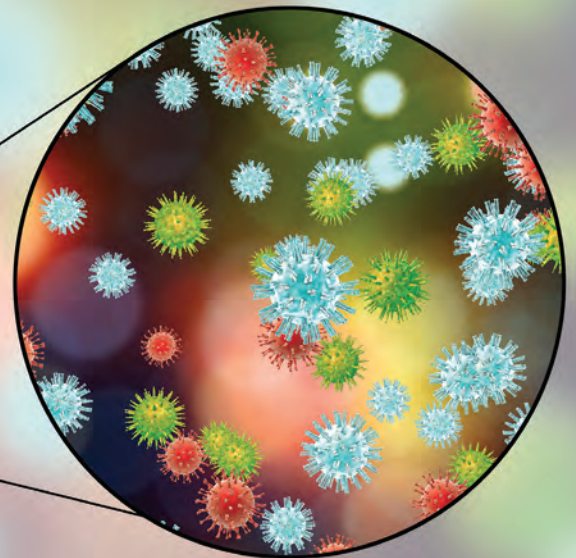
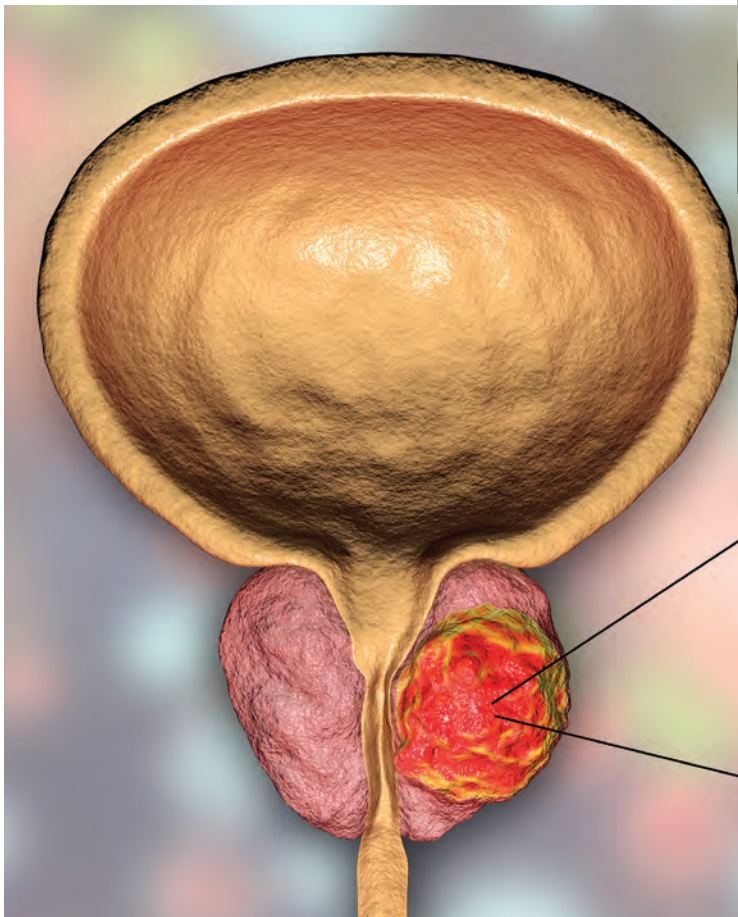


## **Should the NHS implement a screening programme for Prostate Cancer?**



**Barriers to the adoption of healthcare apps amongst patients in a GP practice.**


**Virtual Communication: Merits and Challenges. Is this the new norm?**

**How we adapt to the Future NHS? Food for thought...**

**Obesity in the United Kingdom: Do we need a new approach?**

**An interview with Prof. Robin Sengupta O.B.E. Supporting Trainees in Difficulty.**

**BIDA National Conference, A.R.M., A.G.M. 2022 / BIDA President's Cup / BIDA Fellowship Awards**



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# Editorial

**Mr Amit Sinha** FRCS (Tr&Orth) Consultant Orthopaedic Surgeon Media & Communication Lead, BIDA Editor, BIDA Journal.



We are entering a new phase in our lives with so much turmoil in the economy of the country with a sudden and sharp downturn in confidence of the market. We are now looking up to our newly appointed Prime Minister Rishi Sunak and Chancellor Jeremy Hunt team to make amends.

It is a proud moment to see a British Indian to be at the helm of the country. It is going to be a herculean challenge to turn things around. However, he is well known as a shrewd and keen economist with an eye for finding solutions even in the toughest times, as he offered several schemes during the height of the pandemic. Let's hope he and his team steer the country to safe grounds.

## Strikes in the NHS

The news of the Nurses presumptive demands for a pay rise 5% above inflation, which on current levels amounts to 15% are very much justifiable. Since 2010, the pay of some experienced nurses has fallen by 20% in real terms. This may lead to the biggest nurses strike in NHS history, which could take place before Christmas after a huge number voted for nationwide industrial action. The Royal College of Nursing (RCN) is due to announce the results of its ballot in the next few days.

Junior doctors are facing a similar situation. They have experienced real-term pay cuts of more than a quarter of their salaries since 2008/9. The Government this year gave junior doctors a 2% pay rise. This is not acceptable when other NHS workers have had a pay rise of 4.5%. The BMA has raised its voice and BIDA will fully support the Junior Doctors Group if they resort to industrial action in the New Year if the Government does not comply with the pay demand to restore it to the 2008-9 levels.

## BIDA National Conference

The success of the National Conference at Stoke on Trent has enthused us with considerable pride and constructive passion about the organisation. There has been a sea change in our attitude and a positive excitement for our future. The Executive Committee has

built up several positive strategies to take BIDA from strength to strength. This edition includes a brief report of the proceedings.

This conference highlighted the issues in the NHS affecting regulation of International Medical Graduates (IMGs) and presented several solutions. In my view, "Compassionate leadership" from all those in senior positions will pave the way forward. There should be a concerted effort to understand this. The second theme of the conference stressed on "Strategies on woman's health".

## Articles

Around 11,900 prostate cancer deaths occur in the UK each year, translating to approximately one death every 45 minutes. Partap Shergill and co-authors present a scientifically loaded argument to support a screening programme for Prostate Cancer. Popat and Sinha present the merits and challenges of "Virtual Communication". Quite rightly so, the whole pandemic period converted us to a telecommunication environment. "Zoom" & "Teams" became the buzzwords. However, to apply these principles in medicine safely and with confidence raises fundamental concerns. Mihika Konduru, an A-level student, has done a superb audit to reveal the barriers in the use of Healthcare apps in the community.

On behalf of the Editorial Board I wish to congratulate our colleagues who joined the ranks of earning BIDA Fellowships. We also look up to our role models Prof Dame Clare Gerada, Prof R Sengupta, Prof Shiv Pande and Dr Satya Sharma who feature in this edition in achieving accolades for their contribution to the Healthcare in the UK and internationally.

*"Yesterday I was clever, so I wanted to change the world. Today I am wise, so I am changing myself"* Rumi Quotes

## Amit Sinha

Editor, BIDA Journal



## Instructions for Authors

BIDA Journal is a peer-reviewed journal. We welcome original articles from physicians, surgeons and medical students from any part of the world. These include review articles, scientific articles, case reports, audits and letters to the Editor. Please visit BIDA's website for instructions.

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# National President's Report

Dear Friends,

I would like to start my report by congratulating our new PM Rishi Sunak who has assumed this role as the first British Asian. I have campaigned for Rishi and I hope he can work to support our NHS, particularly with the current issues of backlogs and workforce issues.

It was lovely to see many of our BIDA members at the Annual Conference in Stoke-On-Trent last month. The Conference and ARM/AGM organised by me along with Stoke-On-Trent Division was a huge success. We had an excellent conference with a great agenda, and brilliant guest speakers including Dame Clare Gerada, Jo Gideon M.P. and Prof Iqbal Singh CBE. We were delighted to present our Annual BIDA Special Award for their huge contribution towards International Doctors to Dame Clare Gerada, who has supported a large number of issues related to International Doctors over many years.

# National Chairman's Report

Dear Colleagues,

I must start by congratulating Mr Rishi Sunak who only very recently became the first British Asian Prime Minister of the United Kingdom. It is a matter of pride and honour for all British Asians and goes a long way in proving the quality and fairness that the United Kingdom has. We at BIDA wish very good luck to Rt Hon Prime Minister Mr Rishi Sunak, Jeremy Hunt, the Chancellor, and Steve Barclay, the Health Secretary. At the same time, on behalf of all BIDA members, I would urge them to give the NHS its due worth and provide it with a much needed boost in funding. It is also high time that the new Health Secretary and the new Prime Minister ensured fairness and equality in the National Health Service.

From our organisation's perspective, a lot of you are aware of our very successful National Conference and Annual ARM/AGM. This was hosted by Stoke-on-Trent Division under the guidance of our President, Dr Kanneganti. I must congratulate Stoke Division on hosting such an excellent conference. I am sure that those of you who could not attend will see glimpses of the Conference in this edition of BIDA Journal. It was also encouraging to see BIDA

# National Treasurer's Report

Dear Members,

It gives me a great pleasure to write you as your Treasurer. We have had a great BIDA National Conference and ARM & AGM. Our accounts were presented at the AGM. Our finances are in a reasonably healthy condition. We have a number of loyal members who are enthusiastic and support our national and regional events. Now that Covid is less of a problem, many Divisions have started their face-to-face meetings. I would like every member to bring one more member into BIDA in the next one year so that we can

I attended The President's Cup Cricket final which took place in August between Wigan and North Wales Divisions. Wigan won the final, and it was heart-warming to see the Badge family and their contributions to the match. At our recent AGM/ARM, I was delighted to present the trophy to Wigan Division's team and the 'Man of the Match' Award to Adi Badge. It was also brilliant to see Divya Badge become the first female to play in BIDA Cricket matches, and she played exceptionally well.

BIDA's Executive Committee will now discuss and come up with the actions to implement the motions passed by the ARM.

## Dr Chandra Kanneganti

*National President, BIDA*



members coming out to attend a face-to-face conference. This is going to be the trend of our organisational activities moving forwards.

As COVID pandemic numbers reduce and the virus becomes less virulent, life continues to come to some sort of normality. It is BIDA's intention to mirror what is happening around the world, and therefore, in the next year, our BIDA activity calendar will be full of face-to-face activities including our National Conference, our ARM/AGM, our sporting activities and our much-awaited International Congress.

I am sure you will all enjoy this latest addition of BIDA Journal. Let me wish all of you a very Happy Christmas and a Happy New Year. Please stay in touch and write to me if you want any issues to be taken up by BIDA.

## Dr Ashish Dhawan

*National Chairman, BIDA*



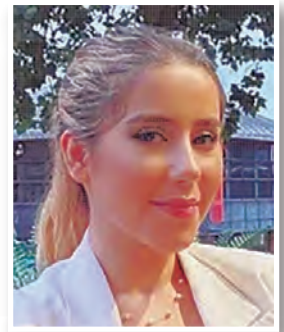
double in number. I would like to thank Mr. Amit Sinha, our National Secretary, Alison from Central Office and my predecessor, Mr. Pranab Sarkar, for all the help and guidance.

## Dr Vinod Gadiyar

*National Treasurer, BIDA*



# BIDA Student Wing Report 2022-23



Dear BIDA Members,

BIDA Student Wing's establishment in 2020 was the best initiative that could have taken place for international students in the UK. Over the past couple of years, BIDA SW has created an inclusive and diverse community with members from more than 39 nationalities across the globe who study in all the UK Medical Schools. BIDA Student Wing's platform allows students to be supported in all steps of their journey.

The support provided by BIDA Student Wing is not only limited to academic and well-being support but ensures international students' voices are heard nationally, and actions are in place to tackle any challenges they may face. Last year, as the BIDA-BMA liaison, I was able to make sure these changes were in place, and this year I was nominated as the President of the BIDA Student Wing. I would like to especially thank Mr Amit Sinha, Dr Sai Ram Pillarisetti and Alireza Sherafat for their handover and continuous support and supervision of the Student Wing. Moreover, this year's committee is full of enthusiastic and proactive members who I'm looking forward to working with. The aim of this year's committee would be a continuous improvement of all the fantastic initiatives that were in place last year, which included (but were not limited to) a webinar series on exam revision, getting involved in extra-curricular activities, career guidance and well-being support. There are additional new plans in place for this year.

Thanks to Emily Rose Wagner, our Academic and Research lead, the Student Wing is organising events in collaboration with Imperial College's Academia and Research Society. Imperial-BIDA joint events include Specialised Foundation Programme mock interviews in October, the Young Researcher's Conference in November, Research Skills Academy & Mentorship in December onwards, and Speed Networking with Researchers in February. Inspired by the success of BIDA National Conferences over the years, Paarth Kishan Gupta, our conference chair, with the help of Emily Rose Wagner, is organising a conference dedicated to medical students with an opportunity for oral presentations and

essay competition submission.

Additionally, our Peer Teaching lead Rebecca Lee has organised several teaching series with the help of BIDA junior doctors for both pre-clinical and clinical year students that would help students with their exams throughout the academic year starting in November. Further to that, the career guidance series led by Khansa Irfan aims to provide information on speciality fields with less attention on them. Examples include Occupational Medicine and Public Health.

