricket, Table Tennis and Badminton Tournaments
- BIDA holds an annual ARM / AGM, which the Central Office subsidises to keep costs low for our members
- BIDA also offers a mentoring service for Doctors' who need guidance.

Dr Birendra Sinha
National President, BIDA

bida National Treasurer's report

Mr Pranab K Sarkar
National Treasurer, BIDA

Dear Members,

In the previous issue of this Journal in October 2019 I reported that, financially, BIDA is going through a challenging time. I cannot honestly say that our financial status has shown any signs of improvement since.

Our total annual Membership income at the end of October 2019 as predicted has shown a significant drop from the previous year. This means that the total income generated for the current year would not be enough to pay for all the expenditures for the next 8 months until the 'new' money from membership subscriptions arrives in October 2020. Following the trend of the past 6 years, one can easily predict that next year's annual income will also show a significant drop, making the matter worse from a financial point of view unless we can manage to find external funding from sponsorships.

To survive as an organisation, BIDA needs to know the honest truth about how much money we have got, how much we are likely to get and how much more we think are going to need.

In view of our present financial circumstances, I believe our financial strategies should be truth to our financial strength and affordability. We collectively need to agree to adopt a financial strategy that would prioritise expenditures that are essential for the smooth running our business. This may mean some further cost-saving initiatives. Otherwise it would be difficult to balance our books.

I am pleased to welcome Alison back to the Central Office after her long sick leave as we will need her invaluable support to manage our business efficiently.

Mr Pranab K Sarkar
National Treasurer, BIDA

bida National Chairman's report

Dr Chandra Kanneganti
National Chairman, BIDA

Dear Colleagues,

The 2020 New Year has brought both fresh challenges and innovative aspirations for BIDA to work both for our members and also for all doctors in NHS.

We have recently worked in conjunction with the British Medical Journal to produce a special edition of the BMJ on racism. The magazine features a number of articles that address the issue of racism in the NHS.

Sadly, we are still hearing stories of unfortunate suicides of doctors who face regulatory processes. Working in conjunction with a number of different organisations, we are supporting ways to end this tragic state of affairs.

It's good to see our Office Manager, Alison, returning to Central Office after her illness. At the time of writing, we are putting plans in place and looking forward to our next ARM in Stoke in 2020. We will send you the finalised dates of the event soon.

We've recently announced that BIDA's annual Badminton and Table Tennis Tournaments will take place in Stoke in May 2020, and I sincerely hope to see many BIDA members participating in both tournaments.

A new GP contract package has been agreed by the British Medical Association's General Practitioners Committee (BMA GPC) with 3 specifications for Primary Care Network Direct Enhanced Service (PCN DES), which seem to be giving opportunities for practices to be resilient and work together.

BIDA has congratulated Mr. Matt Hancock who, following the General Election and the recent Cabinet re-shuffle, will continue as our Health and Social Care Secretary of State. We are pleased to have been invited by his team to work on a number of initiatives to support doctors in the NHS and on work force issues.

BIDA's Executive Committee and Officers will continue to work for all members' interests and for equality and fairness for all doctors in the NHS.

Dr Chandra Kanneganti
National Chairman, BIDA

bida GP Forum Chairperson's report

Dr Preeti Shukla
G.P. Forum Chairperson, BIDA

Dear Members,

It's been a busy few weeks in GP land but interesting.

The publication of PCN draft specifications before Christmas resulted in a huge outcry from the profession. Quite rightly so, as it was an impossible request from PCN's, which are still finding their feet in many areas.

After a robust feedback from the profession on PCN draft, initial contract was presented to GPC on the 16th of Jan. It was rejected with a majority. Our negotiating team went back and a revised version was brought back to GPC on the 6th of Feb, which was approved but not with 100% majority.

As with all negotiations there is some give and take. The GPC thought at that point that it was as good as it gets and accepted it on the profession's behalf. There is going to be a special conference regarding the PCN in the near future, which would provide further guidance to GPC on the matter and future negotiations .

The main headlines of the contract:

- To boost partnership model: All first time partners would get a golden hello of £20,000 pounds as a one off payment plus £3000 pounds for business training.
- The global sum will rise by 4% in 2020/21 equivalent to £93.46 per head.
- There will be 100% reimbursement of all additional staff recruited via primary care networks and more roles have been added to the scheme.
- Mental health practitioners will be added from April 2021 including IAPT therapists.
- GP training numbers will increase by 500 to 4000 a year and it will have 24 months of training in general practice instead of 18 months.
- From 2020/21, all international medical graduates entering general practice training will be offered a fixed five year NHS contract, which should help with visa problems and something we have campaigned for.
- NHSE has diluted PCN care home specifications and practices would get £120 per bed now.
- GP's who are earning over £150,000 pounds a year will be named publicly from 2021.
- GP practices will be assessed against "patient experience" measures in 2020/21.

That's a brief snapshot of the negotiated contract. Please feel free to give feedback and ask for any queries. As ever, I am very grateful for your support and look forward to continue representing colleagues in the best way possible.

Dr Preeti Shukla
G.P. Forum Chairperson, BIDA

A desire for Fair and Just Culture across the medical profession

Claire Light
Head of Equality, Diversity and Inclusion at the General Medical Council (GMC)

In my role as Head of Equality, Diversity and Inclusion at the GMC I get to speak to, and listen to, many doctors. I hear their experiences of education and training, and how their professional lives are going. It's a privilege for me to learn the stories of doctors who are committed and passionate about being the best they can be for their patients and colleagues.

But what I hear isn't always positive. Some doctors tell me of their upset and frustration because they don't always feel that they are treated fairly. And this unfairness manifests in disparate ways, affecting doctors differently depending on the roles, settings and the situations they find themselves in. But no matter how or where unfairness is, it can be very damaging for the individual and their wider environment

What is positive is that we are talking about these issues and getting a greater understanding. This insight helps us to act – and to encourage others to act – when doctors are not getting the fair treatment they deserve.

All this comes as time when UK health services are under a great deal of pressure, and when doctors face very heavy workloads. And in these pressured systems some doctors face additional challenges because to their backgrounds. These are the doctors who have come to work in the UK - international medical graduates (IMGs) - and those from black and minority ethnic (BME) backgrounds.

In 2019, our Workforce report highlighted that the UK health services are more reliant than ever on overseas doctors. For the first time, more non-UK graduates joined the medical register than British-trained doctors. Currently, more than a third of doctors on the register obtained their Primary Medical Qualification (PMQ) abroad.

International doctors make a huge commitment to the provision of UK health services by choosing to come to work within the NHS in the UK and they make a significant contribution to addressing the workforce challenges we face. However, workload pressures and workplace cultures mean that they do not always get the support they deserve or have the same treatment or opportunities as other doctors receive.

In response to these challenges in 2018, we launched an extensive programme of work, to provide better support for doctors working in pressured conditions while also addressing the specific experiences of BME and international doctors. This body of work, which includes the three reports; Caring for Doctors, Caring for Patients, Fair to refer? and the Independent review of gross negligence manslaughter and culpable homicide, is ongoing and we are working with stakeholders across the system to implement the combined recommendations.

The independent review of gross negligence manslaughter and culpable homicide in medicine, by Leslie Hamilton and his working group followed the tragic death of Jack Adcock and the conviction of Dr Hadiza Bawa-Garba for gross negligence manslaughter. The review outlined a series of steps which we and others in healthcare and wider stakeholders must take to help create the just culture that we and doctors wish to see.

The report also said that the GMC must rebuild trust within the profession, this we have fully accepted and are working on.

We are making progress. There is a distance to go but work is underway, as we work alongside our partners across the health services. We share good practice and actively put into practice the recommendations from our reports that shine light on the areas that need to improve.

An area of great concern is that BME doctors are referred by employers and healthcare providers at more than double the rate of their white counterparts; and compared to UK graduates, non-UK graduates at two and a half times the rate and this is a long-standing trend.

As a regulator, our duty is to understand why this is happening and make changes if necessary. To help us explore this disparity in referrals, we commissioned Dr Doyin Atewologun and Roger Kline to investigate, and deliver practical recommendations to help us, and our partners across England, Northern Ireland, Scotland and Wales tackle the issues.

The qualitative research gathered in-depth information and insight into doctors' experiences in primary and secondary care across the UK. Over 260 individuals including GPs, locums, SAS, black, Asian and minority ethnic, and white doctors took part; as well as overseas and UK graduates. Employers and healthcare providers, senior managers and HR leads were also interviewed.

The findings detailed in the report Fair to refer? showed that multiple and intricately linked factors lead some groups of doctors to be referred to us more than others.

Factors identified by the research that contribute to a doctor being referred to the GMC included:

- ***Induction and support:*** Some doctors don't have adequate induction or enough support in transitioning to new social, cultural and professional environments.
- ***Lack of feedback:*** Doctors in diverse groups do not always receive effective, honest or timely feedback because some

managers want to avoid difficult conversations, particularly where that manager is from a different ethnic group to the doctor. This means that concerns may not be addressed early and can therefore develop.

- ***Working patterns:*** Doctors working in isolated or segregated roles or locations lack exposure to learning experiences, senior mentors, support and resources.
- ***Insider and outsider dynamics:*** Some groups of doctors are treated as 'outsiders', which leads to them not having access to as many opportunities and puts them at risk of being stereotyped.
- ***Impact of leadership:*** Some leadership teams are remote and inaccessible, which makes it difficult for doctors to approach them and allows divisive cultures to develop
- ***Blame culture:*** Some organisational cultures respond to things going wrong by trying to identify who to blame rather than focusing on learning. This creates risks for doctors seen as 'outsiders.'

