

bida

Journal

The Journal of
The British International
Doctors' Association
Issue No.2,
Volume 24.
June 2018



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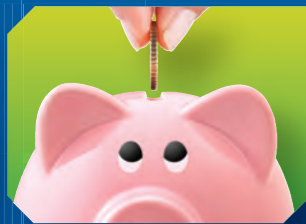
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bida Journal Editorial

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Produced on behalf of the
British International Doctors' Association by:

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Printed by:

Minerva Print
King William House, 202 Manchester Road,
Bolton, Lancashire BL3 2QS
Phone: 01204 397522
E-mail: info@minervaprint.com
Website: www.minervaprint.com

The National Health Service will be celebrating its 70th year on the 5th of July this year. It is the nation's most treasured establishment. Over the years it has played a vital role in the lives of the society and improving the quality of life.

In this issue, Dr Satya Sharma and Mr Nikhil Kaushik have brilliantly displayed "The Good and the Bad" aspects of the service.

What is most important is that we must applaud the vital role every individual in the NHS has played to maintain a cohesive service. The organisation is recognised the best free healthcare in the world. The International Medical Graduates and nursing staff are the backbone of the NHS. The article published in Hindustan Times acknowledges the contribution made by doctors from the South Asian subcontinent. Puskar Bura quotes his experience and has given advice on how to develop qualities to empower their potentials.

There are now grave concerns on recruitment of doctors and nurses. This has been due to a number of factors including the effect of Brexit, migration to Australia and New Zealand, a relatively high drop out rates through out training and strict Home Office regulations etc. The latter have now made headlines by denying the approval of Tier 2 Visa to 100 Indian doctors that had been selected for a 3-year degree programme under Edge hill University as well as other doctors throughout the country. Sanjay Arya has quite pertinently explained the benefits of bringing in these international medical graduates. He goes on to state that this would have a negative impact on service provisions and have the potential in putting our patients at risk. This is because their NHS salaries are too low under immigration rules. What's changed is the Home Office's threshold for granting visas. These are doctors recruited mainly from the Caribbean, India and Pakistan.

The current immigration rules that restrict recruitment of International Medical graduates are adding crisis to some of NHS Trusts that are facing huge shortages.

The British International Doctors Association is disappointed that applying such a 'cap' without recognising the need of the NHS will put many areas of services in the NHS operating at 'fire fighting'



Mr. Amit Sinha
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Co-Editor, BIDA Journal.
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Dr. Ashish Dhawan
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mode where there is greater potential for compromising patient safety. Historically the international medical graduates, in particular, the doctors from the Indian sub-continent have been a significant contribution in sustaining the services. Given that the 'migrant' doctors which account for over 28% of NHS workforce have been fully trained and undergone a rigorous selection process before they are accepted by the regulatory body - the GMC to practice in this country. BIDA is extremely disappointed that the present government has not shown the sensitivity at a time when the NHS is under severe crisis with regards to the medical workforce, which is resulting in the cancellation of operations, outpatient appointments and long queues in Accident and Emergency.

We would like to welcome Dr Buddhdev Pandya MBE as the Corporate Affairs Officer for BIDA. He has two excellent articles expressing his views on setting up a "NHS Commission" as well as "GMC reforms". Mr Sampat's journey has been a tough one. Did the GMC treat him fairly? You must read his letter.

On the scientific front we focus on Katharine Hamlett's review on "Cervical lymphadenopathy in children. Dr. Anwar has given a very detailed account of "Causes of Transient Loss of Consciousness (TLOC) and its management". Mr Selvasekar updates all the laparoscopic surgeons on the issue of robotic surgery.

I am sure a lot of us are looking forward to upcoming world cup in Russia this month. We at the BIDA Editorial Board would certainly like to wish the very best of luck to the England Team.

Finally we hope that you enjoy this edition. Enjoy the summer and keep writing to us.

Best wishes

Ashish Dhawan & Amit Sinha

Co-Editors, BIDA Journal

BIDA National Chairman's Report



Dr Chandra Kanneganti
National Chairman, BIDA

Dear Colleagues,

It has been a very busy few weeks for the BIDA Executive Committee.

BIDA has responded robustly to the unfortunate case of Dr Bawa Garba and has sent a detailed press release with our position statement to work towards stopping scapegoating doctors for systemic failures in the NHS. We have met GMC twice and expressed our views and are involved in this important issue proactively.

We also responded to Normal Williams review of medical manslaughter.



BIDA National Secretary and BIDA Journal Co-Editor Dr Ashish Dhawan speaking on ITV's "Granada Reports" programme about the government's cap on Tier 2 Visas.

BIDA has condemned publicly PM Theresa May's government's cap of Tier 2 Visas, which is causing problems to many international medical graduates. Our General Secretary, Dr. Ashish Dhawan did an excellent interview in many national news channels representing BIDA's views on this issue. We will continue to work hard and put pressure on the Home Office to remove the unnecessary cap of Tier 2 Visas for IMG doctors.

I have been interviewed by Pulse GP magazine and our organisation's views on "Racism in NHS" have been published in their special April edition.

We have met the RCGP education committee team and have agreed on number of actions of joint working supporting international medical graduate GPs. I am thankful to the RCGP for publishing their special program of migrant's contribution to the NHS, where they have opened a special photo gallery about BIDA/ODA with pictures of the founder members of the ODA and details about the history of the organisation.



We are planning Our Annual AGM/ARM to be held at the Daresbury Park Hotel, Warrington, Cheshire WA4 4BB from October 12th-14th. We are currently putting together our programme. Please mark the dates. We look forward to several of our members to attend and represent their divisions.

BIDA International Congress preparations are going well and we are looking forward for an exciting conference in October 2018 in Jakarta.

I would like to welcome Mr. Buddhdev Pandya, OBE who joined our organisation as Chief Officer of Policy to support and advise the BIDA Executive.

Dr Chandra Kanneganti
National Chairman, BIDA

Welcome to new BIDA members

Name	Membership No.	Division
Dr S A Majeed	10558	Manchester
Dr V Malhotra	10559	London Metropolitan
Dr A Sinha	10560	Manchester
Dr S Prasad	1963	Manchester
Dr S Sukthankar	10561	Wigan
Dr A Sukthankar	10562	Wigan
Dr R Jha	10563	Rochdale & Bury
Dr A Shotri	10564	Merseyside & Cheshire
Dr J O'Loan	10565	Merseyside & Cheshire
Dr M Verma	10566	Preston & Chorley
Dr R K Verma	10567	Preston & Chorley
Dr V Joshi	10568	Manchester
Dr P Joshi	10569	Manchester
Dr K Raj	10570	Nottingham & North Trent
Dr (Mrs) A Raj	10571	Nottingham & North Trent
Dr B Cholayil Poornamodan	10572	Stoke-on-Trent & Staffs
Dr S Bhaskaran	10573	Stoke-on-Trent & Staffs

Name	Membership No.	Division
Mr B Thomas	10574	Stoke-on-Trent & Staffs
Dr A Kumar	10575	Wolverhampton
Dr P Sinha	10576	Wolverhampton
Dr R Manghnani	10577	Merseyside & Cheshire
Dr Anju Singh	10578	Merseyside & Cheshire
Mr Vittal Rao	10479	Stoke-on-Trent & Staffs
Dr A Kudra	10580	Nottingham & North Trent
Dr U Prakash	10581	Nottingham & North Trent
Dr M K Shashidhara	10582	Manchester
Dr M Khanna	10583	Nottingham & North Trent
Dr S Shridhar	10584	Nottingham & North Trent
Dr Unnat Krishna	10585	Wolverhampton
Dr Sai Pillarisetti	10586	Preston & Chorley
Dr P K Rao	10587	Manchester
Dr J Chakravarthy	10588	North East
Dr F Yousaf	10589	Blackburn
Dr M Agarwal	10590	Merseyside & Cheshire

BIDA Trainee Forum Chairperson's Message



Dr Aditi Sinha
Trainee Forum Chairperson, BIDA

Dear members,

Junior doctors are the future of the NHS, but will no doubt be facing changes and challenges in the years to come.

Becoming a BIDA member will allow junior doctors a unique opportunity to highlight and vocalise issues that face all doctors as well as provide a platform for ethnic minority doctors to be represented.

The medical educational events that BIDA organise aim to promote a high standard of medical practice but are also an ideal opportunity to network with other ethnic minority doctors.

Furthermore, mentoring in careers and training as well as the advisory services available shows BIDA's commitment to support all their members and junior doctors in particular.

Dr Aditi Sinha MBChB BSC (Hons) MRCPCH
Paediatric ST4. Trainee Forum Chairperson, BIDA

BIDA G.P. Forum Chairperson's Report



Dr Preeti Shukla
G.P. Forum Chairperson, BIDA

Dear friends,

I hope everyone enjoyed the Royal wedding of Prince Harry to Meghan Markle. This is a landmark moment in British history in several ways. The celebration of diversity gave hope to countless immigrants and particularly those working in the NHS considering the hostile environment following Brexit.

Home Office VISA restrictions

Recently the news hit the media that over 1500 visa applications from doctors wanting to work in the UK were refused by the Home Office in last four months. We have highlighted the issue. It is very concerning that we are turning doctors away when the NHS is under such tremendous pressure for recruitment.

Meeting with RCGP Chair

We had attended a meeting with RCGP Chair, Prof Helen Stokes-Lampard and her colleagues to discuss differential attainment in AKT (Applied Knowledge Kit) and CSA (Clinical Skills Assessment). We have given further suggestions on training and targeted support, which were positively received by the college. We will continue to work in collaboration with the college to improve the lives of our colleagues.

Meeting: GPC, England

As your GPC representative I attended the GPC, England meeting. Nigel Watson, who has been appointed by Jeremy Hunt to lead partnership review, gave a presentation. It's an important piece of work and along with Dr Chandra Kanneganti fed into the discussions and raised pertinent points including indemnity. The review is supposed to last nearly a year and we are hoping for a positive outcome.

National Audit Office report

The National Audit Office has released a report on NHS England's management of the PCSE contract with Capita, which illustrates Capita's failure to deliver backroom services for GP practices and individual GPs.

GPC Campaign

GPC has also launched a campaign asking for all general practice staff members and individual GPs who have been negatively impacted by one or more of the service lines to sign the pledge. Please support this campaign, as it will be used to further demonstrate how far reaching the poor delivery of PCSE (Primary Care Support England) is on practice staff and show the Government the number of individuals demanding for the service level to be improved.

NHS Digital Update

NHS Digital has produced the quarterly update on GP workforce figures. There are 316 fewer full-time equivalent GPs in England since December according to new figures from NHS and 1,000 fewer GPs since September 2015. Despite that, trainees on GP training schemes, who towards the end of their training are unable to secure a post or are having to leave the UK because many GP practices do not hold a sponsorship license.

BMA is collating examples to forward to the Health Committee, which will be used as evidence that the process needs to be looked at again and would urge everyone to please forward any such cases.

Welsh Gov. Scheme

I would like to end with sharing the good news that the Welsh Government is set to introduce a state-backed scheme to provide clinical negligence indemnity for GPs in Wales. This represents a very important step towards increasing the sustainability of general practice in Wales.

Thanks for all your support and will continue to work hard for the colleagues and keep raising the issues important to the profession in various forums.

Dr Preeti Shukla

GP Partner, Ewood Medical Centre.
GP Forum Chairperson, BIDA. BMA GPC Rep



Celebrating



A Conversation

On the 5th of July 2018 Britain celebrates the 70th birthday of its much-loved National Health Service.