The promotion of free BIDA membership among students is necessary to make sure support is available to everyone. Thanks to our National Secretary Arefeh Ghodsizadeh, and our National Outreach Officer Renee Punia, we now have more than 15 university representatives across the UK medical schools as well as more than 350 members. This figure is increasing every day and we hope to have representatives and members from every medical school in the UK by the end of November. Moreover, one of the aims of our welfare lead Ananya Srivathsan, with the help of our Journal Representative Prashamsa Manchiraju, is to carry out a survey across all universities across the UK to report on any outstanding challenges students might be facing. This would ensure that the voice of students is heard, and actions are in place when needed by our BIDA SW - BMA Liason Hossein Bonab.

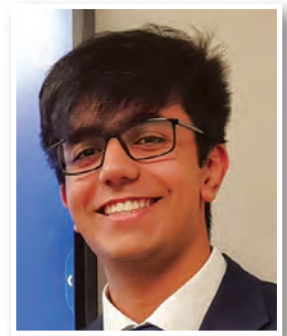
Overall, the opportunity I was given by BIDA allows me to follow my biggest passion for equality, diversity and inclusion to create a platform that provides continuous support that is available to everyone. I'm looking forward to working with all the enthusiastic members of the Student Wing committee as well as BIDA senior members.

**Negin Gholampoor,**

*President, BIDA Student Wing*

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# Should the NHS implement a screening programme for Prostate Cancer?



**Partap S. Shergill**

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## Introduction

The prostate gland provides nourishment for sperm during reproductive years<sup>1</sup>, and subsequently, it does not have any definitive function, but typically enlarges in either a benign or malignant manner. Alarming, 47,600 men are diagnosed with prostate cancer annually, making it the most common cancer affecting men in the UK, with 1 man now being diagnosed every 6 minutes, and worryingly, one man dying per half a football game<sup>2</sup>. Due to the high incidence, prevalence and mortality rates, there have been suggestions whether a prostate cancer screening programme may be beneficial in men in the UK.

## What is a Screening Programme?

The World Health Organisation (WHO) states that the purpose of screening is "to identify people in an apparently healthy population who are at higher risk of a health problem or a condition, so that an early treatment or intervention can be offered and thereby reduce the incidence (number of cases present in the population at a given time) and/or mortality (number of patients dying from a disease) of the health problem or condition within the population."

Essentially, screening aims to act like a sieve, separating the people who probably have the condition that is being tested for, from those who probably do not have the condition.

The WHO has set out 10 principles, which must be assessed when considering the implementation of a screening. These were originally set out by Wilson and Jungner (Box 1), in their paper "principles and practice of screening for disease" published in 1968<sup>3</sup>.

Unlike breast and bowel cancer, the National Health Service (NHS) does

1. The condition should be an important health problem.
2. There should be an accepted treatment for patients with recognised disease.
3. Facilities for diagnosis and treatment should be available.
4. There should be a recognisable latent or early symptomatic phase.
5. There should be a suitable test or examination.
6. The test should be acceptable for the population.
7. The natural history of the condition, including development from latent to declared disease, should be adequately understood.
8. There should be an agreed policy on whom to treat as patients.
9. The cost of case-finding (including a diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole.
10. Case-finding should be a continuous process and not a "once and for all" project.

Box 1. Wilson and Jungner principles of screening.

not run a screening programme to detect prostate cancer. Currently, the NHS provides a test that detects Prostate Specific Antigen (PSA) levels that are present in the blood. If a value greater age-related PSA is detected, the GP is advised to refer the patient for specialist opinion<sup>4</sup>.

Due to the high incidence of prostate cancer, the high death rates and the potential for new diagnostic testing, the question of whether or not every man should be screened for prostate cancer, through the implementation of a national NHS programme has been raised, repeatedly. Each of the 10 principles set out by the WHO will be analysed to investigate whether a screening programme should be initiated for prostate cancer.

## Principle 1:

*The condition should be an important health issue*

The first principle to assess is whether or not prostate cancer is an important health problem for the UK. Critically, "important" can be defined as having a high incidence, high death rate, which has a major impact on the NHS.

Prostate Cancer affects 1 in 8 men during their lifetime<sup>1</sup>. Around 11,900 prostate cancer deaths occur in the UK each year, translating to approximately one death every 45 minutes (one half of a football match!). As such, it is quite clear that it is a very important health problem.

Semi-qualitative interviews were carried out with five prostate cancer support group patients, aged 50-80, discussing their opinions on screening programmes using a questionnaire (Box 2). Patients felt that prostate cancer is ignored and downplayed in society. They felt that this was due to a multitude of reasons. Primarily, they felt that it was due to the

1. What do you understand by the term "Screening Programme"?
2. What are your opinions on the current informed choice programme for Prostate Cancer?
3. In your opinion, what is needed for a successful screening programme to be initiated?
4. The U.K. has already implemented 3 screening programmes for cancers: Bowel, Breast and Cervical. In your view, why would it benefit the population to introduce a similar programme to detect Prostate Cancer?
5. Do you think having a PSA test screening programme would be beneficial?
6. Why do you think that a screening programme for asymptomatic men has not been implemented yet?
7. If the NHS decided to screen people for Prostate Cancer what alternatives could the NHS use apart from PSA?
8. How as a prostate cancer group would you encourage individuals to take part in a screening programme?

Box 2: Questionnaire provided to Prostate Cancer support group

lack of education about what the cancer is, how it can be investigated, and what effects the cancer had on people's lives. People who had previously undergone treatment for prostate cancer, or their family members, only truly understand the true impacts of prostate cancer. There was a strong belief that the UK government should look at improving prostate cancer awareness, instead of relying on prostate cancer awareness and support groups to spread the message to everyone.

Moreover, they said that men, in particular young-aged men (<35 years), feel that there is a certain stigma surrounding their topic. Subsequently, men are less willing to visit their GP or talk to loved ones to discuss the issues or symptoms they are experiencing as they feel it is embarrassing.

Evidently, prostate cancer is a prevalent issue among men in the UK. If men are educated about the severity of the cancer and are confident in expressing any symptoms or issues that they may be facing, it will encourage men to participate in the programme. Therefore, this first principle for screening is met.

### **Principle 2: There should be an accepted treatment for patients with recognised disease**

Patients who are diagnosed with prostate cancer can undergo many different treatments, with most being acceptable to the patient with a successful outcome.

The most common treatment provided is Radical Prostatectomy. The patient's whole prostate gland is removed surgically, alongside the seminal vesicles and lymph nodes to which the cancer may have potentially spread. Robotic surgery potentially reduces the harm that invasive procedures may inflict on patients (i.e. blood loss, tissue damage and protects nerves that are required for penile erections<sup>5</sup>), thus making it acceptable to provide as a form of treatment.

External beam Radiotherapy, can also be given, using high energy external x-ray beams are fired at the prostate gland, damaging the cancer cells. Long-term side effects of radiotherapy are: bowel changes – diarrhoea, increase urgency to go to the toilet and minor bleeding, sexual changes – more difficult for men to obtain and sustain an erection, with over 50% of men being unable to regain some control<sup>6</sup>.

Brachytherapy is also an alternative, a form of "internal" radiotherapy offered to patients whose cancer is at an earlier stage. Small radioactive titanium seeds are implanted into the gland, providing either a high dose of radiation for 6 hours or low dose of radiation over 6 months. Patients are often able to return home within one day of treatment provided<sup>7</sup>. Both options are acceptable treatments for prostate cancer as they reduce the recovery time for patients, allowing them to continue with their life as per usual.

The acceptability of treatments can also be assessed through the experiences of patients. Speaking to one prominent member of the prostate cancer group, he said *"although my treatment was straight forward and without complications, I have heard of several men who have had bad incontinence and love life problems following treatments."* Another patient said, *"if I had known the side effects had been this bad, I would have thought twice about having the operation."*

Nevertheless, the majority of patients feel that their treatment was overall acceptable. This suggests that surgery and radiotherapy could be used as part of the treatment pathway after a positive screen pathway. Each procedure has the ability to cure the cancer, albeit with small probability of side effects occurring in patients. This therefore ensures that the second principle is met.

### **Principle 3: Facilities for diagnosis and treatment should be available**

For a screening programme to be considered, there must be facilities available for diagnosis and subsequent treatment. Although, specific diagnostic tools and treatments are discussed elsewhere in this paper, it

is quite clear that when recommended for a PSA test, a blood test is carried out in the GP surgery. If an abnormal PSA result is received, patients are referred urgently using the suspected cancer pathway referral to a urologist in secondary care (hospital). This aims to provide an appointment with the consultant within a 2-week timeframe. Virtually every NHS hospital in the UK contains a urology diagnostic unit and has appropriate treatment facilities. If a particular hospital does not have adequate treatment facilities, patients are easily referred to cancer centres, within the respective network, for specialist prostate treatment. With this facility and dedicated cancer pathway in place, it ensures that the third principle for screening is also met.

### **Principle 4: There should be a recognisable latent or early symptomatic phase**

Research is being considered on this topic, however, the difficulty is that there is no recognisable latent phase or early symptomatic phase for prostate cancer. Patients only display symptoms when cancer is typically at an advanced stage. The fourth principle for screening is, therefore, not met.

### **Principle 5: There should be a suitable test or examination &**

### **Principle 6: The test should be acceptable to the population**

In current clinical practice, the NHS offers a simple PSA blood test for those men who enquire about the possibility of prostate cancer. PSA testing is unable to formally diagnose a patient with prostate cancer but acts as an indicator, allowing patients to be referred for specialist test e.g., MRI scans and biopsy, to establish or exclude cancer. Age adjusted levels of PSA are used to try and identify men who may have suspected prostate cancer.

Unfortunately, the PSA test is associated with several shortcomings as a potential screening tool. Firstly, the PSA test is not fully reliable, with a low sensitivity rate (not being able to correctly identify that someone does have prostate cancer) Three in four men who have raised PSA levels are found to not have prostate cancer post-biopsy<sup>8</sup>. Similarly, the Physicians Health Study reported a sensitivity of 46% for total cases using a threshold of 4ng/ml (as suspected prostate cancer). Specificity was reported at 91%<sup>9</sup>. Falsely high PSA results can lead to patients undergoing unnecessary biopsies or overdiagnosis. Overdiagnosis occurs when a patient is diagnosed with a disease, which was not detected, would have caused no symptoms or harm to the patient. The consequences are that patients undergo unnecessary treatments, and as such, their risk of developing complications increases<sup>10</sup>.

Moreover, PSA levels can be raised due to multiple reasons for example; UTI, recent biopsy in the past 6 weeks, urinary catheter and ejaculation, which have no direct link to prostate cancer. Interestingly, PSA does have high specificity, meaning it is able to correctly identify that someone does not have prostate cancer.

Even though the PSA test is minimally invasive, the low sensitivity, alongside the difficulty in detecting the staging of prostate cancer makes it less acceptable to the population to be used as part of a screening programme for all men. A patient receiving a false positive can suffer unnecessary risks, which can cause psychological and physical harm to the patient. The low effectiveness of the PSA test is one reason a screening programme for asymptomatic men has not been established, which would bring the patient more harm than good.

In certain patients, prostate cancer can be diagnosed by conducting a Digital Rectal Examination (DRE), and hence could potentially be part of a screening programme, as it takes a short time to conduct. However, the examination is invasive, causing some discomfort for men ranging from minimal to severe.

Several men from the prostate cancer support group, said that they dreaded this examination because of what had been said to them by their friends and found it very embarrassing. Furthermore, urologists are concerned that men are discouraged to visit their doctor for a routine prostate check due to the embarrassing nature of this examination. DRE cannot be used alone for examination for a screening programme, because of poor sensitivity and specificity, and despite the expertise and experience required for detection of the abnormal gland, there is considerable inter and intra observer variation with this examination.

In the past 25-30 years, two major trials have been conducted to investigate whether PSA testing complimented with DRE would be appropriate to use as part of a screening programme. It is vitally important to discuss key elements of these ground-breaking trials in prostate cancer screening.

## Trial 1:

### *The Prostate, Lung, Colorectal and Ovarian (PLCO) Trial*

In the United States of America (USA), the Prostate, Lung, Colorectal and Ovarian (PLCO) trial was launched to investigate whether PSA testing and DRE would be able to reduce the mortality from prostate cancer<sup>11</sup>.

A total of 76,685 men aged 55-74 were assigned into two arms, an intervention (screening) arm and a control arm, at 10 centres between November 1993 and July 2001. In total, 38,340 men were assigned to the intervention arm, undergoing annual PSA testing for 6 years and annual DRE lasting for 4 years. A PSA level of >4.0ng/ml was considered as a positive for prostate cancer, with DRE conducted by professional qualified nurses and physicians. In the control arm, 38,345 men were assigned to standard care (sometimes included opportunistic screening – random PSA test group). Screening culminated in October 2006, during which period every incident of prostate cancer diagnosis and prostate cancer related deaths through the follow up years was ascertained<sup>11</sup>.

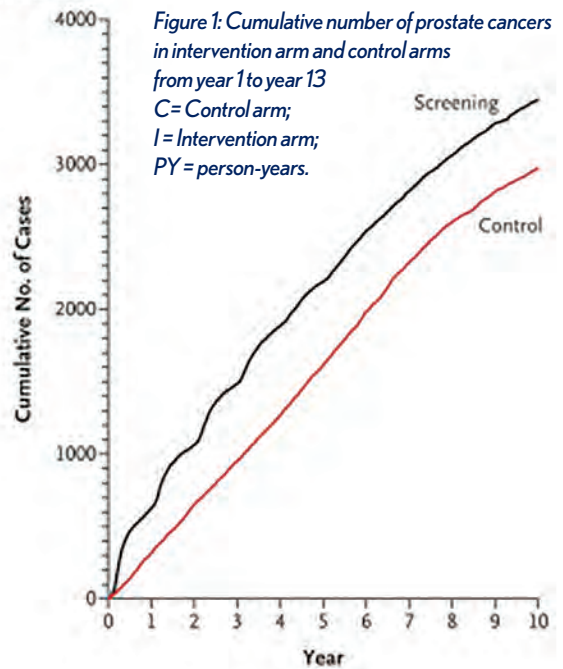
The PLCO trial showed that the incidence of prostate cancer was significantly higher in the screening arm than in the control group after 7, 10 and 13 years (Figure 1). Furthermore, deaths attributed to prostate cancer in the screening arm was higher at all-time points than in the control group (Figure 2). The reported conclusion was that there was no major difference between the proportion of deaths from prostate cancer in both groups of patients.