Fair to refer? identified four key areas where action is needed:

- Improve induction, feedback and support for doctors new to the UK whose role is likely to isolate them, for example locums and doctors in SAS roles.
- Address the systematic issues that prevent a focus on learning, rather than blame when something goes wrong.
- Ensuring engaged, positive and inclusive leadership across the health system.
- Developing a UK-wide mechanism to ensure delivery of the report's recommendations.

Doyin and Roger's practical recommendations were grounded in the promising practices they saw at organisations where strong and positive leadership had embedded a culture of inclusion and fairness.

As your regulator we welcome all these recommendations. By working together with others, we can bring about the positive and effective long-term change needed to improve fairness across the profession. Ultimately, this will improve the quality of care your patients receive.

Also, in response to the review, we have started discussions with Responsible Officers about ensuring safeguards are in place locally so clinical governance arrangements for doctors are fair and free from bias and discrimination.

What we want is to avoid doctors being referred to us for issues that can be prevented, resolved earlier and locally investigated.

We also want to work with employers to improve the consistency and quality of support for IMG doctors. It isn't good enough to recruit a doctor from abroad and then simply leave them unaided to navigate their way through complex healthcare systems. So, one of actions we are taking is a significant investment into our free Welcome to UK Practice WtUKP) workshops.

International doctors tell us that these workshops improved their awareness and understanding of ethical issues they are likely to face working in the UK, as well as how to apply the GMC's guidance to deliver safe care to patients. WtUKP also helped them improve communication skills with patients and to understand better their own learning needs. Three months after attending a workshop, almost two-thirds of doctors had made changes to the way they worked as a result.

However, we know it's challenging for doctors to find time to attend a workshop once they are working. So, more evening and weekend events, more locations, and more linking sessions when doctors are already visiting the GMC, will make this easier.

The GMC will be running as many as five workshops each week, up from three each month. The number of doctors at the workshops has already increased rapidly. Around 100 more attend sessions each month now compared to 2017.

This year we also published a report based on our survey of Specialty and Associate Specialist (SAS) and Locally Employed (LE) doctors. This is the first time these doctors had been asked about their experiences in the workplace:

- About two-thirds of SAS and LE doctors are BME
- 30% reported experiencing rudeness, incivility, belittling and humiliation in their workplaces every day

This is clearly not an acceptable reality for BME doctors. We now need to ensure that stakeholders across the system are aware of and responding to the these and other findings of this survey. It is vital that organisations like BIDA help to ensure that what has come to light is discussed in workplaces across the UK.

We are working together with our partners on long-term changes to improve fairness across the profession. To ensure doctors have the support they need at work, that they are treated fairly, and of course that any interactions with us are appropriate and fair.

We want patients to receive the best possible care, which is best delivered by doctors working in supportive and inclusive surroundings. To deliver good patient care, doctors need well-led workplaces with just and fair cultures, and strong clinical leadership that fosters trust and confidence in employees. All of us who are responsible for the UK's health services have a role to play in developing these environments.

We are with Roger and Doyin when they say in Fair to refer? "We hope that our research will prompt serious sustained work to ensure that all doctors, irrespective of their background or characteristics or mode of employment, are treated fairly within NHS employment, disciplinary processes or GMC referrals."

We need organisations like BIDA to help us ensure that the work and changes that develop from our research remains an important talking point across the system. And for BIDA members to help us support new international doctors, promote the services we offer to support them and ensure a positive experience of working in the UK.

Falls in the Elderly

Dr Dylan Phillips
Speciality Doctor (Care of the Elderly Department)
Countess of Chester Hospital, Chester
(pictured right)

Dr Saurabh Shandilya
Consultant Physician (Care of the Elderly Department)
Countess of Chester Hospital, Chester

Prof Anand Prakash *FRCP*
Consultant Physician (Care of the Elderly Department)
Countess of Chester Hospital, Chester

Falls in the elderly are a common presentation for primary and secondary care physicians[1]. They place a significant strain on the services[1] and can lead to severe injuries including fractured neck of femur[2] and subdural haemorrhage among others[3]. When the fall does not cause significant injury, it still has the potential to cause loss of confidence, fear of falling and reduction of life space for the patient[4,5] (Box 1).

Falls in the elderly:

- Falls are common in the elderly
- Falls have psychological and physical consequences
- There are usually multiple risk factors in the individual who falls
- Multidisciplinary approach to risk identification and mitigation has benefits.

Box 1: Falls In the Elderly

Assessment of the patient presenting with a fall poses several challenges to the treating team as the causes are often multifactorial[6] and require a thorough evaluation of the patient and their surroundings to ensure identification of maximum number of risk factors which can be modified to reduce the risk of subsequent falls[7].

Falls associated with seizures, acute medical illnesses, new onset of persistent neurological signs or symptoms and Transient loss of Consciousness (T-LoC) require an approach focussed on the pathologies leading to these presentations and are not the subject of this article. The assessing clinician should be mindful of pointers in history and examination that indicate the possible diagnosis of epilepsy, sepsis, stroke or syncope and be prepared to initiate appropriate management plans if required.

We will be discussing the common causes of falls in the elderly patient who has fallen in their own environment leading to minimal physical but severe psychological strain. Occasionally this psychological injury does not present itself readily but leads to the patient reducing their physical activity due to fear of falling[8] leading to a cycle of reduced mobility, increased frailty and increased risk of falling[9].

Falls assessment is a multi-disciplinary task and needs to draw upon the expertise of primary and secondary care physicians, pharmacists, physiotherapists, occupational therapists and nurses[10]. The aim of the exercise is not to find the cause of the index fall, but to review the patient and their surroundings for identification of all the risks for falls and planning for intervention to reduce these risks[11]. Like many areas of Geriatric medicine, the best results are obtained with multifactorial risk reduction strategies drawing upon the Principle of Marginal gains.

Common modifiable risk factors for falls in the Elderly

- Incorrect Shifting
- Polypharmacy
- Postural Hypotension
- Benign Paroxysmal Positional Vertigo
- Peripheral Neuropathy
- Strength and Balance issues
- Environmental risks.

Box 2: Common Risk Factors for falls.

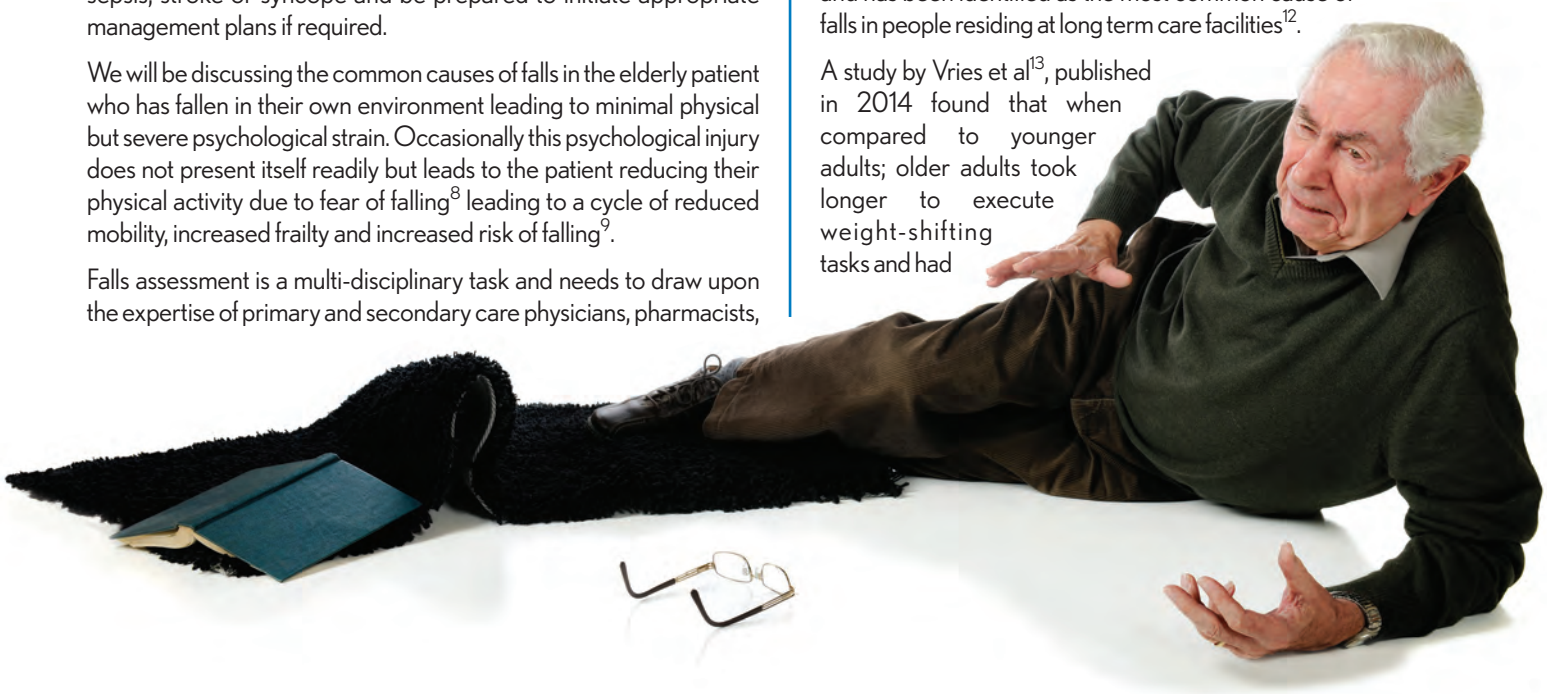
Common Risk factors:

We will now discuss some of the usual culprits and the interventions that can be suggested to modify the associated risks (Box 2).