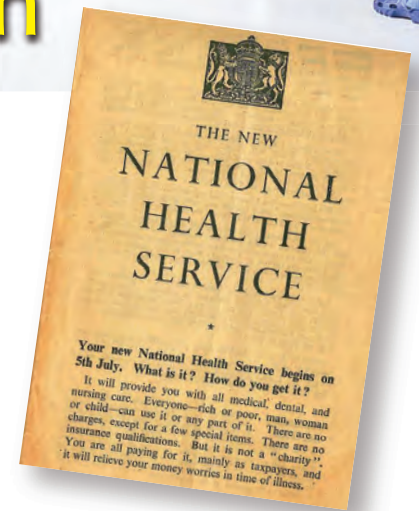
Aneurin Bevan, a lifelong champion of social justice is credited as being the architect of the NHS. Prior to the establishment of the NHS the provision of the healthcare was inextricably bound up with religion and money, thus disadvantaging the poor.

Aneurin Bevan's vision of the NHS was that it would:

- Meet the needs of everyone
- Be free at the point of delivery
- Based on clinical need and not the ability to pay

70 years on, the NHS is still considered the greatest achievement in the history of healthcare in the world. A little over a decade ago Nikhil Kaushik had produced a Bollywood style film (Bhavishya-The Future, 2006) that extolled the virtues of the NHS and touched upon inequalities that exist in the delivery of healthcare across nations.

BIDA Journal Editorial team invited recently retired GP, **Dr Satyavrat Sharma** and **Mr Nikhil Kaushik**, a Consultant Ophthalmologist for a conversation to reflect upon the NHS and its place in Global Health.



Nikhil: Satya you have retired from the NHS after having served as General Practitioner close to four decades. What has appealed to you most about the NHS in the UK?

Satya: I think the Principles and values that guide the NHS, are most appealing; these being:

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

By maintaining its focus on these the NHS has been able to bring the haves and the have not's together. This, I think makes Britain a fare society where the health care is not dependent on one's ability to pay.

Nikhil: I agree, I also think that the politics of

the nation revolves around Health, and the NHS is priority number one for the citizen.

Satya: That is so, but we hear so much that the politicization of the NHS is a bad thing and generally people blame the politicians for the perceived ills of the NHS.

Nikhil: This is a paradox indeed. If the NHS does not remain at the centre of political debate then the politicians pull away from investing in the NHS and effectively that opens up the gates for the private providers. I am not suggesting that there should be no involvement of Private providers but the NHS should be sustained by general taxation if it is to deliver that reassurance to the citizen.

Satya: What do you think are the major achievements of the NHS?

Nikhil: There are many. In the main the several technological advances we now take for

granted have been developed and are provided under the umbrella of the NHS. To mention a few:

- Provision of Perinatal care
- Universal Immunization
- Promotion and focus on Safety measures
- Action on Smoking
- Universal availability of Primary Care
- Various Screening programs
- Free or subsidized Drugs
- High Tech Medicare

Satya: And I think these have produced very welcome results, for example:

- In 1948 the Infant Mortality Rate in UK was 34 deaths per 1000 live births, and now it is 3.8 deaths per 1000 live births (2016 figures)

- The life expectancy in 1948 was 70.1 for women and 65.8 for men, whilst in 2016 it has improved to 83.1 for women and 79.4 for men.
- The cancer survival rate has markedly improved

Nikhil: Absolutely and further more, there are so many technically advanced treatments that have been developed by the NHS. Just to name a few: In vitro fertilisation, joint replacement surgeries and of course treatment of Cataracts with implantation of Intra-Ocular lenses; these are the amazing gifts of the NHS to humanity.



Satya: With such a valuable role the NHS plays in our lives it is no wonder people are sensitive about it and any talk of a threat to the NHS provokes an outcry.

Nikhil: Yes and we should also remember that the NHS provides a cohesive force for local communities and the nation as such. The NHS is the fifth biggest employer in world; employing 1.7 million people that are 2.5% of the UK population and that includes a large number of professionals like doctors and nurses whose primary qualification is from another country.

Satya: So the NHS provides a valuable employment to professionals from other countries.

Nikhil: Indeed it does. In March 2017, the NHS employed 106,430 doctors, 26% of whom had non-UK primary qualification.

Satya: I wonder how this is perceived in countries from where the professional come to work in the UK

Nikhil: This is a mixed blessing as professionals benefit as they gain valuable experience by working in the NHS that they take back to their home countries. The NHS also provides career and future opportunities to those who make UK their home.

Satya: The NHS understandably takes a large chunk of government expenditure.

Nikhil: Absolutely, in the fiscal year 2018, the NHS budget is 146.8 billion pounds that is 18% of all government expenditure second only to biggest spent that is Pensions (20%)

Satya: This is interesting, so this huge spend on Pension can also be blamed on the NHS.

Nikhil: Very true, an increased life expectancy brings its own rewards and challenges and this must be a major concern to our political masters. Unfortunately, although we are living longer, this extended life requires support from the NHS and social services. Nearly half the adults over the age of 65 take one or more prescription medications. So we are seeing that the joy of long life is drowning under the burden of illness.

Satya: And that must be a big concern. How do you see the future and what will be the big challenges to the generation who will care for the ever-rising

bulk of retired citizens?

Above right: Aneurin "Nye" Bevan, the Labour politician who founded the NHS in 1948. Some of his most famous quotes seem even more relevant today (below).



Dr Nikhil Kaushik
Consultant Ophthalmologist



Dr Satya Sharma MBE, DL
GP, Retired

Nikhil: The constantly reducing old age support ratio will be the biggest challenge in the immediate future and the focus I would think will be on a healthy drug free existence. The burden of an elderly infirm population cannot be good for any society.

Satya: I also think we shall have to water down expectations that people have from the NHS; and rejoice in its achievement of an increased life span and independence living widely.

Nikhil: These virtues of the NHS must be shared with other countries too and I feel that the vision of Aneurin Bevan that of a Health Service that meets the needs of everyone, is free at the point of delivery and based on clinical need and not on the ability to pay, should be a universal dream not just limited to Britain. I think time has come for the National Health Service to inspire other nations to follow its example and for humanity to aim for a truly Global Health Service. This I believe will be a fitting tribute to Bevan as we celebrate the 70th year of the NHS. BIDA should champion this cause!



Indian Doctors seen as architects, the lifeblood of Britain's National Health Service

Educated under a medical syllabus influenced by the legacy of the British Empire, Indian doctors came to the UK to train and settled to pursue careers in the NHS.

Prasun Sonwalkar
Hindustan Times, London

As Britain's National Health Service (NHS) completes 70 years, Indian doctors who worked for it over the decades are being hailed not only for their contribution but for their central role in its development as "architects" and "lifeblood".

Set up in 1948 to provide free medical services to all, NHS faced a major shortage in the initial years (as it does now), particularly in areas considered "inner-city" and populated by working class people, where white British professionals were loathe to serve.

Educated under a medical syllabus influenced by the legacy of the British Empire, Indian doctors came to the UK to train and settled to pursue careers in the NHS. Their role is the focus of a new exhibition at the Royal College of General Practitioners (RCGP).

The latest figures show there are 25,711 doctors who gained their qualifications in India, the largest country group in the NHS from outside the UK. There are as many as 1,724 doctors on the register with the surname Patel.

A spokesperson for the General Medical Council, which registers and regulated doctors in Britain, said, "The medical profession in the UK relies on the expertise of doctors from overseas. Their contribution and the diversity of experience they bring are invaluable."

Indian doctors are also reflected in popular British culture, for example *The Indian Doctor*, BBC's five-part television drama set in a south Wales mining village in the 1960s, which starred Sanjeev Bhaskar and Ayesha Dharker and was first broadcast in 2010.

Julian M Simpson, author of a book on doctors from India and South Asia, said: "Doctors from the Indian subcontinent were not just contributing to the NHS, they were its very lifeblood. We should acknowledge they were among the architects of the NHS."

Described as groundbreaking, the RCGP exhibition draws on archival research, photographs and oral history interviews with 40 general practitioners who moved to Britain from South Asia during the early period of NHS.

RCGP president **Mayur Lakhani** said: "General practice in the UK would not be what it is today without the hard work, innovation, and

courage of our predecessors... Indeed, without them, our profession and the NHS might not even exist at all.

"Not only were they doctors, but they became highly valued members of the communities in which they practised. Whilst many faced incredible challenges, our exhibition also documents the overwhelmingly positive and lifelong relationships they forged with their patients."

But the story of Indian doctors in Britain has not always been one of celebration. There have been numerous cases of discrimination and worse, many of them were unable to enter or progress in high-profile medical streams.

The exhibition acknowledges they often faced racial discrimination and, for women, sexual and racial discrimination, when applying for jobs.

Shiv Pande, who gained his medical qualification in Indore and moved to the UK in 1971 to work in cardio-thoracic surgery at the London Chest Hospital, said: "Due to discrimination, I couldn't get further in cardio-thoracic surgery and had to move into general practice. But it was a nice move as I could do more for my patients."

Simpson, on whose book the exhibition is based, said: "The NHS evolved during its first four decades into a system based around general practice and primary care. By becoming family doctors, South Asian doctors prevented a GP recruitment crisis.

"It's important to also remember that the NHS was established to make healthcare accessible to those who could not afford it.

And for millions of people, particularly in working class communities across Britain, accessing that care meant going to see a GP from the Indian subcontinent."

Besides Pande, RCGP honoured six senior doctors from south Asia at the exhibition launch event, including **Has Joshi, KS Bhanumathi, Krishna Rao Korlipara and Sri Venugopal.**

Veteran Liverpool-based Indian doctor Shiv Pande, who has been honoured with an MBE, held senior positions in Britain's medical bodies, raised funds for victims of the Bhopal gas disaster and organised cricket coaching by India's World Cup-winning cricketers in 1984 for Liverpool's unemployed youngsters.

Article reproduced by kind courtesy of The Hindustan Times.



Above: Sanjeev Bhaskar and Ayesha Dharker in the BBC's "The Indian Doctor".

Empowering International Medical Graduates



Dr Puskar Bura
Clinical Fellow,
Department of Cardiology,
Southmead Hospital, Bristol

Right from the inception of the NHS in 1948, the UK has been dependent upon international medical graduates (IMGs). With almost 1 in 3 doctors working in the UK being IMGs, the NHS owes its continuing existence to foreign graduates^{1,2}. Life as an IMG in the UK, however, is far from being easy.

Medicine is a tough profession, more so if you are an IMG. Studies show that IMGs are more likely to be bullied in the workplace, have higher failure rate in postgraduate exams and ARCP³ and are more likely to be brought before regulatory bodies and be subjected to disciplinary procedures. Despite the alarming statistics, little has been done to empower IMGs.



A recent large observational study in the United States⁴ compared differences in patient outcome of two groups of patients, one treated by IMGs and the other by US graduates. Those patients treated by the IMGs had a lower mortality even though patient treated by IMGs had slightly more chronic condition. Needless to say, the study does have its limitations but the lesson that can be learnt from this study is that IMGs need not be stigmatised. Instead they can prove to be an asset for the organisation. For this to materialise there has to be a collective effort, right from "non-IMGs" to organisational bodies like the GMC, NHS England and BMA. Each has a role to play.

Often it is the subtle discrimination and lack of acceptance by peers that creates a 'them versus us' mentality. This clearly needs to stop.

Tiffin et al⁵ suggests that increasing score of IELTS and PLAB would reduce disparities in postgraduate performance between PLAB and UK graduates. As someone who has had first hand experience with IELTS, PLAB and then working in the UK, I would disagree with that suggestion. Despite having scored 8 (out of 9) in my IELTS and having an English step-father, I still struggled with communication in the workplace. An IELTS score of 7 or 7.5 would perhaps not make much of a difference.

With regards to the PLAB exam, it is not as robust as its American counterpart- the USMLE. Match rate for US residency is much lower (49.4%) for IMGs than US graduates (94%). This speaks volumes. There are many institutes in the UK that exploit the repetitiveness of questions in the PLAB exams. Therefore, it is likely that one would pass the PLAB exam after enrolling on such a course.

Perhaps, it is about time that the GMC scrap the PLAB exam and consider replacing it with a more robust exam as opposed to just increasing the pass mark.