In the screening group, 312 deaths due to other reasons (not associated with prostate cancer), while in the control group this was 225 at 10 years. The potential for this excess in the screening group due to overdiagnosis of prostate cancer, shows that there was a slight increase in overall mortality due to extra screening for prostate cancer.

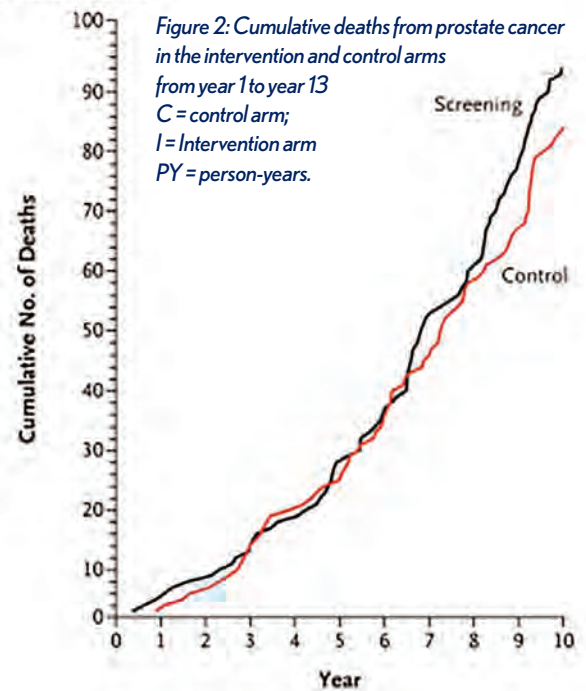
Unfortunately, there are several limitations to the trial itself. Firstly, some patients either had, or were not supposed to have had early detection. There is a possibility that this contributed to the impact of deaths from prostate cancer. The main issue is that there was “PSA contamination” in the control arm. Discussing this issue with a leading UK urologist, he explained that these men would undergo usual care, and a PSA test would be taken when they display symptoms for prostate cancer. However, 50% of the men who were part of the study underwent a PSA test when they were not displaying symptoms, leading to their removal in the study. This impacts the conclusions of the study in terms of credibility and scientific rigour.

The conclusion from the trial appears to be that screening of men does not help to reduce the mortality from prostate cancer. In fact, it only allows for more cases of prostate cancer to be detected from testing. This conclusion could therefore be utilised to inform that PSA screening and DRE should not be introduced due to no reduction in mortality rates. Due to the “PSA contamination” the credibility of the study is undermined, meaning that it is difficult to agree with the conclusion of PSA testing and

**Prostate Cancers**



**Prostate-Cancer Deaths**



DRE not aiding in the reduction of mortality. In addition, the study only considered men aged 55-74, but for a wider screening programme, the trial would have to include men aged less than 55.

## Trial 2: *The European Randomised study of Screening for Prostate Cancer (ERSPC) Trial.*

Initiated in 1993, the European Randomised study of Screening for Prostate Cancer (ERSPC) was set out with the aim of establishing whether PSA testing would lead to a reduction in Prostate Cancer mortality, increase survival and be able to understand whether it would benefit governments to use a PSA screening programme for the whole population<sup>12</sup>.

The trial, which is still active, was a joint study between 7 different countries: Netherlands, Belgium, Sweden, Finland, Italy, Spain and Switzerland, all joining between 1993-1998. France, joined in 2000-2003 as the final centre, but is not included in the mortality analysis due to joining the trial at a later stage. Men were recruited between the ages of 50-73 years old, with a predefined core age group of 55-69 years old



and split between two groups: an intervention arm (screened every year) and a control arm. Screening was with PSA cut off of 3.0ng/ml (any result above would be classed as a positive result). Any screen positive result would have a biopsy taken from them.

The main outcome of the study was reported for the core age group, which consisted of 162,388 men. 145 men unfortunately passed away before the randomisation date, and as such, 72,891 men were placed in the intervention arm, and 89,352 in the control arm. Rate ratios were used to estimate the ratio of mortality/incidence in the intervention group versus the ratio of mortality/incidence in the control group. Number needed to invite (NNI), and number needed to detect (NND) to prevent a death from prostate cancer was calculated. Over 13 years of follow up, incidence of prostate cancer was higher in the intervention arm than the control arm and there were fewer prostate cancer deaths in the intervention arm compared to the control arm, with rate ratios of 0.85 (9 years), 0.78 (11 years) and 0.79 (13 years). (Figure 3). Rate ratios remained constant to 16 years. A reduction in mortality was seen between the intervention arm and the control arm.

Following a 9-year follow up, the NNI to prevent death was 1410, with NND to prevent death is 48. At 11 years follow up, NNI was 979, NND was 35, 13 years follow up, NNI was 781, NND was 27 and after 16 years, NNI was 570 and NND was 18. Clearly, the number needed to invite for screening to prevent death has decreased during the trial. Furthermore, the number of prostate cancers needed to be detected to prevent mortality from prostate cancer has reduced during the trial. The ESPRC showed that PSA screening does decrease mortality from prostate cancer than standard treatment pathway. The trial established a strict protocol, with systematic screening of those in the intervention arm, and little opportunistic screening in the control arm. Consequently, there was less contamination unlike the PLCO trial, which made the result potentially invalid.

From this trial, the conclusion appears to show that there was a reduction in prostate cancer mortality, but there were some limitations to the study. Firstly, during the 9 years follow up, estimates were that 50% of the screen positive detected cases were in fact over diagnosed, and 71% of men were likely to have a prostate cancer diagnosis in the screening group compared to the control group. This probably led to overtreatment such as treating men for a cancer which would not ordinarily have any effect on the patient's life. Hence, treatment is most likely going to be ineffective and increase the risk of complication occurring from unnecessary treatment. The ERSPC trial concludes that PSA screening may not be best for a screening programme due to high level of NNI and NND.

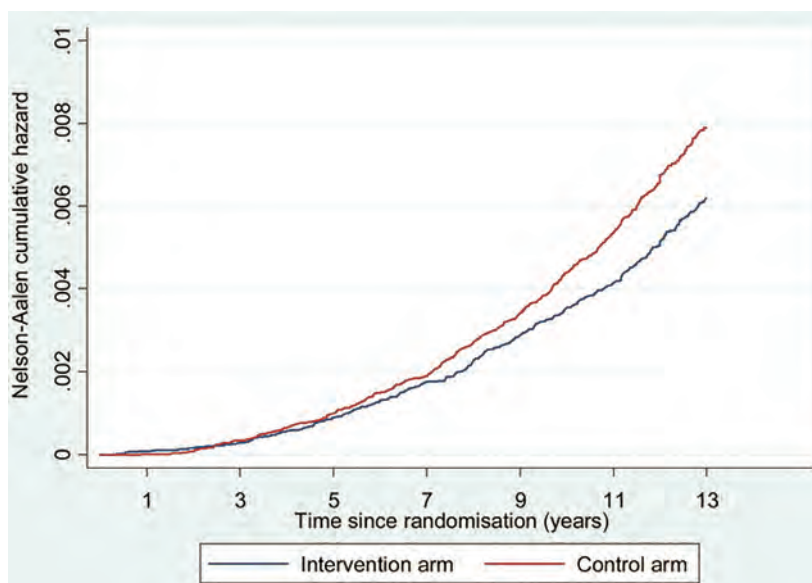


Figure 3: Prostate cancer mortality in the intervention and control arms, according to cumulative hazard.

Ideally, a lower NNI and NND is needed to reduce the cost of a screening programme, reaching low levels in a shorter period of time. This in turn would reduce overdiagnosis and overtreatment, making the programme more effective.

In the last few years, there have been advancements in diagnostic tools, which may be more acceptable, in terms of sensitivity and specificity, to the population. One example is Multiparametric MRI scans (mpMRI) for diagnosing prostate cancer. The mpMRI uses magnetism and radio waves to develop pictures of the prostate from all angles. Scans are non-invasive, only requiring a contrast dye to be injected into the vein, and are safe, as no radiation exposure is required.

Testing the effectiveness of the mpMRI as a diagnostic modality tool was conducted in the PROMIS trial, between 2012 and 2015. In the trial, 740 men with clinically suspected prostate cancer (high PSA or abnormal DRE) were enrolled. Evidence showed that almost a quarter of men who had a "negative" mpMRI could have potentially avoided undergoing a biopsy. Furthermore, for a significant cancer, mpMRI was more sensitive at 93% compares to TRUS-biopsy at 48%. mpMRI also identified significant disease progression of cancer, which PSA is unable to achieve.

Due to the evident effectiveness of the mpMRI as a scanning tool, it has now led to National Institute for Clinical Excellence recommending it as first line investigation for patients who have suspected prostate cancer<sup>13</sup>. Consequently, clinicians and radiologists are able to determine with confidence the staging of the cancer. Clinicians are then able to make easier decisions regarding whether the patient will need to undergo further biopsies or treatment for the cancer, which carry their own risks. The overall likelihood of overdiagnosis occurring is noticeably reduced.

This positive news led to the establishment of the PROSTAGRAM trial, conducted by Imperial College Healthcare and Imperial College London. PROSTAGRAM is a new emerging alternative to PSA and DRE, based on the mpMRI scan, with each scan taking fifteen minutes. 408 men aged 50-69 accepted the offer to partake in the trial. Each patient had a PSA test and prostate ultrasound conducted to compare with results of the scan. It was found that PROSTAGRAM detected twice as many prostate cancers as PSA tests were able to. 17 men were found to have developed an aggressive form of prostate cancer; 14 found using the scan versus 7 with PSA testing<sup>14</sup>.

The success of PROSTAGRAM in outperforming PSA test in detecting prostate cancer has led to considerations of its use in practice after further testing. Both PROSTAGRAM and mpMRI are suitable tests that could be used in a screening programme due to their minimally invasive nature, compared with the associated higher risks of overdiagnosis and overtreatment to that of PSA testing and DRE. Further large volume trials investigating its validation throughout UK, may allow the use of PROSTAGRAM to become a screening tool in the future.

Currently, this principle is not met, but once data from the future PROSTAGRAM study is available, there is quiet optimism that this may change.

## Principle 7:

*The natural history of the condition, including development from latent to declared disease, should be adequately understood.*

Some prostate cancers are aggressive ("tigers"), which may spread quickly to bones and lymph glands, whereas others are very slow growing ("pussycats") and are very unlikely to be a threat to a patient. The natural history of prostate cancer has not yet been fully understood, such that many "pussycat" cancers were unknowingly treated very aggressively.

However, more recently there has been a greater under-

standing of the severity of the cancer, in particular treatment of these “pussycat” cancers. The Prostate Cancer Intervention versus Observation Trial (PIVOT) was established to investigate the differences in mortality between men who had been treated for localised prostate cancer compared to men whose cancer were monitored/observed. The study concluded that men who have low-risk cancer and PSA based screening-detected disease can safely avoid harm and costs of radical treatment, and cause of death is highly unlikely to be due to prostate cancer<sup>14</sup>. This conclusion has been aided by the improvements in mp-MRI scans and prostate biopsy techniques. As such, many prostate cancers are now monitored with “active surveillance” rather than active aggressive treatment, which is reserved for “tiger” cancers. NICE recommends “Active Surveillance” is provided to patients with localised prostate cancer, and for those who are willing to delay treatment until it is absolutely necessary.

Even though the development from latent to declared disease is not clearly understood, there has been a greater understanding in whether or not treatment is needed. The advent of diagnostic tools are needed to understand the severity of cancer, which is critical if we are unable to determine the natural history of the cancer. This principle is not met.

### **Principle 8:** *There should be an agreed policy on whom to treat as patients*

Unfortunately, there is no definite agreed policy of whom to treat as patients. It is difficult to decide whether every man should be tested and treated, or test a limited group of men for example, those at high risk. During my interviews conducted with the prostate cancer support group, they supported the idea of testing every man and men who wish to undergo treatment were given the opportunity. They understood that it would be an appropriate idea to test every man, however, understood that it would not be possible due to the high costs of the programme. Furthermore, current diagnostic tools available may cause more harm to those men who may never be affected by the cancer itself.

### **Principle 9:** *The cost of case-finding (including a diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole. &*

### **Principle 10:** *Case-finding should be a continuous process and not a “once and for all” project.*

There is currently no clear evidence available to determine whether it should be continuous process or not. Logically, the process would be ongoing as prostate cancer can develop anytime during man’s lifetime. Two factors are needed to take into consideration: the cost of diagnostic test and a suitable duration of testing.

PSA testing is relatively cheap, and biopsies cost in the region of £400-500. Each mpMRI scan costs in the region on £350-450. Both diagnostic tools are similar in costs, however, the associated risks with biopsies and PSA testing are greater than that of mpMRI. If a suitable test such as PROSTRAGRAM could be offered, more men would be tested in a shorter time-period. A suitable duration would be testing men every 1.5-2 years, with men visiting their GP when symptoms begin. However, these two principles will be met during the planning phase pre-implementation.

