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BRITISH INTERNATIONAL DOCTORS' ASSOCIATION

Inside:

Potential solutions for long-term NHS survival.

Falls in the older population – an approach to treatable causes.

Reflections of an Elective in General Surgery.

The Dreaded Eye Exam: A quality improvement project and what to know as a non-ophthalmologist.

Rethinking the long middle of kidney care.

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NHS

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Editorial

Prof Amit Sinha FRCS (Tr&Orth). Consultant Orthopaedic Surgeon. Editor, BIDA Journal.

Prioritisation of UK medical graduates

While new legislation to prioritise UK medical graduates for speciality training will certainly help, it will not change the fact that medical student intakes outnumber training jobs by two to one. The choice now facing policymakers is clear: restore balance to the system, or allow erosion of education quality, workforce confidence, and patient care.

The government recently announced during the recent Resident doctors' strike that they have decided to withdraw plans to increase the 1000 specialty trainee places. These further imbalances the equation of the ratio between the number of qualifying doctors and future training posts.

In its Beyond Capacity report, BMA Scotland has warned that medical student numbers have increased sharply over the past decade without matching growth in teaching staff, clinical placements, training posts or employment opportunities.

The report, based on a national survey of 549 medical students across Scotland, also raised concerns that almost one third (32.3%) of respondents said they plan to leave the UK or leave medicine altogether, with 94.3% citing the current employment crisis as a contributing factor.

In the midst of these drastic changes are the International Medical Graduates who have passed their PLAB or those already working as LEDs working towards achieving higher training placements will be put in a seriously disadvantageous position. Their merit may not be recognised. This constitutes discrimination against a group of hard-working international origin doctors who have come to the UK to serve on the NHS. BIDA supports merit in all fields of competition and selection for higher training places in all specialties regardless of where they have graduated from.

Dilemma for medical students in Scotland

Since 2015, the number of medical students in Scotland has increased from 3,928 to 6,761, representing a 72 per cent rise. Current estimates suggest Scotland now has almost twice as many medical students per head of population as England – but unlike in other UK nations, these increases have largely been absorbed within existing medical schools rather than through the establishment of new institutions and without considering training capacity.

This surge in class sizes is forcing students to sit on lecture theatre floors and crowding hospital wards. This is putting educational standards under strain, with 85% of students surveyed believing there are too many medical students at their university. More than three-quarters (75.5%) of students reported reduced access to teaching and learning resources, according to the survey, while 62.6% said they had been turned away from scheduled clinical placements. Concerns about future employment were also widespread, with 99% worried about unemployment after foundation training and 97% believing current intake levels will limit access to specialty training. This rapid expansion, which was intended to strengthen the workforce, is now instead actively undermining confidence, retention, and long-term sustainability.

Articles

We have the second part of Cara Mooney's excellent account of Potential solutions for long-term survival of the NHS. The current state of the NHS is in doldrums with strikes by the Resident doctors and another one being planned by the Consultant group. The issues about pay and the lack of specialty training places puts our young doctors in jeopardy for future employment. Indeed, the NHS is on the crossroad of uncertainty of which direction it needs to take. The government is at the helm and must steer it to safety.

We do have a thought-provoking article by Harsh Sinha, a patient with long-term CKD. It's a must read for all of you. What are your thoughts? The clinical article of Eye Examination is a QI project by Dr Suepiantham is very well written. Dr Anil Kumar presents a clinical approach to plan care of treatable causes of Falls. The travels of Dr MT Hasan to Seoul National University for his elective accounts a fascinating journey into hepato-biliary surgery and Liver transplantations. The culture of having K-pop music in the background in theatre would certainly put surgeons in good mood.

"Music is life itself." Louis Armstrong, Jazz trumpeter

Prof Amit Sinha
Editor, BIDA Journal

Instructions for Authors

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

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BIDA National President's Report

Dear colleagues,

The year has started off with an irrational war in the Middle East and it seems the situation now is likely to become irreconcilable. Unfortunately, this has affected the lives of everyone in this world. Each one of us will have to accept the ripple effect with higher fuel prices and the subsequent increased cost of living. There is also the stark reality of the whole of the Middle East a no-go region for years to come. The Foreign, Commonwealth and Development Office (FCDO) advise against all travel to these countries. Many of us including me faced the distress of cancelling and finding alternative routes of travelling to avoid the Middle East airspace.

March month marked the International Women's Day. From leadership and research to education and clinical practice, women continue to play a vital role in advancing healthcare. It is the responsibility of us all to continue to work towards gender equality in medicine globally. As an organisation, we remain committed to supporting opportunities for all to thrive. I would encourage more woman to take leading roles in the executive committee of the organisation.

One of the most important events we always look forward to is the International Congress at the end of the year. Last year's scientific congress at the beautiful city of Cancun was superb. This always highlights the wealth of talent we have amongst our members in all different specialities in both Primary and Secondary care. This year the Scientific Congress is planned to take place in Cairo. However, the final decision depends on the safety issues of travel and whether the Middle East war finishes on amicable terms or not.

BIDA continues to prepare for the National Conference, which is scheduled for Friday 9th till Sunday 11th October at the Worsely Park Country Club Marriott Hotel, Manchester. Please save the date in your diary.

I attended the Health Mela to celebrate the 25th anniversary of the National Forum of Health & Wellbeing at the Foster Building, University of Central Lancashire on 11th April on the invitation of Professor Romesh Gupta, the founder of the organisation. There was an extremely enjoyable discussion on Hidden Disability at the Breakfast meeting. The hall was packed with doctors, medical students, other healthcare personal of all different disciplines and public representatives. The Health Mela seemed to have been a huge success with hundreds of people from the community attending it.

Prof Amit Sinha *FRCS (Tr&Orth)*

National President, BIDA.
Consultant Orthopaedic Surgeon.
Honorary Clinical Professor, Chester University.

Prof Amit Sinha, President BIDA attended the 25th anniversary Health Mela of the National Forum of Health & Wellbeing at the University of Central Lancashire on 11th April.

BIDA National Chairman's Report

Dear Friends,

I hope you and your loved ones are keeping well. At the time of writing this report, we are entering into another six days Industrial Action from Residents Doctors. BMA ballot for Industrial action from consultant colleagues lingers on the horizon. This all follows from break down of talks with Department of Health and their lack of efforts to address pay erosion. At a time when NHS is so stretched with long waiting times, this will further jeopardise patient care. We sincerely hope that both sides get back on negotiating table to reach a pragmatic solution.

The US and Israel's war with Iran and the instability in the Middle East remains a concern. BIDA International Congress for the same reason has been put on hold whilst we monitor the situation. We sincerely hope that this war comes to a complete end very soon.

BIDA continues with its very busy regular activities calendar with regular EC meetings, educational meetings and other sporting activities. The current edition of BIDA Journal once again covers mix of various medical and medico- political fields that ensure there is something to read for everyone.

Best wishes,

Dr Ashish Dhawan

National Chairman, BIDA.

BIDA Women Doctors' Forum Chair's Report

Dr Anita Sharma

GPwSI Gynaecology

Chair of Women's Doctors Forum BIDA

Dear Colleagues,

I am writing this to give you an update.

The GP Committee for England has formally rejected the imposed 2026 GP contract, reflecting deep concern across the profession. This stance is strongly supported by the outcome of a recent GP referendum, in which 55% GPs voted, with 99% saying no, signalling a clear mandate from the frontline.

Several key issues underpin this decision. Foremost is the requirement for universal same day urgent access. While improving access is a shared goal, the expectation that practices can meet unlimited same day demand within existing workforce constraints is widely regarded as unsafe. It places GPs under sustained pressure to triage and manage high volumes of patients rapidly, increasing the risk of clinical error and undermining continuity of care.

In addition, significant concern has been raised regarding the expansion of "Advice and Refer" pathways. These proposals are seen as eroding GPs' clinical autonomy by limiting their ability to refer patients directly to specialist services, instead introducing additional layers of system control that risks delaying appropriate care. As a result, millions of patients will not be referred to hospital and instead get specialist advice via their GPs under a drive to cut NHS waiting lists, making it harder for patients to see a hospital specialist themselves.

Funding remains a persistent and unresolved issue. Despite proposed uplifts, many practices report that rising operational costs and workload pressures far outstrip available resources, raising serious questions about the sustainability of service delivery under the new contract.

There is also broader unease linked to the wider strategic direction outlined in the National Health Service 10-year plan. Many GPs perceive this as a potential threat to the traditional partnership model, with concerns that it may accelerate a shift towards more centralised or corporate structures.

In response, GPCE has issued a clear position to NHS England and the Government: unsafe elements of the contract must be suspended, and meaningful negotiations recommenced by 30 April. Failing this, the profession has indicated that GPs may be compelled to consider further collective action.

This remains a critical juncture for general practice, with the need for a negotiated, sustainable, and safe contract more urgent than ever.

Despite these challenges, it is important to recognise the continued strength and resilience of general practice. Latest data show that GP teams are delivering over 350 million appointments per year, with the majority provided within two weeks and a significant proportion on the same day. Practices are managing increasingly complex demand while maintaining high levels of patient safety and satisfaction.

GPs continue to act as the front door to the health system, safely managing the vast majority of patient contacts without onward referral, thereby protecting secondary care capacity. This is achieved through effective triage, multidisciplinary working, and a strong commitment to continuity of care where possible.

These achievements underline a key point: general practice is already delivering high-volume, high-quality care under pressure. With the right support, realistic workload expectations, and meaningful investment, it remains well placed to meet future demand while continuing to keep patients safe.

Best wishes

Dr Anita Sharma

Chair, BIDA Women Doctors' Forum

BIDA G.P. Forum Chair's Report

Dr Rakesh Sharma MRCGP

GP Principal, Oswald Medical Centre
Chair GP Forum, British International Doctors Association
Visiting Lecturer, Institute of Medicine, University of Greater Manchester

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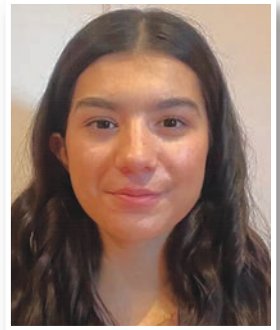
Best wishes

Dr Rakesh Sharma
Chair, BIDA G.P. Forum

Potential solutions for long-term NHS survival



Cara Mooney 6th Form Student, Withington Girl's School, Manchester

This is the 2nd part of 'What measures are essential to sustain the NHS amidst the challenges it faces', which outlines the potential solutions.

International Challenges

A variety of healthcare systems were reviewed and in the questionnaire responses (Appendix 1 - question 19), the French healthcare system was most consistently mentioned as being 'an exemplary model for high-quality, accessible, and efficient healthcare'. France operates a hybrid system that blends public healthcare with compulsory health insurance. The government funds around 70% of healthcare costs, with the remainder covered by private insurance (mutuelles) or direct patient payments . There are many strengths to the French system, such as higher quality patient care and shorter waiting times [(2)]. This is demonstrated by France having more hospital beds and doctors per person than the UK (Per 1000 people, France has 3.4 doctors versus UK having 2.9) [(3)]. This means fewer people are competing for the same number of appointments resulting in faster treatment and shorter waiting lists. In France, there is no need for GP referrals to see specialists, so specialist appointments are booked directly, which is more efficient. In the NHS, patients must see a GP before they can visit a specialist which adds an extra step and creates a bottleneck, delaying specialist care. Patients in France pay a small fee upfront (average is €6.60 with coverage), this discourages people from booking unnecessary appointments and reduces demand [(1)]. However, in the NHS because healthcare is completely free, some people book GP or A&E visits for minor issues, making waiting lists longer for serious cases. In France, patients are discharged faster after treatment as there is better home care available (there are more community nurses and home visits). Whereas in the NHS, hospitals sometimes keep patients for longer than necessary. This blocks hospital beds, which are limited, and causes longer waiting times for new patients. Nevertheless, in France, the government spends more money on healthcare per person than the UK does (12% of GDP on healthcare compared to UK's 10.9% of GDP) [(4)]. Additionally, the French healthcare system is an extremely complex one – multiple insurers and reimbursement processes make the French system more bureaucratic than the NHS.

France offers a strong alternative to the NHS's fully tax-funded model. It maintains universal access but also requires patient contributions, making it more financially sustainable. In the future, to be able to sustain itself the UK could implement small patient charges for non-essential services such as GP visits which could reduce unnecessary demand and improve NHS funding. However, applying this system to the UK would be politically controversial as it challenges the principle of 'free at the point of use' healthcare. The NHS could also learn from France's greater mix of public and private care, as this will spread out the demand so people don't have to rely only on government-funded hospitals, which could reduce waiting times whilst also keeping essential services free. The NHS currently relies on general taxation – a social health insurance model like France's could provide more stable funding.

Funding

Adequate funding is fundamental to the sustainability and effectiveness of the NHS, as it underpins every aspect of healthcare delivery. Despite what seems like eternal financial challenges, it is crucial to explore strategies that address immediate funding needs whilst also promoting long-term efficiency and quality in patient care. Some potential solutions include:

- Increasing government funding
- Prioritising healthcare spending
- Expanding patient contributions for NHS services
- Implementing new funding models

Increasing government funding

Allocating additional funds from the national budget will enable immediate alleviation of financial pressures, improve services, allow the investment in necessary infrastructure, enhance patient care and most importantly allow the NHS to have necessary funding to meet the growing demand for healthcare services.

Regarding increasing government funding, three broader options exist within this solution:

1. Increasing government borrowing
2. Diverting money from other areas of public spending to the NHS
3. Raising more revenue from taxes

Borrowing money can only be a short-term solution. Given the growing population and increased development of the country, spending needs to rise over time so we cannot simply continuously be borrowing more money as more pressures grow [(5)]. While the government may choose to temporarily increase the fiscal deficit, resulting in higher levels of debt, this strategy is evidently unsustainable as a long-term solution.