Having an IMG as a supervisor proved to be very beneficial to me. With the help of my supervisor's experience and advice, not only was I able to pass my MRCP exams and step up as an executive member for the Welsh junior doctors' committee. I was also able to talk about my insecurities and struggles with the supervisor who could guide me in the right direction. It certainly felt like I was thriving during my core medical training years. Perhaps, the deaneries could pair an IMG with an IMG supervisor who can understand foreign sensibilities.

A positive campaign by the likes of BMA would certainly help the cause. RCP excellence award winners for the year 2016 and 2017, Dr Anu Jacob and Prof. Geeta Menon are both IMGs. Highlighting achievements like these would help to end the notion that care provided by foreign graduates is inferior.

Last but not the least, it all boils down to the individual to empower themselves. As someone who has worked in the UK for the last five years as an IMG, I present some suggestions for IMGs, especially for those starting afresh:

1. Be proactive and have a 'growth' mind-set.
2. Invest your time and money in inter-personal skills (e.g. assertiveness) and communication skills
3. Enrol onto a RCP mentoring scheme (it's free of cost to trainees)
4. 'Face value' and first impression are vital. Dress up smartly and always maintain eye contact whilst speaking to someone. Appearing confident makes a difference.
5. Invest in self-help books (e.g. 7 habits of highly effective people by Stephen Covey, Mindset by Carol Dweck, Peak by Anders Ericsson)
6. Reading good literature, including books, journals and newspapers like the Guardian and the Telegraph not only improves one's English but also helps understand British sensibilities.
7. Be open to learning new culture and adapting to it. Joining social groups can be helpful in understanding British culture and way of life.
8. When you need help, have the humility to ask for help. Don't suffer in silence.

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The Home Office: Putting patients at risk



Dr Sanjay Arya

Consultant Cardiologist

Medical Director, Wrightington, Wigan & Leigh NHS Foundation Trust

MCh/MMed is a very successful postgraduate education programme for international doctors, running over the last 12 years in the UK. This is a two to three years programme which provides a structured educational and clinical experience which culminates in the award of a higher degree (MCh for Surgical specialities and MMed for Medical specialities) by Edge Hill University. Over 120 doctors have already obtained their higher degree through this programme.

Thirty five Trusts have joined this programme and doctors work in a structured rotation in their chosen specialty. These doctors occupy posts in several Medical disciplines (A&E, Acute medicine, Elderly care, Cardiology, Gastroenterology etc), Psychiatry, Obstetrics & Gynaecology, Trauma and Orthopaedics and various other branches of surgery (ENT, Urology, Colorectal surgery, Cardiothoracic surgery etc).

There is no doubt that we must manage immigration, but there is and will continue to remain an on-going need to bring doctors from outside the UK for the next few years while we train our own doctors. Brexit is likely to make the situation worse.

There are huge benefits in bringing these International Doctors under this “*Learn, Earn and Return Programme*” run in collaboration with Edge Hill University and Wrightington, Wigan & Leigh NHS Foundation Trust.

- Direct impact on A&E performance and waiting times, at a time when NHS is struggling to meet the four hour target.
- Reducing premium locum costs - One doctor vacancy requires the employer to use locums to fill the gap at a cost of over £150,000 per annum, more than double the cost of an NHS employee. There is going to be a huge increase in locum costs.
- Impact on British trainees: There will be a significant disruption to their training as they will be put in a position where they will have to work additional hours to fill these gaps with reduced quality of training due to increased service commitment.
- Mutually beneficial to both countries through the Learn, Earn and Return programme. The UK is internationally known for delivering high quality teaching and training to overseas doctors, many of whom have gone back with new skills improving patient care in their home country.



- It is a self-funded programme, supported by the General Medical Council (GMC) and Greater Manchester Health and Social Care Partnership.

The Home Office is not allowing us to bring these doctors to fill the huge vacancies that exist in the NHS. There are over 100 junior doctor vacancies that did not have any European Union doctor interested in filling these positions. The consequences of the refusal of Visas to these highly qualified doctors, who have gone through an intense interview process and have passed the GMC conducted English Language test, are serious, both clinically and financially.

We do not believe that the refusal of visas for these overseas doctors has anything to do with racial discrimination. We sincerely hope that the Home Office

will reconsider their decision as the benefits are huge, and are so obvious.

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- Direct impact on clinical care to patients in areas where we struggle to recruit local or EU doctors. No local doctors take these non-career grade posts.
- Direct impact on patient safety: There are huge gaps in the rota in almost all specialties. As a result of these unfilled rotas, there will be a significant effect on patient care, patient safety and risk of errors happening.

The NHS needs a **Royal Commission** to provide a pathway for sustainability



Dr Buddhdev Pandya MBE
Chief Officer for Corporate Affairs,
BIDA

The NHS will be celebrating 70th Anniversary of the NHS in 2018. The state funded service was founded out of a noble ideal that good healthcare should be available to all, regardless of wealth. The NHS has always been a 'poisoned chalice' yet a unique public service, and the envy of the world. The service provision is in need of a thorough and comprehensive review that is politically neutral, and - taking into account it's historical experience - provide a pathway to adopt new advances in science and technology, while embracing the integration of the private sector to meet the growing demands on the NHS. Buddhdev Pandya MBE says, "My preference would be for establishing a 'Royal Commission', which is more appropriate since it would provide a more cohesive approach".

Recently, The Secretary of State for Health The Rt Hon Jeremy Hunt MP has called for adoption of a ten-year strategy for the health service. This is a welcomed approach since temporary solutions based on 'knee-jerk' reactions successive governments have seemed to have added more confusion and failed in providing any sustainable resolution for improvement in the quality of patient care over the years.

The NHS will be celebrating 70th Anniversary of the NHS in 2018. The state funded service was founded out of the noble ideals that good healthcare should be available to all, regardless of wealth. The NHS has always been a 'poisoned chalice', yet a unique public service and an envy of the world.

Many recent reports have highlighted the need to take steps to avoid valuable resources being wasted to ensure better use for improving patient care. There is a common thread through the mismanagement of human resources as well as processes; both requiring innovative and lateral thinking.

There are serious concerns over the current delegated responsibilities through the NHS Trusts for their ability to plan and delivery services, capable to meeting the needs of the changing environment. Many aspects of the functional capacity of these bodies are under question for lacking sensitivity in efficiently recognising and tackling troubled hotspots and influencing processes to bring about long term amicable solution.

The NHS has also inherited a new dynamic of the contract culture since the integration of the Private Sector (Public and Private Sectors Partnerships). It has compounded challenges in many respects, involving monitoring processes and integration of services and related models. It has incubated a culture of uncertainty and fear among the workforce as they fear significant reduction of influence in planning services in their own areas of working. It has impacted on the moral of the front-line workers with its total accumulative effect of creating mismatches in service planning with the availability of the resources and, for that matter balancing the demands with availability of resources.

Many of the shortcomings have been inherited over decade,s as various governments have often tried short-term or popularity measures. There was a significant absence of any coherent long-term view on the level of resources or changes in services required. The NHS is also likely to be a major public debating point in the coming years. While I agree that the NHS may need further funds given the demands on the services, my thought is that merely pouring in funds may not be an ideal solution given the complexity of challenges. The fear is genuine that most possible increases are likely to be swelled up in bureaucracy where the clinicians are not in the driving seat!

The NHS is now facing shortages of specialist staff, GPs and other front-line workers. It confirms that workforce requirement needs to be a part of the long term strategy, particularly when it is highly dependent on migrant workers. It involves education, training, recruitment, retention and career progression and better harmonisation between these elements.

What is required is a comprehensive and thorough review encompassing the past seven decades of service, as much as to consider the impact of the new advance technology, integration of the private sector in relation to the growing demands on the NHS. There may be a case for reflecting on the service delivery structures, regulatory and monitoring regimes for improving accountability and transparency across the NHS.

My preference would be for establishing a 'Royal Commission' with more appropriate terms of reference to provide a more cohesive approach. From Brexit negotiations to the projected numbers of people with diabetes alone, there are more compelling reasons to reflect upon the fiscal implications with considerations that are a politically neutral review of our health services. This is the best environment to prompt a rethink of the whole system and of how society needs to change. Here we have a situation where the NHS has been subjected to being a political football; when people disagree even on whether it has a problem, let alone the possible solutions. A Royal Commission might be that peacemaker, an honest broker with many advantages including the ability to secure the vital cross-party support needed to embed lasting changes, and to de-toxify reforms that otherwise may be too politically dangerous to pursue.

The Royal Commissions are independent – governments cannot interfere once they have started – and therefore sit outside politics. They are also powerful and can compel people to produce documents and other evidence in their enquiries.

And we will need the power to ask difficult questions of experts from all sections of society. We must challenge what we think we know about the problems the NHS faces today. We must think beyond the structures and institutions of the previous century.

It would help converge focus in identifying more productive avenues based on wider input from the critics and political opponents as well as the frontline professionals. At least, their grievances, suggestions and recommendations would find a more structured path way to register concerns. There is a value in allowing engagement of all the stake holders in converging on an exercise to bring about some commons consensus of views on many aspects for suggesting improvement and possible reshaping of the NHS.

A Royal Commission is a major form of an ad-hoc formal public inquiry into a defined issue, and available to the government to inquire into various issues. Commissions report findings in the form of advice, and recommendations made are not legally binding but can form the basis for a potential green paper for developing the necessary legislation or amendments.

Perhaps, all we need is to form a view and bring this to the attention of our Members of Parliament and to the Secretary of State for Health for their consideration.

A position statement from the Association of Laparoscopic Surgeons of Great Britain and Ireland (ALSGBI) on Robotic Surgery



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Summary

Association of Laparoscopic surgeons of Great Britain and Ireland (ALSGBI) has been in the forefront of the development in minimal access surgery in the United Kingdom. ALSGBI provides a structure for training to promote safe practice of multi-professional minimal access surgery. Robotics in surgery has been in clinical use for some time and the association fully understands the need to embrace robotics in surgery but feel a cautious approach in the introduction to clinical practice based on the clinical and cost evidence with training for surgeon and the team to perform the procedure competently. There should be a strong clinical governance arrangements locally and NHS should adopt the technology appraisal guidance provided by National institute for health and clinical excellence (NICE). The cost of the current robotic system is a huge financial challenge however, ALSGBI believes in establishing high volume centres which will enable establishing and sustaining high quality service and also provide centres of excellence in high quality training. The training needs to be team based, structured and accredited. The clinical outcomes should be defined, measured and recorded prospectively in clinical trials or through a national registry.

Introduction

Robots have been used in assisting surgeons to perform surgical tasks in orthopaedics, neurosurgery and cardiac surgery for some time however there has been exponential increase in the use and popularity following the introduction of robotic prostatectomy. Nowadays robotics is widely used in general surgery, gynaecology and head and neck surgery.

Clinical application

Despite the increased popularity of robotic prostatectomy which is recommended by NICE as the technique of choice, there is no unequivocal evidence to show its superiority over traditional laparoscopic surgery in other surgical procedures. Further trials are required to ascertain the long-term benefits of robotic surgery in oncology, functional outcomes including QoL and to assess the cost effectiveness. In other pelvic surgeries the use of robot has shown marginal benefit but has involved greater costs and longer operating times.

In 2000, the Da Vinci robot was approved by FDA for use in laparoscopic surgery. The Da Vinci system overcomes some of the limitations of the standard laparoscopy and allows for precise dissection in a narrow confined space, hence the increasing application in robotic assisted laparoscopic prostatectomy. The advantages include stable operator controlled camera system; high definition 3-D magnified view, articulating instruments with seven degrees of freedom, improved ergonomics, motion scaling and tremor filtration. The short term benefits are mainly related to reduced wound related complications. However robotic surgery is more expensive than laparoscopic surgery and open surgery. There is some evidence

to suggest robotics may reduce the learning curve and may enable open surgeons to take up minimal access surgery. Although the initial set up costs are high, increased competition from manufacturers and wider dissemination of the technology may drive the costs down in future.