## **Discussion**

In conclusion, there is a strong and valid argument for the NHS to implement a screening programme for prostate cancer. Based on Wilson and Jungner’s principles, prostate cancer is an important health condition for men, affecting 1 in 8 men during their lifetime. If we can detect men who have prostate cancer early, we are able to implement treatment pathways, which can cause minimal risks and harm to patients, and informing personalised and tailored treatment. This requires public awareness of prostate cancer and the impact, which is currently lacking.

However, early detection can lead to an issue called Lead time bias. It occurs when prostate cancer is detected earlier through screening or active surveillance then it would have been diagnosed based on clinical appearance<sup>16</sup>. A patient displaying no symptoms had a PSA test conducted 8 years ago as part of a screening programme, leading to detection of prostate cancer, and formal diagnosis. The same patient started to display symptoms, now after 8 years. If no screening programme was present, this would have led to his diagnosis. The patient undergoes treatment and passes away 5 years later. A false sense of an increased survival rate is created, as it looks like the patient has lived an extra 13 years due to his early diagnosis, and extra 5 years due to delayed diagnosis, but the patient has lived the same years. Those extra 8 years fuelled with anxiety and worry, affecting their quality of life. If a screening programme is implemented, patients must be informed of the risks and be provided with adequate counselling.

PSA testing and DRE are not being completely acceptable as a diagnostic test for prostate cancer, as reported by the PLCO and ESPRC trials. New techniques, for example, mpMRI and PROSTRAGRAM, are practical replacements as acceptable diagnostic tests. If continued funding is provided, further research can be provided to improve these techniques. Unfortunately, the expensive nature of scans and time to conduct them would not make it a cost-effective screening programme.

## **Conclusion**

In conclusion, a screening programme for prostate cancer does fulfil many of the screening principles, four key ones are not being met, with current clinical practice protocols. As such, from screening perspective, there are potential harms of current diagnosis and treatment options. However, it is expected that the four missing principles may be met in the near future, if new techniques used for diagnosing prostate cancer are found to be cost-effective, and all men can be tested regularly for prostate cancer. As such, at present, it cannot be argued that the NHS should implement a screening programme for prostate cancer for the entire male population.

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# Supporting Trainees in Difficulty



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## Early identification and appropriate intervention as needed if a trainee is in difficulty.

It is the job of the Clinical Supervisor (and his/her team) to work with the trainee and report any concerns to the Educational Supervisor and/or College Tutor.

### Possible causes of difficulties:

- Generic development
- Failing exams
- Questioning career/specialty choice
- Clinical performance
- Issues with non technical/technical skills
- Lack of leadership skills
- Issues with decision making
- Communication skills and team working
- Environmental
- Culture
- Workload
- Dysfunctional team
- Bullying
- Personality clash
- Lack of resources
- Stress due to exams
- Sickness or ill health
- Drug and alcohol abuse
- Mental Health
- Undiagnosed disability

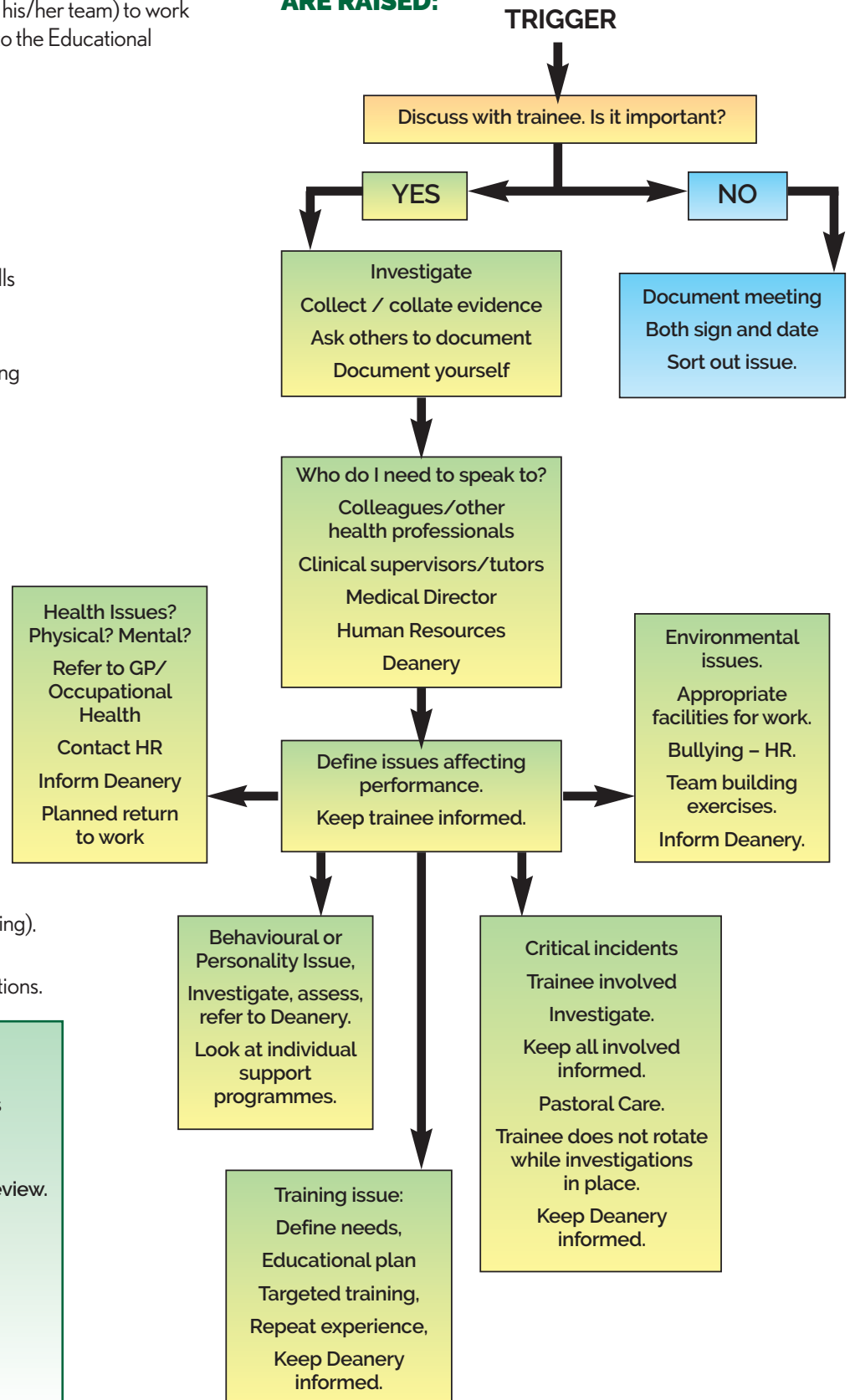
### Action required once aware of difficulties.

- Document concerns, investigate and document yourself.
- Speak to trainee. (document the meeting).
- Involve others.
- Different causes require different solutions.

### TAKE HOME MESSAGE.

1. Document all concerns/meetings.
2. Consider appropriate assessments to gain more information.
3. Use feedback.
4. Do not wait until the next annual review.
5. There should be no surprises at the annual review.
6. Involve clinical and educational supervisors at all times.
7. Keep the Deanery informed.
8. Think patient and personal safety at all times.

## WHEN CONCERNS ARE RAISED:



# Virtual Communication: Is it here to stay?



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## Introduction

Traditionally in the NHS, 'Face to face' communication with patients and colleagues is considered as a standard 'normal' practice. Although the concept of Telemedicine is not new to the NHS due to the promising popularity of private mobile health-delivery platforms such as Babylon Health UK, Push Doctor, and DOCTORNOW the adoption of virtual consultations in the NHS has been prompted by the necessity of the "Lockdown" during the Covid-19 pandemic.

Till a few years ago, the uptake in Primary Care was quite low, as noted by Brant et al that 86% of the 318 practices they surveyed had no intentions to use virtual consultations, with fewer than 10% having done so at any point in the past.<sup>1</sup> GPs were almost unequivocal in explaining this lack of engagement. The arguments put forward were, "virtual consultations are detrimental to clinical practice, due to limited information exchange and an inability to perform examinations, and thus provide low levels of diagnostic certainty".<sup>2</sup> Other barriers to adoption included a perceived increase in workload, concerns over patients' security, and technical issues. All these negative arguments have changed during the unprecedented times of ongoing COVID-19 pandemic. Virtual communication with patients and the colleagues using video has opened up a new frontier in the field of communication. Virtual communication has been recognised as an effective means of communicating with patients in the clinical settings; and with colleagues in different strategic multi-disciplinary team (MDT) meetings, collaborative workshop and educational and training meetings (e-Learning) etc. It has been suggested that virtual communication will become a standard component of future clinical practice in term of communicating with patients and colleagues. Is this the new norm?

## Definition

In the United Kingdom (UK), the National Health Service (NHS) defines remote consultation as: 'an appointment that takes place between a patient and a clinician over the telephone or using video, as opposed to face to face'<sup>3</sup>

The digital strategy was first outlined in the Long Term Plan in England<sup>4</sup>. This was built on the success of electronic prescribing, which is now used in more than 93% of England's GP practices, saving the NHS £136 million in the 3 years from 2013 to 2016 and the NHS e-Referral Service, creating expected savings for the NHS in excess of £50 million a year.<sup>5</sup>

## Preparation

The biggest concern raised has been complete lack of preparation of the clinicians and the public prior to widespread implementation and use of the virtual platforms during the covid-19 pandemic. The primary care had experience of telephone consultations prior to the pandemic but in the secondary care this was limited to Dermatology and Fracture clinic consultations only. This sudden change in delivery initially took everyone by surprise but the response for adoption was overwhelming unanimous.

## Related Challenges

This new method of communication was compounded by other concerns during the height of the Covid-19 pandemic. There were considerable fears for personal and family safety, uncertainty about jobs, furlough, complete isolation for the vulnerable etc.

## Concerns

Clinicians concerns are manifold (Table 1). Apart from Safety, security and privacy concerns have been raised about "patients lost in the system", particularly if a change of plan is made to see the individual face-to-face at the next clinic. Most clinicians are aware of the technology but some traditional and senior ones may still find it challenging.<sup>6,7,8</sup> The studies indicate that both patient and clinician participants were concerned about the technical skills needed for remote consultation and were concerned about internet connections, loading up data or measurements (for example blood sugar or blood pressure) and how secure this was. Predictably, many felt unprepared and unsupported.<sup>8</sup> Both patients and clinicians expressed their fears of loss of privacy, which face-to-face consultation is able to offer.<sup>9</sup>

### Clinician's concerns

1. Some clinicians may express concerns – unskilled/ no guidance
2. Inequalities of access
3. Legal liability
4. Privacy & security
5. Patients getting lost in the system – loss of continuity of care
6. Inadequate assessment
7. Risk of Data breaches

Table 1: Clinician's Concerns

It is understood that both patients and clinicians must have had to quickly develop new communication skills without any preparation, which may have impacted the effectiveness of the consultation.<sup>8</sup>

It is often felt that there is a distinct altered dynamics in remote consultations in that both clinicians and patients could not rely on non-verbal means of communication. At times, anxiety regarding using remote means affected the content of the consultation.<sup>6,8</sup>

### Patients' concerns

1. New technology – Feel unsupported and unskilled
2. Anxiety about effective communication
3. Worried about missed diagnosis
4. Loss of privacy
5. Lack of rapport

Table 2: Patients' Concerns

Patients may often feel that the whole process is very clinician-orientated.<sup>8</sup> Sometimes new patients are not given the choice over their appointments. Quite often it may not involve them. Patients may feel that their consultations needed to be face to face such as when they wish to mention something private or for making important decisions. This can cause some anxiety and resentment.

There has been widespread fear among patients that their consultation might contain inaccuracies due to their inability to communicate effectively with their clinician. It is likely that these concerns are from the elderly and

also those who are digitally challenged.<sup>10</sup> Only time will tell and perhaps experience and reassurance will allay these anxieties.

We are all aware that if there is previous rapport between patient and the clinician or an established diagnosis, which only requires a follow up progress, then this form of communication works well. This is not always achievable in remote consultation for those coming in for the first visit. Listening, understanding and responding to the patient's emotional needs, recognising appropriate body language are key assets of a face-to-face consultation. These could be missed in remote consultations.

Remote consultations are not fit for clinical conditions when a through physical examination is mandatory to reach a diagnosis, during difficult conversations and dealing with bad news and consultations with the vulnerable. The need to work remotely has also affected how teams interact and staff in training are supported or otherwise.

Consent is another issue which needs to be worked out in the remote method of consultation. Information governance is an important area to consider as well when using social media platforms to reduce the risks of data breaches. Patient's confidentiality must not be breached. Therefore both the GMC and the Defence organisation have taken appropriate steps to recognise these limitations to safeguarding the interests of the patient as well as appreciate boundaries of risks taken by the clinicians. The Defence unions have regularly organised modules on this subject.

## Advantages

Virtual communication has shown to be effective and convenient for patients. Consultation can be carried out from the comfort of patient's home. Some patients find this acceptable and productive in terms of instant engagement, faster outcome of consultation and improved satisfaction.