Incorrect Shifting:

In order to maintain balance when standing and mobilising without falling, people must adjust their posture and shift their weight. Incorrect Shifting is defined as a patient directed movement which leads to the centre of gravity for the patient falling outside their base of support and has been identified as the most common cause of falls in people residing at long term care facilities[12].

A study by Vries et al[13], published in 2014 found that when compared to younger adults; older adults took longer to execute weight-shifting tasks and had



less fluent movements. The study concluded that such findings indicated the elderly population may be at higher risk of inability to maintain postural control when challenged by external forces, in turn increasing their risk of falls.

When moving, maintenance of balance is achieved by shifting your centre of pressure position, in order so that your centre of mass remains within your base of support[14, 15]. When mobilising unaided, the base of support is formed by the feet; however when using mobility aids, the base of support changes shape. The use of a walking stick alters the shape to a triangle and using a frame causes the creation of a rectangular base. In these situations an incorrect posture when mobilising will lead to a fall. Such alterations are important to identify, as physiotherapy led instructions can reduce this risk considerably.

Polypharmacy:

As yet there is no universally accepted definition for polypharmacy. A systematic review conducted in 2017 identified 138 definitions. The criteria used varied with some definitions based only on the number of medications a patient was taking, whilst others considered the duration of such therapies and some were solely descriptive terms[16].

Despite such discrepancies in its definition, it is known that polypharmacy in older people can be associated with negative health outcomes[17]. Specifically in relation to falls, the concurrent administration of 4 or more prescribed medications is an independent risk factor[18].

It is not uncommon for an elderly patient to be on multiple medications as they tend to accumulate various diagnoses during the course of their life. Several prescribed drugs remain on the repeat prescriptions in spite of having outlived their usefulness. Furthermore the targets for intervention for several pathologies vary with age and thus medications that were useful at a younger age might be identified as being detrimental in old age. For example, the Milan Geriatrics 75+ cohort study[19] identified 165 mmHg to be the systolic blood pressure, which was associated with the greatest longevity in patients aged 75 and over. Aggressive management of hypertension in the elderly should therefore be tempered with individual risk assessments, including that of falls. A medication review, often pharmacist led, is a useful way of identifying medications that are no longer suitable for a patient[20].

The STOPP/START criteria[21] or the American Geriatric Society Beers criteria[22] can be excellent guides to base medicines optimisation in the elderly on.

The concepts described above give rise to the notion of appropriate and inappropriate polypharmacy which is the current model of thinking. This consideration acknowledges that although a risk factor for falls, polypharmacy can be wholly justifiable if the medications involved have been reviewed.

Postural Hypotension:

Postural Hypotension is a common finding in the elderly[23] and is defined as a sustained reduction of at least 20 mmHg in systolic blood pressure or 10 mmHg in diastolic blood pressure within 3 minutes of standing or head-up tilt to at least 60° on a tilt table[24].

There are numerous factors that can contribute to the presence of this clinical sign and each of them must be identified for all individuals. Examples include the side effects of medication, hypovolaemia, cardiac problems, adrenal insufficiency, altered regulatory mechanisms controlling blood pressure and autonomic dysfunction[25].

Importantly the clinical sign can be symptomatic or not and this must be established at the outset, because treatment is aimed at symptom reduction and improving the patient's functional status[26]. Symptoms when present are diverse and can include nausea, light-headedness, dizziness, visual blurring and syncope[27].

In relation to falls, a systematic review and meta-analysis undertaken by Mol et al in 2019[28] found postural hypotension to be significantly positively associated with falls in older adults. It advised that investigating for and subsequently treating postural hypotension in an attempt to reduce falls was clinically relevant.

Treatment options depend upon the underlying contributing factors; but any culprit medications must be reviewed and stopped if appropriate. Furthermore general advice, including the maintenance of good hydration and techniques for standing up are also beneficial. More specific physical counter-manoeuvres to reduce pooling of blood in the lower extremities can also be offered[26]. Underlying medical conditions should be addressed; however if the patient remains symptomatic from an ongoing postural drop in blood pressure once all modifiable factors have been addressed, then a trial of medications, such as Fludrocortisone or Midodrine, can be considered.

Benign Paroxysmal Positional Vertigo (BPPV):

BPPV is defined as a disorder of the inner ear, which is characterized by repeated episodes of positional vertigo[29]. It is caused by an accumulation of loose calcium crystals (otoconia) within the semi-circular canals of the inner ear. When the head moves, it induces movement of the otoconia, which in turn causes movement of the endolymph and it is this that produces the sensation of vertigo[30].

The pathology is common with a lifetime incidence of 10%[31] and its identification is clinically important given that it causes impairment of daily activities and increased risk of falls[32].

BPPV can present in different ways and may or may not be associated with falls. The Dix-Hallpike manoeuvre is the most common diagnostic aid that is used; however this is only positive when the posterior semi-circular canals are affected[33]. Additionally the manoeuvre does not have 100% diagnostic yield and thus current NICE guidelines suggest that when negative it should be repeated one week later[34].

Treatment of BPPV largely centres around manoeuvres that attempt to reposition the loose otoconia; with the Epley manoeuvre being the most commonly utilised. In relation to the elderly, various publications have shown a significant decrease in falls and improvement in functional status post treatment[35].

Peripheral neuropathy:

The underlying contributing factors for peripheral neuropathy are varied; with diabetes mellitus being the leading cause worldwide[36]. Some estimates suggest a 7% prevalence for chronic poly-neuropathies in the population of those over 65 years of age[37].

Its presence in the elderly population is of great importance as it leads to impairment of distal proprioception and reduction in strength which in turn causes instability and thus increased risk of falls[38].

The identification of this risk factor is therefore significant. Dependent on the underlying causes identified, these may be treatable however even if they are not then other interventions can be undertaken to reduce the risk of falls. Examples include patient education and the use of a walking aid. Other measures include ensuring that there is adequate lighting especially during the night, reduction of uneven surfaces in the house and a review of footwear.

Strength and Balance issues:

Research has shown that some of the most significant intrinsic risk factors for falls are age-related reductions in both strength and balance[39]. Therefore it is often beneficial to assess such areas when considering falls prevention in the elderly patient.

Validated assessment tools have been produced to aid with this and can vary greatly in relation to their complexity and duration. The most simple and most commonly used is the 'Timed Up and Go' (TUG) test in which an individual must rise from a chair, before walking to a line three metres away and then returning and sitting back down[40]. The use of such assessment tools, including the TUG test, is suggested in the current NICE guidelines[41].

Identification of those vulnerable and at risk is essential, as thereafter exercise programmes can be formulated to improve balance and strength and in turn reduce the rate of further falls[42]. It is essential however that the patient is consulted and involved in their ongoing care; as they must be trained to perform the exercises correctly and without assistance. Such independent continuation of the exercise programme after cessation of the intensive phase under physiotherapy guidance is essential for the benefits to be maintained.

Environmental risks:

In addition to any medical or physiotherapy led input; it is also essential that the patient is seen holistically in their own environment. This will ensure that potential risks in the environment are assessed and addressed. The involvement of the occupational therapist is invaluable in this and will contribute further to a reduction in the risk of falls.

Conclusion:

In this article we have attempted to address some of the common risk factors identified in the assessment of the elderly population that have fallen. Additionally it has been highlighted that often there are multiple contributory elements in any one individual and identification of them all is key in order to reduce the risk in each category. The elderly are likely to have multiple pathologies and hence individualized management strategies that address all the identified modifiable risks are the key towards reducing the burden of falls in this group.

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A complete list of all the references used in this article can be obtained from the Editor upon application.

Getting Juniors involved in teaching

Prof. David Brigden
University of Bolton
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Doctors have many roles and responsibilities beyond clinical medicine, one of which is as a teacher. *(GMC, Good Medical Practice, 2013).*

Some find teaching a challenge, for others the art of teaching comes more naturally. Whatever your initial experience or capabilities, most doctors find teaching enjoyable and rewarding.

Starting foundation training can be both a daunting and exciting experience. It is a busy time where interests such as education may be side-lined whilst you get to grips with the job. However, being a Junior Doctor provides many opportunities to teach.

Firstly, this can be on the wards with medical students; observing student/patient interaction; discussing cases or interpreting results. Secondly and probably more formally, some Foundation Schools offer teaching posts as part of Foundation Training. These tend to be F2 posts and are often difficult to secure, but they can provide good experience and an insight into education as a career.

Local undergraduate departments can also provide opportunities helping with curriculum teaching, leading and facilitating small group sessions, or even bedside teaching. Not only will this enhance your teaching skills and force you to consolidate your knowledge, but also observed teaching experience is a mandatory part of your e-portfolio.

Increasingly doctors are taking time out after Foundation Training to pursue specialist interests and strengthen their CV. Many Trusts offer twelve month teaching fellow posts, some are purely teaching with no clinical commitments, while others are associated with a speciality and demand a quantity of clinical work.

To find out more about available jobs, either contact Trusts directly or search NHS jobs (www.jobs.nhs.uk).

Create a free NHS jobs account and receive email alerts when jobs are advertised matching your own specifications. This is a great way to identify and apply for local teaching fellow posts.

Getting Formal Qualifications

Although experience of teaching is essential, more formal qualifications in education are becoming desirable. There are numerous courses available across the country. These range from postgraduate certificates to doctorates, all with flexible study options.

Most universities offer programmes in clinical or medical education. Broadly they involve gaining an understanding of recognised learning theories and teaching methods. The key is to choose a programme that suits you. This means considering whether you prefer face to face or distance learning and the level of study. Most start with a certificate or diploma.