Robotic technology is rapidly evolving with the development of new robotic prototypes for single incision surgery. Robots designed for specific procedures rather than current generic system will enable procedure specific improved outcomes with decreased complications along with cost effectiveness in future.

Training in Robotics

Currently in the UK, knowledge and skills are acquired through specialty training or on pre- or post-CCT fellowships. Operative experience can be gained by mentored practice or by the use of simulators. Trainees must have satisfactory knowledge of the specific characteristics of the robotic platform and trained by the appropriately trained and experienced trainers. Equally important in robotic surgery is the team training with the robot. At present apart from few robotic prostatic fellowships most of the robot training is provided by the manufacturer of the single currently commercially available and approved surgical robot. Ideally health care providers should have the ability and the resources to train surgical teams in all aspects of surgical care including robotics.

Training in laparoscopic colorectal surgery has been streamlined using the modular approach and through the LAPCO programme (<http://lapco.nhs.uk/>). Similar training model needs to be established for robotic surgery. There are some unique considerations such as port placement where collisions of the arms have to be avoided, additional arm under the surgeon control, increased reliance on visual clues due to lack of tactile feedback with the current system. In addition, team training with enhanced communication is needed between various members as the surgeon is away from the patient, scrub team and the anaesthetist. There is a huge amount of literature on calculating the learning curve based on surgical competency and patient outcomes in laparoscopic surgery. Similar methodologies need to be adopted in achieving competency in robotic surgery. Using the cusum and operating time, appropriately 15-30 cases is thought to be the required to achieve competency in robotic rectal resections based on prior experience in minimal access surgery.

The association would recommend a competency based training in robotic surgery based on the European robotic urological society fellowship programme and the European academy of robotic colorectal surgery. The training needs to be a standardised structured programme with assessment of knowledge by completing the Intuitive surgical online robotic training module, followed by training in the wet lab including animal and human cadaver training. Non-technical skills training for the teams is important followed by team observation visit to a proctor site followed by few proctored cases +/- assessment of



technical competence by video analysis with ongoing audit of the clinical practice.

Quality Assurance

As a new technology, robotic surgery should be subjected to the all the currently defined quality indicators for surgical practice including mortality, oncological safety, complications, and quality of life assessments and follow the NICE approved process of assessing clinical and cost effectiveness. Standardisation of surgical training and its application is vital to ensure that newer technologies are validated appropriately.

Conclusion

Robotic surgery with the Da Vinci surgical system is increasingly used in a wide range of surgical specialties. This technology aims to improve outcomes when compared to open surgery and to overcome some of the limitations of laparoscopic techniques. Despite increasing use, apart from prostatic surgery there is no unequivocal evidence to show the superiority of robotic surgery over the traditional laparoscopic techniques. As there is a greater focus on early intervention and quality of life, there is likely to be development of robotic platforms for procedure specific or platforms for specific parts of the procedure

rather than the currently available single robotic system used in all specialties to cover the entire surgical procedure. At the same time there is advancement in laparoscopic surgery with 3-D technology and improved instrumentation. An area of considerable interest, unique to robotic platforms is the ability to integrate electronic systems such as cross-sectional imaging and programmable parameters into a robot, allowing 3-D lesion definition, plotting no-go anatomical danger zones facilitating dissection in the ideal plane in oncosurgery. In training, robotics lends itself to telementoring as a training tool. Establishing small number of accredited, adequately resources, high volume centres of excellence with the additional remit of delivering training would provide a suitable framework for training in robotic surgery in the UK similar to the models established for training in laparoscopic colorectal surgery.

Contributors

- | | |
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Transient Loss of Consciousness

and differentiation among important causes

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Consciousness is 'the state of awareness of the self and the environment'⁽²⁾ and has two components: content (awareness) and arousal (degree of wakefulness from deeply unconsciousness to fully awake). As a person cannot be aware without being awake, hence these two aspects are not independent. Considering this definition, unconsciousness might also have 'content' and 'arousal' parts but this is not clinically relevant. If 'unconsciousness' were also used for content, then the word would also cover the mental state during absence and partial complex seizures: wherein patients have impaired awareness, and content is affected. Such forms of epilepsy do not usually cause collapse, however. Patients appear 'awake'; meaning the 'arousal' aspect is unaffected. The term 'unconsciousness' is not used for these conditions and the international League Against Epilepsy (ILAE) uses 'impaired' consciousness to describe consciousness in these states. Partial complex seizures and absences therefore do not usually enter the differential diagnosis, needed to distinguish clinically between the principle causes of syncope and epilepsy.

"TLOC can be defined as a transient, self limited loss of consciousness usually leading to a collapse". The Oxford English dictionary also defines blackout as *"temporary loss of consciousness"*, and "blackout" is valuable parlance for everyday communication with patients and between doctors. Blackout does not prejudice the underlying cause of loss of consciousness. Unlike TLOC it is commonly used in everyday English, and widely

understood by patients, relatives and doctors.

Causes of TLOC:

Causes of collapse and TLOC are given in Figure 1.1. The causes of TLOC are syncope, epilepsy and psychogenic blackouts, with some very rare exceptions. Although psychogenic blackouts are not really blackouts, they only appear to be syncope. All these causes have distinguishing clinical features but misdiagnosis occurs frequently, and it is known that epilepsy is commonly diagnosed in patients with syncope⁽¹⁾. Misdiagnosis of epilepsy occurs because syncope is often convulsive with abnormal movements and incontinence⁽²⁾. This is discussed later in detail.

a) Syncope

Syncope is the most common cause TLOC. The word syncope is derived from the Greek words, 'syn' meaning 'with' and the verb 'koptein' meaning 'to cut' or more appropriately in this case 'to interrupt'⁽³⁾. There has been a lot of confusion in defining syncope. Van Dijk⁽⁴⁾ et al has described the condition in detail. Syncope must be distinguished from TLOC itself and recognized as a common cause of TLOC. In some conditions, consciousness appears to be

lost, which is probably the case in psychogenic blackouts. Many causes of TLOC are not due to syncope (Fig 1.2), but many past definitions of syncope are very unhelpful, because they confuse syncope and TLOC. For example, in the Framingham study and in many medical textbooks, syncope is defined as a *"sudden loss of consciousness associated with inability to maintain postural tone, followed by spontaneous recovery"*. This is not a definition of syncope, but a definition of TLOC/blackout. In some publications, even stroke, TIA and epilepsy were considered among causes of syncope, but TIAs specifically do not cause TLOC.

More recently, definitions more closely detail the underlying pathophysiology. Syncope is now defined by the European Society of Cardiology as a *"TLOC due to transient global cerebral hypoperfusion characterized by rapid onset, short duration and spontaneous recovery"*⁽³⁾. Thus, syncope is only diagnosed if abrupt loss of cerebral blood flow is thought to be the cause of TLOC, and not simply in TLOC. Causes of syncope are mentioned in table 1.1

Three most common causes of syncope are: reflex syncope, syncope due to orthostatic hypotension, and syncope with cardiac/cardiopulmonary cause.



Due to head trauma

Concussion, loss of consciousness is usually transient with a variable duration.

Not due to head trauma

Disorders are not always transient. If they are, they are not necessarily self limited or short lived. Examples are: Intoxication, Metabolic disorders, subarachnoid hemorrhage, epilepsy etc.

Syncope

Generalised epilepsy

Steal or vertebrobasilar TIA

(TLOC rare, other neurological symptoms present)

Figure 1.2: Syncope in relation to real and apparent loss of consciousness

Reflex (neurally mediated) syncope

Vasovagal: Mediated by emotional distress: fear, pain, instrumentation, blood phobia, or by orthostatic stress

Situational: cough, sneeze, gastrointestinal stimulation (swallow, defaecation, visceral pain), micturition (post micturition), post exercise, post prandial, others (e.g., laughter, brass instrument playing, weightlifting)

Carotid sinus syncope

Atypical forms (without apparent triggers and/or atypical presentation)

Syncope due to orthostatic hypotension

Primary autonomic failure: pure autonomic failure, multi-system atrophy, Parkinson's disease with autonomic failure, Lewy body dementia

Secondary autonomic failure: diabetes, amyloidosis, uraemia, and spinal cord injuries

Drug induced orthostatic hypotension: alcohol, vasodilators, diuretics, phenothiazines, antidepressants

Volume depletion: haemorrhage, diarrhoea, vomiting, salt depletion

Cardiac Syncope (cardiovascular)

Arrhythmia as primary cause:

Bradycardia: sinus node dysfunction (including bradycardia/tachycardia syndrome), atrioventricular conduction system disease, implanted device malfunction

Tachycardia: supraventricular, ventricular (idiopathic, secondary to structural heart disease, or to channelopathies)

Drug induced bradycardias and tachycardias

Structural disease: Cardiac: cardiac valvular disease, acute myocardial infarction/ischemia. Hypertrophic cardiomyopathy, cardiac masses (atrial myxoma, tumours etc.), pericardial disease/ tamponade, congenital anomalies of coronary arteries, prosthetic valve dysfunction

Others: pulmonary embolism, acute aortic dissection, pulmonary Hypertension

Table 1.1: Causes of Syncope(5)

Reflex syncope

Normal cardiovascular reflexes maintain the blood pressure and cerebral perfusion, and a major component of this is the maintenance of peripheral arteriolar tone. Arteriolar tone is maintained by sympathetic outflow, mainly to skeletal muscle capillary beds. Sudden loss of this tone causes blood to rush into skeletal muscle, and away from other organs. When the body is upright, the effect on the brain is maximised,

because of the orthostatic effect which further reduces perfusion pressure to the upper parts of the body. Cerebral hypoperfusion, especially if marked and abrupt, results in loss of function with loss of consciousness, and affects the anti-gravity muscles supplied by the motor cortex which is the highest part of the brain. This characterises 'vasodepressor' of reflex syncope. However, there is a variable component of "cardioinhibition". This is characterised by abrupt vagal stimulation, slowing or even stopping the heart, transiently. If both mechanisms occur in same individual, it is called 'mixed' type of reflex syncope.

There has been much debate as to whether decreased cardiac output or vasodilation is the dominant hypotensive mechanism preceding vasovagal syncope. Wieling et al⁽⁶⁾ did an analysis of classical papers and concluded that reduction in cardiac output, rather than vasodilation, may be the primary cause of hypotension of vasovagal syncope.

Reflex Syncope is characteristically spontaneous without a good explanation, or associated with certain stimuli, such as the sight of blood or a needle. Sometime there are other specific situations with specific provocateurs causing reflex syncope such as micturition or cough syncope. Different types are described in table1.

Conditions misdiagnosed as syncope:

The most important differential diagnoses for syncope are epilepsy and psychogenic blackouts. Metabolic disorders may cause collapse and altered consciousness, but they rarely correct themselves rapidly and spontaneously as syncope does. In other very rare circumstances, such as cataplexy, there is no TLOC, although consciousness is affected. The most important principle in the differential diagnosis of patients with blackouts is that diagnosis is based predominantly on clinical evaluation. This should be backed up by a 12-lead ECG in all cases, and only a few patients are typically diagnosed with more sophisticated and expensive testing. Hence, the important clinical features are discussed below. Table 1.2 summarises the conditions misdiagnosed as syncope.