Studies have indicated high patient satisfaction rates<sup>11,12</sup>. Buvik et al. instituted a randomized controlled trial in Norway involving patients receiving real-time orthopaedic video consultations and patients receiving traditional in-person visits.<sup>13</sup> Of the 389 patients included in the study, 99% rated the consultation as very satisfactory or satisfactory; furthermore, 86% of the videoconferencing patients preferred a video-assisted consultation as the next visit.

Primary care clinicians have welcomed the infection control benefits, empty waiting rooms that accompanied the initial shift to remote. Most clinicians will continue to promote this concept to their patients.

It requires a very astute clinician to recognise during a remote consultation that it may not lead to an accurate clinical assessment. It will give immense comfort and a sense of direction to both the clinician and the patient to organise a face-to-face consultation at a later date. This will help in understanding the limitation of a video consultation.

Cost effectiveness is another influencing factor. A study showed that using video conferencing for orthopaedic consultations in the remote clinic costs less than standard outpatient consultations at the specialist hospital.<sup>14</sup> However the total number of patient consultations should exceed a critical number per year. That depends on the costs per consultation of the specific units. It is cost saving for the patients as well, as it avoids travelling. This in turn reduces the carbon footprint. What we are not aware of is the percentage of remote consultations taking place in the NHS, which have proven to be beneficial to both patients and the NHS.

## Virtual communication with colleagues

This has been recognised and accepted as an effective way of conducting strategic meeting, seminars, conferences; and teaching and training (e-learning) with readily available e-documents and materials. The format of medical meeting / conference will probably change permanently following the pandemic and with the potential for more conferences to be hosted virtually without affecting the academic value.

This innovative way of communicating with clinical colleagues has proved to be productive and effective. There will be no wasting of valuable time with travelling distances and associated costs in terms of travelling and accommodation.

There is a concern that this would be disastrous for face to face networking valuable for collaborative research and projects and sharing ideas. Trust and confidence building can be a challenge. There is no room for engaging people to get the desired outcome.

## Conclusion

Virtual communication has a wider appeal. However, embedding complex virtual consultation service within the routine practice in the NHS can be challenging. Flexible use of virtual communication in conjunction with face-to-face consultation can be offered to patients as an alternative to face-to-face consultation in the clinic setting. Some concern, however, may remain regarding the quality of communication.

While there are many positives to online delivery, it does also pose many challenges – the greatest of these being the lack of interaction, which we believe is critically important for social cohesion, belonging and communications.

Reassurance that remote consultations are well planned, resourced, documented, governed and preceded by training would help to give patients and clinicians more confidence for a clear pathway for the future. Current indications are that clinicians now see the potential of remote consultation, that their fears have not been played out and that, with more control of the way the process works, they can see the advantages.

The Covid-19 pandemic has had a global impact on health care. It has been an absolute challenge for both clinicians and patients. We are slowly coming out of this pandemic. Primary care has been further challenged by the politicians to go back to face-to-face consultations, however they have maintained a balance to keep the services going smoothly. I presume the secondary care have learnt lessons and are now in the process of perfecting the techniques.

The clinician's duty is to provide care for every patient to the best of his or her professional ability whichever form of communication the clinician prefers to use. Communication should be focussed, optimal and efficient.

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# Barriers to the adoption of healthcare apps amongst patients in a GP practice



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## Background

The Covid pandemic has highlighted the importance of adopting digital health technology<sup>1</sup>. Patients are increasingly expected to use digital apps in the management of their healthcare. Digital healthcare apps can potentially improve patient care, reduce burden on GP surgeries and help with sustainability by enabling remote care and reducing CO<sub>2</sub> emissions from car journeys<sup>2</sup>. However, the adoption rates of these healthcare apps are still low and reported to be around 30% in general<sup>3</sup>. Several potential factors have been reported to affect patient engagement with digital healthcare apps<sup>4</sup>. Studying the barriers to adoption of digital health technology is crucial for understanding interventions needed to increase patient engagement with digital healthcare. Most of the available literature studying the barriers to adoption of digital healthcare have been from studies conducted prior to the Covid-19 pandemic. With increasing reliance on digital healthcare (post pandemic), we hope to understand current patient engagement rates with digital healthcare apps and barriers to adoption in a GP surgery in England. Lessons learnt from this study may be useful to work out interventions needed to improve patient engagement rates with digital health.

## Aim

We wanted to understand the adoption rates and barriers for patient engagement with digital health technology in a GP practice in Stoke-on-Trent.

## Methods

We approached patients who were attending GP surgery over a week and enquired whether they were using the NHS app or Patient access app. The NHS app is being increasingly promoted as the digital front door for patients to manage their health. This GP surgery is using Patient access app to manage patient bookings and scheduling. Since this was partly a qualitative study as well, we prepared a questionnaire to form the basis of a semi-structured interview to learn about adoption rates and patients' attitudes toward these apps. After ascertaining whether the patients already had an NHS login, we helped them (patients who did not have a login) set up an account for these apps as they were waiting for their GP appointment. During this process, we conducted the interview. By encouraging an open conversation, we were able to obtain patients' perceptions on the apps, if they understood the functionalities and benefits of the apps and any barriers they faced in using these apps.

## Results

We interviewed 75 patients as part of this study. Data from interviews with each patient revealed the adoption rates, potential barriers to accessing the NHS app and Patient Access app

### 1. Adoption rates of Patient access app (fig. 1)

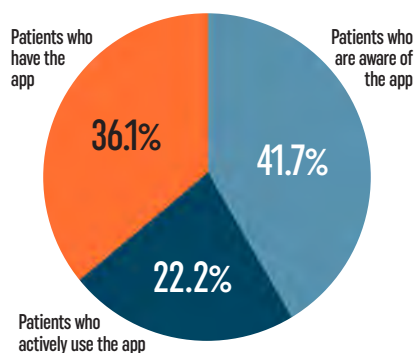


Figure 1: Uptake of Patient Access

- 15 patients had heard of the Patient Access app.
- Of those who had heard of it 13/15 (86.7%) had downloaded the app, however only 8/13 (61.5%) actively used the app.

### 2. Adoption rates of NHS app (fig. 2)

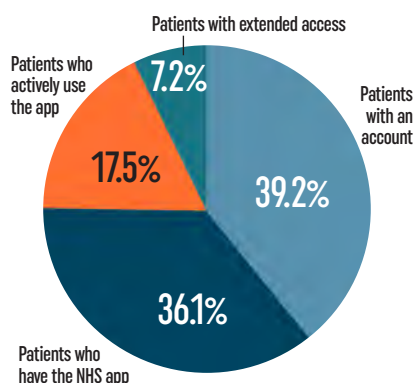


Figure 2: Uptake of NHS App

- 36 patients already had an NHS login, however several patients did not even realise that they had an NHS login. Of those patients who had an NHS login, 35/36 (97.2%) had downloaded the app. Furthermore, only 17/36 (47.2%) of the patients who had an account actually use the app. This shows that the usage rate of the NHS app is significantly less than those who have an account.
- 7 patients already had extended access feature in the NHS app

### 3. Barriers to adoption

#### Lack of awareness

- Among the patients who did not use the apps, the main reason for not using the app was a lack of awareness of the purpose and functionalities of the app: a common misconception was that coming into the surgery in person is easier than online. Since they did not commonly use apps for healthcare, they felt accessing healthcare through these apps might be difficult and cumbersome.
- However, the interviews also revealed that there was no apprehension in using these apps once the benefits of the app were explained to them.
- "A lot of people have NHS logins but not many understand what these are for, if more people understood what the app was for, I think more people would download it." - A quote from a patient when they were told about the app.
- Of the 68 people who did not have extended access in the NHS app, 91.2% of patients requested to sign up for the NHS extended access after being told about the benefits of the feature.

#### Digital illiteracy

- The vast majority 73/75 (97.3%) of patients had good digital literacy as they were very comfortable downloading an app from Google Play/ App Store with very little help.
- We found only 2 patients had digital illiteracy. Both were elderly patients.

#### Digital poverty

Only 1 patient had difficulty accessing the internet and therefore had difficulty accessing the apps.

#### Uptake of the app after interview:

- In total 21 out of 27 patients (77.8%) who did not have either of the apps agreed to sign up once they were informed of the benefits of the apps.
- However, 6 people did not want to download the app - there was an even split between elderly and young in this group of patients.
- Of the three elderly patients: 2 stated they weren't comfortable with digital technology and the other had limited internet access.

- Of the younger generation they had a general reluctance due to infrequent visits and needs with healthcare providers.
- There were a few carers among the patients who felt it was cumbersome to download multiple apps for the people they care: they were unaware of the linked profile feature in the NHS app, where you can link multiple accounts onto one main account.

## Discussion

In the UK 23.6 million of 67.88 million (34.8%) people are verified users of the NHS app<sup>5</sup>. Compared to this, we found that a greater proportion of patients in this study cohort 48% have gone through the verification process on the NHS app. This shows that the GP surgery has a greater adoption of the app compared to the general public. However, there could be a selection bias here as most patients attending the GP surgery were seeking healthcare and therefore more likely to use healthcare apps. Comparatively, there is less adoption of the Patient Access app - where only 17.3% have downloaded the app.

We found that only 47.2% of patients in this study group, who had an NHS login actively used the app. The remaining 52.8% do not use the app despite having an account. If the results of this study were to be extrapolated to the rest of the UK population, then one may assume that a large proportion of the 23.6 million people who have downloaded the NHS app may not be actively using the app.

The most prominent bottleneck in adopting healthcare apps in this study group is lack of patient awareness regarding the usefulness of these apps. This is due to lack of understanding of the app's functionalities and how they can make accessing healthcare easier. This was confirmed by the fact that when the benefits of the apps were explained to them, most patients were very eager to sign up - with the exception of 6. In addition, of those that were persuaded to create an NHS login and download the NHS app, 93.1% wanted the extended access (where patients are able to view blood test results and book pre-bookable appointments.)

This shows that after understanding the benefits of the app, patients had a higher performance expectancy. According to the UTAUT model (Unified Theory of Acceptance and Use of Technology) of factors affecting acceptance of technology, 'performance expectancy' indicates the individual's belief that using the system will help him or her to attain gains in job performance<sup>6</sup>. The increased performance expectancy of the patients after counselling them influenced them to get the extended access- this is corroborated with existing literature.<sup>7</sup>

The lack of awareness of the benefits of the app was common both in the older and younger age groups. 3 out of the 6 patients who refused to sign up for the app were in the younger demographic. This group felt that they did not need to use these apps due to their perceived limited need to seek healthcare in general. Again, this reflects a low

performance expectancy in the youth as a factor in their decision not to download the app.

There is evidence to show that individuals without a persistent health issue are less likely to use digital healthcare apps for their care as they don't perceive a need for self-management<sup>8</sup>, although, it has been suggested that individuals change their behaviour if they perceive a threat to their health.<sup>9</sup>

Another problem in adoption of apps (among mainly the older patients) is digital illiteracy (the inability to use digital tools on a daily basis) among patients. 2.7% of patients had very little understanding of technology- so were unable to sign up for the app. NHS digital predicts that by 2030 4.5m people (8% of the population) will remain digitally disengaged<sup>5</sup>. Furthermore, a study that took place in 2018 stated that 11.1% of the West Midlands (where the study site was situated) are non-internet users and 9% had zero basic digital skills<sup>10</sup>. Our results are lower compared to the general population, showing that in this GP Surgery, digital illiteracy is not a main barrier to adoption of Healthcare apps. This was evident as most of the patients were easily able to download the app and had access to their email when prompted to do so. Only 1.3% of patients suffer from digital poverty in this study group, this is again lower than national average (the Digital Poverty Alliances data, reports a 6% prevalence of digital poverty in the UK).<sup>11</sup>

The specific features of the app could be targeted to specific patients, for example, many caretakers were not aware of the linkage profiles which can be used to link various logins onto one main account. This could significantly help many carers. A few carers asked whether they had to download multiple apps for each person- proving that there is a lack of understanding of many key features in the app.

Data from NHS digital shows that the NHS app helps increase the number of repeat prescriptions taken online each year.<sup>5</sup> Spreading awareness of the app and encouraging patients to use healthcare services online can help with the NHS net zero targets by decreasing the number of car journeys. In addition, increasing adoption of digital healthcare by patients has potential for reducing the increasing burden on clinical and administrative staff in GP surgeries.

There are other potential factors we haven't fully investigated in this study such as rates of digital healthcare adoption with relevance to patient ethnicity where language may be a barrier<sup>12</sup> and other issues such as the effect of high deprivation and education levels in accessing digital healthcare. These could be areas of further research.

## Learning Points

1. Lack of awareness amongst patients is the main barrier to digital healthcare adoption
2. Educating patients about the benefits of the app could increase compliance and adoption.
3. Patients may not be actively using healthcare apps despite downloading them

4. Further studies are required to assess the effects of digital poverty, illiteracy, social and ethnic factors in adoption rates of digital healthcare

## Recommendations from the study:

The predominant barrier to patient engagement with healthcare apps is lack of awareness. Interventions that increase patients' understanding of these apps and the benefits it can accrue to them can potentially increase patient engagement. We suggest the following measures can be easily adopted by GP practices to improve patient uptake of healthcare apps:

- Posters and leaflets set up around the GP practices
- NHS app video ads displayed on the waiting room TV
- Health professionals to raise awareness of the app during blood clinics (allowing patients access to their results on the app)
- Information of the app and its functionalities being sent home along with prescription letters (permitting patients to order their repeat prescriptions online for the next time)

## Conclusion

Whilst digital health technology is improving at a rapid rate, the general population is unable to keep up with new advances predominantly due to lack of awareness and education regarding its benefits. If clinicians find a way to engage more patients to use the app, they can reduce burden on NHS workers, promote a greener NHS and digitally empower patients to self-manage their healthcare journey. The findings from our study can be used by staff in GP surgeries to maximise adoption rates of the NHS app.

