# bida JOURNAL

THE JOURNAL OF **THE BRITISH INTERNATIONAL DOCTORS' ASSOCIATION**
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Inside:

# National Conference 2025

## Friday 19th September 2025 (CPD 1.5 points equivalent)
## Saturday 20th September 2025 (CPD 5 points equivalent)

## *Bridging the gap: Prevention through Education*

Venue: DoubleTree by Hilton Hotel, Warrington Road, Hoole, Chester, Cheshire CH2 3PD

### Friday 19 September

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|---|---|
| 18.00 – 19.00 | Registration of Delegates |
| 19.00 – 19.05 | Chairman's Address **Dr Jay Nankani**, Chairman BIDA North Wales Division |
| 19.05 – 19.10 | Welcome Address **Prof Amit Sinha**, National President, BIDA |
| 19.10 – 19.20 | Chief Guest **Rt Hon Sir Mark Tami MP** Member of Parliament (Alyn & Deeside) |
| 19.20 – 19.50 | **Dr Yee-Ping Teoh**, Consultant Chemical Pathologist<br>Management of LDL-C – Are statins enough? |
| 19.50 – 20.20 | **Mr Ram Prasad**, Consultant Breast & Aesthetic Surgeon<br>"Enhance, Empower and Evolve" Science of Sculpting — Navigating the modern Aesthetic landscape |
| 20.20 – 20.30 | Felicitation of Guest of Honour<br>**Prof Bim Bhowmick OBE** Retired Consultant Physician, Glan Clwyd Hospital<br>Former Associate Postgraduate Dean, Cardiff University |
| 20.30 | Vote of thanks |