Disorders with partial or complete LOC but without global cerebral hypoperfusion

Epilepsy

Metabolic disorders including hypoglycaemia, hypoxia, hyperventilations with hypocapnia

Intoxication

Disorders without impairment of loss of consciousness

Cataplexy (Sudden and transient episode of muscle weakness due to some trigger such as laughing, crying and terror, consciousness is not affected)

Drop attacks (Sudden spontaneous falls while standing or walking with complete recovery in seconds or minutes)

Falls

Functional: (Psychogenic pseudosyncope)

TIA of carotid origin

Table 1.2: Conditions incorrectly diagnosed as syncope

b) Epilepsy

Epilepsy is conceptually defined as a disorder of the brain characterized by an enduring predisposition to generate epileptic seizures and by the neurobiologic, cognitive, psychological and social consequences of this condition⁽⁷⁾. There is requirement of at least one epileptic seizure, which is a transient occurrence of signs and/or symptoms due to abnormal excessive or synchronous neuronal activity of the brain. More recently a practical clinical definition of epilepsy has been agreed by International League against Epilepsy (ILEA) and is described by any of the following conditions⁽⁸⁾;

1. At least two unprovoked (or reflex) seizures occurring >24 h apart
2. One unprovoked (or reflex) seizure and a probability of further seizures similar to general recurrence risk (at least 60%) after unprovoked seizures, occurring over the ext 10 years.
3. Diagnosis of an epilepsy syndrome

Epilepsy is not necessarily life-long and is considered to be resolved if a person has been seizure free for 10 years, with 5 years free of antiepileptic medications, or when that person has passed the age of an age-dependent epilepsy syndrome. Many clinicians believe that two documented unprovoked seizures are required for the diagnosis. Crucially, generalised epilepsy is a cause of TLOC, but there is no change to cerebral perfusion in the pathogenesis of it. Other forms of epilepsy should not cause confusion with syncope or psychogenic blackouts as they tend not cause collapse with TLOC.

c) Psychogenic Seizures

The term 'psychogenic syncope' is a misnomer. "Psychogenic pseudosyncope" (PPS), is a better term, but can still cause confusion. Using "syncope" can imply to some that cerebral perfusion is impaired, and to others that there is TLOC. Many different terms have been used, including 'self-induced syncope'⁽⁴⁾. Rueber and Elger⁽⁹⁾ described it as 'episodes of altered movement, sensation, or experience similar to epilepsy, but caused by psychological process and not associated with abnormal electrical discharges in the brain'. Unfortunately, whilst this excludes epilepsy, it doesn't exclude syncope. 'Psychogenic pseudosyncope' refers to episodes when patients appear unconscious but are not. Related terms are 'psychogenic seizure', 'psychogenic coma' or 'pseudo-unconsciousness', depending on the clinical presentation. Three psychiatric conditions may underlie 'psychogenic pseudosyncope'. One is conversion disorder, in which patients have unexplained somatic symptoms, suggesting a neurological or general medical condition. As a rule, the symptoms cannot, after appropriate investigation, be fully explained by a general medical condition, the effects of a substance, or

Transient Loss of Consciousness and differentiation among important causes

as a culturally sanctioned behaviour or experience⁽⁴⁾. Secondly, in a factitious disorder, symptoms are intentionally produced, with the motivation being to assume a sick role⁽⁴⁾. In malingering, the motivation of symptom production is an external incentive, such as economic gain or legal responsibility⁽⁴⁾. Malingering is probably very rare today and care should be taken to label this a cause as it will be counterproductive.

Psychogenic blackouts usually last much longer than syncope: patients may lie on the floor for many minutes; 15 min is not exceptional. Other clues are a high frequency of attacks in a day, and the lack of a recognizable trigger. Injury does not exclude psychogenic blackouts: trauma was reported in 50% in pseudoseizures⁽¹⁰⁾. The eyes are often open in epileptic seizures and syncope but are usually closed in psychogenic blackouts. Full documentation of attacks is needed to aid diagnosis. This is extremely difficult to organize. Parameters required to assess fully are posture and muscle tone (video recording or neurological investigation), BP, HR, and EEG. "Functional" disorders combine apparent unconsciousness with loss of motor control, while normal BP, HR, and EEG rule out syncope and most forms of epilepsy. Increased heart rate in relation to the apparent loss of consciousness has been suggested by Leiden group⁽¹¹⁾ as important recognizing feature in patients with psychogenic syncope. Same group has also shown that frequent, long attacks with the eyes closed during apparent TLOC are pathognomonic for PPS^(12,13). Having objective physiological data is extremely useful in confirming the diagnosis. Giving a 'psychogenic' diagnosis to patients may be difficult, but objective data are invaluable. A psychological explanation may imply to patients that they are personally responsible or that they simulate attacks on purpose. However, psychogenic blackout patients see their attacks as involuntary, (as they probably are). Stressing that attacks are as involuntary as syncope or an epileptic seizure avoids stigmatization, avoids counterproductive clashes, and provides a therapeutic opening. A further feature of psychogenic blackouts is that many sufferers have also been sufferers of physical and sexual abuse in childhood⁽²⁾. Many patients, perhaps all, with psychogenic syncope have had and may continue to have reflex syncope⁽¹⁴⁾.

1.1.2: Abnormal Limb Movements and distinguishing different types of TLOC:

Generalized seizures produce TLOC and should be distinguished from syncope. Generalized seizures may be tonic, clonic, myoclonic, tonic-clonic, or atonic, depending on the predominant muscle activity observed during the seizure. A generalized seizure is a

Clinical findings suggest the diagnosis	Epilepsy likely	Syncope likely
Symptoms before the event	Aura (Such as a funny smell)	Nausea, vomiting, abdominal discomfort, feeling of cold, sweating (neurally mediated)
Findings during loss of consciousness (as observed by an eyewitness)	Tonic-clonic movements are usually prolonged and their onset coincides with loss of consciousness. Hemilateral clonic movement Clear automatism such as chewing or lip smacking or frothing at the mouth (partial seizure) Tongue biting a) Lateral-epilepsy b) Tip-reflex syncope Blue face	Tonic clonic movements are always of short duration (<15 s) and they start after the loss of consciousness
Symptoms after the event	Prolonged confusion Aching muscles	Usually of short duration Nausea, vomiting, pallor (neurally mediated)

Table 1.3: Clinical features distinguishing epilepsy and syncope

seizure 'whose initial semiology indicates, or is consistent with, more than minimal involvement of both hemispheres'⁽¹⁵⁾ and this is naturally a very expert judgement to make a clinical diagnosis. Although loss of consciousness is not included in the definition, abnormal neuronal activity of major parts of both hemispheres generally results in loss of consciousness. Myoclonic seizures are the sole exception, as these seizures usually present without affecting consciousness. 'Tonic' refers to a sustained increase in muscle contraction lasting a few seconds to minutes. Myoclonus is defined as 'a sudden, brief (< 100 ms) involuntary single or multiple contraction(s) of muscle(s) or muscle groups of variable topography (axial, proximal limb, distal)', and is thus flitting or random. Clonic refers to 'a myoclonus that is regularly repetitive, involves the same muscle groups, at a frequency of ~2-3/s, and is prolonged', so that these movements are more repetitive and regular. Tonic-clonic refers to 'a sequence consisting of a tonic followed by a clonic phase'. Finally, atonic seizures are characterized by 'a sudden loss or diminution of muscle tone without apparent preceding myoclonic or tonic event lasting 1 to 2 s, involving head trunk jaw, or limb musculature'. Atonic attacks are rare and occur almost only in small children.

Both syncope and psychogenic blackouts are commonly associated with limb and facial movements⁽²⁾. Critically, stiffness and myoclonus are not restricted to epilepsy. They were observed in 90 % of healthy subjects who intentionally provoked syncope⁽¹⁶⁾. Observations of such movements is reported in 12 %⁽¹⁷⁾ to 46 %⁽¹⁸⁾ of fainting blood donors. Abnormal movements mimicking a 'seizure' can be produced because of cerebral anoxia and can be easily confused with tonic-clonic movements of epilepsy. This is 'convulsive syncope' which has resulted in misdiagnosis of epilepsy. Lempert et al induced this phenomenon in healthy medical students while observing the effect through video cameras⁽¹⁶⁾. Similar movements can be produced during tilt table induced Reflex Syncope (Zaidi et al.⁽¹⁾). Caution is needed

therefore when using the word 'seizure' to describe abnormal movements in TLOC, since many physicians would equate seizure with 'epileptic attack' potentially giving rise to a misdiagnosis. Interestingly, the ILAE does not restrict the use of "seizure" to epileptic attacks.

With the focus on careful history taking and clinical diagnosis, expert working groups have defined distinguishing features. ESC guidelines (2009)⁽¹⁰⁾ have described some distinguishing clinical features between epilepsy and syncope (Table 1.3).

Conclusion:

It is important to appropriately differentiate causes of loss of consciousness. Appropriate history taking and clinical examination play an important role. By doing this high and risk patient can be identified and unnecessary hospital admissions can be prevented.

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A complete listing of all the references used in this article is available from the Editors on request.

“The GMC needs reforms to improve confidence in the medical profession. It needs to replace outdated, cumbersome and inflexible legislation with new streamlined processes to deliver a model of regulation that is flexible to the needs of the modern workforce”.



Dr Buddhdev Pandya MBE
Chief Officer for Corporate Affairs, BIDA

The Chief Executive of the General Medical Council Mr Charlie Massey said, *“Patients and the profession deserve better than this and it is time for the government to find the time to make the legislation fit for the world we live in”.*

Earlier this year, I publicly expressed the view in support of establishing a “Royal Commission” for undertaking a thorough and comprehensive review of our NHS to suggest pathways to make the services more efficient and fit for embracing modern advances in medicinal science and technology for improving patient care.

The Chief Executive of the ‘regulatory’ body - the GMC, for the medical doctors has also highlighting the need for replacing an outdated, cumbersome and inflexible legislation prevents the GMC from supporting doctors and protecting patients. www.gmc-uk.org/news/31512.asp

Having spent nearly two and the half-decade working in support of the physicians, I agree with Mr Charlie Massey, the CE of GMC that patients and the profession deserve better than this and it is time for the government to find the time to make the legislation fit for the world we live in.

In a GMC press release, Mr Massey, Chief Executive of the General Medical Council, said: *“Successive governments have repeatedly promised to reform the GMC’s legislative framework and repeatedly failed to deliver. The need for reform is growing acuter with each year that passes. It is crucial the government now takes the opportunity to commit to reform as it considers responses to its consultation.”*

He saw their ambition to innovate and act at pace hampered by current legislation; which is a far too cumbersome process and prescriptive.

Having spent considerable time with many doctors caught into the maze of accusation of wrongdoings while supporting these doctors, particularly the international medical graduates, I believe that tolerating of the culture of

racial discrimination and equality is still prevailing.

Both the GMC and CQC are often oblivious to the level of bullying and management malice inflicted against the individual professional complainant. By the time the defence mechanism kicks in, it is too late to retrieve any damage done to the career of the professional. I share the view that many incidences could be better dealt with in other ways when currently it is reported that around 75% of our investigations closed with no further action. The local Trusts are ill-prepared to identify hot-spots and tackle the issues to arrest acceleration

to reporting stage to the GMC without compromising patient safety. The impact is hugely underestimated for this causes needless distress for both doctors and patients. It is also a waste of resources. The changes cannot be achieved through piecemeal changes to legislation.

We should also welcome the views of the Bow Group Health Research Fellow, Jon Stanley, who has called for reform comes in a response to the government’s recent consultation on professional regulation. It cites the GMC, patients, the medical profession, other regulators and the political parties across the UK the called for a new, high-level legislative framework that delivers autonomy and flexibility so they can better protect patients, support doctors, improve medical education and deliver for the wider health system across the UK.

The Bow Group considers the proper regulation of doctors to be essential to the confidence required of the medical profession The Bow Group notes that overseas and ethnic minority doctors are more likely to be struck off and that this shapes the public’s view. It calls for urgently examined by Parliament to consider amendments to the Medical Act.

It is 70th Anniversary of the NHS this year and I wish to echo the views of the Bow Group that emphasises that the patients and the profession deserve better than this and it is time for the government to find the time to make the legislation fit for the world we live in.