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# How do we adapt to the Future NHS? From the Editor's Desk

## 1: An aging population

The NHS has been very slow to adapt to the changing demographics of the population. In fact, this has been ignored in planning. Whilst the population is growing and the elderly age group is expanding, the workforce in all sectors has been reducing. We really need to celebrate aging but ensure the community enjoy their final years with healthy living. The NHS can adapt and begin to put a lot more emphasis in public health measures but at the same time create a balance between demand, workforce and provision of resources. This is indeed a tall order. We need the whole society to take responsibility.

## 2: Digital Technology

Modern times require innovative ideas. Virtual communications, online appointments, access to investigations and results etc have made a difference. The traditional clinician will worry about losing touch with their patients, or missing a clue and others about GDPR regulation but more importantly the elderly not knowing how to use this modern technology. It is essential to recognise that it reduces the carbon-footprint. This technology may well increase management and therefore, has to be flexible and be adapted very wisely.

## 3: Workforce Crisis

Political changes and short-term planning has led to this crisis. In fact for the wise this current state was quite predictable. Brexit, political uncertainty and stricter Home Office regulations have worsened this. Loss of bursary has discouraged nurses to take up this profession. If the future of the NHS is to be secured, then long-term planning requires some firm decisions. The NHS has been too much dependent on patchwork by filling in their workforce from overseas. This is not working anymore. The politicians should recognise this.

## 4: Communication Crisis

In the midst of modernisation and each one of us trying to achieve targets and responsibilities, the NHS has forgotten the importance of interactive human communication. The departments and surgeries have become so big that we do not know each other. There is very little interaction between Primary care and Secondary care physicians. Each one is a name on a list. Can this barrier ever be crossed?

## 5: Social Care

Increasing longevity has brought in a conglomeration of different co-morbidities. These are treatable to an extent but how can you get tackle the issue of "Loneliness"? Is this the root cause of several other issues, which affect the person? How can we bring compassion and happiness into this equation? The future years of the NHS requires a concerted effort to improve the situation in Social care. Communities need to get together on this.

# Medical Quiz

**1** A 20-year-old African lady has presented to One Stop Breast Clinic following a referral from GP. She felt a lump in her breast a few weeks ago and presented to GP. The lump has slightly grown in size according to her. The lump feels tender to touch. On examination it feels smooth, firm and well-defined and is described as a "mobile mouse". Ultrasound examination has confirmed diagnosis of "Fibroadenoma" and the size is 4.5x4.7x5 cm. BIRADS score is reported as 3<sup>1</sup>.

What is the appropriate management plan?

1. *Reassurance and discharge*
2. *Excision of fibroadenoma*
3. *Mastectomy*
4. *Follow-up in three months at One Stop Clinic*
5. *Follow-up in 12 months at One Stop Clinic*

**2** A 53-year-old gentleman has presented with severely distended non-tender abdomen. The patient has a background of chronic constipation. AXR showed coffee bean sign and CT scan result is consistent with diagnosis of Sigmoid Volvulus<sup>2,3</sup>.

What is the management plan?

1. *Rigid sigmoidoscopy and flatus tube insertion*
2. *Emergency laparotomy*
3. *Hartmann's procedure*
4. *IV antibiotics and fluids*
5. *Next day laparotomy*

**3** What are the NICE guidance recommendations when investigating patients with a new diagnosis of hypertension in relation to detecting end organ damage<sup>4?</sup>

1. *Urine albumin:creatinine ratio for proteinuria and dipstick; HbA1c, U&E and lipids, ECG and Fundoscopy*
2. *Echocardiogram, KUB Ultrasound, HbA1c and Fundoscopy*
3. *Urine albumin:creatinine ratio for proteinuria and dipstick; HbA1c, U&E, lipids and ECG*
4. *U&E, lipids, ECG and Fundoscopy*
5. *There is no set standard test and it is decided as per clinician's judgment*

**4** A 38-year-old lady is presented to ED with reduced consciousness (GCS :13), low Blood pressure (78/56 mmHg), and low blood sugar (3.1). Bloods have been taken and U&E came back abnormal with low sodium (128) and high potassium (5.9). FBC was normal. No signs of trauma or infection been seen. It is the first presentation of this kind and the patient does not have any medical background. What is the most important condition to consider in this situation?

1. *Diabetic Ketoacidosis*
2. *Addisonian Crisis*
3. *Subarachnoid haemorrhage*
4. *Haemorrhagic stroke*
5. *Rupture of Abdominal Aortic Aneurysm*

**5** A 43-year-old lady had 4 episodes of loose stool (type 7) last week and booked an urgent telephone appointment with GP. She had noticed small amount of blood in her stool as well. The GP diagnosed her with gastro-enteritis and advised her to have more fluids and rest at home. The GP also advised her to call 111/999 if she develops signs of severe dehydration. The patient was not satisfied with GP instructions on fluid replacement and was fully convinced she needed some antibiotics as she had a bug in her stomach. She then decided to take some antibiotics that she had kept in her cupboard. She has now presented to ED with lethargy, abdominal pain, dark brown urine and she says she is passing very little urine since the night before. She cannot remember what antibiotics she has had over the last few days. What is the main diagnosis and what is the main bug causing it?

1. *Acute Tubular necrosis; Norovirus*
2. *Acute Tubular Necrosis; E. coli O157*
3. *Haemolytic Uraemic Syndrome; E. Coli O157*
4. *Haemolytic Uraemic Syndrome; Norovirus*
5. *Haemolytic Uraemic Syndrome; C. difficile*

**Answers on page 27**



# An interview with **Prof. Robin Sengupta O.B.E.** Emeritus Consultant Neurosurgeon

## *Where were you born?*

I was born in Burma to Bengali parents with high values and simple living.

## *How was your childhood and what inspired your progress?*

There were times in my childhood when it was a struggle to make two ends meet. My father gave me spiritual heritage through teachings of Lord Buddha and Swami Vivekananda. My mother was illiterate but highly intelligent with a great sense of humour. I was inspired by the teachings of Swami Vivekananda.

I even started selling fruits so that I could earn the school fees. When I was 13, I got the opportunity to be a house teacher to look after a couple of toddlers in exchange of fees and living expenses. After obtaining a scholarship in Matriculation and through the generosity of others, I competed intermediate science before moving to Calcutta in 1955. Through a divine intervention, I was introduced to the Principal of a Medical College Col. K.C. Sarbadhikary. He facilitated my admission to the National Medical College. I also worked as a paramedic with St. Johns Ambulance to earn my living expenses.

## *Tell us about the start of your medical career.*

I studied medicine at Calcutta University securing Gold Medal in 1956, Certificate of



Honours in Surgery in 1957 and graduating in 1961. My journey to the UK, by trains and ship, commenced 1st May 1961 from Howrah station. After the usual initial challenges and a few locum jobs, I moved to Newcastle where my wife was to join. Some dispute with colleagues prompted me to resign, but destiny then landed me a locum job in Neurosurgery.

## *How did you get interested in Neurosurgery?*

I obtained Fellowship of the Royal College of Surgeons of Edinburgh in 1967 and the Royal College of Surgeons of England in 1969. I won The Cairns Memorial Traveling Fellowship in 1974, which allowed me to pursue further research in my chosen field of neurosurgery at the world-renowned Massachusetts General Hospital in Boston, USA. Whilst working with Prof. Ojemann and studying the Circle of Willis, I developed a keen interest in the surgical management of cerebral aneurysms. This subsequently became my lifelong passion.

I travelled extensively, visiting international centres of excellence; notable names include Yasargil (Zurich), Norlen (Gothenburg), Leksell (Stockholm), Samii (Hannover), Drake (Ontario), Penfield (Montreal) and Sugita (Japan).

On my return to the UK, I obtained a MSc from the University of Newcastle upon Tyne and accreditation as a fully trained neurosurgeon in 1976. I was appointed Consultant Neurosurgeon in 1978 and became Chairman of the Division of Neurological Surgery in 1992. I retired in 2002.

## *What are your academic passions?*

Whilst having a very busy neurosurgical practice in Newcastle, I always

maintained a passion for academia and attracted many international neurosurgeons for a period of training. Many Indian neurosurgeons have reached heights following training under my tutelage.

My research interests included international studies related to Aneurysms, EC-IC Anastomosis and STICH. I have published extensively including co-authoring a monograph on "Subarachnoid Haemorrhage" with Dr Victor McAllister.

## *What have been the highlights of your career?*

During my long professional career I have won many awards including Distinction award in 1989, A Merit award in 1992 and BEK Medal of the Dutch society in 1999, "Vivekananda Samman" award by the President of India in 2012, "Lifetime Achievement" award by Madras Neuro Trust and by the Neurologists of Eastern India in 2013, and "Neurosurgeon of the Millennium" by the Neurological Society of India. I was awarded The Medal of Honour of the World Federation of Neurological Societies in 2017 - the highest honour for any neurosurgeon.

I have also been recognised with The Pride of the North, elected by the people of the North-East of England and title of the Officer of the Order of the British Empire (OBE), conferred by the Queen in 2016.

The BBC also filmed me on 22nd April 2003 for a documentary "A Picture of Health" as "A Day In The Life of Robin Sengupta - Brain Surgeon at Work".

I conceived and built an Institute of Neurosciences in Kolkata, which I am proud to say, is now established as a centre of excellence and accredited for post-graduate training in the fields of Neurology and Neurosurgery.



# BIDA National Conference

The Lecture Theatre, Potteries Museum & Arts Gallery,

Stoke-on-Trent, Staffordshire. 8 October 2022 - A brief report

**Mr Amit Sinha** Organising Secretary, BIDA National Conference

## “Fairness & Regulation – What’s next?”

The improved post-pandemic situation gave us some confidence to organise the National Conference this year. Our President, **Dr Chandra Kanneganti** was fully prepared to welcome us to Stoke on Trent. **Dr Vinod Gadiyar** as the Chairperson of the Conference did a splendid job in organising the programme with the support of the Conference Committee. The rest of the team got busy with other responsibilities. This included preparation of the ARM sessions under the able leadership of **Dr S Chandran** and **Dr Leena Saxena**. **Alison Sherratt** co-ordinated the essential provisions.

For the first time the National Conference was being organised with the ARM/AGM meetings as well on successive days. The team effort resulted in a highly successful National Conference, which was conducted in a hybrid mode, with delegates in attendance at the conference as well as online. The initial preparation led to considerable anxiety but the talented technical expertise of **Stevie Robinson** was well supported by the Sound and Visual technician, **Mitch Walker**. They did a superb job.

The Lecture Theatre at the Potteries Museum and Arts Gallery gave us a superb platform for everyone to enjoy a feast of wonderful lectures from guest speakers both in attendance as well as those who could join online. Following the Welcome address, **Rt. Hon. Ms Jo Gideon M.P.** from Stoke-on-Trent Central addressed the Conference.

The first session lent itself well with the theme of the Conference with **Tista Chakravarty-Gannon**, Head of Outreach Operations, **Prof Iqbal Singh CBE**, Consultant Physician and Chair of CESOP and **Dr Chaand Nagpaul**, Immediate Past-Chair of Council of BMA. Discussions were centred on how the GMC as our regulator has reached out to doctors, rising problematic issues of racism, and efforts to achieve equality in Health and Medicine. The second session was a series of brilliant lectures by **Dr Arun Baksi**, Emeritus Consultant Physician, **Dr Habib Naqvi**, Director of NHS Race & NHS observatory, **Dr Ben White**, Medicolegal Consultant and Case Team Lead MPS, and **Mr Alistair McLellan**, Editor of HSJ presenting with solutions and measures like the idea of introducing “Internal Security Panel” in all Trusts and Health Boards and supporting doctors in difficulty or tackling health inequalities in the community. The NHS recovery is not going to be an easy task as reiterated by Mr McLellan.

The lunch time session was for the Junior Doctors and the medical students, with a series of essential advice on how to step forward to ensure selection in the training pathway. **Ms Ritika Rampal** presented the guidance for Surgery, **Dr Gurkaran Singh** for GP training, and **Dr Silas Joshua** for Internal Medicine.

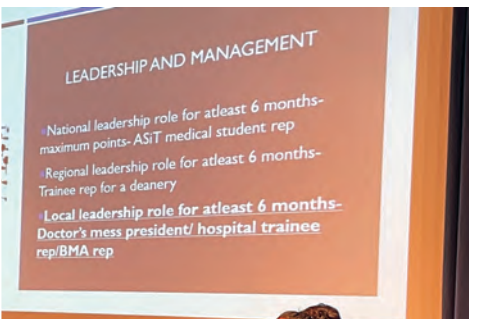




The third session included **Dame Prof Clare Gerada** who highlighted the tremendous contributions made by International Medical Graduates (IMGs) since the inception of the NHS. However, they are made to feel like belonging to a different tribe who have still not been accepted by the “locals”. Her advice was to continue to breakdown barriers on all fronts. **Prof Arpan Guha**, Deputy Medical Director, NHS England gave a sterling talk on how his team during the Covid pandemic a policy of “Command and Control” at one of the biggest Health Board in Wales was able to control the VUCA (Volatility, Uncertainty, Chaos, Ambiguity) environment. This was an opportunity to develop “Compassionate Leadership” collaborating with all colleagues working at the front doors in finding suitable solutions. All BAME doctors were involved. **Dr Amit Kochar**, Associate Specialist in ENT and Chair of the Specialist and Associate Specialist Committee gave a passionate lecture fighting for “Recognition, Rewards and Well Being” for LED and SAS doctors. There are over 105,000 doctors in this category serving the NHS. Over the years positive steps have been taken to achieve these goals. Their invaluable contributions have now led to recognition of “Autonomous working”

The final session devoted to “Woman’s Health” was presented by **Dr Anita Sharma**, GPsSi Gynaecology, Oldham and **Dr Uma Marthi**, GP partner at Castleton Health Centre at Rochdale and a member of the Medical Advisory Panel for Endometriosis, UK. Dr Sharma is passionate about different strategies to maintain and improve woman’s health. She was critical that the health system of research and policy has been designed for men by men leading to gaps in data and evidence in particular for menopause and endometriosis and several others. Facilities for reproductive health care are not standardised in the country. High profile reports are not putting woman at the heart of the health services. It is time that woman’s voices must be heard. Dr Uma Marthi gave a wonderful insight into presentation of pelvic pain caused by endometriosis in the reproductive age of a woman. This is referred to as a “Missed disease”.