A second option is to spend more on the NHS without changing the total level of government spending, by reducing spending in other areas. To a significant degree, this is what has happened in recent decades. For example, the share of public spending has been devoted to health increased by over 9 percentage points over the same period, while the share devoted to defence spending fell by over 5 percentage points [(6)]. Spending on other areas such as housing and roads has also fallen sharply over this

time. However, similar reprioritisations in the future appear more difficult as there have already been very sharp cuts in many areas of public spending recently.

Therefore, for increasing government funding, higher taxes are most likely the main potential source of additional money for the NHS in the medium term. According to the primary research I conducted in the format of a questionnaire, 19 out of the 29 responses (66%), supported increased taxation to increase the funding towards the NHS [1]. However, despite these results, many did not agree with increasing taxes due to the 'high cost of living' and 'taxes currently being very high compared to other countries'. Additionally, while people may be willing to pay some additional tax, it is less clear that they would support tax rises of the magnitude required to fully fund the sort of increases in public spending discussed above. There is also a political risk as it is almost inevitable that the link between any tax and actual health spending will not be one-for-one. This poses risks of further loss of public faith in the government.

Prioritising healthcare spending

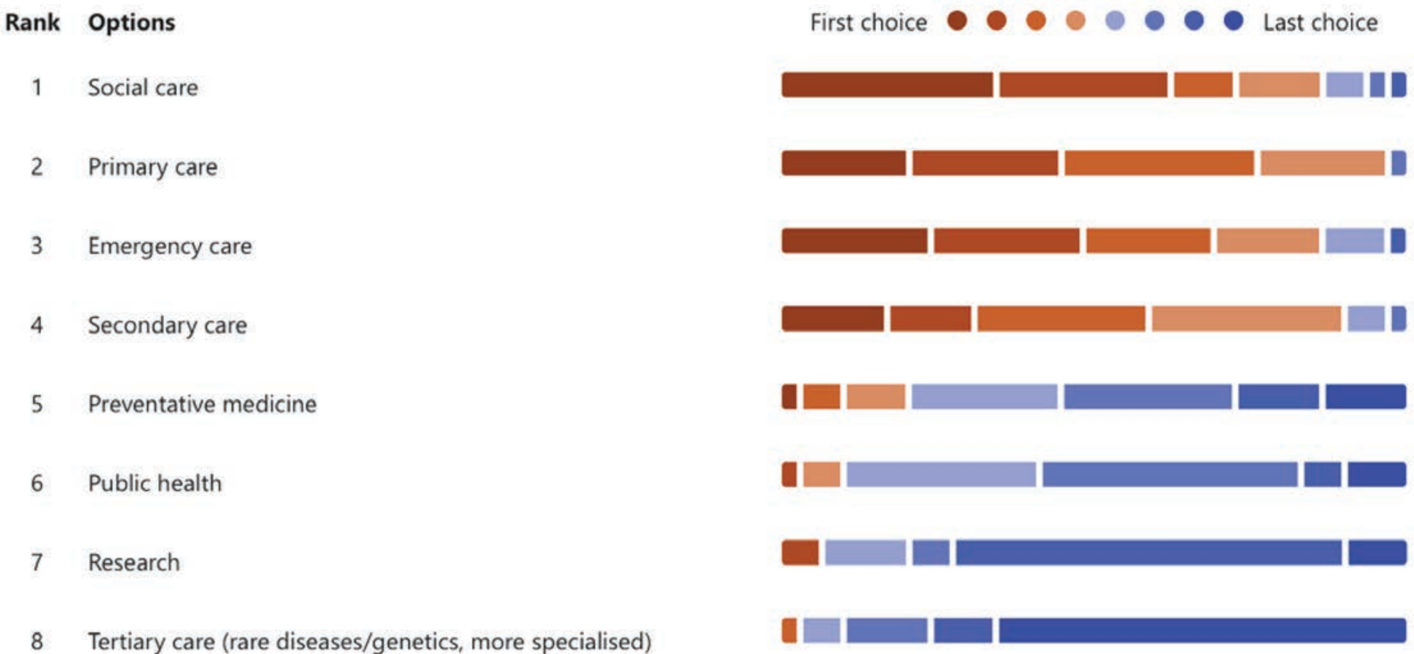
Prioritising healthcare spending consists of allocating funds strategically and focusing on areas with the greatest need such as primary care, mental health services and preventive care. According to my primary research, the majority of respondents believed that social care was under the greatest financial strain illustrating the immense necessity to improve these areas. This is shown via the graph I created (below). Shifting financial resources from hospital-centric services to primary and community care can increase preventative measures and reduce hospital admissions. By directing funds towards preventative care and early intervention, this can reduce the incidence of severe health issues leading to better patient outcomes and long-term cost savings[7]. Eliminating funding for low-value or ineffective treatments helps minimise unnecessary expenditures[8]. However, an overemphasis on financial targets may lead to underfunding in critical areas such as emergency care which could adversely affect patient safety and service uality. Limiting funding may cause restricted access to specific services or medications which may lead to public discontent, particularly if patients feel deprived of necessary care. Effective prioritisation therefore requires a balanced approach that considers cost-effectiveness and public needs to ensure the NHS remains sustainable.

Expanding patient contributions for NHS services

Another solution includes expanding the charging of patients using NHS services, as per the French model previously discussed. This could include patients paying for hospital accommodation, GP appointments and much more. This could discourage unnecessary use of services, improving efficiency. However, it risks undermining the NHS's founding principle of free healthcare at the point of use, potentially widening health inequalities and deterring patients from seeking timely treatment which could lead to worse long-term health outcomes. This course of action may be expensive to operate and could also pave the way for expanding charging for treatments, which could result in patients becoming bankrupted if they become seriously ill. To implement expanded charging for NHS services effectively, it is imperative to establish comprehensive and transparent guidelines. These guidelines should clearly delineate the services subject to charges, detail the associated costs, and specify eligibility criteria for exemptions or financial assistance programs designed to support individuals facing financial hardship. Ensuring public awareness and understanding of these policies is crucial to maintain trust and equitable access to healthcare services. For instance, the NHS Low Income Scheme offers financial support to eligible individuals, assisting with costs related to prescriptions, dental care, and other health expenses[9].

Implementing new funding models

Finally, another potential solution, again using ideas from the French system, consists of the NHS collaborating with the private sector as this can provide funding as well as expertise. Public private partnerships (PPPs) within the NHS involve collaborations where private sector entities participate in financing, constructing and managing healthcare facilities or services traditionally provided by the sector [10]. Increasing the number of these will



provide immediate funding for large scale healthcare projects without requiring upfront public expenditure, facilitating the development of modern facilities and infrastructure. They also allow for the distribution of certain risks, such as construction delays or budget overruns, to private partners, potentially reducing the financial burden on the public sector. Although PPPs are often more complex than traditional public financing methods, requiring meticulous management and oversight to ensure public interests are safeguarded. Also, the involvement of private entities in public healthcare can raise concerns about transparency and accountability, especially if profit motives are perceived to compromise patient care standards. However, this can be overcome with careful consideration and robust governance [11].

Ageing population

One key solution to help overcome the challenges of an ageing population is promoting healthy ageing. Implementing preventive measures and health promotion campaigns such as healthy ageing through lifestyle changes can significantly reduce the burden on the NHS by preventing or delaying the onset of chronic diseases. Encouraging exercise, balanced diets and early health screening improves long-term patient outcomes while reducing costly hospital admissions. For example, a study involving over 100,000 middle-aged individuals found that adherence to healthy dietary patterns increased the likelihood of reaching 70 without major chronic diseases [12]. Public health campaigns and community-based initiatives empower individuals to take control of their own health, ultimately easing pressure on NHS resources. However, these measures require sustained investment and public engagement, and their impact is gradual, rather than immediate – yet it is long lasting.

Furthermore, another solution includes increasing the investment into specialised geriatric services, including geriatric assessment units, community-based care and rehabilitation services to ensure the NHS is equipped to meet the unique age-related conditions such as dementia and frailty [13]. This could improve patient outcomes as there is improved quality of care for elderly patients, which could lead to reduced hospital admissions and transfers. However, this approach requires additional funding, time, and resources for training programs, at a time when the NHS is already facing severe workforce shortages.

Technological advancements also offer revolutionary solutions. AI driven diagnostics, wearable devices, telehealth, and remote monitoring can help reduce the need for hospital visits and detect health problems earlier, while assistive technologies can aid the elderly and allow them to live independently for longer [14]. However, high initial costs and concerns over digital literacy among older patients pose barriers to widespread adoption as there may be potential resistance from patients unfamiliar with technology. There are also concerns about data security and patient confidentiality. However, these are just initial, short-term amendable disadvantages which can be overcome and therefore technology will be an extremely advantageous tool for the NHS in the long term.

Improvement of integrated care models such as bringing together healthcare and social care services will provide comprehensive and coordinated care for older adults [15]. This would replace the fragmented system we have now, as there are separate providers for medical and social care. This will ensure that the elderly receive the correct care at the right time and could create a more seamless system, improving discharge planning, reducing the likelihood of hospital readmissions and therefore reducing hospital overcrowding [16]. However, past attempts at integration have faced financial and bureaucratic obstacles, making implementation therefore look less attractive and seemingly more complex. Additionally, increasing investment in social and community care will enable elderly patients to receive care in their homes rather than hospitals. This would ease NHS pressures and improve quality of life, however, requires substantial government funding and faces staffing shortages within the social care sector. Given the rapid rise in the elderly population, these solutions must be urgently considered A combination of approaches, rather than a single intervention, will be essential in ensuring the NHS remains sustainable.

Technology

Technology has the largest potential to transform the NHS system in most aspects, such as improving the accuracy of care, enhancing precision medicine, freeing up time for NHS staff and reducing waiting lists. The government should therefore optimise technology and usage thoroughly to allow workforce pressures to be alleviated. Potential solutions for the emerging challenges regarding technology include integrating digital health and Artificial Intelligence thus saving time. More research and funding is required to enable the development and utilisation of such systems.

The figure below shows that the majority of technologies have a positive impact on staff and that these technologies are likely to reduce administrative burden, automate repetitive tasks and streamline workflows. The technologies that demonstrate predominantly positive results include tracking/barcode scanning of drugs/tools and computerised screening of tests/records [17]. This implies that the NHS should increase the amount of technology that can integrate seamlessly into existing workflows, as these yield the greatest benefits. Moreover, the figure below does not fully take into account AI which can potentially yield even greater benefits.

If the NHS plans to invest in and implement complex systems such as EHRs and robotic-assisted surgery, they must ensure that investment in user-friendliness, training and support are also accomplished alongside this implementation to ensure that staff time is saved overall, rather than reallocated to troubleshooting new systems.

Emerging, advanced technology such as telemedicine, remote monitoring, electronic health records and the use of AI (to name a few) should also be implemented to enhance efficiency and empower patients to manage their own health. The potential uses of AI are widespread, from clinical uses to administrative support, in primary care settings, hospital settings and consist of unforeseen uses [14]. AI has already shown promise in detecting diseases like cancer earlier than human doctors. However, reliance on AI raises critical ethical concerns including job displacement, data privacy risks and accountability for errors. Therefore, AI should be used carefully and cautiously especially during the familiarisation process [18].

Most technologies reviewed showed a mixed impact on staff time

The proportion of studies reviewed, for each technology, that showed a positive impact versus no or negative impact on staff time

Negative or no impact | Positive impact

Technologies

Tracking/barcode scanning drugs/tools
Automated drug dispensing in pharmacy or wards
Computerised decision support
Computerised screening of tests and records
Automated or AI-assisted planning, eg rosters
Remote monitoring
Digital comms and display tools
3D printing or imaging
Speech recognition tools
Telemedicine
Other eg delivery drones, assistive technology
Computerised prescribing
Patient education, eg online or video
Electronic health records
Robotic-assisted surgery

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Percentage of studies

Data from a rapid review of 467 studies that assessed whether a particular technology saved health care staff time, using published and unpublished studies available in English from any country between 2010 and 2023

Technologies often promise productivity benefits, yet these are seldom released immediately. This is due to the new skills that take time to learn, meaning there is a significant lag between the introduction of a new technology establishment and demonstrable results. This means that when the government plans to implement new advancing technologies, they must be based on realistic timescales, with a distinction between the acquisition and initial embedding of a technology and the productive use of it. Also, there are a range of technologies which currently are in place in the NHS but aren't being used to their full productive potential. A greater focus on optimising these could generate near-term productivity gains. For example, modernising

outdated IT systems would immensely improve efficiency, reduce administrative burdens and enhance patient care. Integrated digital records would allow seamless communication between hospitals and primary care establishments. However, large-scale updates require significant investment, and past NHS IT projects have faced delays and cost overruns. Additionally, staff need time to train and adapt, meaning productivity may decline before it improves, and this may temporarily increase workloads. To successfully implement this solution, a phased and strategic approach is essential. Staff training should be prioritised, and this will allow for long-term efficiency and productivity.

To improve cyber and data security whilst using these advanced softwares, dedicated strict data protection policies must be implemented that comply with GDPR and NHS digital security standards. Ensuring secure storage and access controls will prevent breaches of sensitive patient data [19]. Establishing these measures requires significant investment in infrastructure, cyber-security training and ongoing system updates which can be costly and time-consuming. Overly rigid security protocols may create inefficiencies, slowing down data access for healthcare professionals and potentially delaying patient care. Striking a balance between robust security and operational efficiency is essential for successful implementation. In some cases, this activity can also be delegated to the private sector.

Staffing

No single solution will solve the NHS staffing crisis. Improving staff working conditions will take time and effort across the health and care system, at all levels of care. A combination of long-term workforce planning, improved data collection and analysis, developed recruitment and training strategies, implementing the use of advanced technology and increasing the health and wellbeing services for staff are all essential14. However, it is essential to carefully evaluate potential solutions to determine which options will be most constructive in the future.