Cervical Lymphadenopathy in Children

Introduction

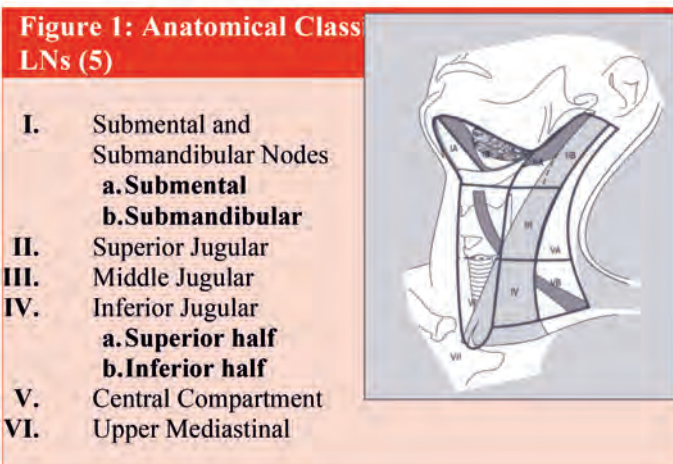
Lymphadenopathy is defined as the disease of lymph nodes whereby there is an atypical number, size or consistency of nodes⁽¹⁾. Lymphadenopathy with signs of inflammation is typically referred to as Lymphadenitis⁽²⁾. Enlargement of cervical lymph nodes (LNs) is a common presenting sign in children and can present a diagnostic challenge. Studies have found that many as 38-45% of healthy children have palpable neck LNs⁽³⁾. Whilst benign pathology is more common, malignancies are possible and a source of significant parental concern/anxiety. A structured approach allows for consistency in management and can allay parental concerns.

There are numerous causes of lymphadenopathy (table 1). In contrast to adults, infective and congenital aetiology are more prevalent in children⁽⁴⁾.

In this article we discuss the anatomy, pathophysiology, aetiology, and suggest an evidence based, practical approach to the investigation and management of cervical lymphadenopathy in children.

Anatomy

Anatomical division of lymph nodes based on the American Medical Association Consensus statement (figure 1) can indicate the source of primary pathology due to lymphatic drainage and allows for communication between colleagues at MDT discussions.



Pathophysiology

Lymph nodes are structured collections of immune cells that act as a filter for antigens in extracellular fluid⁽⁶⁾. There are numerous lymphocytes and antigen-presenting cells in LNs which help to identify and filter antigens found in places such as the blood, skin and gastrointestinal tract.

Neonates start with scarcely detectable LNs but this rapidly changes in childhood. In contrast to adults, children have a very variable LN mass due to the constant exposure to new pathogens⁽⁷⁾. In the first 12 years of life, lymphoid mass increases rapidly in size to double that of an adult at puberty⁽⁸⁾. During adolescence, atrophy of this mass occurs and continues into adult life⁽⁶⁾.

Table 1: Aetiology of Childhood Cervical Lymphadenopathy (4)

Infection	Viral – <i>Infectious Mononucleosis (EBV), Cytomegalovirus, Viral URTIs, HIV, Parvovirus, rubella, measles, mumps</i> Bacterial – <i>Cat Scratch Disease, Tuberculosis, S. aureus, Group A streptococcus etc</i> Protozoal – <i>Malaria, Toxoplasmosis, Leishmaniasis</i> Fungal – <i>Aspergillosis, Candida.</i> Other Parasites – <i>Schistosomiasis, Filariasis etc.</i> Acute lymphadenitis – any pathogenic infection
Iatrogenic	Post-immunisation Phenytoin / Isoniazid / Allopurinol
Auto-immune	Systemic Lupus Erythematosus (SLE) Juvenile Rheumatoid Arthritis Kawasaki Disease Sarcoidosis Serum Sickness
Malignancy	Hodgkin's Lymphoma (HL) Non-Hodgkin's Lymphoma (NHL) Leukaemia Nasopharyngeal Cancer Neuroblastoma Sarcoma
Lympho-proliferative	Castleman Disease
Chronic/ Other	Atopic Eczema Histiocytosis Neimann-Pick disease Gaucher Disease

The mechanism of lymphadenopathy is frequently divided into the following⁽²⁾:

- Reactive hyperplasia of lymph node cells in response to a stimulus e.g. viral lymphadenitis
- The inward migration of inflammatory cells in response to bacterial infection
- Tumour invasion into the lymphoid tissue e.g. metastases and lymphoma

Aetiology

There are numerous causes of paediatric cervical lymphadenopathy (table 1). Citak et al found that out of 282 children studied with cervical lymphadenopathy that had benign disease, only 36% had a specific identifiable aetiology. Of these, the most prevalent causes were Cytomegalovirus, Infectious Mononucleosis and Acute Lymphadenitis⁽⁹⁾. In another study by Bozlak et al, the most common malignant cause for cervical lymphadenopathy found was Lymphoma, which was mainly in older children⁽¹⁰⁾.

History and Examination

In children presenting with a neck mass, a comprehensive history and head and neck examination should always be carried out to help narrow down a diagnosis. This should include the assessment of peripheral LNs and a general physical examination⁽¹¹⁾. As seen in table 2, there are many differential diagnoses of neck masses in children. Patient age is a key factor in ascertaining diagnoses as different disease processes have characteristic age associations.

Miss Katharine Hamlett

Core Surgical Trainee, ENT, Blackpool Teaching Hospitals NHS Foundation Trust

Mr Neil Killick

ENT Specialist Registrar, Blackpool Teaching Hospitals NHS Foundation Trust

Dr Vineeta Joshi

Consultant Paediatrics, Wigan, Wrightington & Leigh NHS Foundation Trust

Mr Vikas Malik

Consultant ENT Surgeon, Blackpool Teaching Hospitals NHS Foundation Trust



Above, l to r: Miss Katharine Hamlett, Dr Vineeta Joshi and Mr Vikas Malik

Table 2: Differential Diagnoses of a Neck Mass in Children

Branchial Cyst

Cystic Hygroma

Thyroglossal Cyst

Dermoid

Malignancy

Lymphadenopathy

Infection – abscess, lymphadenitis etc.

Haematoma

Salivary Gland mass

Sternocleidomastoid tumour

Infections

History of immunisations, medications, foreign travel and pets may also help to determine diagnosis e.g. in cat-scratch disease, parasites etc. A study by Neidzielska et al found that the most common associated symptom of children with cervical lymphadenopathy was fever, occurring in 24.1% (4).

Malignancy

The history should include onset, duration and speed of growth of the LN, as this may help to

determine the likely diagnosis. For example, in HL, there is slow growth in LNs, whereas the change is more rapid in NHL (10). Duration and size of the lesion is significant because a lesion present for greater than 4 weeks has an elevated probability of being malignant in nature (12). A cohort study by S. Bozlak et al found that predictive factors for malignancy were LNs greater than 30mm, rubbery textured nodes, elevated serum CRP and LDH and increased growth in the node at follow-up (10). Position of the lymph node is also significant as supraclavicular nodes in children are usually indicative of malignancy (10). The site of the swelling, including whether it is unilateral or bilateral is also useful in determining cause.

Autoimmune Diseases

A small subset of patients with lymphadenopathy will have an autoimmune aetiology. Systemic features such as a fever persisting beyond 5 days, strawberry coloured tongue with fissuring of lips, bilateral conjunctivitis (non-purulent), angioedema with induration on the hands and feet and dysmorphic-looking skin rashes are signs of Kawasaki disease (13). SLE

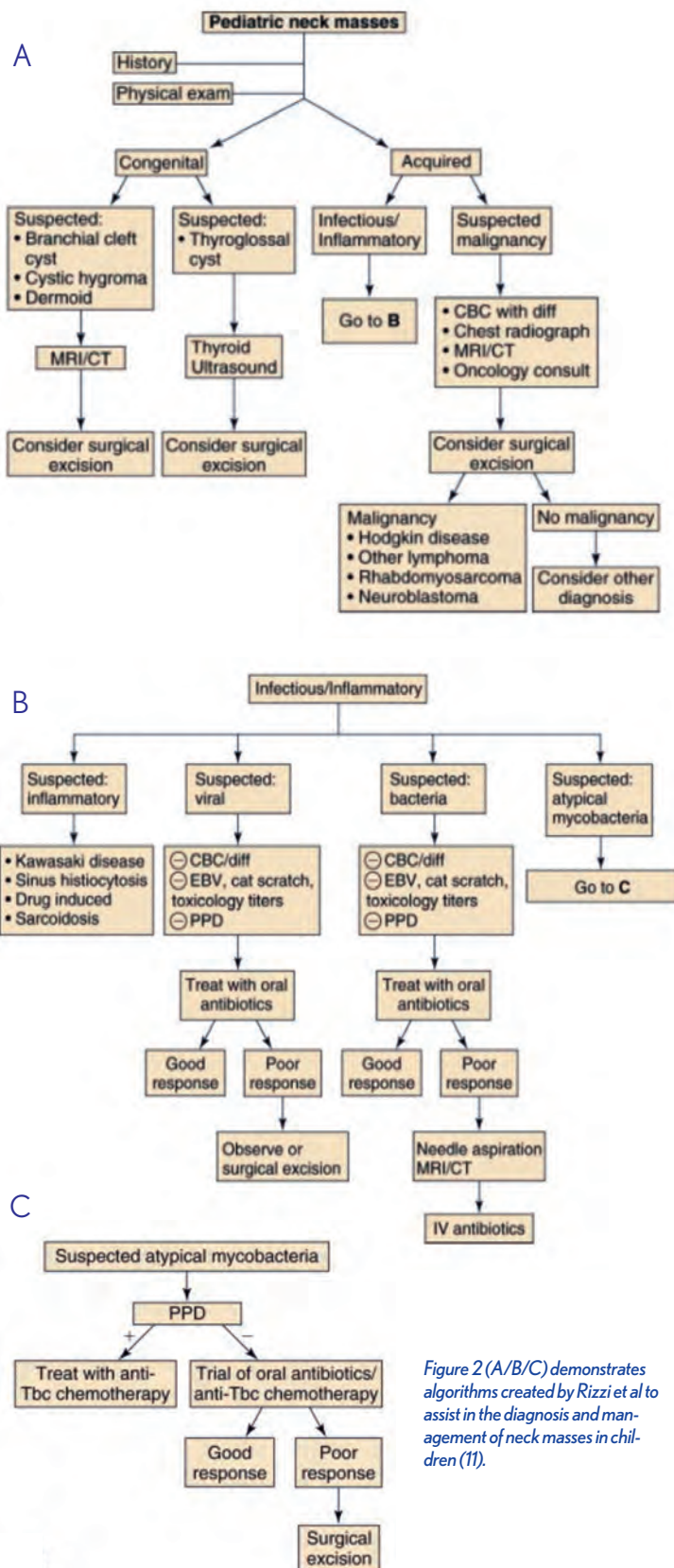


Figure 2 (A/B/C) demonstrates algorithms created by Rizzi et al to assist in the diagnosis and management of neck masses in children (11).

Cervical Lymphadenopathy in Children

often presents with the characteristic malar rash, lymphadenopathy, fever, weight loss, fatigue and occasionally Raynaud's phenomenon⁽¹⁴⁾. Joint management with the Paediatric team is essential.

Investigation and Management

Studies suggest that children with LNs measuring less than 20mm diameter, with no red flag symptoms or with obvious signs of infection can be observed for 10-14 days⁽¹⁵⁾. If there is enlargement or the node does not regress, further investigations should be done including at least the basic serum tests and appropriate imaging.

Blood Tests:

Bloods tests should include FBC, U&Es and CRP to assess for infective pathology. Trial with antibiotic therapy is then often adopted if infection markers are elevated.

Microbiology:

Specific serological tests for CMV, HIV, EBV and Bartonella may also be done based upon the presenting history. Tuberculosis (TB) testing can be performed if the child is at risk. A throat swab may also help identify infective oropharyngeal causes and help guide treatment.

Imaging:

Ultrasound is a valuable tool to assess enlarged LNs in children due to lack of radiation exposure, ease of access and simplicity to perform in trained hands. Chest X-Rays may be required to identify changes associated with diseases such as Histiocytosis, Sarcoidosis or TB⁽¹⁵⁾.

Surgery:

If after 4 weeks there is no improvement, an excisional biopsy is the next step⁽¹⁵⁾. Excisional biopsy is the gold standard as fine needle aspiration is often challenging to execute in an awake child and is frequently non-diagnostic⁽⁴⁾.