The Conference Gala Dinner was at the impressive Jubilee Hall of the Town Hall of Stoke-on-Trent city. We were all mesmerised by the grandeur of the majestic place. The master of ceremony, **Suresh Chandran** entertained us with an unrelenting humour and thumping enthusiasm.





It was an appropriate occasion to honour the Guest of honour, *Prof Dame Clare Gerada* with the "BIDA Special Award". Currently President of the Royal College of GP, she has a particular interest in mental health and substance misuse and is Chair of the charity, Doctors in Distress. She has been a role model to all doctors, in particular the International Medical Graduates. Her words provided a clear message and encouraged all IMGs to stand up to injustice and fight against all hurdles to earn the respect they deserve.

The gala dinner ended with entertainment, music and dance, a fitting finale to a wonderful memorable day.



# BIDA A.G.M. / A.R.M. 2022

Mirchi Restaurant, Stoke-on-Trent. 9 October 2022

**Dr Suresh Chandran** Chairman, BIDA ARM 2022

**Dr Leena Saxena** Vice-Chairperson, BIDA ARM 2022

## ARM Motions 2022

The BIDA ARM Meeting 2022 was held in Mirchi Restaurant on Sunday 9th October 2022. The meeting was well attended and all the delegates actively contributed to the meeting.

### Pre-ARM

ARM Agenda Panel:

1. **Dr Suresh Chandran.** ARM Chair
2. **Dr Leena Saxena.** ARM Deputy-Chair
3. **Dr S Sarker,** Immediate Past Chairman, BIDA
4. **Dr Jay Nankani,** Immediate ARM Chair, BIDA

There was an overwhelming response from various Divisions. The ARM Agenda Panel received 21 motions. The Panel had a tough time in narrowing down the Motions to 11 which were discussed during the ARM on Sunday. One emergency Motion was also presented.

All the 12 motions have been summarised below:

### Motions:

#### 1: GMC and MHPS:

##### Motion 1A:

Proposer Mr Amit Sinha, National Secretary, BIDA

The EC committee proposes to raise awareness of unfairness and lack of support to individual doctors who have to go through internal investigations of MHPS and recommends:

- (i) to support the concept of setting up of an "Internal Security Panel" with statutory rights to assess the fairness of the complaint, support the individual doctor and monitor the process.
- (ii) support that these Internal Security panels be given statutory rights to function effectively.
- (iii) plans to write to our MPs to gather support.

**Against: 1 For: Rest Abstain: None**

**Outcome : Motion carried over**

##### Motion 1B:

Proposer Dr Sai Pillarisetti, Junior Doctor Forum Chair, BIDA:

That this meeting believes that minority ethnic doctors are disproportionately affected by GMC's Fitness to Practice proceedings and calls BIDA to

- (i) Lobby for including Unconscious Bias Training in the curriculum at every stage of medical training, beginning from medical school and continue into their final stages of their career.

**Against: 0 For: Unanimous Abstain: None**

**Outcome : Motion carried over**

#### 2: Medical Students:

##### Motion 2A:

Proposer Mr Amit Sinha, National Secretary, BIDA

The EC committee proposes the justification for formation of the BIDA Student Wing

- (i) to expand our committee to include medical students in particular international medical students
- (ii) to spread the message of fairness and equality to international medical students in UK medical schools

**Against: 0 For: Unanimous Abstain: None**

**Outcome : Motion carried over**

##### Motion 2B:

Proposer Prof Arpan Guha, Merseyside & Cheshire Division

This ARM is dismayed that the lack of visible influence of BIDA in new medical schools that are exclusively admitting international students resulting in:

- i. lack of mentoring and support to IMGs
- ii. lack of awareness of the work of BIDA
- iii. losing out on the members of the future

The ARM, therefore, calls for urgent action to redress this issue through the creation of a dedicated subgroup to include Divisional representatives where such schools are located to work with clear plans and outcomes for engagement with this neglected population.

**Against: 0 For: Unanimous Abstain: None**

**Outcome : Motion carried over**

##### Motion 2C:

Proposer Mr Amit Sinha, National Secretary, BIDA

BIDA members have regularly offered clinical attachments to international doctors coming to give their PLAB or after they have passed the exams. This EC committee proposes that

- (i) they be offered **free associate membership of BIDA** before they start their clinical attachment with the proviso of becoming a full trainee member when they get a job in the NHS.
- (ii) they be given **career advice and mentoring**

**Against: 0 For: Unanimous Abstain: None**

**Outcome : Motion carried over**

#### 3: Salary and Contracts

##### Motion 3A:

Proposer Dr Shikha Pitalia, Secretary Wigan Division:

This Representative Body believes that Primary Care Network configuration should be based on like-minded practices working together to deliver more effective patient outcomes.

# BIDA A.G.M. / A.R.M. 2022 ARM Motions

*Against: 0 For: Unanimous Abstain: None*

**Outcome : Motion carried over**

## Motion 3B:

Proposer Prof. Sanjay Arya, Hospital Doctors' Forum Chair

This conference believes that significant pension tax changes are needed urgently to prevent exodus of senior doctors in the NHS.

*Against: 0 For: Unanimous Abstain: None*

**Outcome : Motion carried over**

## Motion 3C:

Dr Sai Pillariseti, Junior Doctor Forum Chair, BIDA:

Junior doctors pay has declined in real terms by over 25% since 2008 and with inflation in the double digits. This conference believes that

- (i) it is time to stand by our colleagues in the BMA by escalating this issue to the highest level for review
- (ii) if required, participate in strike action

*Against: 0 For: Unanimous Abstain: None*

**Outcome : Motion carried over**

## 4: BIDA Issues

### Motion 1A:

Proposer Dr Jay Nankani, North Wales Division

That this meeting is concerned of increasing disconnect between the centre and all its divisions. There is urgent need for regular and better communication. We propose:

- (i) inclusion of Division Leads in the EC meetings to improve communication
- (ii) regular meetings with office bearers to discuss specific issues.
- (iii) representation of EC members and/or office bearers at the division meetings (virtual or face-to-face)

*Against: 0 For: Unanimous Abstain: None*

**Outcome : Motion carried over**



## 5: Education and Training

### Motion 5A:

Proposer Prof. Sanjay Arya, Hospital Doctors' Forum Chair

Locally Employed doctors (LED) form a significant proportion of medical workforce.

This conference believes that they should have nationally recognised contract and guaranteed access to training and personal development plan.

*Against: 0 For: Unanimous Abstain: None*

**Outcome : Motion carried over**

## 6: Equality and Diversity:

### Motion 6A:

Proposer Prof. Sanjay Arya, Hospital Doctors' Forum Chair

45% of hospital doctors working in the NHS are of BAME ethnicity.

- (i) This Conference believes that the number of BAME hospital doctors receiving National Clinical Excellence Awards (now called National Clinical Impact Awards) should be proportionately increased.
- (ii) This conference believes that steps should be taken to increase the number of BAME doctors receiving the New Year Honours List / Queen's Birthday list for their contribution to the NHS.

*Against: 0 For: Unanimous Abstain: None*

**Outcome : Motion carried over**

## 7: Emergency Motion:

### Motion 7A:

Proposer Dr Chandra Kanneganti, National President, BIDA

That this meeting is dismayed at the lack of female representation at officer level and in BIDA conference, which was highlighted by the Guest Speaker.

This meeting should acknowledge and urge BIDA EC to come up with an action plan to proactively encourage female leadership in BIDA.

*Against: 0 For: Unanimous Abstain: None*

**Outcome : Motion carried over**

# BIDA Fellowship Awards 2021 & 2022

This year was special, as Fellowship awardees of both 2021 and 2022 were announced at the National Conference Gala Dinner on 8th October and felicitated at the AGM the following day. The President, Dr Chandra Kanneganti read the citations and all Fellows received their scroll of honour and the Fellowship badge.

## Fellowship Awardees 2021:

### Dr Kalpana Upadhyay

Consultant Obstetrician & Gynaecologist,  
North Wales BIDA Division

### Dr Ravi Sharma

Consultant Physician and Gastroenterologist,  
Rochdale BIDA Division

### Mr Amit Sinha

Consultant Orthopaedic Surgeon, North Wales BIDA Division

## Fellowship Awardees 2022:

### Dr Anita Sharma

GPsSi Gynaecology, Rochdale,  
Chair BIDA Woman's Forum, Rochdale BIDA Division.

### Dr Shikha Pitalia

Co-Founder SSP Health; Co-Founder Pall Mall Medical,  
Wigan BIDA Division.

### Mr Sanjoy Bhattacharyya

Consultant ED, Blackburn BIDA Division



Dr Jay Nankani collects on behalf of Dr Kalpana Upadhyay.



BIDA President Dr Chandra Kanneganti with Dr Anita Sharma



Dr Shikha Pitalia is presented with her BIDA Fellowship.



Dr Ravi Sharma is presented with his BIDA Fellowship.



Mr Amit Sinha is delighted to collect his BIDA Fellowship.



Mr Sanjoy Bhattacharyya is appointed a Fellow of BIDA.



2021 and 2022 BIDA Fellows with members of BIDA's Executive Committee at the presentation ceremony.

# BIDA President's Cup Cricket Final 2022

**Mukesh Hemmady** FRCS (Tr&Orth) BIDA National Sports Co-Ordinator

**On a beautiful summer's day, Wigan and North Wales divisions locked horns into what turned out to be a mouth-watering contest.**

Wigan won the toss and elected to bat. Their openers, Adi and Diya Badge had a steady stand of 35 for the first wicket before Diya was out stumped. The opening bowlers for North Wales bowled with metronomic accuracy and excellent field placements restricted the run rate. Senior Badge arrived at the crease to give company to his son and there was a flurry of boundaries and sixes and both batsmen scored centuries. Then came Shehzad who with his lusty hitting scored a quick-fire 29. Wigan's innings closed on a whopping 294 for 5 in 30 overs that I am reliably informed is a record score in a BIDA match.

North Wales's run chase was somewhat stymied by the early fall of wickets but the ship was steadied by veterans Ravi Adapala (42) and Tushar Mahambrey (78) and at one time it appeared that they would make a good fist of the chase but Badge senior struck to get a vital breakthrough by bowling Adapala to put the brakes on the Welsh run chase. The run rate kept climbing and score board pressure kicked in and the North Wales team had to go for it resulting in a clatter of wickets and their innings folded on 193 handing victory to the hosts by 101 runs. Adi Badge was declared 'Man of the Match'.

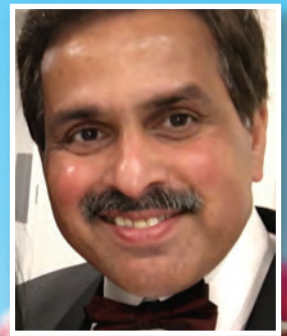
The game was played in good spirit and camaraderie. Old friendships were renewed and new ones forged. Family members, in particular children seemed to have had a whale of a time on a beautiful sunny day

For the Badge family it was a script no one could have written. Their family, visiting from India, saw the grandson and son in law score match winning tons and the grandfather handed the 'Man of the Match' prize to the grandson - a script written by the Gods!

Two records in this tournament-highest score in a BIDA game and Diya Badge was the first girl to play for BIDA - and I hope she is a trailblazer!

**All in all a good day out and a fitting finale to the BIDA cricket season 2022. Hopefully, we have shaken off the cobwebs of the pandemic.**

At the recent BIDA ARM/AGM, The President's Cup was awarded to **Dr Amit Anand**, captain of the triumphant Wigan Division cricket team. A special commendation certificate was given to **Diya Badge**, and the 'Man of the Series' award to **Adi Badge**.



*The teams from Wigan and North Wales Divisions before the start of the contest.*





# Congratulations!



## Dr Satya Sharma MBE

Congratulations to Dr Satya Virat Sharma M.B.E.. The University of Wolverhampton awarded him an Honorary Degree of Doctorate of Science in September this year for his outstanding contribution to the healthcare sector, both in the UK and internationally.



## Dr Shiv Pande MBE

A Doctor, faith leader and charity fundraiser who has touched the lives of many was made a 'Citizen of Honour' in a special ceremony at Liverpool Town Hall on Wednesday, 10 August (above).

Dr Shiv Pande MBE, who has lived in the city for five decades, started his career as a surgeon at Broadgreen Hospital before going on to serve some of Liverpool's most disadvantaged communities as a GP for 30 years.