The first step to solving the staffing crisis will be improving data collection and analysis on staff movement and attrition in health and social care. Having a clear understanding of why staff leave, where they go, and what would encourage retention is crucial to allowing the potential solutions and improvements to NHS staffing be impactful. The fragmented makeup of the social care sector, with varying security of relationship between employer and employee makes it difficult to interrogate reasons for staff movement. The UK Government's response to the Health and Social Care Committee's burnout inquiry acknowledges this, proposing an extended NHS staff survey to include social care and standardise wellbeing scores. However, primary care should be included as well [20].

Secondly, an additional proposition is implementing more environments in the workplace which protect and encourage the wellbeing of staff. This enhances working conditions to attract and retain healthcare professionals. For NHS staff, flexible working arrangements typically require staff being flexible to fit in with the NHS's needs, with little flexibility in return from the organisation to meet the staff's own needs. When staff are expected to give discretionary effort but don't receive the same adjustments in return, it can lead to more staff vacancies. Successful governments have recognised that flexible working leads to higher levels of job satisfaction, attracts people to an organisation and enables people to fit work alongside other interests. This allows them to have an overall higher quality of life, so they are more likely to work to their full potential, remain in their roles longer, and contribute more effectively to the organisation's success [21]. Therefore, the government should mandate the NHS to introduce standards for facilities, working conditions and work scheduling across the system. All staff should have adequate spaces and time for breaks, rest and sleep, along with access to lockers, bathrooms and nutritious food. Employers should receive funding to meet these standards. Work schedules should be based on realistic forecasting, allowing safe shift swapping, sufficient breaks, compliance with the Working Time Directive, considering fatigue and involving staff with knowledge of the speciality to consider the demands that will be placed on them.

Although NHS mental health and wellbeing hubs were established in response to the pressures of the COVID-19 pandemic, they were later evolved to address systemic issues, including burnout, suicide risk, workforce wellbeing and turnover. The hubs played an important role in the NHS retention rates and also led to improvements in patient care, showing the direct positive correlation of improving staff conditions on the NHS system. However, the funding for these hubs ended on 31st March 2023 [21]. Therefore, the government could reintroduce the ring-fence around funding for evidence-based mental health and wellbeing services for NHS staff across England and commit to it continuing in the long term. This would provide vital, long-term support for staff. Although, financial constraints make long-term funding commitments difficult and prioritising these services could divert resources from other critical areas which have a direct impact on a patient's care. Another weakness is that without structural changes to address underlying workplace pressures, such as excessive workloads and poor staffing levels, wellbeing initiatives alone may only offer temporary relief. For lasting impact, funding must be paired with structural reforms to create a truly supportive working environment [22].

Another solution to reduce staff shortages is increasing the recruitment and training of NHS staff. Targeted recruitment campaigns should be implemented which are not only attractive to employees but also works to recruit and retain staff. NHS employers suggest target areas for focus for employing organisations, such as encouraging flexibility and supporting new starters; however, there is a lack of research on what is proven to keep people in post. This could also be overcome by increasing medical schools' capacity by establishing new schools or expanding existing ones in order to train more doctors to help meet the growing demand. The NHS is already in the process of implementing this as the NHS has called for the government to double the number of medical school places by 2030. There are also requests to double the number of adult nursing places by the end of the decade. This will create a more sustainable supply of NHS staff, reduce the number of vacancies and reduce the reliance on international recruitment. Specifically, this can address regional shortages as doctors can be trained locally, in areas with a growing demand for medical staff. However, each medical student costs the NHS around £230,000 to train, so the NHS will have to reallocate its funding [23]. The training of a doctor also takes at least 10 years, so this won't solve immediate

shortages, but will be a longer-term solution. This will not increase retention rates and still poses the risk of trained staff leaving for better paid or less demanding jobs.

Financial incentives consisting of pay, taxation and pensions must be optimised but do not exonerate the need to optimise working conditions. To increase a sense of commitment, engagement and those being appropriately valued at work, improving pay for the NHS staff is a unique lever that only the government has. The government should ensure that NHS staff are appropriately reimbursed for their skills, time commitment, expertise and contribution. Closer attention should be paid to the impact of inflation and increased cost of living on staff, and to levels of pay across the NHS and how they compare with other sectors to ensure that a career in the NHS remains attractive [20]. This solution could also decrease the amount of NHS staff to private healthcare or international opportunities. However, this solution does require sustained government investment, and with NHS budgets already stretched, higher wages may divert funds from frontline care, exacerbating existing financial pressures. Additionally, pay rises can improve short term morale and satisfaction but don't address underlying issues, such as work-load, burnout, and career progression. So, there is a risk that staff may still continue to leave. Therefore, increasing pay must be part of a broader strategy not a stand-alone fix.

While the NHS Long Term Workforce Plan was a crucial step forward in setting workforce targets [20], it provided limited strategies for retaining staff, improving working conditions and tackling burnout [24]. Without retention measures, recruitment alone may not be enough to sustain the NHS workforce in the years to come.

Ultimately, taking the time to care for the carers in all health and social care settings will improve productivity and staff retention as well as provide safer care. Staff wellbeing primarily needs to be improved so that productivity, staff retention, safer care and therefore attractiveness to the job will all increase [25]. This can be achieved through all different levels, such as on a small scale where doctors can be encouraged to talk about their day with other professionals so they feel as if they have someone to talk to and offload their troubles to as even these small acts will help reduce some of their pressure, which can lead to less people leaving the profession and decrease the stress-related or illness absences among those who just find it too much. This is also achievable on a larger scale, where the government can be held accountable and take multiple actions to ensure the staff are supported through better working conditions so they can remain resilient and motivated, resulting in an effective and sustainable NHS for future generations.

Conclusion

To conclude, after thoroughly researching the issues which have the potential to make the NHS less sustainable in the future, it is demonstrated that with an ageing population, advancing technology, financial pressures and a staffing crisis this is an increasingly complex topic. The NHS has the potential to remain sustainable but requires compromises and implementation of certain measures. It is clear that no single solution will be enough to secure the NHS's future. I believe that funding is the key issue which needs to be primarily addressed, perhaps as discussed via the French model, as funding underpins many of the other challenges and essential measures.

Government funding should better prioritise NHS spending and focus on improving preventative measures and patient education which will decrease the burden and severity presenting to the NHS. In the long term, the NHS can use this to enable investments into Artificial Intelligence and advances in technology which will help to further improve efficiency and streamline care. This will all enable and maintain the sustainability of the NHS in the future. The size of the NHS means we have a unique opportunity to bring significant gains to the overall system.

Ultimately the NHS is more than just a healthcare system for Britain, we are very fortunate to have this important system and should do our very best to continue to provide accessible high-quality care for our future generations.

About Cara Mooney

Cara Mooney is a Year 12 student currently studying A Levels in Maths, Biology, Chemistry, and Further Maths. With a strong ambition to pursue a career in medicine, she has a keen interest in the healthcare system and its future. Her publication explores the essential measures needed to sustain the NHS amid its current challenges, reflecting both her academic focus and passion for improving patient care in the UK.

Appendix 1: Primary Research

Please follow the link below for the Questionnaire on Financial Challenges in sustaining the NHS which informed this article:
**https://forms.office.com/Pages/ResponsePage.aspx?id=
MytDbWIC80m18AhJSXd7QjootaPh0zhAuuSJkTOKBshUOE04UkFJQ0g4VjlPT0VURTdJWlo5T0JJRi4u**

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From the Science Desk (1)

Concepts of Exercises

1. A systematic study from China with more than 1500 participants found that low-middle intensity aerobic exercise was most effective at lowering systolic blood pressures with significant improvements in triglycerides, high-density lipoprotein, low density lipoprotein, and BMI among tested exercise strategies in young to middle-aged adults with prehypertension or hyper tension[1].
2. A RCT from Canada revealed that 12 weeks of HIIT (High intensity interval training), MICT (Moderate to vigorous continuous training), and NW (Nordic walking) had positive effects on depression, functional capabilities, and quality of life in patients with coronary artery disease[2].
3. A systematic review of 10 studies also confirmed that Nordic Walking was associated with the most improvement in functional capacity compared with MICT, HIIT, and home-based cardiac rehabilitation among patients with coronary artery disease[3].
4. A meta-analysis of 20 studies with more than 1800 patients found that, compared with the control groups, exercise was associated with significant improvements in balancing ability, walking ability, and cognitive function in patients with a history of stroke. This led to a significant improvement in quality of life among these patients. Exercise programs > 3 months in duration were also associated with improvement of depressive symptoms[4].
5. A prospective study followed the results of more than 116,000 US adults for 30 years. The US Department of Health and Human Services Physical Activity Guidelines advise Americans to perform a minimum of 150-300 min a week of moderate exercise or 75-150 min a week of vigorous exercise, or an equivalent combination of both[5]. The researchers found that individuals who completed twice the currently recommended range of moderate or vigorous physical activity weekly, or an equivalent combination of both, had the lowest long-term risk for mortality. (Medscape)

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Re-thinking the long middle of kidney care

Harsh Sinha
Person living with chronic kidney disease

Author's Perspective

For close to twenty-five years, I have lived with chronic kidney disease across multiple health systems – in Dubai, Singapore, India, and, for the past five years, within the UK's NHS. Dialysis has not yet been required, although I am on the active transplant list. Now in my mid-seventies, and of South Asian origin – a group at higher risk of kidney disease – this experience has offered a longitudinal view of how kidney care is structured and delivered.

This article reflects that lived experience, focusing on what the system does well, what it overlooks, and where a reframing could meaningfully influence outcomes and lived experience.

The two familiar phases of kidney care

Kidney care is largely organised around two recognised phases.

The first, and most developed, is therapy. This phase begins when kidney function has declined to the point where renal replacement therapy – dialysis or transplantation – becomes imminent. It is highly visible, specialist-led, and supported by substantial clinical infrastructure.

The second is prevention. This focuses on identifying and managing risk factors such as hypertension, diabetes, and obesity to reduce the likelihood of kidney disease developing or worsening. While conceptually important, prevention remains variably implemented and comparatively under-resourced.

In practice, prevention often functions as an adjunct to a therapy-centric model rather than as an equal pillar of care, with most attention and resources concentrated downstream.

Between these two phases lies a prolonged period that is less clearly defined.

The long middle

Between prevention and therapy sits a long, largely unstructured phase of care. This period often begins when kidney deterioration is first detected – frequently through routine blood tests – and can extend for two decades or more before renal replacement therapy is required.

Kidney damage progresses quietly, without perceptible symptoms. Day-to-day life often feels normal, creating the impression that little is changing. [1]

This silence has consequences. For individuals, it reduces urgency. For the system, it normalises a model of observation rather than intervention. "Watchful waiting" becomes the default.

Referral to nephrology typically occurs part-way through this period. Even then, care may remain focused on monitoring change rather than actively influencing its trajectory.

Positioned between upstream prevention and downstream therapy, this long middle is where most people with chronic kidney disease live – yet where care is least explicitly structured.

Active Preservation: defining the phase

This prolonged period can be understood as a distinct phase of care: Active Preservation.

Active Preservation begins at first detection of kidney deterioration and continues until renal replacement therapy is introduced. Its purpose is to slow progression and preserve kidney function, independence, and quality of life for as long as possible.

This is not a passive phase. It requires intent, structure, and sustained engagement.

It represents a shift from predominantly downstream management of failure to earlier, upstream influence on disease trajectory.

The three coordinated levers of Active Preservation

In practice, Active Preservation operates through three coordinated, patient-centred levers:

- Medicines, which manage underlying conditions and modulate risk
- Diet, which directly influences the metabolic load on compromised kidneys
- Lifestyle, including physical activity, weight management, and avoidance of harmful exposures

These levers are interdependent, with effects that are often multiplicative rather than additive.

Education is an enabling function – supporting individuals to understand, implement, and sustain these interventions in daily life.

Framed this way, Active Preservation is not something delivered to patients, but something enacted with them.

Why medicines alone are not enough

Medicines play an essential role in slowing progression by controlling underlying conditions.[2] However, they act indirectly – modifying factors that influence kidney function rather than acting on the damaged kidneys themselves.

Diet, by contrast, interacts directly with compromised kidneys on a daily basis. What is consumed can either reduce physiological burden or accelerate decline.

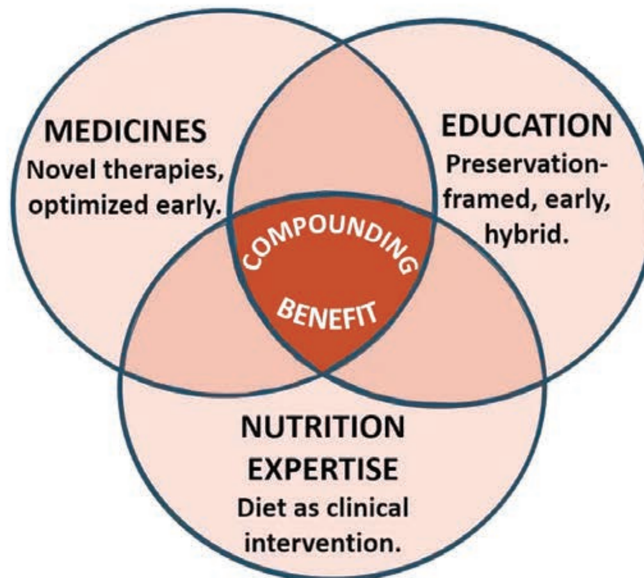
Nutritional management in chronic kidney disease is complex, stage-dependent, and requires individualisation based on biochemical and clinical parameters.[3] Yet many people continue to follow generic dietary advice that may not be appropriate for their condition.