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BIDA 2018 ARM & AGM

BIDA AGM 2018

A REMINDER - WE'LL SEE YOU THERE!

The 43rd Annual General Meeting of the
British International Doctors' Association
will be held on **Sunday 14th October 2018**
at the **The Daresbury Park Hotel,**
Warrington, Cheshire WA4 4BB

Hosted by BIDA's Merseyside and Cheshire Division.



(All fully paid members are cordially invited to attend, but please note that prior notification to Central Office is required).



Congratulations!

Congratulations to Dr Sangeeta Ahuja, who has been appointed as the Consul General at St Petersburg.

She is the daughter of Dr Satish Ahuja and Late Dr Raj Kumari Ahuja from Wigan.

She graduated with a PhD from the London School of Economics and Political Science. She has held several distinguished posts in the Diplomatic service since 1998. Her current post in the Foreign office in Russia can be regarded as second only to the British ambassador based in Moscow.

Mrs Ahuja is married to Jan Hofheiz and has three children. She started her diplomatic career as a Desk officer with the Africa department. She then moved on to become a Second Secretary in Ankara between 2000 till 2003, before securing the role of the Section Head in the European Directorate. She progressed to the Polish capital as the First Consul and served as the Consul General for a brief period and remained there till 2010. She was then posted to Washington DC as the First Consul fulfilling her role in the Foreign and Commonwealth Office.

Her father, Dr Satish Ahuja is a General Practitioner in Wigan since 1970. He has been an active member of BIDA and has served as Vice President and Treasurer of BIDA in 1977 - 2003. Our compliments to the Ahuja family for this proud achievement.



Congratulations to Professor Dr Shiv Pande MBE DL JP FRCGP, who has been appointed as 'Visiting Professor' at Bolton University.

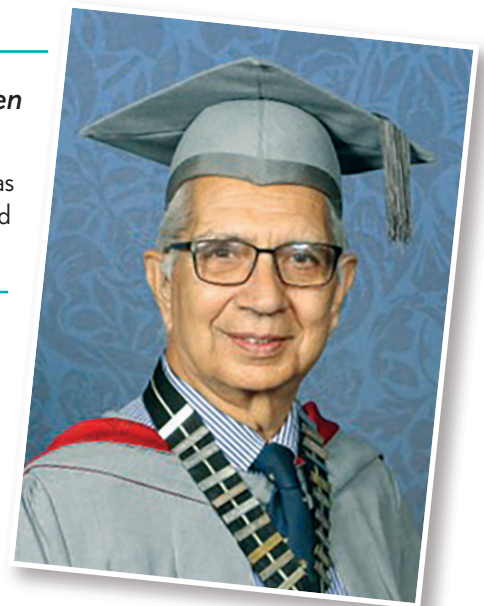
He has been a committed member of BIDA (Previously ODA) having served the organisation as an Executive officer in various capacities, including as National Chairman between 2002 and 2005.



Welcome to BIDA for Mr Buddhdev Pandya MBE, who has been appointed as the Chief officer for Corporate Affairs for BIDA.

Mr Pandya has years of experience in policies and campaigns relating to racial justice, equality and corporate governance. As Chief Officer, his role will be an advisory one in supporting the officers of BIDA.

Mr Pandya has served as Director of Policy and Governance at The British Indian Psychiatric Association. He is also the publisher of 'Gujarat UK Journal' for the Indian diaspora, and key-movers and shakers in India. He was Director of the British Association of Physicians of Indian Origin (BAPIO), a national body that he had helped to establish. He also helped to develop and became managing editor for publishing 'The Physician', its medical journal. He was also chief editor of Asian Lite, an award-winning ethnic publication.



Did you know?

Air pollution is now one of the main causes of premature death in the UK, second only to smoking.

There have been 40,000 deaths annually related to air pollution causing multiple medical conditions in both children and adults. Further evidence has linked maternal polycyclic aromatic hydrocarbons (PAH) to mental health problems in children of primary school age. Diesel exhausts are the main cause. (BMJ 2016;355:i6726)

Collecting garbage involves breathing in microbes. A Danish study finds that these become highly concentrated in the cabs of bin lorries. There are 111 times as many fungi and 7.7 times as many bacteria in the cab air of the lorry as compared to the air outside. Most of the fungi are *Penicillium* spp, and fortunately most of the bacteria are harmless. (Ann Occup Hyg 2016)



Tackling Obesity, Diabetes and Metabolic Syndrome Study Day



For Physicians, Surgeons, GPs and AHPs

Tuesday 10th July 2018 at

The Mayo Building, Salford Royal NHS Foundation Trust Stott Lane, Salford M6 8HD

8:45 to 9:00: **Welcome:** Mr Chris Brooks *Group Medical Director, Northern Alliance*
Introduction: Mr Siba Senapati *Chairman of Obesity Awareness & Support, OASIS-GB*

Session 1: Chair: Prof. Martin Gibson

9:00 to 9:25: **Current obesity epidemic and its effects on health and well-being**

Dr Akheel Syed *Consultant Endocrinologist Salford Royal NHS Foundation Trust*

9:25 to 9:50: **Obesity and Sleep Disorders: is there a relationship?**

Dr Victoria Cooper *Principal Sleep Physiologist, Salford Royal NHS Foundation Trust*

9:50 to 10:15: **Obesity and Kidneys**

Dr Smeeta Sinha *Honorary Senior Lecturer University of Manchester*

10:15 to 10:40: **Is obesity a Psychiatric Disorder?**

Dr J S Bamrah *Consultant Psychiatrist and Honorary Reader University of Manchester*

10:40 to 11:00: **Coffee Break**

Session 2: Chair: Dr Biswamohan Misra

11:00 to 11:20: **Ethnicity, Culture and Diabetes**

Dr Naveed Younis *Consultant in Diabetes/Endocrinology Manchester University NHS Foundation Trust*

11:20 to 11:40: **Obesity, Lipoproteins, Microangiopathy and the effect of Bariatric Surgery**

Dr Handrean Soran *Consultant Physician and Endocrinologist, Manchester University NHS Foundation Trust*

11:40 to 12:00: **Current innovative medical management of Obesity**

Prof John New *Professor of Medicine, Salford Royal NHS Foundation Trust*

12:00 to 12:20: **Role of surgery in tackling obesity, diabetes and metabolic syndrome**

Prof Siba Senapati *Consultant Upper GI and Bariatric Surgeon, Salford Royal Hospital*

12:20 to 12:40: **Panel Discussion / Q&A**

Panel of 2nd Session Lecturers

12:40 to 13:40: **Lunch**

Session 3: Chair: Dr Akheel Syed

13:40 to 14:05: **Tackling Diabetes – Role of General practitioner and Commissioner**

Dr Naresh Kanumilli *Diabetes Network Lead for Greater Manchester and East Cheshire*

14:05 to 14:30: **A Patient's experience of Bariatric and Metabolic Surgery**

TBC

14:30 to 14:55: **Role of gut microbiota in diabetes: can we alter it?**

Prof Andrew McBain *Professor of Microbiology University of Manchester*

14:55 to 15:20: **Public Health Interventions in the Management of Obesity**

TBC

15:20 to 16:30: **Discussions**

Prof Siba Senapati *Consultant Upper GI and Bariatric Surgeon, Salford Royal Hospital*

16:30 to 16:40: **Vote of Thanks**

Mr Jack Carney *Co-chair, OASIS-GB*

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OASIS-GB
AWARENESS ON OBESITY

 **BAPIO**
BRITISH ASSOCIATION OF PHYSICIANS IN OBESITY



Dear Editor,

Is the General Medical Council really draconian or are they fairest of all health organisations in the UK?

Performing needless operations has recently attracted a lot of judicial and media attention following the conviction of a doctor for performing needless breast surgery⁽¹⁾. The case resulted in a huge amount of money being offered to those affected⁽²⁾.

At this juncture, it is important to analyse if this conviction is an isolated incident or if the practice of performing needless operations is a common place. Is payment by results enticing organisations and individuals to perform more interventions than necessarily required? Could the number of needless surgeries be larger in procedures in which the chances of adverse outcomes are less? The three times higher rate of knee arthroscopy in one part of Scotland as compared to another⁽³⁾ and the overall higher rate of knee arthroscopies in England as compared to Scotland all show that needless surgical interventions are more common than what may be perceived⁽⁴⁾. Over time it has become both the culture and expectation that medical consultation should be followed with an investigation or intervention. The health professional has a need to both themselves and the patient to be seen to be doing something. This in addition to rewards for increased payment for increased numbers of performed procedures, can together fuel unnecessary interventions.

The author has had a difficult journey in the course of the last 15 years when attempting to highlight needless interventions. The author faced numerous investigations, was forced to resign from an NHS Trust and had his practicing privileges terminated from a private hospital for bringing to light the practice of needless surgical interventions. During this same period the author was referred to the General Medical Council on two occasions. The General Medical Council's main purpose is to protect patients. None of the complaints to the GMC were from patients, but rather were from co-working health professionals.

In addition to being investigated by the local hospital trust on multiple occasions, the author was referred to National Clinical Assessment Service (NCAS). It was assumed that an organisation like NCAS would be fair in its assessment but unfortunately this wasn't the case. As part of the assessment, 64 patients were asked to rate the author on a scale of 0 to 5 on the quality of care they received from him. In spite of the author receiving a score of 4.84 compared to the previously published average of 4.55⁽⁵⁾, the NCAS's opinion was that the author's interaction with patients was not adequate. The author believes that the NCAS does not have the right to ignore an objective opinion by patients and replace it with a subjective opinion by its assessors. If the subjective opinion of the assessors supersedes the objective opinion of the 64 patients then the exercise of requesting these patients to give their opinion is farcical. Despite questioning the nature of the NCAS report, the author accepted the offer to retrain. The retraining was described by an NCAS advisor as one of the best that the advisor had seen in his experience. However following completion of retraining, the author returned to the parent Trust to find that the same Clinical Director with whom he had been having difficulties was still in post even after a period of 9 years.

It is possible to hold a view that a person who has been at the sharp end of many investigations may not have the credibility or the authority to provide a feedback of the investigations or the investigating bodies. However such a feedback can help us move from a blame culture to a just culture.

The author also accepts that any such opinion from the one who has been investigated on numerous occasions is bound to be subjective and cannot

be purely objective as there is no scale to measure fairness. In the author's personal opinion the General Medical Council has been the most fair in its dealings as compared to the NHS Trust, the National Clinical Assessment Service (NCAS) and the Private Independent Hospital.

This personal view though subjective is important because it is generally assumed that the General Medical Council is very Draconian and punitive to doctors especially from ethnic minority backgrounds and doctors who've graduated from outside the United Kingdom. An investigation into one's practice is stressful⁽⁶⁾. There have been concerns that GMC's fitness to practice proceedings has led to increased suicides among the doctors being investigated⁽⁷⁾. The author accepts that investigations into one's practice is very stressful but equally wishes to reassure other doctors on the sharp end of investigations that the GMC seemed to be the fairest of them all.

Unconscious bias⁽⁸⁾ is universal. It can affect investigators. It is possible that the General Medical Council has been the fairest because it is more aware of unconscious bias and has taken steps to combat and avoid this bias.

The author wishes to raise the following questions as food for thought: Is plurality of thought accepted by peers even if it affects earnings? Can authorities silence whistle-blowers with the use of unwarranted investigations? Are the organisations that investigate individuals always fair or could unconscious bias affect the outcome? And finally did Paterson escape the net⁽⁹⁾ since 1996 because of unconscious racial bias. As a Caucasian did he fit the pattern of a respectable genuine doctor and would a black and ethnic minority doctor be brought to check much earlier?

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P.S. The author is willing to disclose the final NCAS report to authorities for verification of facts stated above. The author also encourages readers to visit <http://www.shirepro.co.uk/index.php> to have a greater understanding of unconscious bias.