To find out more about individual courses visit the University's website. Some Trusts can also help with funding of qualifications.

Summary

Teaching is an important activity for Doctors today. Opportunities to teach, ranging from informal sessions to accredited qualifications make themselves available as early as medical school.

Be proactive in finding and taking these opportunities. (GMC Tomorrow's Doctors, 2009).

Teaching
in the Clinical setting

Clinical teaching is a critical part of Medical Education. Without it, students and trainees would be unable to place their theoretical learning into a practical context.

Prof. David Brigden
University of Bolton, University of Liverpool

Consultants are generally seen as effective role models, who demonstrate professionalism, but the literature implies that there is a wide variation in the quality and reliability of teaching in respect to venue, setting and speciality.

With adequate preparation, learners are able to reflect upon both social and healthcare experiences and the actions of healthcare professionals using the GMC Duties of a Doctor as a framework.

If learners are removed from the clinical environment, isolation from patients can lead to a dislocation of theory from practice. Teaching and learning in any clinical setting is difficult to plan, highly dependent on context and is under ever increasing pressure from service provision. However, it can provide unique opportunities for educational contact when used appropriately.

Four issues that could improve learning in the clinical environment are:-

1. Integration of the learner into authentic clinical settings.
2. Equipping the learner with survival skills.
3. Better use of the clinical environment and resources for learning.
4. Expertise in using I.T.

Consultants often bemoan the fact that junior learners seem unable to recall facts and apply knowledge to patients' problems. Research has shown that separation of the basic sciences from clinical care compounds this problem, and that integrating the curriculum at medical school and bringing students into contact with patients early will engage these active learners.

Problem and case based courses help to link basic and clinical sciences and have a more patient centred approach.

Learners need proper briefing before moving into new environments. They also need time to reflect on the experience.

Challenges for learners and teachers include:-

1. Interpersonal skills such as giving and receiving feedback, dealing with abuse.
2. Coming to terms with illness and dying and dealing with other ethical problems.
3. Identifying positive coping strategies.
4. Making effective use of time and resources.
5. Obtaining and managing information.

In many areas of the world I.T. can provide enhanced communication and provide rapid access to knowledge data bases. It is essential that teachers integrate I.T. systems into the curriculum and align the educational design and assessment to the medium.

Systems can be developed to allow remote access to improve time management and effectiveness.

Monitoring and evaluation are key aspects of the educational process, electronic feedback can be utilised to provide rapid feedback to faculty.

The use of I.T. in clinical teaching can facilitate:-

1. Self directed learning.
2. Remote delivery of teaching materials.
3. Electronic communication between teacher and learner.
4. Self assessment.
5. Accessing data bases.
6. Logging process on e-portfolios.
7. QA and evaluation of educational events.

Staff and faculty development are key elements to ensure that medical teachers deliver effectively. It is imperative to ensure everyone is well prepared, intended learning outcomes are identified and known by learners and teachers alike and that the teaching and assessment methods are appropriate.

Reflection is a key aspect of adult learning and giving good feedback is essential to this process.

Evaluation and feedback to the learners should be given immediately after the learning event, outside of the examination room, but in a safe and private area for the learner.

Messages to take home:-

1. Faculty development is essential to optimise the effectiveness of clinical teaching.
2. Teachers should be well prepared for each teaching exchange.
3. Teachers should be able to assess the learning needs of their students, and
4. Set (and deliver) optimum learning outcomes.
5. Teaching should be aligned to the assessment methods, which are to be applied.

Tackling Obesity and its Impact on Health Study Day

Mr Babur Ahmed
Senior Clinical Fellow and Organising Secretary
Salford Royal Foundation Trust

Prof Siba Senapati
Consultant Bariatric Surgeon and Organising President
Salford Royal Foundation Trust
(pictured right)

On the 6th of April 2019, OASIS-GB held their annual study day on epidemic of obesity and its impact on health. Following two previous successful years, this was the 3rd study day of this kind, which was organised to raise awareness on the impacts of obesity on various aspects of health and the latest research and evidence on how best to tackle these ill effects. The study day was held in the Mayo Building at Salford Royal Foundation NHS Trust and was a Royal College of Surgeons of Edinburgh approved educational event, attracting 5.5 Continuous Professional Development points.

The study day was organised by OASIS-GB and BIDA and supported by BAPIO. It attracted a number of speakers including consultants of different specialities, dieticians, psychologists, general practitioners and patients from all over UK. Like previous years it was attended and participated by an audience of around 80 people comprising of medical and health professionals from various backgrounds.

The day started by registration of the attendees with a welcome pack and refreshments. **Professor Siba Senapati**, Consultant Bariatric Surgeon and Chairman of OASIS-GB opened the proceedings of the day with a welcome note in which he briefly highlighted the impacts of morbid obesity on health and the purpose and aims of the study day.

The morning session was chaired by **Mr Khurshid Akhtar**, lead of Upper GI and Bariatric Surgery services at Salford Royal Foundation NHS Trust. This session included talks from five speakers who highlighted the multitude of ill-effects of obesity and the challenges associated in their management. **Dr Venkat Sridharan**, Consultant Physician, Royal Oldham Hospital explained how patients with morbid obesity are linked to a spectrum of metabolic illnesses like diabetes, metabolic syndrome and cardiovascular issues, which can be resistant to medical treatment. **Professor Andrew Renehan**, Consultant Surgeon at The Christie Hospital, discussed his research in the increased incidence and prevalence of various cancers in patients with morbid obesity and the current awareness guidelines produced by Cancer Research UK. He also explained the challenges morbid obesity poses in management of such cancers. **Dr Phil Evans**, Honorary Senior Lecturer at University of Manchester and Consultant Physician at Salford Royal, explained how obesity can lead to the development and worsening of chronic kidney disease, and how this can be reversed with the correction of morbid obesity. He also made us aware, the current concerns with equity of care to end stage renal disease pts with morbid obesity. **Dr J.S. Bamrah**, Consultant Psychiatrist elaborated on the psychological aspects associated with obesity like anxiety, depression and other behavioural diseases and current awareness campaign to tackle obesity in parliament especially on sugar tax. The first session came to a conclusion following the talk of **Mr Nikhil Sharma**, Consultant Trauma and Orthopaedic Surgeon at Wrightington Hospital who stressed upon the impacts of morbid obesity on joint diseases like arthritis, poor mobility and the challenges in the surgical management of these illnesses and its long-term outcome.

The second session was chaired by **Dr Prasana Rao Balakrishna**, Consultant Diabetologist at Manchester Royal Infirmary. This session further focused on the multi-spectral health effects of obesity. **Dr Sanjay Arya**, Consultant Cardiologist & Medical Director at Wigan and Leigh Foundation Trust discussed the increased cardiovascular risks associated with morbid obesity. **Dr Sangeeta Das**, Consultant Obstetrician and Gynaecologists at Royal Bolton Hospital talked about the increased link of obesity and infertility. **Dr Michelle Makintosh**, Consultant Gynaecologist at St Mary's Hospital Manchester discussed her research of increased risk of endometrial cancer in patients with morbid obesity. She further discussed the evidence of regression of endometrial pre-cancerous changes with successful treatment of obesity. **Dr Akheel Syed**, Consultant Endocrinologist at Salford Royal Foundation Trust discussed the recent evidence in medical management of morbid obesity and its related metabolic syndrome. The second session came to a conclusion following the talk of **Professor Siba Senapati**, Consultant Bariatric Surgeon and Chairman of OASIS-GB in which he discussed various surgical procedures like gastric bypass, sleeve gastrectomy and gastric banding, and the latest evidence in the surgical management of morbid obesity and its associated metabolic syndrome.

Following a lunch break, the third and final session commenced and was chaired by

Dr Sanjay Arya, Consultant Cardiologist & Medical Director at Wigan and Leigh Foundation Trust. The first talk by **Dr Hugh McMurtry**, Consultant Hepatologist at Salford Royal Hospital focused on the impact of morbid obesity on liver and the current increased prevalence of fatty liver disease and non-alcoholic fatty liver disease. He also made it clear that currently obesity is the leading cause of Liver cirrhosis than alcohol. He discussed that it is reversible in the early stages with the treatment of obesity, however, if left untreated, can progress to irreversible chronic liver disease and cirrhosis of liver. **Dr Girish Patel**, General Practitioner Sides Medical Centre at Swinton discussed the challenges faced in the management of obesity at the primary care and community level. He talked about various community based activities and how getting involved in them can create a positive change. **Chris Slater**, Bariatric Specialist Dietician at Salford Royal Foundation Trust talked about the impact of tackling obesity by healthy eating and balanced diet. The session also included talks from a few patients who shared their experience following bariatric surgery and the positive impact it had following their significant weight reduction. The session came to a conclusion after the keynote lecture from **Dr Aseem Malhotra**, Honorary Consultant Cardiologist in Lister Hospital Stevenage on the science of the Pioppi diet and the evidence of how it impacts tackling obesity and its associated comorbidities.

The day came to a conclusion with a vote of thanks from **Mr Jack Carney**, Co-Chair OASIS-GB.

The study day raised awareness on how morbid obesity is a multispectral illness with various physical and psychological aspects and discussed the research and evidence on successfully managing it both in the community and hospital settings.