The Unstructured Long Middle

PREDICTION	ACTIVE PRESERVATION ~20 – 25 YEARS	THERAPY
At-risk population	Population living with kidney disease	Dialysis or transplant
Stage	1 2 3a: 3.95m; 3b 4: 3.25m*; total 7.2m*	5: 0.07m

Kidney Care UK, January 2026

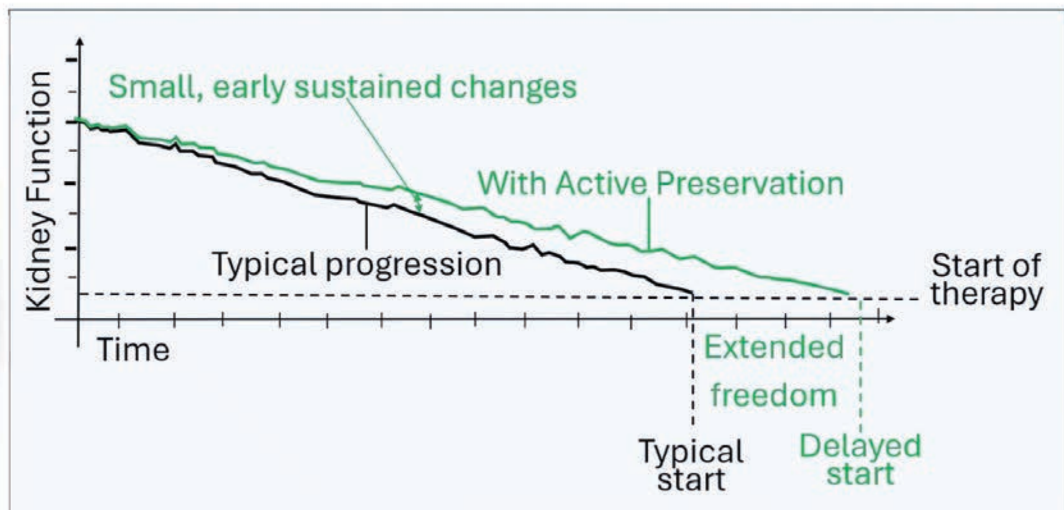
Active Preservation: 3 levers



- Medicines do not act in isolation.
- Their effect is amplified or blunted by diet and behaviours.

- If one leg is underdeveloped, the compounding benefit is lost.

Trajectory is the Strategy



Recentring the role of diet and the dietitian

Given its direct and continuous impact, diet should be central to Active Preservation. In practice, however, dietetic input is often limited to general advice or intermittent consultation.

If diet is disease-modifying, it should be treated with the same rigour as medication — prescribed, monitored, and adjusted over time.

This requires dietitians to function as integral members of the care team, with continuity and accountability aligned to outcomes.

Quantifying the opportunity within the long middle

The potential impact of Active Preservation is best understood in terms of trajectory rather than endpoints.

Even modest delays in progression to dialysis, when applied across large populations, translate into meaningful reductions in healthcare demand and cost. Given the scale of early-stage chronic kidney disease, small shifts in the rate of decline can have disproportionate system-level effects.

Current provision of renal dietetic services in the UK is limited, constraining the ability to deliver continuous, individualised dietary management during this phase. [6]

If a portion of the downstream costs associated with dialysis were deferred through delayed progression, this could create head-room for reinvestment in upstream care – including a substantial expansion of dietetic capacity.

The principle is straightforward: small, sustained changes in trajectory can release resources to support preservation at scale.

The problem of silence

A defining feature of this phase is the absence of symptoms. Kidney damage produces no immediate discomfort to prompt behavioural change. [1]

This silence reinforces inaction – both for individuals and within the system. Seemingly benign choices, repeated over years, can meaningfully influence progression.

Preservation must therefore be actively supported, structured, and sustained.

Preservation rather than preparation

Much of what is currently described as patient education is implicitly framed as preparation for therapy.

Reframing education around preservation alters this dynamic. It aligns with present priorities – maintaining independence and slowing progression – rather than focusing primarily on future treatment.

A reframed journey

If the journey of kidney care were redrawn, prevention and therapy would remain essential anchors.

Between them, Active Preservation would be recognised as a long, purposeful phase – one that actively influences trajectory and extends meaningful autonomy.

Kidney disease may not be reversible, but its progression is modifiable. [2]

If this phase remains undefined, the system will continue to manage failure downstream rather than preserve function upstream.

Box 1. Illustrative scenario: economic impact of delayed dialysis

- Early-stage CKD population (UK): ~4 million [4]
- Assumed progression subgroup: 1% (40,000 individuals)
- Annual progression to dialysis: ~2,000 individuals
- Estimated annual dialysis cost per patient: ~£30,000–£35,000 [5]

Scenario:

If dialysis initiation is delayed by 1 year:

- Deferred annual cost ≈ £60–70 million

Implication:

Even partial reinvestment could support a substantial expansion of dietetic capacity.

Figures are illustrative and intended to demonstrate order of magnitude.

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The dreaded Eye Exam

A quality improvement project and what to know as a non-ophthalmologist

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QI Project supervised by: **Dr Natalie Beveridge** (Acute Medicine Consultant) Whiston Hospital, Mersey and West Lancashire NHS Trust
Dr Magda Nasher (Acute Medicine Consultant) Whiston Hospital, Mersey and West Lancashire NHS Trust

Background

Headache and hypertension are two of the most frequent referrals in Acute Medical Units (AMUs) and Emergency Departments. NICE guidelines are clear that fundoscopy must be performed as part of headache and hypertension assessments [1,2]. Optic disc oedema and retinal haemorrhages in these presentations are "red flags" for serious intracranial pathology and accelerated (malignant) hypertension [1,2]. Despite this, fundoscopy is underperformed [3,4]. Reported barriers include limited confidence, lack of working equipment, and competing clinical priorities. Improving access to equipment and enhancing clinician confidence were therefore identified as key priorities to improve patient safety in our AMU.

Aim

To increase performance of fundoscopy for headache and hypertension patients at Whiston Hospital AMU.

Methods and PDSA cycles

A baseline review of medical records was conducted using coded data of all patients discharged with a primary diagnosis of headache or hypertension over a 12-month period. Plan-Do-Study-Act (PDSA) cycles were implemented.

An initial AMU clinician survey explored clinicians' confidence, self-reported practice, and barriers to fundoscopy. Interventions were planned based on key themes identified from survey results.

PDSA cycle 1: A new panoptic ophthalmoscope was introduced as a tool that makes fundus visualisation easier. Additionally, two wall-mounted ophthalmoscopes were installed to improve equipment access.

PDSA cycle 2: A practical teaching session on how to perform fundoscopy using the new equipment took place to improve skill and confidence.

PDSA cycle 3: A knowledge-based teaching session took place to improve awareness of fundoscopy indications, retinal pathologies and management pathways.

A follow-up survey was distributed after the above cycles to re-assess confidence, self-reported practice, and perceived impact. Fundoscopy performance data was collected on monthly basis over six months from PDSA cycle 1 to 3.

Results

A total of 337 headache patients and 156 hypertension patients attended AMU over a 12-month period. Baseline of 20% and 28% of headache and hypertension patients had their fundi examined, respectively. In the initial clinician survey (33 respondents, includes all grades from FY to consultant), 15% said they 'always' or 'most of the time' performed fundoscopy for headache patients; while 36% said they did for hypertension patients. Key barriers reported included lack of equipment, limited confidence using ophthalmoscopes, and uncertainty about abnormal findings.

After completion of three PDSA cycles, performance of fundoscopy increased to 30% (+10%) for headache patients and 51% (+23%) for hypertension patients. Repeat survey (22 respondents) found that 90% of AMU clinicians have used the new panoptic ophthalmoscope and gave it positive feedback, while 56% have attended teaching related to eye examination and found it very helpful. The percentage of clinicians who reported performing fundoscopy 'always' or 'most of the time' increased to 77% for both headache and hypertension.

Conclusion

This project highlights that simple, targeted interventions – ensuring accessible equipment and regular training – can meaningfully improve the uptake of an underused but critical clinical skill. However, sustainability was challenged by frequent staff rotation, typical of AMU settings. According to the Diffusion of Innovation Theory, successful adoption of new clinical behaviours requires them to be perceived as advantageous, compatible with existing workflows, and easy to implement [6]. Incorporating fundoscopy teaching into AMU staff induction and maintaining visible, accessible equipment are likely to enhance long-term adherence.

Is Fundoscopy really that important? A patient case:

A 44-year-old woman presented to A&E with two-day history of moderate unilateral headache described as "throbbing" and "pulsating" sensation. No other symptoms. Normal observations, bloods and neurological exam. Patient was discharged.

Patient returned to A&E one week later due to persisting headache. No new symptoms. A&E doctor performed fundoscopy this time and found unilateral optic disc swelling. Urgent CT head and orbits found an orbital cavernous haemangioma. Patient was referred to ophthalmology and listed for surgery.

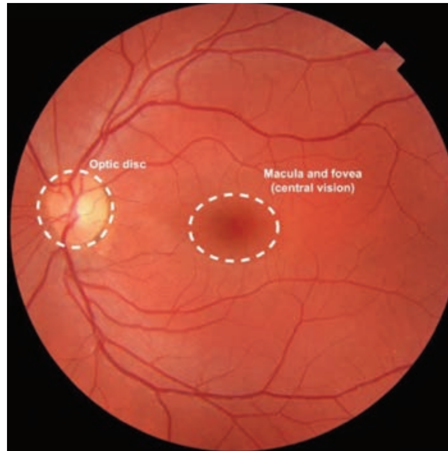
Orbital cavernous haemangiomas are the most common benign orbital tumours in adults, most common in middle-aged women [5]. Delayed treatment can mean permanent vision loss.

Tips for Fundoscopy

1. **Make it easy for yourself:** Dark room, dilate the eyes (e.g. tropicamide 0.5% 1-2 drops in each eye), patient should look at far point (not at you to avoid pupil constriction). Approach patient from 45 degrees temporally. You will need to get closer to the patient's face than you probably think!
2. **What to look for:** Optic disc is located nasally (why you should approach temporally). Trace the blood vessels. A simple "disc seen, margins clear, no haemorrhage" note shows appropriate assessment.
3. **Trouble shoot:** If you wear glasses, keep your glasses on and keep the ophthalmoscope lens power on zero. If patient is very near- or far-sighted and you struggle to focus the image, adjust ophthalmoscope power to the power of the patient's glasses (e.g. for myopic patient with prescription of -4.00, adjust ophthalmoscope power to –4 or closest value).
4. **A helpful tool GPs, A&E and medical doctors may like:** The Arclight is a very small, portable 2-in-1 ophthalmoscope and otoscope. Affordable and far easier than traditional tools for examining the fundi and ears. See ***arclightprojectshop.co.uk***. (The author has no affiliation with Arclight).

Ophthalmoscopy:

The examiner must get close to the patient's face in order to get focused view. Hold the ophthalmoscope in your left hand to examine the left eye, the right hand for the right eye. Image credit: Richard Leung, published in Community Eye Health Journal Vol.19 No.57 March 2006.



Normal fundus image of left eye

Key structures labelled.

Image adapted from Mikael Haggstrom via WikiMedia Commons.

The Arclight

Read more about how to use the Arclight on https://www.geekymedics.com/an-introduction-to-the-arclight/.

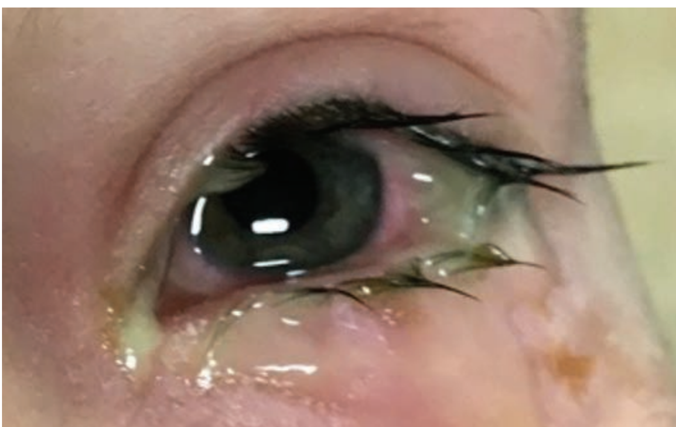
Image credit: https://arclightprojectshop.co.uk/products/arclight?srsltid=AfmBOoqtIlhuksErDZZVF52SAmkax76tzJBM2pIUFxvlpcswkPV34Hlz

Eye presentations in A&E and GP

"My eye's red, itchy, discharging... (+/- mild pain)"

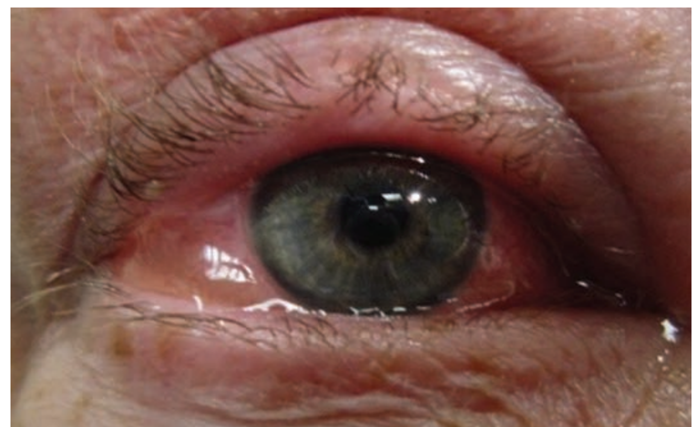
What is the predominant symptom?

- Thick/purulent discharge > Bacterial. Tx: antibiotics, swab +/- refer to ophthalmology for follow-up.
- Watery discharge > Viral. Tx: artificial tears.
- Itch > Allergic. Tx: allergen avoidance, cold compression, cautious use of topical anti-histamines.