Mr George Ampat

Consultant Orthopaedic Surgeon

OBITUARY

Dr Tasadduq Hussain

MBBS, FRCS

5th June 1930 – 28th February 2018

Tasadduq Hussain was born on June 5th 1930 to Soghra and Qurban Hussain about the time that Maharana Bhupal Singh ascended the throne in Udaipur.

He was also blessed with three younger sisters and a younger brother – Fatima, Hamida, Themida and Siraj.

Tasadduq was educated at Vidyabhavan School in Udaipur and always spoke fondly of his school days. His specialist subjects were Urdu Literature and English; he had a wide English vocabulary and a passion for Urdu poetry.

Cycling seemed to play a big part of his early life. In India in the 1940s having a cycle was a bit like having a sports car. No-one else at his school had one so he was the envy of the entire class. It was a privilege he did not squander and it seems he was almost glued to it from the age of 8 to 17. He would regularly take his small cousins on his bike and cycle around Karachi pointing out all the sights.

After leaving school Tasadduq travelled to Pakistan to visit family, but just as he arrived in 1947 the Partition of India was announced and he was unable at that time to return to Udaipur. He therefore undertook his University career in Pakistan and gained entry to Karachi Medical College qualifying as a doctor in 1957. He returned to his beloved Udaipur to take up a post in the local hospital, but when it was discovered that his degree was from Pakistan, he was told he could not practise unless he acquired a medical diploma from India or another recognised country. This was the impetus that saw him on a flight to London in May 1960. He quickly embraced the vibrant culture of his new home and embarked upon a surgical internship. He met his future wife, Sharifa Dawood, when they were both working in Wales in 1962. They were married in 1963 and had 2 children Sofia and Nasir Hussain. With his family in tow, he worked all round the United Kingdom from London to Cardiff, from Dorset to Northshields, but he finally settled in Scotland where he would remain for the rest of his adult life.

Once he had attained his professional degree in surgery he flourished in the world of orthopaedics. Very much a practical specialty, this suited him down to the ground. He was bold and unafraid to tackle difficult problems. This combination coupled with his almost limitless capacity for hard work meant that he quickly became the most experienced and capable registrar in his department and, although at that time there was still a degree of prejudice within the profession, he was so well thought of by his consultants, they supported and pushed through his application to become a consultant himself, amongst some of the first Indians in the UK to achieve this position.



He obtained his consultant post in Hairmyres Hospital, East Kilbride and this became his home and his family for the next 20 years. During these working years and beyond he forged many lasting friendships and always went the extra mile to welcome and befriend folk arriving in the UK for the first time, trying to find their feet and integrate into the local culture. He was also a great traveler and he and his wife and family roamed extensively around the world experiencing many different cultures.

Without doubt his greatest passion in the 2nd half of his life was horticulture culminating in him being featured on national TV in a programme about Britain's best gardens and he regularly won prizes in horticultural shows.

It would be a challenge for anyone to find a more generous, more selfless, industrious, egalitarian, gregarious and unique individual than Tasadduq Hussain. He sprinkled these qualities tenderly and carefully all over the world just as he sprinkled his beloved plants and flowers tenderly and carefully with water. And he cultivated and cherished not only thousands of beautiful blooms, but also his children, his grandchildren, his loyal and loving extended family and many, many friends.

He led a long and complex life but was, at heart, a simple man. And the simplest part of Tasadduq was the unconditional and instinctive love of his family and friends. And his friends were his family anyway. He was a man who would think twice about paying full price for a potted plant, but would, without a moment's hesitation, lavish time, money and effort onto anyone who asked for it, or whom he simply thought needed it. He did this, not for approval, or to build up a complex web of favours for personal gain, or to impress people. He did it simply because he was Tasadduq.

Tasadduq Hussain passed away on February 28th 2018. He is survived by his loving family: Sharifa, his wife, his 2 children, Sofia and Nasir Hussain and his five grandchildren, Catriona, Robbie, Euan, Lewis and Michael.

British International Doctors' Association Ltd

(formerly ODA)

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Chairman: Dr Chandra Kanneganti
Treasurer: Mr P K Sarkar

1st June 2018

Dear Delegate

13TH BIDA INTERNATIONAL CONGRESS - JAKARTA - 22ND & 23RD OCTOBER 2018

We are delighted to have received your booking for the BIDA International Congress being held in Indonesia on the 22nd and 23rd October 2018.

The Scientific Programme for the Congress is in the process of being put together and the programme will be CPD accredited. We would be grateful if you would inform us if you wish to participate in the Scientific Sessions, but please note that we would be unable to pay any honorarium.

If you would like to give a presentation, which should be approximately 15-20 minutes in duration, please inform the Central Office of the topic you wish to speak on. Unfortunately, we cannot guarantee that your topic will be included, as there will be presentations from speakers from Indonesia as well as representatives from BIDA Executive team.

We would appreciate receiving your reply by 31st August 2018 and look forward to your interest.

Kind Regards

Yours sincerely

Dr Sanjay Arya
Chairman, Scientific Committee

Dr Chandra Kanneganti
BIDA, Chairman

Dr Ashish Dhawan
BIDA Secretary & Convenor



BIDA FELLOWSHIP AWARDS 2018

Dear Colleagues,

As you know BIDA awards 'Fellowships' to some members who have made an outstanding contribution to the Association. These awards are made at the ARM/AGM in the Autumn and if you would like to nominate a member from your division, please do so, but kindly note that nominations are to be received no later than Friday 29th June 2018.

It would be of assistance if the nomination could be supported by a brief CV of the nominee.

I look forward to receiving your nominations.

Yours sincerely

Dr Birendra Sinha
National President - BIDA



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For BIDA news and views, issues, the latest Scientific articles, and so much more, keep in touch with us today.

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Divisional News

North Wales Division Educational Meeting

North Wales Division led by Dr Jay Nankani has been organising regular educational meetings for its members. We recently had Dr Sumit Gulati, Consultant Anaesthetist from Liverpool, who gave an illuminating talk on "Pain management & the role of Opioids". This was attended by a large number of BIDA members.

Photo (from left to right) Mr N Kaushik, Mr P Anandaram, Mr A Sinha, Dr S Gulati, and Dr J Nankani.



Nottingham and North Trent Division Barn Dance

Dr Rahul Mohan, Chairman, Nottinghamshire and Trent Division and his team organised a Barn Dance event on 24th March. It was attended by 60 members who found it really quite enjoyable and had a fun-filled evening. It was a pure Scottish touch, which was brought to Nottingham.



BIDA Sports Event 2018

National Badminton & Table Tennis Tournament

The North-East BIDA Division hosted this year's BIDA National Table Tennis and Badminton Championships at Thornaby Pavilion at Thornaby. The venue is in the outskirts of Stockton town. This year we combined the event of the two sports. We had a good attendance of around 60 players with family members, who all participated in the event.

We had representation from our executive committee: Dr Sarup Tayal (Chair), Dr Ram Singh, Dr Prathish Thakkar and myself (Viswanath YKS).

This year's winners are as follows:

National Table Tennis:

Singles **Mr Sarang Sapre** - Merseyside (Gold Medal)
Dr Prathish Thakkar - North-East (Runner Up)

Doubles **Dr Chakrapani Kalluri and Dr Vikram Narula** - North East (Gold Medal)
Dr Sunil Sapre and Sarang Sapre - Merseyside (Runner Up)

National Badminton:

Singles **Dr Chakrapani Kalluri** - North East (Gold Medal)
Dr Jaganath Chakravarthy - (Runner Up)

Doubles **Dr Jaganath Chakravarthy & Dr Chakrapani Kalluri** - North East (Gold Medal)
Dr Amit Chauhan and Dr Prathish Thakkar - North East (Runner Up)



Congratulations to the winners and thank you to all the players who participated in the games, and also to the family members. We are looking forward to receiving the trophies at BIDA's National A.G.M.

Mr Viswanath YKS North East BIDA



13th BIDA INTERNATIONAL CONGRESS JAKARTA & BALI, INDONESIA

(22nd to 23rd October 2018)

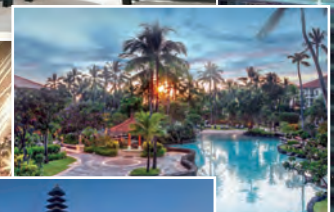
BRITISH INTERNATIONAL
DOCTORS' ASSOCIATION
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Mandarin Oriental Hotel, Jakarta



Laguna Resort and Spa, Bali

FULL PACKAGE (Congress and Touring)

Price: £ 2435.00 per person
(Twin or Double share)

£ 2945.00 per single person

£ 1935.00 per child
(in parent's room)

£2305.00 per person
(Adult, 12 years or over with extra,
based upon triple-sharing)

Price includes:

- Fully ATOL protected Holiday.
- Return International flights on scheduled airlines with departures from Manchester and London Heathrow.
- One-way Domestic flight on scheduled airlines with departures from Jakarta to Denpasar (Bali).
- Return transfers: airport – hotel – airport.
- Cultural Welcome to Indonesia at Jakarta Airport.
- Welcome Dinner and enjoy the Cultural Event.
- 3 nights' accommodation at the Mandarin Oriental (5 Star) Hotel in Jakarta.
- 2 full days Conference package at the hotel.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day one of conference.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day two of conference.

- 1 Gala Dinner with Local Beer, Soft Drinks & Juice.
- 6 nights accommodation at the Laguna Resort and Spa in Bali.
- 1 Dinner including local performance with instruments and DJ music.
- Internal flights Jakarta to Denpasar in economy class.
- Tour of Uluwatu Temple, Pandawa Beach, Kecak and Fire Dance Performance.
- Dinner included at Jimbaran Bay.
- Full day Tour, Heartland of Bali, with Lunch at Batur Lakes.
- Full day Traditional Village Sightseeing.
- Full day Ubud Town & Tanah Lot Temple and lunch at local restaurant.
- Exclusive Cruise to Lombok island with snorkelling equipment, Village tour, Unlimited Banana Boat, Semi- Submersible coral viewer, BBQ lunch, snack on the way back, 3 glasses of beverages (1 Soft Drink, 1 Beer, 1 House wine) private cruise and private beach club on the island.

CONFERENCE PACKAGE

Price: £ 1799.00 per person
(Adult, Twin or Double share)

£ 2199.00 per single room

£ 1435.00 per child
(2-11 years Sharing with 2 full
paying Adults)

£1805.00 per person
(Adult, 12 years or over with extra,
based upon triple-sharing)

Price includes:

- Fully ATOL protected Holiday.
- Return International flights on a schedule airlines with departures from Manchester and London Heathrow.
- Return transfers: airport – hotel – airport.
- Cultural Welcome to Indonesia at Jakarta Airport.
- Welcome Dinner and enjoy the Cultural Event.
- 3 nights' accommodation at the Mandarin Oriental (5 Star) Hotel in Jakarta.
- 2 full days Conference package at the hotel.
- Conference Venue available from 08.00 – 17.00 (2 Full days).
- Morning and afternoon coffee break with refreshment.
- Buffet lunch at function room.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day one of conference.
- Full day Jakarta Tour (for Spouses & Non-attendees) on day two of conference.
- 1 Gala Dinner with Local Beer, Soft Drinks & Juice.

OTHER INFORMATION

- **Currency:** Indonesian Rupiah £1 = 18343 (Approx).
- **Weather:** Sunny 30 Degrees in Jakarta and around 27 Degrees in Bali.
- **Packages are exclusive to BIDA members.**
- **Non-BIDA members** are welcome to join at a supplement of £100.00 per person.
- **For bookings and enquiries**, please contact BIDA Central Office, or call Bolton Travel on the phone numbers detailed below.
- **LIMITED AVAILABILITY!**
Closing Date for bookings:
As soon as all places are filled (first come, first served basis) or 15th March 2018 (whichever is earlier).



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TOGETHER, WE ARE STRONGER



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

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

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

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



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

We look forward to hearing from you!



www.bidaonline.co.uk