Tackling Childhood Obesity in Salford

Thursday 24th March 2020 *at* Salford Royal Hospital Stott Lane, Salford M6 8HD

The Problem

Obesity is a rapidly growing national problem, with clear evidence to show this can be an issue founded in childhood. Through BMI measurements taken in the first and final years of primary school we can see that overweight and obesity are growing significantly- with a continuation of this problem into adulthood, if left unaddressed. Further, there is robust statistical evidence through Public Health England to show that the margins for physical inactivity and obesity are widening and that areas of disadvantage are suffering disproportionately

The Opportunity

There is evidence to show from other parts of the UK that "strong ownership, leadership and partnership" are successful factors in tackling obesity. For some time now in Salford, there has been an encouraging gradual strengthening of partnership working between medical intervention and prevention services.

The seminar is intended to be of interest to:

- Medical practitioners and associated professionals
- Those with decision making authority and carrying influence over the lives of young people in Salford (managers from nurseries, schools, youth provisions)
- Strategic managers and elected representatives from the Council and Public Health.

The Programme

What Are The Specific Challenges And Consequences Of Childhood Obesity In Salford?
(Guest Speaker Inputs)

Professor Siba Senapati	Salford Royal NHS Foundation Trust
Dr Kalpesh Dixit	Salford Royal NHS Foundation Trust
Lynn Burney	Salford Royal NHS Foundation Trust
Dr Mars Skae	Manchester University NHS Foundation Trust
Deborah Thompson	Public Health Consultant
Professor Alex Blakemore	Brunel University
Jack Carney	Salford Metropolitan Athletic Club

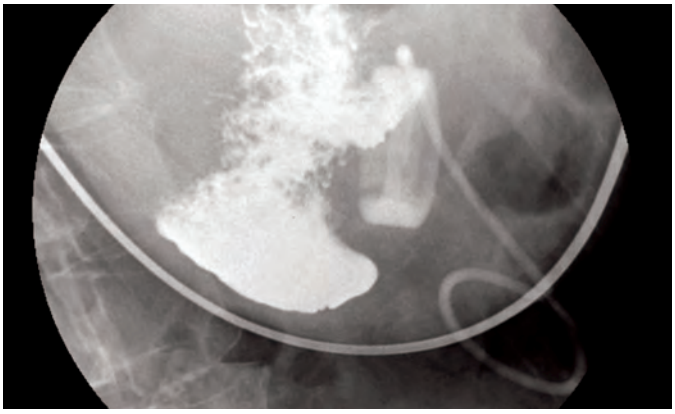
Sharing Experiences And Approaches - And Agreeing Actions To Reduce Childhood Obesity In Salford (Task Groups)

Agreeing The Methodology For Measuring Impact (Summary)

To reserve a place on the seminar please send your contact details to :

Chris Slater	Chris.Slater@srft.nhs.net
Jack Carney	jcarney171@gmail.com

Medical Quiz



What is the diagnosis?
What is the clinical presentation of this condition?
How do you manage this condition?
Answers on Page 23

Did you know?

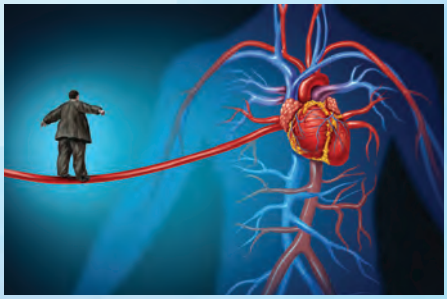
Should healthy people take an aspirin a day?

A meta-analysis of 13 trials with 164,225 participants with no cardio-vascular disease with median age 62, baseline cardio-vascular risk 9.2%; it was found that aspirin was associated with a lower risk of cardiovascular events (number needed to treat 265) and an increased risk of major bleeding (number needed to harm of 210) compared to placebo or no aspirin. If 1000 healthy people take a daily aspirin, approximately 4 will benefit from a cardio-vascular point of view and a similar number will have a major bleed. On the basis of this study, it doesn't seem taking a daily aspirin is justifiable, but is worth discussing with the patient.

JAMA 2019;321:277-287

Cardiovascular fitness and Stroke

A Norwegian study recruited 2000 men aged 40 – 59, measured their fitness with a bicycle ergometer on two occasions 7 years apart and followed them for 10 years (Stroke). Those who started unfit but got fitter had less than half the risk of stroke of those who remained unfit. On the other hand, those who started fit but became unfit had twice the risk of those who stayed fit.



BMJ 2019;366;l466

The fat-diet-heart hypothesis

This is far from simple. The idea that food cholesterol was to blame for heart disease has been disproven, and replaced by total fat hypothesis, and then the saturated fat hypothesis. Demonising one major food group or type of fat is a mistake. Foods contain a wide range of saturated, monounsaturated and polyunsaturated fatty acids in varying proportions and the different fatty acids never exist in isolation. The other factor we need to understand is that each one of us humans respond differently to the food we consume.

BMJ 2019;364:170

Ayurvedic Medicine:

Origins, Philosophy and Effectiveness

Amit Sinha
FRCS (T&O)
Consultant Orthopaedic Surgeon

Ayurvedic medicine is one of the world's oldest medical systems and remains one of India's traditional health care systems. This established medicine was developed during antiquity and the medieval period, and as such is comparable to pre-modern Chinese and European systems of medicine. How has Ayurveda maintained its place in contemporary medicine, in spite of fierce competition with allopathic medicine? This led my inquisitiveness to explore into the origins and details of this fascinating subject.

Origins

According to modern Ayurvedic sources, the origins of Ayurveda have been traced to around 6,000 BCE[1]. Some of the concepts of Ayurveda have existed since the times of Indus Valley civilization. The first recorded forms of Ayurveda as medical texts evolved from the Vedas. Ayurveda is a discipline of the upaveda or "auxiliary knowledge" in Vedic tradition. The origins of Ayurveda are also found in Atharvaveda[2,3], which contains 114 hymns and incantations described as magical cures for diseases. There are various legendary accounts of the origin of Ayurveda, that it was received by Dhanvantari or Divodasa from Brahma[4].

There are three principal early texts on Ayurveda, the Charaka Samhita, the Sushruta Samhita and the Bhela Samhita. The Chinese pilgrim Fa Hsien (c. 337–422 AD) wrote about the healthcare system of the Gupta empire (320–550) and described the institutional approach of Indian medicine. This is also visible in the works of Charaka, who describes hospitals and how they should be equipped[5].

The Mahabharata of Vedavyasa is an encyclopaedic work, which has got some importance from the standpoint of Indian medical science also. According to it Ayurveda was a compulsory subject, which was taught to everybody. Perhaps, Mahabharata is the first epic, which presents the term Ayurveda[6].

Ayurveda is one of the few systems of medicine developed in ancient times that is still widely practiced in modern times. The political debate about the place of Ayurveda in contemporary India has continued to the present, both in the public arena and in government[7,8]. Ayurveda developed significantly during the Vedic period and later some of the non-Vedic systems such as Buddhism and Jainism also developed medical concepts and practices[9]. In the present era, it has re-emerged to play a vital role in several countries like India, Nepal, Sri Lanka etc. The Ministry of Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa Rigpa and Homoeopathy (AYUSH) in India purposed with developing education, research and propagation of indigenous alternative medicine systems in India has now been established on the 9th of November 2014. Debate about the place of Ayurvedic medicine in the contemporary internationalized world also continues today.

Basics

Ayurveda derives from the Sanskrit words Ayus (life) and Veda (knowledge), meaning knowledge of life and longevity. It's based on the belief that health and wellness depend on a delicate balance between the mind, body, and spirit. If your mind, body, and spirit are in harmony with the universe, you have good health. When something disrupts this balance, you get sick. Genetic defects, injuries, climate and seasonal change, age, and your emotions can upset this balance. The main goal is to promote good health, not fight disease. But treatments may be geared toward specific health problems.

Basic tissues (*Dhatu*)

Plasma (rasa) Blood (rakta) Muscles (mansa)
Fat (meda) Bone (asthi) Marrow (majja)
Semen (shukra)

Elements (*Panchamahabhuta*)

Earth Water Fire
Air Ether (Space)

Gunas (*Qualities*)

Heavy/Light Hot/Cold Unctuous/Dry
Dull/Sharp Stable/Mobile Soft/Hard
Non-Slimy/Slimy Smooth/Coarse Minute/Gross
Viscous/Liquid

Box 1: Basics of Ayurveda

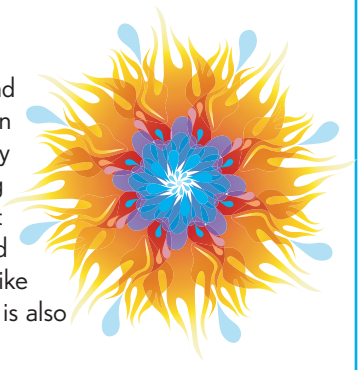
Ayurveda names seven basic tissues (dhatu), and has historically divided bodily substances into five classical elements - panchama-habhuta. These are organized in ten pairs of gunas (Box1).

The five basic elements combine and interact in the human body to form three life forces or energies, called doshas. They control how your body works. They are Vata dosha (space and air); Pitta dosha (fire and water); and Kapha dosha (water and earth). Everyone inherits a unique mix of the three doshas. Each one controls a different body function. Ayurveda teaches that each person should modulate their behavior or environment to increase or decrease the doshas and maintain their natural state.

Vata Dosha

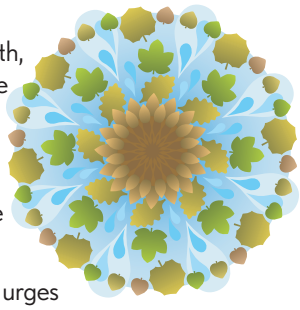
This controls very basic body functions, like how cells divide. It is considered the most powerful of the three doshas. It controls the mind, breathing, blood flow, the heart and ability to get rid of waste through the gut. Any factor, which disrupt the function of these organs increase the risk of developing anxiety, asthma, heart disease etc. therefore, it would be appropriate to look after your diet and ear sensibly, stay away from pollutants, meditate and keep calm, avoid fear and grief and sleep early.