Bacterial Conjunctivitis

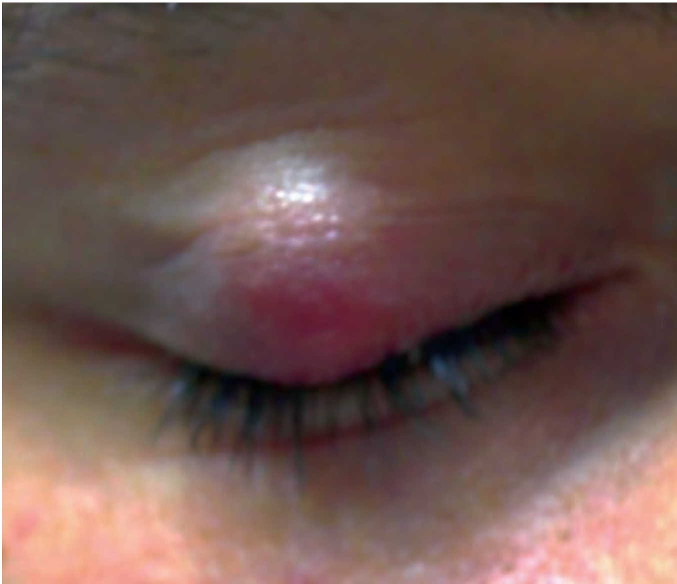
Image credit: Gzzz via WikiMedia Commons.



Allergic conjunctivitis with conjunctival oedema

Image credit: James Heilmann MD via WikiMedia Commons.

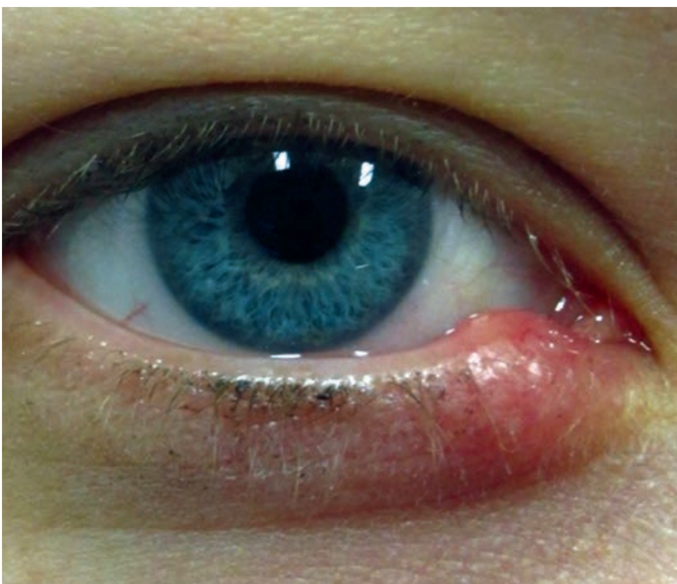
Eyelid lump: Chalazion vs Stye



Chalazion

Image credit: Poupig via WikiMedia Commons.

- Blocked oil gland.
- Hard, often painless lump.
- Differentiating feature O/E: Can appreciate gap between location of lump and eyelid margin.
- Tx: Warm compress and lid massage (usually takes 4-6+ weeks to resolve if diligent). If persists, may be candidate for steroid injection or surgery.

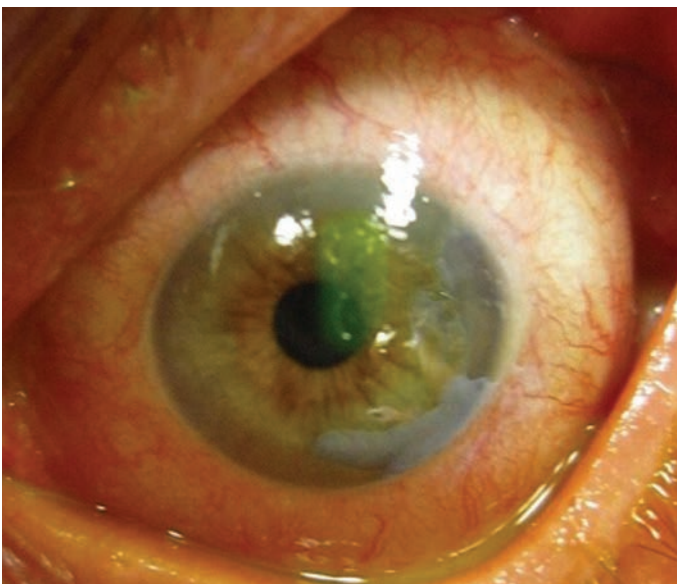


Stye

Image credit: James Heilmann MD via WikiMedia Commons.

- Blocked oil gland at eyelid margin that's infected.
- Painful.
- Differentiating feature O/E: Lump located at eyelid margin. Can appreciate a "head"/punctum of the lump.
- Tx: OTC solutions, antibiotics.

Was hit in the eye, now feels very sore +/- photophobia +/- red eye



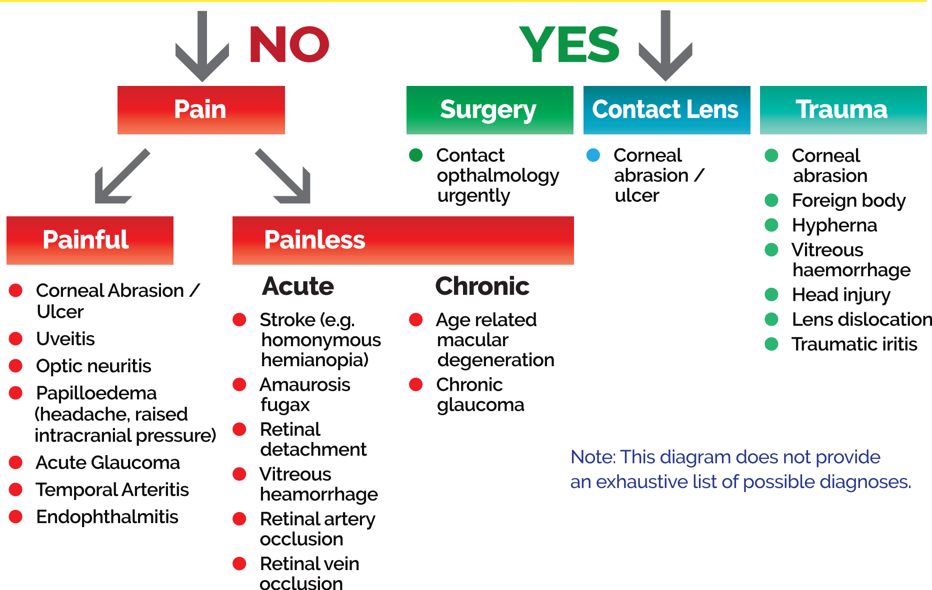
Working diagnosis: Corneal abrasion

- Document visual acuity and visual field.
- Examine cornea surface with fluorescein (1-2 drops per eye) under blue light. Evert upper and lower eyelids to ensure no foreign body remaining. Abrasions in the shape of lines are particularly concerning for foreign body trapped under eyelids.
- Tx: cover with topical antibiotics +/- artificial tears.
- Most will heal within 24-72hr. May refer to ophthalmology for follow up to ensure complete healing.

Cornea abrasion stained green with fluorescein

Image credit: James Heilmann MD via WikiMedia Commons.

Differential diagnoses for vision loss



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Take-home message:

1. Do fundoscopy on everyone presenting with headache or hypertension.
2. Key finding not to miss is optic disc oedema / papilledema.
3. Teaching is an effective intervention that a doctor at any level can initiate to have a meaningful impact on patient safety.

Would the Gulf War affect drug supply to Europe?

Towards the end of the last century, in the wake of globalisation, most of the chemical plants for producing active pharmaceutical ingredients were moved to countries such as China and India, where labour costs were lower and environmental protections were less stringent than those required in the West. What Europe did not realise until now that apart from rise of prices for fuel and gas there is a risk of short supply of medicines if the Gulf war carries on for several more months.

Many of the most common active ingredients are produced from petrochemical precursors extracted in Persian Gulf countries, which refine them and then send them by ship through the Strait of Hormuz to the chemical plants in India and China. Paracetamol, for example, is produced starting from phenol – itself derived from cumene, which has petrochemical origins – which is converted into para-amino-phenol and then acetylated. Metformin, the world's most prescribed type 2 diabetes drug, relies on dicyandiamide, which in turn is derived from natural gas derivatives. Antibiotics like amoxicillin and ciprofloxacin require methanol, acetone, and dichloromethane as solvents in their extraction and crystallization processes. Oncology and biologic drugs rely on an energy-intensive cold chain and packaging made of polyethylene, polypropylene, or PET — all derived from naphtha.

India, particularly in its three major pharmaceutical industrial districts of Mumbai, Chennai, and Hyderabad, produces most of the medicines destined for low- and middle-income countries, as well as 20% of all generic drugs worldwide. To do so, it imports $4.35 billion worth of active pharmaceutical ingredients every year, three quarters of them from China. But the critical precursors that Chinese and Indian industries need to synthesize those active ingredients – methanol and ethylene glycol – depend largely on the Strait of Hormuz.

The system has about 2-3 months of buffer, but if the conflict continues, the cost of packaging, transportation, and insurance will also be felt at the pharmacy, not just at the petrol pump. *(Univadis Italy, Medscape Network).*

Falls in the Older Population

An approach to treatable causes

Dr Anil Kumar Consultant Physician & Geriatrician at University Hospitals of North Midland, Stafford, England.
& Honorary Senior Academic Fellow, Keele Medical School, England.

Falls are very common presentation in the older adults for both primary care and secondary care. Traditionally, the older population in the western world is defined as 65 years and over, which is linked to the retirement age. However, those with underlying health conditions could be vulnerable to falls even when not traditionally old.

A Fall[1] is defined as an unexpected event in which the participants come to rest on the ground, floor, or lower level.

There are treatable and non-treatable causes of Falls. In this article, focus will be on clinical approach to falls, including management of treatable causes. This will also touch on deprescribing and medicine optimisation.

Fall – why it matters?

Falls can occur at any age, they become increasingly common as people get older. Around a third of people aged 65 and over, and around a half of people aged 80 and over, fall at least once a year. According to NICE, between 2019 and 2020, there were around 234,800 emergency hospital admissions in England related to falls among people aged 65 and over. Around 157,370 (67%) of these admissions were among people aged 80 and over[2]. The consequences of fractures are significant, with a 1-year mortality rate of 31% after a hip fracture[2]. It affects families & carers too. NHS and Social care costs nearly 6 million per day for hip fractures following fall which equates to £2.3 billion per year[3].

It takes away confidence of the patient, loss of independence, causes distress, pain, injury including fractures, could be life changing event including death.

An appraoch to Falls:

It is important to take a thorough history to establish if this was Fall with a preserved consciousness or Fall due to loss of consciousness i.e. Syncopal episode or seizure. However, sometimes this may not be very clear cut but one needs to proceed and decipher as best as one could. It is crucial to get eye witness account, if available, as it helps a lot to establish the circumstances surrounding the fall. Was this the first fall or history of recurrent falls? Does the fall happen only when standing? Does the person fall backwards (PSP- Progressive Supranuclear palsy) or on a particular side (cerebellar) or feels the knees just gave away and slumped on the floor (musculoskeletal issues).

In taking the history, include the relevant past medical history of diabetes (if so for how long and how was the control) and Alcohol intake (how much and how long).

What are the medications the person has been taking especially

if any new medication added or timing of the medication changed? Diuretics, sedatives and blood pressure medications are particularly to be reviewed.

Be observant not to miss subtle features of Parkinson's disease i.e. hypomimia, hypophonia, salivary drooling, resting tremors in the limbs but sometimes it could be present in the chin too. Physiological ageing and frailty are evident which should not be missed.

Speech can also give some indications to the causality of current problems if this was like slow & low volume speech suggestive of Parkinson's disease or slurred growl suggestive of PSP or having some features of expressive dysphasia or receptive dysphasia which may suggest if there was any cerebro-vascular event, or if this was staccato speech suggestive of cerebellar involvement.

One needs to be aware of swallow involvement. If this is involved, then the cause needs to be explored further as this could be the presentation of neuro-degenerative condition too.

Eye movements gives important clues as to the causes of fall. Check if there are any nystagmus. The best way to establish in elderly is by doing slowly & gently. It is important to avoid extreme positions. One also needs to be watchful of oscillo-scopic movements of the eyeball. Also look at the up and down movements of eyeball i.e. excursions of eye movement. If limited excursion, may be suggestive of progressive supranuclear palsy.

Generally, starting the clinical examination with the lower limbs helps. Is there disproportionate wasting of quadriceps ? – as this could suggest steroid induced myopathy (especially if the person has been on long term steroid for example Polymyalgia rheumatica) or this could also suggest amyotrophic changes in a diabetic patient. If there are fasciculations which may indicate in the direction of anterior horn cell disease (MND – Motor neurone disease). An inverted champagne bottle appearance of the legs may suggest Charcot-Mary-Tooth disease. Check for tone and tendon reflexes. If exaggerated, could this be due to upper motor neurone problems or simply anxiety[4]. If reduced, is it due to lower motor neurone issues? Check for peripheral neuropathy with both crude touch and vibration sense by the tuning fork. Peripheral neuropathy itself could be the reason for fall. Element of peripheral neuropathy could be due to diabetic autonomic involvement, alcohol related issues or other causes. Sometimes, simply age related peripheral neuropathy may be present. It is good practice to check for Vit B12, Folate and TSH as these are treatable causes of peripheral neuropathy. Planter reflexes to be included in the interpretation of clinical findings.

General physical examination is sensible to exclude any mass/tumour as it will point towards malignancy which is associated with Sarcopenia and wasting. Cardiovascular examination is crucial to exclude any aortic stenosis[5]. If it is present and there is suggestion for syncopal episode, then this warrants in-patient Cardiology opinion and Echocardiogram. Of course, we should not miss sight of a 12 lead ECG!