### Saturday 20 September

| | |
|---|---|
| 08.30 – 09.00 | Registration – Delegates |
| 09.00 – 09.05 | CHAIRMAN'S ADDRESS: **Dr Ashish Dhawan** National Chairman, BIDA<br>Consultant Cardiologist, Wrightington, Wigan & Leigh Teaching Hospitals<br>PRESIDENT'S ADDRESS: **Prof Amit Sinha** National President, BIDA.<br>Consultant Orthopaedic Surgeon |
| 09.05 – 09.10 | WELCOME ADDRESS: **Prof Ravish Katira**<br>Chairman, BIDA National Conference 2025<br>Consultant Cardiologist. Whiston Hospital, St Helens & Knowsley Teaching NHS |
| 09.10 – 09.25 | KEYNOTE SPEAKER<br>**Dr Mumtaz Patel** President Royal College of Physicians, London<br>Consultant Nephrologist |
| **Session 1 :** | **Regulation & Accountability in the NHS** |
| **Chairpersons:** | **Prof Sanjay Arya OBE, Dr Shikha Pitalia** |
| **Panellists:** | **Dr Raj Verma, Dr Shanu Datta** |
| 09.25 – 09.40 | Message from **Charlie Massey** CEO GMC<br>**Tista Chakravarty-Gannon** Head of Outreach Operations, GMC<br>Prevention of GMC referrals |
| 09.40 – 09.50 | **Prof Chaand Nagpaul CBE** General Practitioner<br>Chair Harrow LMC and NW London LMC Network, and RCGP Council Member<br>"From hospital to community" – What future does the NHS 10-year plan hold for General Practice. |
| 09.50 – 10.00 | **Mr Ramesh Balasundaram** Consultant Orthopaedic Surgeon<br>Planned Care Lead, Betsi Cadwaladr University Health Board<br>Accountability in the NHS |
| 10.00 – 10.10 | **Dr Gurpreet Singh MBE** Consultant Urologist<br>Non-Executive Director, Southport & Ormskirk Hospitals NHS Trust<br>How to stay out of trouble |
| 10.10 – 10.30 | Panel Discussion |
| **Session 2 :** | **Medical Education** |
| **Chairpersons:** | **Prof Sanjoy Bhattacharyya, Dr Vinod Gadiyar** |
| **Panellists:** | **Prof Raj Murali MBE, Mr Pragnesh Bhatt** |
| 10.30 – 10.40 | **Dr Mumtaz Patel** Consultant Nephrologist<br>President, Royal College of Physicians, London<br>Differential Attainment: Challenges & Solutions |
| 10.40 – 10.50 | **Dr Richard Vautrey** General Practitioner<br>President Royal College GP, London<br>Medical Education and the role of the RCGP |
| 10.50 – 11.00 | **Prof Arpan Guha** Consultant Anaesthetist<br>Dean, University of Greater Manchester Medical School<br>Educating doctors of the future: fit for purpose |
| 11.00 – 11.15 | Panel Discussion |
| 11.15 – 11.45 | Coffee Break – Meeting with Exhibitors |
| **Session 3 :** | **Preventative Medicine** |
| **Chairpersons:** | **Dr Shamim Rose, Paarth Gupta** |
| 11.45 – 11.55 | **Dr Sakthi Karunanithi**<br>Director, Public Health Lancashire & South Cumbria ICB<br>The NHS recovery – who will make the key decisions, and how?' |
| 11.55 – 12.05 | **Prof Thara Raj** Director of Population & Health Inequalities,<br>Warrington & Halton Hospitals NHS Trust<br>Embedding a prevention and health inequalities approach within the hospital |
| 12:05 – 12.15 | **Prof David Brigden** Lancaster University Medical School<br>Old age medical & social care. |
| 12.15 – 12.30 | Panel Discussion |
| 12.30 – 13.15 | BIDA's 50th Anniversary Celebration Felicitation<br>**Prof Amit Sinha / Dr Ashish Dhawan**<br>Past – Present – Future:<br>**Dr Surendra Kumar, Dr Sai Pillarisetti, Paarth Gupta** |
| 13.15 – 14.00 | Lunch & Meeting with Exhibitors |
| **Session 4 :** | **Women's Health** |
| **Chairpersons:** | **Dr Anita Sharma, Dr Marguerite O'Riordan** |
| 14.00 – 14.15 | **Dr Latifa Patel**<br>ST7 Resident Doctor Respiratory Medicine, Manchester<br>Former Chair Representative body & Equality lead, BMA<br>The cost of sexism in medicine |
| 14.15 – 14.30 | **Miss Sujata Gupta**<br>Consultant Obstetrics & Gynaecology, Stockport NHS Foundation Trust<br>Are women getting the care they deserve? Bridging the gap in gynaecology waiting times in the UK. |
| 14.30 – 14.45 | Panel Discussion |
| **Session 5 :** | **Resident Doctors Session – Podium Presentation** |
| **Chairpersons:** | **Mr Alireza Sherafat / Dr Momna Raja / Dr Negin Gholampoor** |
| 14.45 – 15.00 | |
| 15.00 – 15.20 | Coffee Break – Meeting with Exhibitors |
| **Session 6 :** | **Diabetes / Endocrinolgy** |
| **Chairperson:** | **Dr Rakesh Sharma** |
| 15.20 – 15.35 | **Prof Franklin Joseph** Consultant Endocrine, Diabetes & Metabolism,<br>Countess of Chester Hospital<br>Medical management of Obesity |
| **Session 7 :** | **Cardio Metabolic Endocrine MDT** |
| **Chairpersons:** | **Dr Ashish Dhawan, Dr Suresh Chandran** |
| 15.35 – 16.15 | **Dr Chetan Upadhyaya**, Consultant Cardiologist<br>**Dr Yee-Ping Teoh**, Consultant Chemical Pathologist<br>**Prof Franklin Joseph**, Consultant Endocrine, Diabetes & Metabolism |
| 16.15 – 16.30 | **Veronica Trotter**<br>Finance Talk - Quilter |
| 16:30 | Vote of thanks: **Dr Sai Pillarisetti**, National Secretary BIDA |

# Editorial

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

## *BIDA ARM/AGM 2025*

This year is our 50th anniversary, a very special milestone. We have stood the test of time with our resilience and team spirit. We remain a vibrant group of General Practitioners, Hospital Consultants, Doctors in training, LEDs and medical students (BIDA Student Wing) all united with our motto of "Equality & Fairness".