Pitta Dosha



This energy controls digestion and secretion of hormones, which help in metabolism of digestion. Extremely sour or spicy foods and spending too much time in the sun can upset this balance. Any disruption can lead to gastro-intestinal conditions like Crohn's disease and infections. It is also linked to heart related conditions

Kapa Dosha



This energy regulates muscle growth, body strength, weight and the immune system. Too much sweet, excess salt or water intake in the diet upsets this energy and can cause diabetes, obesity, cancer etc. Sleeping during the day should be avoided.

It is advocated that suppressing natural urges is considered unhealthy and can lead to illness. One must stay within the limits of reasonable balance and measure when following nature's urges. There is emphasis on moderation of food intake, sleep, and sexual intercourse.

Ayurvedic Philosophy

This advocates a holistic approach to physical and mental health during diagnosis and therapy. Western allopathic medicine tends to focus on symptomatology and disease, and primarily uses drugs and surgery to rid the body of pathogens or diseased tissue. The focus on preventative medicine is a recent phenomenon and currently being emphasized. Ayurveda focuses less on the disease condition and mainly takes into account the individual's unique physical and emotional makeup, the primary life force, and the balance between all three of these elements.

Ayurveda follows the concept of "Dinacharya", which states that natural cycles (waking, sleeping, working, meditation etc.) are important for health. Hygiene, including regular bathing, cleaning of teeth, tongue scraping, skin care, and eye washing are all advocated. Ayurveda also focuses on exercise, yoga, and meditation and occasionally on "Sattvic" diet.

Recommendations may include the implementation of lifestyle changes; starting and maintaining a suggested diet; and the use of herbs. The goal of treatment is to cleanse the body of undigested food, which can stay in the body and lead to illness. The cleansing process is called "panchakarma", which is designed to reduce the symptoms and restore harmony and balance. The Ayurvedic practitioners believe that there are channels (srotas) that transport fluids, and that

Ayurvedic Medicine:

Origins, Philosophy & Effectiveness

the channels can be opened up by massage treatment using oils fomentation. They might rely on blood purification, medical oils, massage, herbs, and enemas or laxatives etc.

6. Purified opium is used in a few Ayurvedic preparations and is said to balance the Vata and Kapha doshas and increase the Pitta dosha[11]. It is prescribed for diarrhea and dysentery, for increasing the sexual and muscular ability, for sedation and pain relief. Opium preparation could be used with camphor in acute gastro-enteritis. Camphor counteracts the respiratory depressant effect of opium. Cannabis has been mentioned in early texts.
7. Oil and tar can be used to stop bleeding. Oils are also suggested for regular consumption, anointing, smearing, head massage, application to the forehead (Shirodhara)

Components of Ayurvedic Science

The earliest classical Sanskrit works on Ayurveda describe medicine as being divided into eight components:

- kayachikitsa: general medicine, medicine of the body
- kaumara-bhrtya (Pediatrics): Discussions about prenatal and postnatal care of baby and mother, methods of conception; choosing the child's gender, intelligence, and constitution; and childhood diseases and midwifery.
- salyatantra: surgical techniques and the extraction of foreign objects
- shalakyatantra: treatment of ailments affecting ears, eyes, nose, mouth, etc. ("ENT")
- bhutavidya: pacification of possessing spirits, and the people whose minds are affected.
- agadatantra/vishagara-vairodh tantra (Toxicology): It includes subjects about epidemics, toxins in animals, vegetables and minerals and recognizing those anomalies and their antidotes.
- rasayantantra: rejuvenation and tonics for increasing lifespan, intellect and strength
- vajakaranatantra: aphrodisiacs and treatments for increasing the volume and viability of semen and sexual pleasure. It also deals with infertility problems and spiritual development (transmutation of sexual energy into spiritual energy)

Box 2: Components of Ayurvedic science

Methods of Treatment

1. Two of the eight branches of classical Ayurveda deal with surgery (Salya-cikitsa and Salakya-tantra).
2. Plant-base medications derived from roots, leaves, fruits, bark, or seeds such as cardamom and cinnamon[10].
3. Animal products used in Ayurveda include milk, bones, and even gallstones.
4. Minerals (sulphur, arsenic, lead, copper sulfate and gold) are also prescribed and added to the herbal medication.
5. Alcoholic beverages called Madya are prepared in different methods. These cause purgation, improve digestion or taste, create dryness, or loosen up the joints.

Effectiveness and Safety

There have been a few well-designed clinical trials and systematic research reviews, which suggest that Ayurvedic approaches, are effective[12].

- A 6-month study, a randomised controlled clinical trial compared two Ayurvedic formulations of plant extracts against the natural product glucosamine sulphate and the drug celecoxib in 440 people with knee osteoarthritis[13]. All four products provided similar reductions in pain and improvements in function.
- Ayurvedic medications are also effective in rheumatoid arthritis[14,15]. A preliminary and small NCCIH-funded 2011 pilot study [16] with 43 people found that conventional and Ayurvedic treatments for rheumatoid arthritis were similarly effective for 36 weeks.

- A recent review in 2019 focuses on the merits of the philosophy of Ayurveda[17]. Both Western and Ayurvedic medicine focus on reducing the HbA1c. Where Ayurveda differs is that it looks at the functionality of a person in the context of striking a balance between the life forces or doshas that each individual possesses.
- A study from Brazil concludes that turmeric, an herb often used in Ayurvedic preparations, may help with ulcerative colitis[18], as it has effective inflammatory action.
- A Cochrane database review[19] concluded "Curcumin (Turmeric) may be a safe and effective therapy for maintenance of remission in quiescent Ulcerative Colitis when given as an adjunct therapy along with mesalamine or sulfasalazine".
- According to Cancer Research UK, there is no reliable evidence to support its use as a treatment for cancer.
- Evidence is not convincing for the use of any Ayurvedic herbal treatment for heart disease or hypertension, however a number of herbs could be considered for further research[20].
- Use of Heavy metals: Studies from the USA have confirmed that some Ayurvedic medicines may contain potentially harmful levels of heavy metals (lead, arsenic and mercury). There is risk of developing associated toxicities [21,22,23].

Conclusion

Approximately 40% of adults in the United States report using complementary and alternative medicines (CAMs). Globally, estimates of alternative medicine users are even higher, with the World Health Organization (WHO) finding approximately 70–80% of all people utilizing non-allopathic medicines, mainly of herbal sources, in their health care[24]. Up to 80% of India's population is estimated to use Ayurveda, either exclusively or in combination with other medical therapies[25].

The philosophy of Ayurvedic medicine hinges on the holistic approach to assess the whole individual and advice to improve the quality of life brought through diet, lifestyle, yoga and "panchkarma" process in some cases. The National centre of Complimentary and Integrative Health based in Maryland, USA plans to research this aspect of Ayurvedic intervention. They are funding another research project to study the mechanism by which an extract from Butea monosperma (BME) flowers may protect against joint destruction from osteoarthritis (BME is widely used in Ayurveda for arthritis and other inflammatory diseases in India).

There is a recent report of AIIMS, New Delhi planning to come together with All India Institute of Ayurveda and the Central Council for Research in Ayurvedic Sciences to delve deeper into the probability of treating cancer with Ayurvedic drugs. More research is required to study the effectiveness and safety of Ayurvedic medications[26].

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National Clinical Excellence Awards:

Improving the quality and success of BME applicants

Dr Sanjay Arya FRCP
Medical Director & Consultant Cardiologist
Wrightington, Wigan & Leigh
NHS Foundation Trust
Member, ACCEA North West

Prof Iqbal Singh OBE FRCP
Medical Vice Chair ACCEA North West
Chair, Centre of Excellence in Safety for Older People (CESOP)

The objective of the national scheme is to reward consultants and academic GPs who show the greatest sustained levels of performance and commitment to the National Health Service and in a way that is transparent, fair, based on clear evidence and perceived to be so.

Criteria for Excellence

Performance over and above the standard expected of a consultant in their post.

- Sustained commitment to patient care, public health.
- Delivering high standards of care.
- Demonstrating strong commitment to values and goals of the NHS.
- Outstanding contributions exceeding contracted job plan/role.

There are 4 levels of national award - bronze, silver, gold and platinum. These awards are hugely prestigious and also carry a significant financial incentive (which is pensionable). It is therefore important that the process is open, transparent, fair and has credibility. About 5% of the consultant body hold national awards from silver to platinum and these are equally distributed across the 13 regions. The number of BME consultants receiving a national award over the last four years has been around 18-22%, and although it is pleasing to note that the proportion (%) of applicants from BME consultants has increased to around 21-22%, the total number of applicants has been decreasing (Table 1). We would encourage BME doctors to apply as the success rate is gradually getting better.

The evidence required is:

Standard application form completed by consultant with personal statement, job plan summary and the five domains:

- ***Domain 1 – Delivering a High Quality Service***

  Evidence should show achievements in delivering a service which is safe, quality assured, and where opportunities for improvement are consistently sought and implemented.

- ***Domain 2 – Developing a High Quality Service***

  Evidence should show how applicants have significantly enhanced the quality and safety of the local service(s) more widely within the NHS.

- ***Domain 3 – Leadership and Managing a High Quality Service***

  Evidence should show how applicants have made a substantial personal contribution managing a local service, or national/ international health policy development.