It is always good idea to get the patient to walk if safe. It gives a lot of clues as to the reason for fall and what could be done to improve it. Hemiplegic gait is self-evident but one has to be careful not to miss subtle signs if the involvement has been very small. Similarly, Parkinson's disease with tremors in hand, stooped posture with short shuffling gait and cogwheeling and rigidity are good signs not to be missed. Cerebellar gait involves

walking like a drunkard & to one side. When there is poor ground clearance and it seems the feet is glued to the floor, called magnetic gait, suggestive of Normal pressure hydrocephalus (NPH), however, sometimes Vascular Parkinsonism can present like this. Similarly there are other gaits which are unique i.e. High stepping gait, Equine gait & waddling gait.

'Timed up and go Test' (TUG)[6] which also includes 360 degrees turn is a useful test. It gives a good idea of falls risk, mobility and frailty in comparison to the age and gender. Patient & family education are important. If above test is abnormal, then referral to the therapy team is helpful for gait and balance exercises. Rhomberg's test could be done (only if the patient is safe to do so) which may substantiate your clinical findings.

Recording of postural blood pressure to exclude any Orthostatic hypotension is vital in the falls management. The methodology is important. RCP London has given good guidance on this[6]. In a nutshell to lie the patient for 5 minutes before taking the BP and Pulse. Once the patient has been standing the BP and pulse are repeated in one minute and three minutes to see if there was any postural drop. By definition, a drop of 20 mm of Hg in systolic or 10 mm of Hg diastolic or drop of systolic blood pressure to <90 mm of Hg is classed as Orthostatic Hypotension/ Postural hypotension[7].

Medication review: This brings back the Geriatrician's scalpel which is the pen for pharmacy reconciliation and optimisation of medications (Falls Risk increasing Drugs)[8]. Each medication needs to be reviewed keeping in mind the risk versus benefit and the clinical presentation.

Some of the manageable causes of Falls which are found in the clinical practice:

History and clinical examination with some relevant tests will clinch the diagnosis & treatment is quite rewarding.

- Orthostatic hypotension
- Parkinson's disease
- Seizures
- Polymyalgia Rheumatica
- Normal Pressure Hydrocephalus
- Treatable Cardiovascular conditions (Aortic stenosis etc.)
- Subdural bleeds & Stroke

Another aspect of Fall is **Transient Loss of Consciousness** (T-LoC). This condition is missed if we are not careful with history taking. Syncope and seizure are common presentation of this condition.

Syncope[9] may be defined as a spontaneous, transient, loss of consciousness with complete recovery due to the transient loss of cerebral perfusion. This could be due to Orthostatic hypotension or Neuro-cardiogenic syncope.

The table at the bottom of the page gives features to identify one from the other based on the history.

Presentation of Orthostatic hypotension includes dizziness, a common presentation. Sometimes there could be darkening of the vision. Of note is **Coat hanger Pain**.[10, 11] In this condition, pain is distributed in the lower part of neck and across the shoulder due to poor blood supply to neck muscles (areas involved under typical coat hanger). This is a unique presentation of orthostatic hypotension. One needs to be aware of this condition. Patients with Coat Hanger pain end up visiting various specialists with various investigations.

It is important to manage the patients with Orthostatic Hypotension non-pharmacologically before going on Pharmacological management. Following are the general non-pharmacological management one should consider:

Non-pharmacological interventions [12]:

- Correcting the physiological deficits i.e. replacing lost volume – (drinking water around 1800 to 2000 mls is good) – crucial intervention
- Sleeping with a shallow pillow – raise the head of the bed by 10°- decreases Na loss
- Small frequent meals
- Increased salt intake – Crisps, add extra salt helps if indicated
- Judicious exercise
- Full length Compression stockings (Grade II) and Abdominal binders – which could be removed at night
- Learn to do counter-exercise manoeuvres to prevent the syncopal episodes

Avoid:

Standing up quickly
Straining at stool
Hot baths
Large meals (which are rich in carbohydrate)
Excessive Alcohol
Prolonged standing
Severe exertion

Medication review and reconciliation

- Stopping night sedation especially Z drugs (Zopiclone, Zolpidem….)
- Anti-hypertensive medications & diuretics need judicious review
- Any other unnecessary medications could be stopped
- Changing the timing of the medications generally helps a lot.

Pharmacological interventions:

- Generally **Floudrocortisone**[12] is initiated. Start small dose and go slow. It works by fluid retention which may in theory impede with rehabilitation.
- **Midodrine**[12] starting small dose and titrating to the response. Try to avoid in the late evenings as potentially it could cause supine hypertension. Scalp itching due to pilo-erection, could present as a side effect which one should be aware. If so, decreasing the dose works good.

Orthostatic hypotension	Neuro-cardiogenic syncope
Generally in older population	Generally in younger population
Chronic presentation	Acute presentation
Posture related	Posture may not be relevant
Predictable	Unpredictable
Warning in the form of hypotension	Warning in the form of vagal stimulation

- **Pyridostigmine**[12] could be used but one of the side effects is diarrhoea. If patient develops this, then it becomes counterproductive as loss of volume occurs which does not help with the condition.
- In very difficult cases, all above could be tried to see the response and act. If still symptomatic, one should seek specialist advice before resorting to rest of life on wheel chair!

For **Neuro-cardiogenic syncope**[13] management, following are very helpful:

- Keep hydrated
- Regular exercises
- Avoid triggers
- Warm environment, Excess alcohol, Extreme fatigue, Hunger, Prolonged standing, Emotional & Stressful situations
- Be alert to abort –
- Counter exercise manoeuvres

Some of the collapses in the elderly could include **Seizure**. History is crucial including the eye witness account. The investigation and treatment are very different, hence spending some time on history taking is rewarding .

The following table[14] gives features which would help differentiate one from the other.

Those in red are quite discriminatory in clinical practice to identify seizure from syncope.

	Syncope	Seizure
Prodrome	Almost always	Common (aura)
Onset	Gradual	Usually sudden
Duration	1-30 secs	3 minutes
Colour	Very pale	Cyanosed
Convulsions	Common	Common
Incontinence	Uncommon	Common
Lateral tongue bite	Very rare	Common
Recovery	Rapid	Slow
Injury	Rare	Common

Conclusion

Falls are a serious problem in older adults and recurrent falls lead to rise in morbidity and mortality in this population, as well as premature nursing home admission and reduced functionality. The 'non-treatable' causes primarily constitute the inherent, age-related physiological changes and chronic irreversible conditions like Dementia, Post stroke damage, Parkinson's disease with advanced balance issues etc, that cannot be cured. The article dealt with 'treatable' causes but early recognition of 'non-treatable causes is equally essential for them to be manageable.

Final Nuggets:

1. If the mind does not know, the eyes will not see
2. Water keeps you upright
3. It is rewarding to identify and treat treatable causes of Fall

Some of the abbreviations:

NPH – Normal pressure hydrocephalus

PSP – progressive supranuclear palsy

MND – Motor neurone disease

Hypomimia – poor facial expression

Hypophonia – abnormally quiet voice

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Reflections of an Elective in General Surgery

Mohamad Tanbir Hasan 3rd Year Medical Student Lancaster Medical School, Lancaster University.

I had the privilege to participate in a 5-day observership at Seoul National University Hospital (SNUH) with the Liver team through the International Fellowship Program, under the guidance of Professor Suk Kyun Hong. As third-year medical students in the UK, our jobs are to take histories, bloods, and other small tasks, but surgical exposure in theatre always seemed quite limited. I've always had an interest in General Surgery in my local hospital, observing countless parathyroidectomies and hernia cases. Still, I have never been exposed to major hepatic surgeries such as hepatectomies and transplants. I didn't think the liver was my forte when looking for opportunities to observe surgeries – we were taught more medicine than surgery when doing the liver module, so hepatic surgery was still new to me

Culturally, South Korea and the UK are very different, especially in the hospital surgical hierarchy. Compared to the UK, where students ask multiple questions during surgical procedures, Korea follows a more Asian-parenting style, with students following instructions and asking questions later rather than there and then. During my observership, I had the chance to learn from Professor Kwang-Woong Lee - in all honesty, Professor Lee's teaching style was initially quite shocking: he was straightforward and high-intensity, and very old school! Especially coming from the UK system, where surgeons constantly encourage you to ask questions, it was a significant culture shock, but as I came to follow him around and observe his surgeries, I realised his teaching style was incredibly effective. He kept the other fellows and me on our toes at all moments! But it was moments like these that encouraged us to read ahead and know the procedure like the back of our hands. He gave us a taste of how intense surgery really is and the importance of understanding the procedure well to prevent mishaps - an important lesson, and I'm pretty sure the other fellows and I will remember the significance of grafts in reducing congestion in liver transplants from now on!

Language was also another element that taught me a lot in Korea; I can only understand simple words like "pain" and "where". However, my time in the outpatient department with Professor Su-Young Hong revealed to me the importance of not only verbal language but also non-verbal cues that patients can give us. We had a patient with a severely enlarged liver, and from the movement of their hands, as well as the way in which they verbalised the words in Korean, you could definitely gauge what they were telling you. Adding this on with scans and LFT values I could see on the computer, you could put two and two together, and end up with a decent set of differentials. Although it seems pretty simple at

first, it gave me a strong appreciation for looking at the patient as a whole. Medical school does teach us a lot about recognising body language, but doing so with patients whom I really struggled to understand directly tested my ability to read body language.

Liver transplantation was another aspect I wanted to observe during my observership at SNUH, but I must admit, the curiosity of seeing any transplant would get me excited! According to Medical Korea, the country performs the highest number of living donor liver transplantation (LDLT) operations in the world annually, with 21.61 out of every 1 million people receiving an LDLT [1,2] – this could be attributed to the strong presence of Confucian values and the concept of Filial Piety in Korean culture and society [3], encouraging the use of LDLTs. During the two transplants I got to observe, I was with Professor Young-Rok Choi as he carried out the removal of the liver from the donor. Seeing the accuracy and speed of his skills in clipping and removing the liver was almost hypnotic, as was the agility with which he moved the laparoscopic equipment. And once it was out, seeing the liver in front of you clicked something inside of me. All of a sudden, all the anatomy learnt in my first year of medical school flooded back in, and I labelled them in my head (much more efficient than Anki!) whilst they carried out bench surgery to reconstruct vascular and biliary structures. The best part of all of this, however, was Professor Choi treating us to lunch!

Once we returned for the recipient portion of the transplant, I had the chance to scrub in during the closure of the abdomen. Seeing the new liver attached to the upper right quadrant, along with the surrounding anatomical structures, was mesmerising to me. The highlight was seeing the diaphragm move up and down, with a subtle pulsation of the heart on the left hemidiaphragm, and repositioning the bowel to help close the abdomen. All of this was happening whilst a plethora of K-Pop played in the background, which I was familiar with, having watched countless episodes of Hospital Playlist and other medical K-Dramas! And I must admit, the Korean surgeons have a much better taste in music than our surgeons back in the UK!

My experience in Seoul has been eye-opening. Seeing a transplant for the first time in my life, as well as learning how different yet familiar medical practice and culture were from those in the UK, gave me great insight into the diversity of the surgical world. I loved every second of my time at SNUH, from walking down the corridors with my coffee very kindly provided by the Professors, all the way to running down to theatre so that I don't miss the next case! The experience has been invaluable, providing key information to help me decide which speciality I'd like to pursue in the future. I want to thank Professor Hong and Nurse Amelia Jeon for their hard work in helping me organise this observership. I'd also like to thank Professor Young-Rok Choi, Professor Kwang-Woong Lee and Professor Su-Young Hong for their invaluable teaching, as well as the other fellows and medical students I was with, for making this experience one that I will remember.

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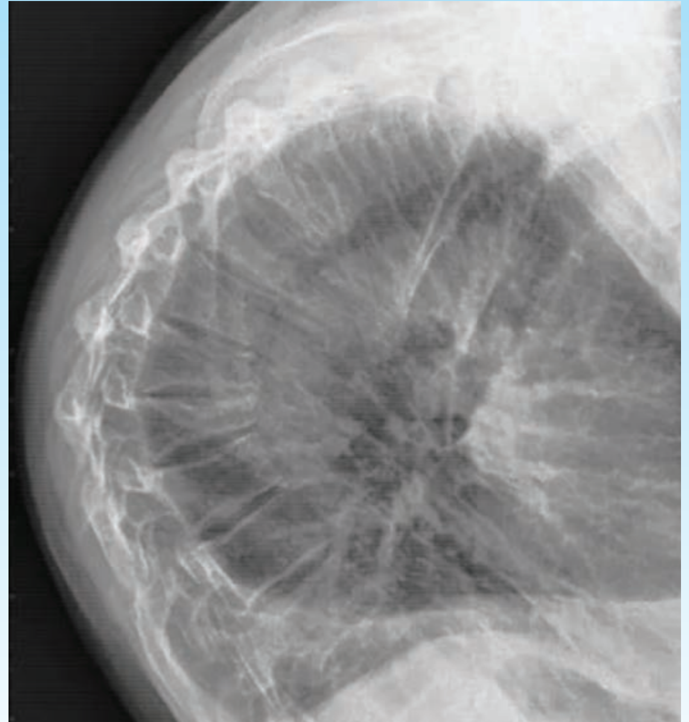
Medical **Quiz**



1. *What is your differential diagnosis?*
2. *What is the likely diagnosis?*
3. *What investigations would you perform?*
4. *What are the risk factors for Osteoporosis?*

Answers on page 27

Neurodiversity amongst Doctors

Neurodivergent individuals are those whose brains and cognitive functioning differ from what is considered typical. The estimation is that up to 15% of the population are neurodivergent. The conditions include autism, ADHD, dyslexia, dyspraxia, dyscalculia, and Tourette syndrome. There is greater awareness, wider diagnostic criteria, and improved understanding of these conditions — particularly in adults and women.