# Obesity in the United Kingdom: Do we need a new approach?



**Prof. Siba Senapaty** Consultant Bariatric Surgeon

Obesity is a chronic disease with significant impact to the health and well being of an individual. Currently we are in a global epidemic of obesity and present interventions at various levels have not had any impact on it. As the WHO has identified, there are multiple root causes of obesity and unless we understand and tackle them, we will not be able to achieve our goals. The *OASIS-GB* (*Obesity Awareness and Support Information Services-Great Britain*) was founded seven years ago by me with my colleagues and friends from various organisations and institutions with a view to educate both the medical fraternity and the public. This year we organised our fifth annual conference as hybrid by both face to face and webinar on 18th July at Salford Royal Hospital Mayo building. This event of OASIS-GB is supported by Northern Care Alliance, University of Salford, BAPIO, British Obesity and Metabolic Surgery Society and British International Doctors Association. We had 142 delegates of various health professionals, faculty from universities, city council officials and volunteers of different organisations, with 90 face to face and 52 in the webinar.

The day started with a welcome address by our Northern Care Alliance Chief Executive Officer *Dr Owen Williams*. He stressed the importance of understanding the disease of obesity. His focus has also been on the current inequality of care received by some of our patients depending on their ethnicity, culture and belief and his vision to tackle them. I introduced our delegates about the day's program and our vision of OASIS-GB. We divided the day in three sessions, the first session started with *Lisa*, a patient who had surgery for obesity. She eloquently described how obesity impacted her life both physically and mentally and how things have significantly improved since her surgery. She was followed by *Dr Stuart Flint*, who is the Associate Professor of Psychology, who very lucidly described misconceptions of obesity especially addressing stigma attached to obesity both in the society and social media. *Prof. Farooqi*, a world leader on Genetics from Cambridge University described the genetic influences of obesity and current research in this field. The current World Obesity Forum President, *Prof. John Wilding* of the University of Liverpool, described the causes and health consequences of the global increase of obesity.

Following a brief coffee break we proceeded to our second session, which was on "*The Management of Obesity*". *Prof. Akheel Syed* reminded us of the impact of obesity on health, followed by *Prof. Sanjay Arya* who eloquently described the close link between obesity and the heart. The trio from the University of Salford, *Dr Anna Robins*, *Dr Paul Sindall* and *Dr Phil Gray*, proposed a novel, holistic and evidence-based weight management program for the future. Over the last few decades there have been significant advances in our understanding of the pathophysiology of obesity and more recently there have been advances in pharmacotherapy, which was simplistically described by *Prof. Wilding*. Currently obesity or metabolic surgery is the most effective treatment for obesity and I described the current surgical approaches to tackle obesity. This was followed by a healthy lunch break, and the third and last session was "*Considerations for obesity services*". The current President of the British Obesity and Metabolic Surgery, *Prof. Vinod Menon* started with the role of safe surgery as an important part of weight loss journey. This was followed by patient experiences, tackling obesity in early years and regional and national strategies on food and healthy weight - what works. My co-chair *Jack Carney* described the current various activities carried out by OASIS-GB in the schools and communities. He also thanked all our delegates and sponsors. I would like to thank BIDA's Executive for their continued support of me in organising this national event.

A message from Quilter Financial Planning Limited.

# NHS Pension Annual Allowance Errors

Over the years NHS Pension experts **Quilter Financial Advisers** have identified and corrected numerous errors that were causing overstated Annual Allowance growth figures. This has enabled NHS Pension members to reduce their Annual Allowance charge.

Our biggest correction, to date, reduced the member's Annual Allowance charge by **£83,000**.

## Incorrect Pensionable Pay

Your pensionable pay is used to work out the NHS Pension benefits that you have accrued for Annual Allowance purposes. If the pensionable pay used is incorrect then this can have significant impact on your Annual Allowance calculations and any subsequent charge. We can review and correct your records if you have been impacted by this. There are two main categories that have led to incorrect pensionable pay being used:

- **Best of 3 issue** – The entitlement to 95 officer pension benefits are based on 1/80th of the best of the last three year's pensionable pay for each year of pensionable membership in the Scheme. The annual allowance statements do not take the 'best of the last three years' into account, they are produced on the basis of using the last year's pensionable pay.

Where Officer pensionable pay goes down one year then up next, you can be incorrectly paying for the same growth twice.

Best of 3 should apply. Any instances back to 2010/11 could impact you. An example of this would be a reduction in On Call Intensity in one year, followed by an Increment in the following year.

- **Misallocated arrears** – This occurs where there are pensionable pay arrears that should have been paid in a previous tax year but are allocated to one tax year on your NHS Pension records. When arrears for a previous year are allocated to one tax year, they create an artificial spike in pensionable pay that result in the accrued NHS Pension benefits being overstated and an artificial spike in Annual Allowance charge. An example of this would be historic, backdated Clinical Excellence Awards.

## Incorrect Carry Forward

Carry Forward enables you to use the last 3 years of unused Annual Allowance. However, those previous 3 years are impacted by the years previous to them. We have seen a number of Carry Forward calculations not using the full extent of historic carry forward. In particular, the rules around the mini tax years of 2015/16 mean you may need growth figures back to 2010/11. A simple way to check if you've been subject to this error, is to contact NHS Pension Agency (0300 3301346) and obtain your historic growth figures back to 2010/11 and enter the details on HMRC's Annual Allowance calculator ([hmrc.gov.uk/tools/annualallowancelimit](http://hmrc.gov.uk/tools/annualallowancelimit))

If you would like a review of your NHS Pension and get help with any of the issues above, please contact Quilter at [bida@quilter.com](mailto:bida@quilter.com) (quoting **BIDAad2210**).

Quilter Financial Advisers are included on the NHS Employers list of organisations who are able to give expert guidance and advice on pension tax issues for members of the NHS Pension Scheme.

We provide Holistic Financial Advice and produce bespoke NHS Pension reports that take the information from your payslips, Total Reward Statements, Annual Allowance Statements, Tax Returns and use this information to:

- Project your NHS Pension benefits to your chosen retirement date
- Calculations based on both standard pension award and maximum lump sum award
- Estimate current and future Lifetime Allowance and Annual Allowance
- Check the accuracy of your NHS Pension record and Annual Allowance history

**Quilter**  
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# Medical Quiz Answers

**1 Correct answer is 2. Excision of fibroadenoma.**

Surgical management with excision should be offered to patients with large and symptomatic fibroadenoma<sup>1</sup>.

**2 Correct answer is 1. Rigid sigmoidoscopy and flatus tube insertion.**

This is the first line management of sigmoid volvulus<sup>2,3</sup>.

**3 Correct answer is 1. Urine albumin:creatinine ratio for proteinuria and dipstick;**

HbA1c, U&E and lipids, ECG and Fundoscopy. Please refer to NICE guidance on investigations for end organ damage in a patient with newly diagnosed hypertension<sup>4</sup>.

**4 Correct answer is 2. Addisonian Crisis.**

It can be the first presentation of Addison's disease. Hypotension, reduced consciousness, hypoglycaemia, hyponatraemia and hyperkalaemia are signs of Addisonian Crisis.

**5 Correct answer is 3. Haemolytic Uraemic Syndrome; E. Coli 0157.**

Patient has had antibiotics while having gastroenteritis with E. coli 0157 which has caused Haemolytic Uraemic Syndrome. It presents with reduced urine output, haematuria, hypertension, lethargy and confusion.

## References:

1. Cerrato F, Labow B. Diagnosis and Management of Fibroadenomas in the Adolescent Breast. *Seminars in Plastic Surgery*. 2013;27(01):023-025.
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3. Scharl M, Biedermann L. A Symptomatic Coffee Bean: Acute Sigmoid Volvulus. *Case Reports in Gastroenterology*. 2017;11(2):348-351.
4. Recommendations | Hypertension in adults: diagnosis and management | Guidance | NICE [Internet]. Nice.org.uk. 2022 [cited 5 September 2022]. Available from: <https://www.nice.org.uk/guidance/ng136/chapter/Recommendations>

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# Teriparatide is recommended as first-line treatment for patients at **very high fracture risk**<sup>1,§</sup>

Download our **free** clinical summary based on the latest NOGG guidelines<sup>1</sup>

[stada.rxdetail.co.uk/movymia-guidelines](https://stada.rxdetail.co.uk/movymia-guidelines)

Contains Movymia (teriparatide) promotional information.



**Movymia**<sup>®</sup>  
Teriparatide

20 µg/80 µL solution for injection

A teriparatide biosimilar from Thornton & Ross, STADA<sup>2</sup>

§ NOGG very high risk is identified as a FRAX-based fracture probability that exceeds the intervention threshold by 60%. It can be used to identify patients who likely require specialist referral for assessment of their osteoporosis (which should include DXA measurement of BMD), and further consideration of appropriate treatment strategies.<sup>1</sup>

## **Movymia 20 micrograms/80 microlitres solution for injection** **Prescribing Information. Please refer to the Summary of Product Characteristics before prescribing Movymia.**

**Presentation:** Each cartridge of 2.4 mL of solution contains 600 µg of teriparatide (corresponding to 250 µg per mL). **Indication:** In adults for the treatment of osteoporosis in postmenopausal women and in men at increased risk of fracture. In postmenopausal women, a significant reduction in the incidence of vertebral and non-vertebral fractures, but not hip fractures has been demonstrated. Treatment of osteoporosis associated with sustained glucocorticoid therapy at increased risk of fracture. **Dosage and administration:** Administered once daily by subcutaneous injection in the thigh or abdomen using the Movymia Pen. Adults – Recommended dose is 20 µg administered once daily. Patients should receive supplemental calcium/vitamin D supplements if dietary intake is inadequate. Maximum duration of use is 24 months and this course of treatment should not be repeated over a patient's lifetime. Renal impairment – Not to be used in patients with severe renal impairment; caution is advised for patients with moderate renal impairment. Hepatic impairment – Caution is advised. Paediatric population and young adults with open epiphyses – Should not be used. **Contraindications:** Hypersensitivity to the active or any of the excipients. Pregnancy and breast-feeding. Pre-existing hypercalcaemia. Severe renal impairment. Metabolic bone diseases (inc. hyperparathyroidism and Paget's disease) other than primary osteoporosis/glucocorticoid-induced osteoporosis. Unexplained elevation of alkaline phosphatase. Prior external beam or implant radiation therapy to the skeleton. Patients with skeletal malignancies or bone metastases. **Warnings and Precautions:** **Serum and urine calcium** – In normocalcaemic patients, slight and transient elevations of serum calcium concentrations have been observed; any blood samples for serum calcium measurements should be taken at least 16 hours after the most recent injection. Routine calcium monitoring during therapy is not required. Teriparatide may cause small increases in urinary calcium excretion. **Urolithiasis** – Caution is advised in patients with active or recent urolithiasis due to the potential exacerbation of this condition. **Orthostatic**

**hypotension** – Isolated episodes of transient orthostatic hypotension have been observed, typically within 4 hours of treatment, and had been resolved within a few minutes/hours by placing the patient in a reclining position. This did not preclude continued treatment. **Renal impairment** – Caution is advised in patients with moderate renal impairment. **Younger adult population** – Experience in younger adults (inc. pre-menopausal women) is limited and treatment should only be initiated where the benefit clearly outweighs the risk. **Fertility, pregnancy and lactation:** Women of child-bearing potential should use effective methods of contraception and if pregnancy occurs, treatment should be discontinued. This product is contraindicated in pregnancy and breast-feeding, effect on fertility is unknown. **Undesirable effects:** **Serious common side effects:** Syncope, hiatus hernia; **Other serious side effects:** Tachycardia, nephrolithiasis, anaphylaxis, renal failure; **Other very common side effects:** Pain in the limb; **Other common side effects:** Anaemia, hypercholesterolaemia, depression, dizziness, headache, sciatica, vertigo, palpitations, hypotension, dyspnoea, nausea, vomiting, gastro-oesophageal reflux disease, sweating increased, muscle cramps, fatigue, chest pain, asthenia, mild and transient injection site events, including pain, swelling, erythema, localised bruising, pruritus, minor bleeding at injection site. For full list of side effects, consult SmPC. **Special precautions for storage:** Once in use, the pen should be stored in the refrigerator between doses and a new sterile pen needle must be used for each injection. Do not freeze. Protect from light. Do not store with the needle attached. **Legal Category:** POM. **Pack size and price:** 1 carton of Movymia 2.4 mL cartridge and 1 pen pack (£235) and 1 carton of Movymia 2.4 mL cartridge (£235). **MA Number:** PLGB 11204/0337 **MA Holder:** STADA Arzneimittel AG, Stadastrasse 2-18, 61118 Bad Vilbel, Germany. **UK Distributor:** Thornton & Ross Ltd, Linthwaite, Huddersfield, West Yorkshire, HD7 5QH. **Full SmPC available from the UK Distributor. Date of preparation:** November 2022. **Unique ID number:** UK-MOVY-11

Adverse events should be reported. Reporting forms and information can be found at [www.mhra.gov.uk/yellowcard](https://www.mhra.gov.uk/yellowcard). Adverse events should also be reported to Medical Information on 01484 848164.

1. National Osteoporosis Guideline Group UK (NOGG), clinical guideline for the prevention and treatment of osteoporosis. Updated September 2021. Available at: <https://www.nogg.org.uk/full-guideline> [accessed November 2022]. 2. Movymia 20 micrograms/80 microlitres solution for injection Summary of Product Characteristics (SmPC), Available at: <https://www.medicines.org.uk/emc/product/10780> [accessed November 2022].