- ***Domain 4 – Research and Innovation***

  Evidence should show how applicants have made a contribution to research over and above their contractual obligations.

Table 1: Number of BME Consultants receiving a national award in England, 2011 – 2018

	2011	2012	2013	2014	2015	2016	2017	2018
Number of BME Applicants *(% of total applicants)*	274 (14.36%)	299 (16.49%)	311 (18.49%)	282 (20.09%)	229 (21.24%)	237 (21.48%)	231 (22.99%)	221 (22.95%)
Total awards	300	301	300	300	299	300	300	300
Number of awards to BME Consultants *(% of total applicants)*	42 (14%)	41 (13.62%)	51 (17%)	37 (12.33%)	66 (22.07%)	64 (21.33%)	64 (21.33%)	54 (18%)

- ***Domain 5 – Teaching and Training***

  Evidence should show how teaching and training forms a major part of the contribution applicants make to the NHS, over and above contractual obligations

It is mandatory to have employer recommendation and it is beneficial to have third party citations

Citations:

- Should comment on quality of achievements
- Assists ACCEA in assessing the evidence submitted by the applicant
- Draws attention to elements that may be liable to misunderstanding
- Quality of citations matters not the quantity
- Should relate to achievement within the competence of the nominating body
- Should be submitted by the President or Chairman of the nominating body
- Should not be provided by a colleague from the same institution

The Exam Approach

The Principles:

There are five domains - all five domains are marked, however the personal statement and the job plan are not marked. The latter two serve to give a profile of you. Complete the five domains first and work out for yourself what your strengths and weaknesses are.

When the domains are completed go back and do the personal statement bringing out, in four points, what is so special about you. Similarly with the job plan, it is very important that you stress what you are doing over and above what would be normally expected of you.

If you put something important in either the personal statement or job plan, and do not repeat it in the domains, then it is sadly lost.

Use the embedded ability to format the text you import. Do not format outside as importing the document seems to distort it. The embedded tool is quite good.

Remember, as with exam marking, it is very hard to read closely written text. It is much easier to read text with bullet points or numbered and much easier to read spaced out text.

The Form:

1. **Personal statement**
- This should highlight the key achievements, presented in detail in the rest of the application form
- It is not scored
- This is published for successful applicants

2. **Job Plan**
- Summarises the candidate's job
- Excellence does not require additional activity before it can be judged to be 'over and above' expectations
- But excellence may be judged differently for contributions that are a major part of the job receiving dedicated support
- State what achievements are in an honorary capacity

3. **Five Domains:**
- It is important to put something in each domain.
- Research is a difficult one. If none, then the fact that there is no set up in the consultant's role to do research is taken into account.
- Remember that clinical audits can be included here as the domain does span Research and Innovation.
- At the end of the application you will see your weaknesses and this will help for strengthening subsequent applications
- For all applications, including bronze, the additional boxes in the domains of leadership/management; research/innovation and teaching/training can be used.

General Principles

It is important to show what you have achieved in developing and giving high-quality patient care. You need to demonstrate your commitment to improving the NHS. Clinical excellence is about providing high-quality services to the patient in front of you. It is also about treating as many patients as possible by using resources efficiently and making services more productive. You need to show the award assessors evidence of how you made services more efficient and productive and improved quality at the same time, as well as demonstrating your role as an enabler and leader of health provision, prevention and policy development and implementation

Based on the strength of the applications, the regional sub-committees and then the National Committee recommends applicants for national awards to health ministers for them to agree.

The sub-committees are regional groups that assess new and renewal applications for national awards for applicants in their area. They assess what you have achieved against the expectations of your contract as described in your job plan, recognising excellent service over and above this. It consists of a lay chair, medical vice-chair, employers, professional and lay members.

Equality

- Equal opportunity to make case
- Standardised structured application form
- Objectivity in evaluation
- Scoring system, twin short listing routes
- Transparency of criteria and outcomes
- Guides, personal statements
- Support for under-represented groups in enhancing quality of applications
- Equal treatment for part time, flexible working and post career breaks

Further reading: ACCEA: Guide for applicants – National Clinical Excellence awards 2019.

ACCEA
ADVISORY COMMITTEE on CLINICAL EXCELLENCE AWARDS

The final timetable for the planned 2020 Awards round has been published on the website:
www.gov.uk/government/organisations/advisory-committee-on-clinical-excellence-awards

2020 ACCEA Awards Round:

Applications open: Friday 13 March 2020 **Applications close: Thursday 7 May 2020**
Outcomes will be announced to applicants in **December 2020**. Further questions? Contact: **accea@dhsc.gov.uk**

Please cascade this information to your members and ensure that your own internal processes allow applicants sufficient time to complete and submit their applications to ACCEA.

Department of Health & Social Care

ACCEA. Workforce Division, Acute Care and Workforce Directorate, Department of Health & Social Care, Quarry House, Leeds LS2 7UE
E-mail: **accea@dhsc.gov.uk** *Telephone:* **0207 972 4608** *Follow us on Twitter* **@DHgovuk**

Letter *to the Editor*

"Our pioneering home visiting solution – Primary Care sees a glimmer of hope"

Dr Shika Pitalia
GP and Director of SSP Health, Secretary Wigan BIDA Division

Dear Editor,

The current controversy about possible changes to the GP contract in relation to home visits forgets this issue has been debated for a long time. Back in 2012, BIDA invited me to speak at its international conference about SSP Health's Acute Visiting Service (AVS), which at that point had be running for six years. Schemes similar to our AVS, which we pioneered in 2006, have started to spring up across the UK in the years since I spoke to delegates – and now the penny seems to have dropped that it is an effective and workable solution to the thorny question of home visits.

A forward-thinking organisation such as BIDA obviously recognised the merits in our scheme and I hope I convinced delegates of its worth. It certainly had proved to be extremely effective in streamlining how we tackled home visiting.

I designed the scheme as a dedicated service, fully triaged and audited, when I chaired a commissioning consortium, United League Commissioning, in St Helens and Wigan. At the time of its launch, with the blessing of the then primary care trust, our AVS was heralded as an 'innovative approach' to a growing problem locally – an increase in unscheduled admissions to A&E, 50% of which were regarded as being able to be treated in the community.

Home visits were redesigned in our practices, with all patients requesting one initially given an immediate phone consultation with a GP or nurse, and then that triage process leading to a referral to the scheme or the offer of a routine GP in-practice appointment.

The scheme had a dramatic improvement on efficiency, both on home visits and in the surgery. Initial findings showed that 43% of people needing a home visit by a 'scheme doctor' were seen within 30 minutes, compared with less than 5% previously from the patient's own GP. The average time spent with such patients also increased from eight to 20 minutes. In practice, access to surgery appointments became easier and we had more ability to ensure patients saw their own doctor due to reduced pressure on GP time. It also proved beneficial in reducing hospital admissions and re-admissions, saving the trust money.

Crucially, 90% of patients who used the service said they were satisfied with the experience. However, at the time of reorganisation of commissioning in 2013, funding for the AVS service was reallocated – but we continued it at our Wigan practices at SSP Health's expense, as we recognised the immense worth of the system.

We were also intent on expanding it and the AVS has been functioning extremely well across our GP practice locations throughout the North West. The AVS was successful in a clutch of awards, and tens of organisations nationwide asked me to show them how the service worked. I have been pleased to see that many areas across the country now have a form of my original scheme in place.

The AVS continues to be a valuable feature of our service delivery at SSP Health, although it has altered to keep pace with changing needs and priorities – for instance, our advanced nurse practitioners now also partake in the service alongside GPs, and paramedics are also involved at our Carlisle practices.

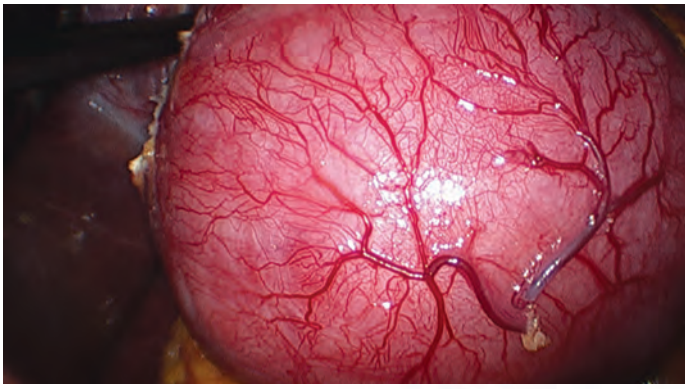
The move to create this type of service on a national level is well overdue, as we have been advocating our blueprint for it as a success story for more than a decade. We at SSP Health would gladly share our experience in this with anyone who wants to hear how it works on the ground.

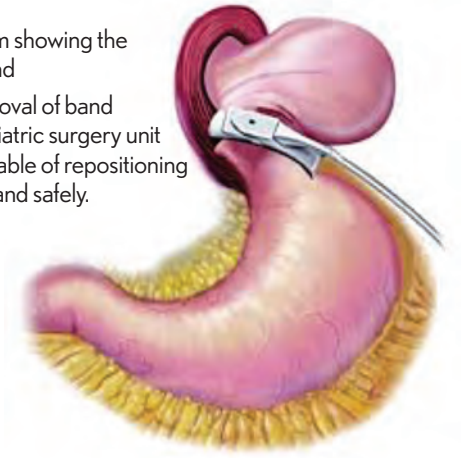
Dr Shika Pitalia

GP and Director of SSP Health,
Secretary Wigan BIDA Division

Medical Quiz Answers

1. **Diagnosis: Slipped gastric band**
2. **Clinical presentation:** History of gastric banding in the past. Not able to tolerate anything or persistent vomiting or spitting
3. **Management:**
   Barium swallow to confirm the diagnosis (as shown in the first picture), showing the slipped band. Laparoscopic finding of hugely distended and congested gastric pouch above the band.