Research from University College London studied the medical records of 2877 doctors accessing NHS Practitioner Health formental health support found that 35% screened positive for ADHD, which is significantly higher than the 2%-3% prevalence in the general population[1]. Other studies in Saudi Arabia and China have also reported higher rates of ADHD in medical students compared with the general population. Many remain undiagnosed, while others may hide or mask their diagnosis or differences.

It is possible that healthcare careers attract neurodivergent individuals because of the strengths that can accompany their conditions. Clinicians with autism may have excellent attention to detail, strong memory, innovative approaches to problem-solving, exceptional visual and mathematical abilities, and strong adherence to guidance. They may also demonstrate honesty, punctuality, and reliability. The concern is that they may face challenges managing uncertainty, struggle with social rules, find sensory environments overstimulating, and be at higher risk for burnout due to masking to fit into social norms. (Sarah Townley, Medscape)

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BIDA International Conference 2025

Hyatt Playa Del Carmen, Cancun, Mexico, Weds 19 & Thurs 20th November

Committee and Organization:

The Conference Committee was chaired by Dr. Suresh Chandran and included Prof. Sanjay Arya OBE (who unfortunately was unable to attend), Dr. Leena Saxena, and Dr. Usha Chandran. The organizing committee curated a program spread across one-and-a-half days, covering a diverse range of medical topics. Alison Sherratt from BIDA central office also helped immensely in organising the conference and later gathering feedback and sending out attendance certificates.

Day 1:

The Conference began with a welcome address by Dr Suresh Chandran, Chairman Organising Committee followed by BIDA Chairman Dr Ashish Dhawan's and BIDA President Prof Amit Sinha's address to the audience.

- **Session 1**:
  Chaired by Dr. Leena Saxena and Prof. Videsh Raut

Prof. Ravish Katira opened with a presentation titled: To drink or not to drink; that is the question. Dr. Anil Kumar followed with a discussion on falls in the elderly and treatable causes. The session concluded with Prof. Amit Sinha highlighting the effects of obesity on weight-bearing joints.

- **Session 2**:
  Chaired by Dr. Veena Jha and Dr. Ashish Dhawan

Mr. Nanik Vaswani opened the floor to urology-related questions from the audience. Mr. Anurag Golash provided an update on Robotic Assisted Laparoscopic Surgery, and Dr. Suresh Chandran concluded the session with a talk on the challenges of medical appraisal.

- **Session 3**:
  Chaired by Dr. Usha Chandran and Prof. Amit Sinha

Dr. Vivek Malhotra used various radiological images to identify types of arthritis, followed by Dr. Neha Dalal, who discussed the current state and challenges of digital pathology in the NHS. Finally, Dr. Jasbir Chhabra shared his experiences training as a yoga teacher in Rishikesh, India, and extolled the virtues of yoga.

- **Session 4**:
  Chaired by Dr. Shalini Gadiyar and Dr. Suresh Chandran

Dr. Anita Sharma explained the diagnosis and management of endometriosis. Dr. Bhavna Pandya then provided insights into how South Asian women healthcare professionals navigated challenges during COVID-19 and beyond. The day concluded with Prof. Gurpreet Singh offering valuable tips for surviving and succeeding in the NHS.

Day 2 Sessions:

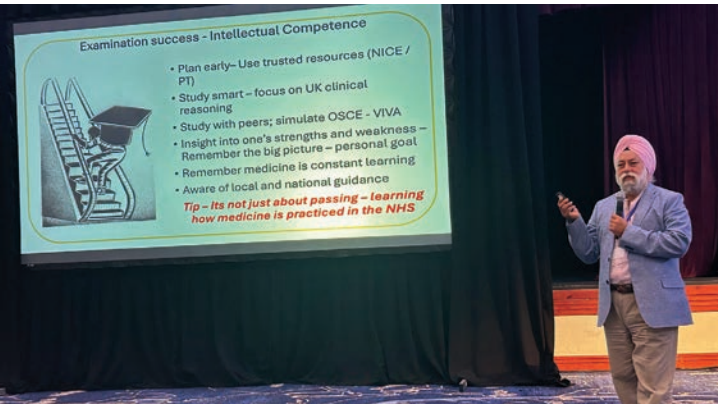
- **Session 5**:
  Chaired by Dr. Anita Sharma and Dr. Vinod Gadiyar.

Dr. Sanjiv Sinha spoke on stress management in UK General Practice, followed by Mr. Ram Prasad on aesthetic surgery after pharmacological weight loss. Dr. Vijay Kumar wrapped up the session discussing Stem Cell and PRP clinical applications.

- **Session 6**:
  Chaired by Dr. Yamini Malhotra and Dr. Sanjeev Saxena

Dr. Nikhila Deshpande discussed recent advances in the management of depression, focusing specifically on rTMS. Dr. Tulika Prasad delivered a lecture on management of adult ADHD, and Dr. Vinod Gadiyar closed the presentations by discussing the "good, bad, and ugly" face of opioid therapy.

- **Conclusion**: Based on audience feedback, the conference was highly successful, featuring many erudite and expert speakers. Engagement was excellent, to the extent that Q&A sessions frequently had to be curtailed due to time constraints.



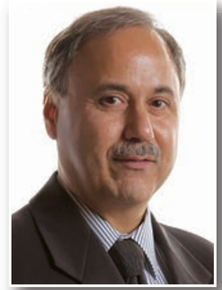
Speakers at the 2025 International Congress included (above, top row, l to r) Dr Sanjiv Sinha, Dr Neha Dalal, Dr Nikhila Deshpande, Mr Ram Prasad, (middle row, l to r) Dr Vijay Kumar, Dr Vivek Malhotra, Dr Vinod Gadiyar, Prof Amit Sinha, and (bottom row, l to r) Prof Gurpreet Singh and Prof Ravish Katira. Below: The International Congress Chairperson's Panel, including Speakers.

Opposite page: Prof. Amit Sinha delivers his opening address to the Congress

International Conference Speakers:

Day 1, Session 1

To drink or not to drink; that is the question



Prof Ravish Katira *Consultant Cardiologist, Merseyside & West Lancashire NHS Teaching Hospitals, Prescot; Institute of Medical Sciences, University of Greater Manchester*

Low to moderate alcohol consumption has been associated with a reduced risk of some cardiovascular diseases in certain studies. However, there are alcohol related risks including cancer and cardiovascular harms. In this lecture, Prof Katira will explore the current evidence.

Falls in the Elderly – an approach to treatable causes

Dr Anil Kumar *Consultant Geriatrician, University Hospitals of North Midland, Stafford*

Falls are very common presentation in the older adults for both primary care and secondary care. It takes away confidence of the patient, could be a life changing event. It affects families. It is associated with morbidity and mortality. There are treatable and non-treatable causes of Falls. This talk will focus on clinical approach to falls, including management of treatable causes. It will also touch on deprescribing and medicine optimisation.

Effect of obesity on weight bearing joints

Prof Amit Sinha *Consultant Orthopaedic Surgeon; Honorary Clinical Professor, Chester University. National President, BIDA.*

80 – 95% of patients who suffer from knee and hip osteoarthritis (OA) are overweight or obese. Unfortunately, this problem will increase over time as the world population ages and their declining health leads to further physical disability. Over the last decade, the prevalence of OA has increased by 25% in Western countries. The knee is the most frequently affected joint, as compared to the hip joint.

Prof Sinha will also explore the cost implications and other risks associated with obesity.

Day 1, Session 2

"Any Urological Question"

Mr Nanik Vaswani *Consultant Urological Surgeon, Chesterfield Royal Hospital*

Mr Vaswani will let the audience decide the agenda of his talk. He will leave it to the audience to ask him any urological questions. Mr Vaswani believes that a heterogenous audience does not get enough time to ask a specialist questions about their specialty. So, he will be trying this unique approach. Mr Vaswani expects this to be a very interactive and interesting session.

An introduction to Robotic Assisted Laparoscopic Surgery - is it as good as it sounds?

Mr Anurag Golash *Consultant Urologist and Clinical Lead, University Hospital of North Midlands, Stoke on Trent*

Mr Golash had established minimally invasive surgery in his department in 2004 and then moved on to robotic surgery since 2014. His major area of interest is robotic surgery for kidney, and he reported the world's day case laparoscopic nephrectomy in 2006. He was awarded the Citizen of the Year award by Staffordshire Council for his role in minimally invasive surgery.

His talk will focus on Robotic assisted laparoscopic surgery in Urology.

Why are appraisals a nightmarish experience?

Dr Suresh Chandran *Consultant in Acute Internal Medicine and Revalidation Lead; Oldham Care Organisation*

Despite appraisals and revalidation being firmly embedded in our professional lives, many doctors still find appraisals a nightmarish experience. Dr Chandran will draw upon his experience as the Appraisal and Revalidation Lead in Oldham Care Organisation to explore the reasons behind it and also share some tips to make appraisals a fruitful experience.

Day 1, Session 3

Identifying Common Patterns and Turning Radiology into an Ally

Dr Vivek Malhotra *Consultant Radiologist and College Tutor; West Herts Hospitals NHS Teaching Trust*

This talk focuses on the radiological approach to arthritis, with an emphasis on identifying the common sites and characteristic imaging features of different types of arthritis. It also aims to demystify key radiological terms frequently encountered in reports and to clarify how imaging can serve as a valuable ally – rather than an adversary – for general practitioners in the diagnosis and management of arthritic conditions.

Digital pathology in the UK: Current state, challenges and the future with Artificial Intelligence.

Dr Neha Dalal *Consultant Histopathologist, University Hospitals Birmingham; Honorary Senior Lecturer at School of Cancer Sciences, University of Birmingham*

Digital pathology is revolutionising the way we report histopathology, and the NHS is promoting its roll out in laboratories across the UK.

Dr Dalal's talk will cover:

- What is Digital Pathology and its status in the UK and NHS
- RCPath Best Practice and Guidelines
- Technical workflow
- Pros and cons of digital pathology
- UK examples and pilot sites
- Role of AI
- Future roadmap for the UK

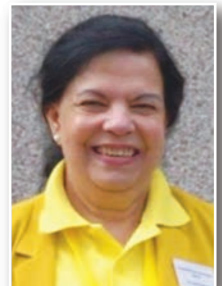
Yoga for health in the modern era- The Rishikesh experience

Dr Jasbir Chhabra *Consultant Intensive Care and Anaesthetics at Lancashire Teaching Hospitals NHS Trust*

In today's busy life esp with us as doctors, it's difficult for most of us to take time out to look after our own health. We often forget to prioritize our own health and well-being. This presentation explains what 'Yoga' truly is; gets rid of some of the myths and wrong concepts in people's minds and discusses some comparisons to aerobic and gym exercises that one often involves in for improving our health. Dr Chhabra will also go through his experience in Rishikesh where he completed a 200-hour Yoga Instructor Course to qualify as a teacher recognised globally by Yoga Alliance, the apical world body for Yoga today.

Day 1, Session 4

Endometriosis Diagnosis and Management

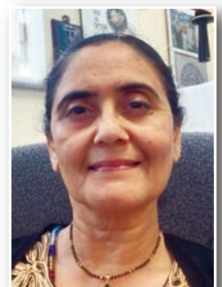


Dr Anita Sharma *GP with Special Interest in Women's Health; GP Appraiser - NHSE*

Dr Anita Sharma's talk will focus on the following areas:

1. Women's Health strategy (2021)
2. Diagnosis and management of Endometriosis
3. Raising funds for Endometriosis Charity

Navigating Silence and Voice: South Asian Women Healthcare Professionals in the NHS During COVID-19 and beyond



Dr Bhavna Pandya *Consultant Nephrologist and Physician; Honorary Senior Clinical Lecturer, Liverpool University NHS Foundation Trust*

Dr Pandya's talk will focus on how race, gender, and professional identity intersect to shape risk, silence, and discrimination. Her study provided insight into how institutional and cultural dynamics constrain voice and inclusion for South Asian women in the NHS. Dr Pandya will argue that voice is not just a personal capacity but a structural condition that can either reinforce silence or enable change. Her study highlighted the need for structural reforms that strengthen psychological safety, ensure clarity around rights and protections, and address the persistent gap between inclusion rhetoric and lived experience

Surviving and Thriving: Secrets for success in the NHS

Prof Gurpreet Singh *Retired Consultant in Urology; Former Associate PG Dean; NED Southport NHS Trust; Trustee BAUS; Chair of Fitness to Practice Tribunals; Lead Assessor NCAS*

Prof Singh draws on his experience as a Training Programme Director and Associate Dean; as well as his experience as a Chair of Fitness to Practice Tribunals and a Lead Assessor for NCAS to talk about how an IMGs can best navigate the NHS landscape, and what it takes to achieve their potential and excel.

Day 2, Session 5

Stress-recognition and management in General Practice in UK

Dr Sanjiv Sinha *GP Trainer and Appraiser; Clinical Tutor; Formerly TPD, West Midlands Deanery*

GP practices across the country are experiencing significant and growing strain with declining GP numbers, rising demand, struggles to recruit and retain staff and knock-on effects for patients. General practitioners in the UK are experiencing the highest stress and lowest job satisfaction when compared with colleagues in nine other high-income countries, an analysis has found. Dr Sinha will also focus on various sources of stress and distress and the effects they have on the working environment.

Medication, Motivation and Makoevers: Aesthetic Surgery after Pharmacological Weight Loss

Mr Ram Prasad *Consultant Breast and Body Aesthetic Surgeon, Pall Mall Medicals and WWL NHS Foundation Trust*

Weight loss drugs, particularly GLP-1 receptor agonists are causing significant body transformations for many patients. While the drugs are effective for weight reduction, rapid or major weight loss often creates new aesthetic and reconstructive concerns issues. Weight loss drugs increase demand for aesthetic surgery. Mr Prasad will focus on skin laxity, facial changes, breast changes, psychological / lifestyle factors and market dynamics

Stem cell/PRP & its Clinical applications

Dr Vijay Kumar *General Practitioner with interest in Regenerative Medicine*

Regenerative medicine is an emerging field with varied clinical applications across the medical specialities.

Dr Kumar's talk will focus on:

a) Basics of stem cell and types of stem cell.

b) What is PRP and method of obtaining PRP?

c) Use of PRP in MSK and Plastic/ Aesthetic medicine

Day 2, Session 6

Recent Advances in depression and anxiety treatment

Dr Nikhila Deshpande *Consultant Psychiatrist at Cheshire and Wirral Partnership NHS Trust; Founding Director of Tranquil TMS, Cheadle*

Up until 2008, the main treatment for anxiety and depression was psychotropics. But in 2008, FDA approved Repetitive Transcranial Magnetic stimulation (rTMS). Repetitive Transcranial Magnetic (rTMS) is the cutting-edge treatment for depression and anxiety. rTMS is a non-invasive, medication free neuro-modulatory treatment which is providing a ray of hope for the patients suffering from depression and anxiety disorders. NICE approved rTMS in 2015. Dr Deshpande would share her experience of treating patients with rTMS.

Adult ADHD Diagnosis and management

Dr Tulika Prasad *Consultant Psychiatrist, Penn Hospital, Wolverhampton BCHF Trust*

ADHD is a neurodevelopmental disorder characterised by persistent inattention, hyperactivity, and impulsivity. ADHD has a chronic course with symptoms that begin in early childhood but often persist into adult life.

Diagnosis of ADHD in adulthood requires ancillary information supporting onset of symptoms in childhood (before 12 years of age).

Dr Prasad's talk will focus on the diagnosis and management of ADHD

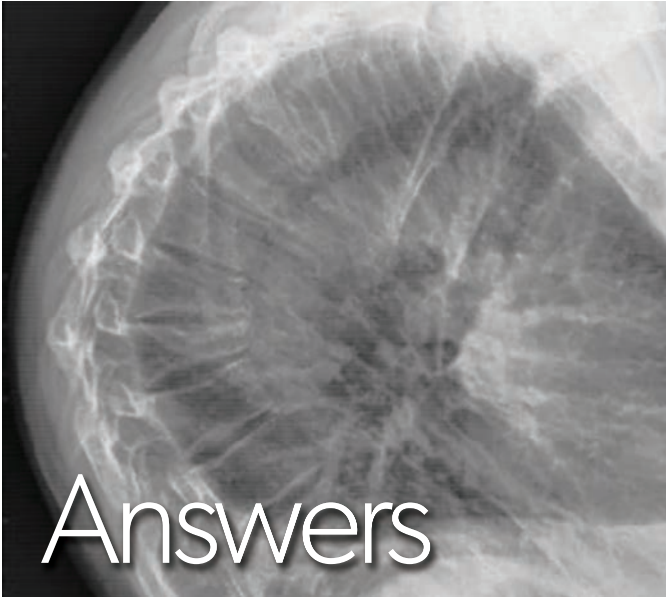
Opioids: The Good, the Bad, and the Ugly

Dr Vinod Gadiyar *Consultant in Anaesthesia and Pain Medicine; Northern Care Alliance NHS Foundation Trust, Manchester*

Dr Gadiyar will be exploring the effectiveness and beneficial effects of opioids(the Good), the possible side effects (the Bad) and their wider societal impact (the Ugly).

Opioids (morphine and morphine like drugs) have been used in pain medicine for a long time. Opioids are very potent and effective analgesics and work through the opioid receptors in the central nervous system. They are the mainstay in the management of intra and post operative pain and cancer pain. It became acceptable to use opioids for chronic non cancer pain from around 1987. However, the long-term use of opioids can lead to several problems.

Medical Quiz



1. What is your differential diagnosis?

1. Advanced osteoporosis.
2. Scheurmann's disease
3. Tuberculosis of spine
4. Secondaries of the spine

2. What is the likely diagnosis?

Advanced osteoporosis with multiple osteoporotic fractures.

3. What investigations would you perform?

Blood tests (FBC, Urea & Electrolytes, LFTs, Bone profile, Vit D, Tests for Multiple myeloma, CXR)

4. What are the risk factors for Osteoporosis?

Primary risk factors

1. Advanced age
2. Poor health/ Fragility
3. Previous history of fracture
4. Female sex
5. Dementia
6. Recurrent falls
7. Oestrogen deficiency (early menopause, prolonged pre-menopause amenorrhoea, bilateral ovarienectomy)
8. White race
9. Current cigarette smoking
10. Alcoholism
11. Low body weight (<127ibs)
12. Lifelong low calcium intake
13. Inadequate physical activity

Secondary risk factors

14. Genetic disorders (Cystic fibrosis)
15. Hypogonadal states (Anorexia nervosa, Panhypopituitarism)
16. Endocrine diseases (Adrenal insufficiency, Diabetes Type I
17. Gastrointestinal conditions (IBD, Coeliac disease)
18. Haematologic disorders (Leukaemia, Sickle cell disease)
19. Autoimmune conditions (RA, Lupus, Ankylosing Spondylitis)
20. Others (MS, End stage CKD, Sarcoidosis)
21. On medications which are associated with low bone density

Remembering...

Dr Kamala Pati Singh

1944 - 2025

It is with deep sadness we announce the passing of Dr Kamala Pati Singh on 12 November 2025, at St Helier Hospital, Carshalton.

Dr. Kamala Pati Singh was a General Practitioner in Grimsby with a lifelong commitment to paediatrics and primary care. Born in Bhagwanpur, Bihar, he qualified at Darbhanga Medical College before moving to the UK in 1978.

His early UK career included SHO posts in Paediatrics at Burnley and Grantham, and in Psychiatry at Preston and Bury. He then transitioned to general practice in Grimsby, where he was known for a tireless work ethic. He was a dedicated member of the Overseas Doctors Association (ODA) until his retirement in 2007.

He passed away from an acute intracerebral haemorrhage.

A passionate football fan, he balanced a demanding career with his love for the sport. He leaves his wife, Pankaj Singh, and three sons: Nilesh, Sameer, and Shashank.

BIDA News

Mr Ravi Badge attends PULSE 2026

Mr Ravi Badge was invited to attend PULSE 2026 – Platforms for Unified Learning, Skills, Health & Education, a flagship global summit presented by the Medical Education and Drugs Department (MEDD), Government of Maharashtra. The summit took place on 27–28 March 2026 at the Jio World Convention Centre, Mumbai. Pulse 2026 is positioned as a global, high-trust platform bringing together over 2,900 leaders across academia, clinical practice, government, industry, and investment to co-design the future of medical education and healthcare. The summit focused on advancing education excellence, accelerating AI adoption, strengthening workforce development, catalysing cross-border research, and enabling investment-led collaborations.

He was invited to meet the Chief Minister of Maharashtra and share the vision of Sports Medicine ecosystem and exchange MoU on the model suggested.

Congratulations!

Dr Sunil Sapre

Congratulations to Dr Sunil Sapre. He has been selected to umpire the I.T.T.F. World Table Tennis Team Championship at London in April 2026.

Dr Pragnesh Bhatt

Sincerest congratulations to Dr Pragnesh Bhatt, who has been officially appointed as a Member of the Spine Committee of the World Federation of Neurological Sciences (WFNS).

WORLD FEDERATION OF NEUROSURGICAL SOCIETIES

SPINE COMMITTEE

WFNS SPINE COMMITTEE

CERTIFICATE OF APPOINTMENT

This is to certify that

Dr.Pragnesh Bhatt

(Name of Appointee)

has been officially appointed as a Member of the Spine Committee of the World Federation of Neurosurgical Societies (WFNS).

This appointment is made in recognition of the appointee's professional standing, expertise, and commitment to the advancement of spine surgery, education, and scientific collaboration within the WFNS.

The Executive Board of the WFNS Spine Committee looks forward to the appointee's active participation in future educational, scientific, and academic activities of the Committee.

Issued on this day,

Prof. Luis Borba, WFNS President

Prof. Nikolay Peev Chair, WFNS Spine Committee

Prof. Fatos Olldashi, Chair, WFNS Spine Committee

News from our New Website https://www.bida-online.com

Too many roles - why your GP is splitting

A fresh perspective on why family doctors are leaving the profession has just appeared in GP Online - *https://www.gponline.com/viewpoint-why-experienced-gps-leaving-nhs-keep/article/1954486*

And while workload, acting as an admin machine, social worker, dentist etc, are just some of the reasons, others expressed by our members are even more insidious.

The rise of racism and fear of visiting patients in some so-called flag waving areas is one. Assaults on GPs are also too common with some reporting being attacked because they would not prescribe antibiotics!

Certainly the reputation of the family doctor has fallen, and hasn't been helped by long waiting lists for appointments.

BIDA both welcomes overseas medics to the UK and supports all who are here doing their best to tend to the sick.

COVID Report: we fell short on caring for BAME employees

The findings of Baroness Heather Hallett enquiry into Britain's response to the COVID enquiry highlighted what voices on the ground were telling us.

Individual medics performed heroically during the pandemic, but lives were lost sometimes needlessly – and not just those of clinicians, either.

Working within healthcare settings is still seen as worthy within many diverse communities in the UK. That also includes those who care for patients at their bedside and clean wards and theatres so that we might be able to perform surgeries and procedures.

The enquiry is a four-year report so we will be studying it thoroughly over the coming time.

But we will do so in memory of all the patients and colleagues who were lost – including those whose vital non-clinical work makes healthcare possible.

Read more about the enquiry, at *https://news.sky.com/story/covid-inquiry-latest-report-to-set-out-impact-pandemic-had-on-nhs-and-patients-13521346*

BIDA National Sports Secretary's Report

Mr Ravi Badge MSc, MRCS, DNB(Orth.), MS(Orth.), FRCS(Tr. and Orth.)
Consultant Upper Limb Surgeon, Warrington and Halton Hospitals NHS Foundation Trust (NHS). National Sports Secretary, BIDA.

BIDA Cricket & Sports Update 2025

In 2025, BIDA introduced a significant change to its annual President's Cup Cricket Tournament by adopting the T20 format. This allowed for more matches per team while aligning the competition with the globally recognised format of the game.

The transition proved highly successful, producing competitive, fast-paced, and engaging cricket across all participating divisions. The tournament showcased strong participation, excellent sportsmanship, and high-quality performances, reflecting the continued enthusiasm for cricket within BIDA.

The 2025 final between Wigan and Stoke Divisions could not be completed due to adverse weather conditions and pitch availability. Following discussions between BIDA officials and both teams, it has been agreed that the final will be played at the start of the 2026 cricket season, with further details to be announced in due course.

Looking Ahead – Future Format Considerations

Based on recent experience, several challenges have emerged, including:

- Reduced number of participating divisions
- Dependence on player availability
- Limited access to high-quality grounds
- Weather-related disruptions

To address these challenges, an alternative format is being explored – hosting the tournament over an extended weekend in Spain or Portugal.

While this option presents logistical and financial considerations, it is potentially achievable with appropriate sponsorship and player contributions.

This proposal will be taken forward following engagement with cricket-playing divisions, as well as gauging interest from divisions not currently participating. Members across all divisions are encouraged to get in touch and express their interest in helping shape this initiative.

BIDA Golf

Alongside cricket, the BIDA Annual Golf Tournament continues to grow in popularity. It has attracted a diverse group of members, contributing positively to engagement and expanding participation within BIDA sporting activities.

Planning for the 2026 Golf Event is already underway, and we are pleased to confirm that it will take place on:

- **9th October 2026**, at
- **Worsley Park Country Club, Marriott Hotel, Manchester**

The continued success of both cricket and golf events reflects the enthusiasm, commitment, and camaraderie of BIDA members.

BIDA sporting initiatives continue to play a vital role in uniting British international doctors through sport, collaboration, and community engagement. We look forward to building on this momentum in 2026 and beyond.

Mr Ravi Badge *National Sports Secretary, BIDA.*

Congratulations to Diya and the Badge Family

Diya Badge – England Under-19 Women's Cricket

A truly proud moment for the Ravi Badge family, and for everyone who has directly or indirectly contributed to Diya's cricketing journey, as we saw her make her debut for the England Under-19 Women's team in Australia last month.

The BIDA cricket tournament has been very special to the Badge family over the years. Ravi Badge (Orthopaedic Consultant) has been playing in the Wigan Division since 2008, and both his children, Aditya and Diya, have regularly contributed to their teams' success over the past few years. They are a wonderful example of how BIDA engagement extends to families – helping build a strong community and reflecting the enthusiasm, commitment, and camaraderie of its members.

This truly is just the beginning of a very special journey.

A little girl who once simply followed her brother into the sport we all love has today carved out her own path in cricket. Watching her passion, commitment, and hunger to improve has been incredibly inspiring. The game has shaped her

not only as a player, but also physically and mentally as a person. Notably, Diya was the first girl to play in the history of the BIDA Cricket Tournament – an environment she embraced fully and where she was warmly welcomed across all divisions.

Perhaps that is why seeing both children

embrace sport so seriously means so much. Aditya played for Nottinghamshire County until the age of 18 and is now pursuing both hockey and cricket at Loughborough.

Diya has chosen to focus on cricket, and to see her receive her England cap during the England Under-19 tournament in Brisbane, playing against Australia and Sri Lanka, is a moment of immense pride. To wear the Three Lions jersey is truly special.

This is only the start – a journey that the Badge family, and indeed the wider BIDA community, will cherish for years to come.

17TH BIDA INTERNATIONAL CONFERENCE

EGYPT | 15–24 NOV 2026

Journey to Egypt

Travel back in time to the land of pharaohs

Organisers:

Dr. Suresh Chandran, Dr. Vinod Gadiyar & Dr. Ravish Katira

In association with Bolton Holidays – Sebi & Team

For Enquiries & Booking:

Please contact us at: Sebi (0114 4630 0406)

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