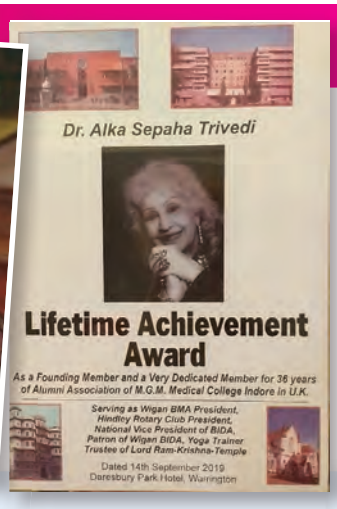


Schematic diagram showing the slipped gastric band

Laparoscopic removal of band preferably at a bariatric surgery unit or by surgeon capable of repositioning or removing the band safely.

Achievements by BIDA Members

Dr Alka Trivedi



Congratulations to BIDA National Vice-President

Congratulations to Dr. Alka Trivedi, the National Vice-President of BIDA and Patron and President of BIDA, Wigan Division. She has been awarded the lifetime achievement award from the Mahatma Gandhi memorial medical college for her social work, community and charity services for many years. She is the Founder member of the reunions of her Medical Alumni. She was also recently appreciated for the most popular dance presentation at the International reunion of her college, which was front-page news of many newspapers.

Dear Sir,

I want to thank BIDA and the BIDA family for all your support and encouragement. In past 4 years, when my life came to a standstill after a sudden calamity in my life, BIDA proved that it's not only a medical political organisation, but also an extended family.

My heartfelt thanks to you all. I would like to extend my thanks through you to colleagues of my medical college, my close friends and my daughter Anita both for keeping my morale high and for all of their encouragement. Please convey my prayers and best wishes to BIDA to continue all the good work.

Dr Alka Trivedi

Dr Shika Pitalia

Congratulations to SSP Health Director Dr Shikha Pitalia who has been named in the Manchester Power 100 list.

The list profiles the most influential people in the Greater Manchester area and includes business people, politicians, music idols and sportsmen and women, as well as those involved in the arts and public service. Dr Pitalia appears at number 54 in the list – one above Manchester United player Marcus Rashford!

The entry highlights SSP Health as the *"largest provider of primary care GP services in the North West of England, one of only three such organisations in England serving more than 100,000 patients".*

Dr Pitalia is the only doctor or healthcare professional in the list and it also names her as Secretary of the British International Doctors' Association, Wigan Division.

Dr Pitalia said: *"It is lovely to be honoured in this way but more importantly it puts SSP Health more firmly on the map in terms of our importance to primary care in the North West of England.*

Greater Manchester has always been SSP Health's heartland and we have been at the forefront of the fast-paced changes in primary care which has been seen in recent years across the city region.

It is our continued commitment to excellence in healthcare – which is ingrained in everyone at SSP Health – that is being highlighted in this award."

Dr Biplab Das

Congratulations to Dr Biplab Das for receiving a "Lifetime Achievement Award" from the RCGP, Mersey faculty.

Dr Das is the Chairman of the Merseyside and Cheshire Division of BIDA. He is also the immediate past Chairman of Liverpool Local Medical Committee. He also serves as an under-graduate teacher and examiner of Liverpool Medical School.

Dr Das has been invited to sit in the interview panel to select Medical Students and to join the Faculty of Academic of Clinical Educators for Liverpool Medical School.

He is President of The Bengali Association of Merseyside and the North of England, which is involved with various religious and cultural activities.

Something to shout about?

Let us know your news! This is YOUR Journal – Use it! Contact the editor today at amitani2000@yahoo.co.in or bida@btconnect.com

COUNTRY : JORDAN (JORDAN CLASSIC TOUR)

Duration : 6 Days / 5 Nights **Starts from £ 600 pp**

Tour Highlights :

- Umm Qais - Jerash - Desert Castles - Madaba
- Mount Nebo - Erak Castle - Ajloun - Petra - Wadi Rum - Dead Sea

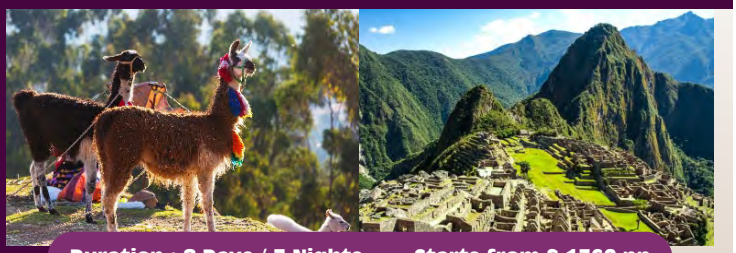
Inclusions

- 5 Nights Accommodation in Hotels
- Visa to Jordan for non-restricted nationalities to Jordan -
- Meeting & assistance services upon arrival to Jordan -
- Transportation in air-conditioned vehicle with English-speaking driver -
- Private English speaking guide during the tours -
- 03-hour jeep tour in Wadi Rum - •Entrance fees as per program -

Price

- Package Cost with Standard Hotels **on request**
- Package Cost with Superior Hotels **on request**
- Package Cost with Deluxe Hotels **on request**

COUNTRY : PERU / SOUTH AMERICA



Duration : 8 Days / 7 Nights **Starts from £ 1360 pp**

Sacred Valley Tour Highlights :

- Qorikancha Temple - Cusco Cathedral
- Plaza De Armas - Saqsaywaman - Awana Kancha
- Moray Ruins - Ollantaytambo
- Vistadome Train - Sun Temple - Machu Picchu
- Aguas Calientes City - - Peru Rail Titicaca - Lake Titicaca
- Uros floating Islands - - Taquile island - Sillustani Ruins

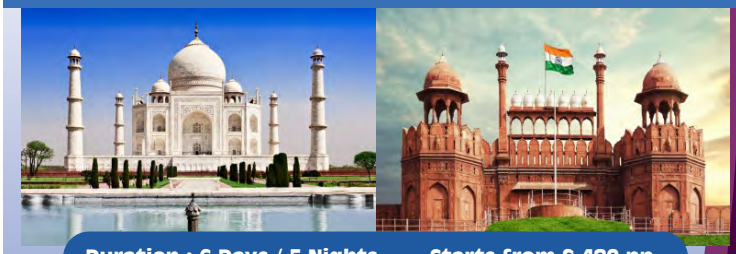
Inclusions

- 7 Nights Accommodation in Hotels
- Transportation as per the program in A/C vehicle with an English speaking driver.
- Sightseeing with Group
- (For more than 4 Passengers sightseeing will be on private basis)
- Entrance Fees. English Speaking Guided Tours
- Internal Flights and Train within Peru

Price

- Package Cost with Standard Hotels **on request**
- Package Cost with Deluxe Hotels **on request**
- Package Cost with Premium Hotels **on request**

COUNTRY : INDIA



Duration : 6 Days / 5 Nights **Starts from £ 480 pp**

India Golden Triangle Tour Highlights :

- New Delhi & Old Delhi Tour
- Taj Mahal Agra Tour
- Jaipur Pink City Tour

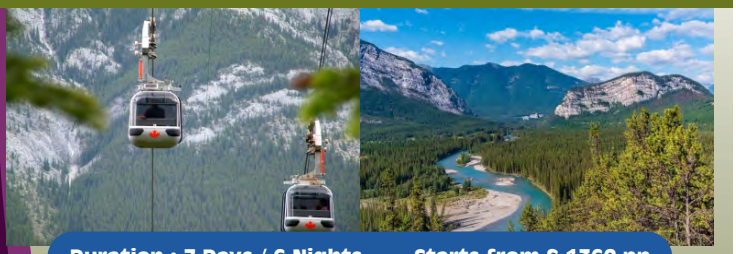
Inclusions

- 5 Nights Accommodation in Hotels
- Meeting and assistance on arrival / departure
- Transfer from airport to hotel and vice-versa.
- Monument & Entrance Fees
- Sightseeing, excursion and Surface travel as per program. by A/C Vehicle
- English speaking local guide at Jaipur, Agra and Delhi
- Elephant failing Jeep ride in Amer Fort – Jaipur

Price

- Package Cost with Standard Hotels **On Request**
- Package Cost with Deluxe Hotels **On Request**
- Package Cost with Premium Hotels **On Request**

COUNTRY : CANADA



Duration : 7 Days / 6 Nights **Starts from £ 1360 pp**

Canadian Rockies & West Coast Golden Way

Tour Highlights :

- Canmore • Full day Icefields Parkway Tour • Lake Louise •
- Guided tour of Banff • Banff Gondola ride • Tour of Yoho National Park •
- Revelstoke –by the banks of the Columbia River •
- Three Valley gap • Kelowna • Guided tour of Vancouve •
- Capilano Bridge Park & Cliffwalk •

Inclusions

- 6 Nights Accommodation in Hotels
- Dedicated English speaking Tour Director – Day 1 to 6
- Deluxe tour transportation
- Tours and Transport on SIC Basis with Group - Entrance Fees
- Tour of Yoho National Park, Spiral Tunnels and the Natural Bridge
- Park & Cliffwalk Capilano Bridge, Park & Cliffwalk

Price

- Package Cost with Standard Hotels **On Request**
- Package Cost with Deluxe Hotels **On Request**
- Package Cost with Premium Hotels **On Request**

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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:*
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- Nominations for excellence awards
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