We have a strong democratically elected executive committee. We organise regular division educational meetings, annual conferences both national and international, and an oncology conference and support Obesity conferences every year. Our peer reviewed BIDA Journal gives a platform for one and all to contribute to. Those who love cricket or golf can become our sports members.

BIDA welcomes all international medical doctors working in the NHS to become members of our association. We are a professional organisation with a strong family like bonding which offers plenty of opportunities to express your thoughts, seek mentorship and friendship.

### Resident doctor's viewpoint

The soft deals offered by the government were getting access to hot meals when working overnight, having some exam fees paid, receiving funding for equipment such as stethoscopes and getting mess rooms and changes to the way their postgraduate training was organised. The student loan relief was also relayed to the media but it seems it never got discussed. The verbal deal did not address the crux of the contention; the BMA's demand that resident doctors receive a 29% pay rise over the next few years.

The Rt Hon Wes Streeting has refused to reopen negotiations over the 5.4% salary increase he has given resident doctors this year. The message from the resident doctor's team is loud and straight forward, "We cannot be clearer: it was the government that ended the talks. Resident doctors do not want to strike."

The BMA says that despite a 5.4% average pay rise this year, following a 22% increase over the previous 2 years, pay is still down by a fifth since 2007 once inflation is considered. The union confirms that a pay uplift of 26% is needed to reverse real-term wage decline. Under the circumstances the chances are that there will be a deadlock between the government and the BMA. Truly this stalemate will widen the gulf between the two.

We remain concerned for the welfare of our doctor colleagues as well as the patients. We support the demands of the resident doctors, as they are fair and reasonable. Medicine is a vocation but also a means of a livelihood after years of hard work. The early training period of these young resident doctors is a vital time to inculcate the spirit of teamwork, friendship and ethos of NHS principles. The government is duty bound to be kind and considerate to these special group of professionals.

### Articles

Dr Anita Sonsale, as a Consultant ENT surgeon at Birmingham describes a very special service she is offering to professional singers, teachers and lecturers through a dedicated Professional voice user's clinic.

Generally, patients are anxious, apprehensive and fearful of the unknown when they enter a hospital. What does help a great deal is the environment and the design of the hospital, which plays a unique role in calming the nerves. Mrs Manchanda, a builder and a hotelier based in India presents a unique personal perspective of how this aspect affects the psyche of the individual patient and aids in recovery.

Dr S Chandran, an Acute Consultant physician presents a detailed description of the responsibilities of a medical examiner.

Prof Brigden, a lifelong educationalist has penned another 2 articles for our medical students and young doctors, which outlines the advice on writing for publications and teaching ethics.

Drs Amar and Poonam Singh are based in the USA. They specialise in preventing, treating, and reversing chronic diseases using an evidence-based holistic approach. Their trip to Kilimanjaro gives a unique perspective of their journey of self-discovery and sparks spiritual awakening.

We all look forward to welcoming you at the BIDA ARM/AGM starting with the North Wales Division Educational evening on Friday 19th September, followed by the National Conference the following day at Double Tree by Hilton Hotel at Chester.

***If you want to walk fast, walk alone.***
***But if you want to walk far, walk together*** (Ratan Tata)

**Prof Amit Sinha**
*Editor, BIDA Journal*

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## 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.

## Contents:





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# BIDA National President's Report

## Dear friends and colleagues,

**This is our 50th year, an opportune time to change tack. I would like to promote BIDA's call for "Prevention rather than cure".**

For years we have focussed on issues of complex nature long after it's already too late. The horse has already bolted out of the stables. We cannot stop it and the race in most cases of our IMG doctors ends up in failure, as all the odds are stacked up against them. BIDA cannot change the system it has been fighting for the past 50 years. It cannot win against institutional racism, unconscious bias and differential attainment at all levels of progress.

Although we remain steadfast and committed to our motto "Equality & Fairness for all", we admit that the world is unequal, and we must accept that inequities in our healthcare system cannot be balanced fully. Can it be improved? I believe that it can be.

For all these years we have been trying to tackle the issues at the wrong end where in the vast majority we cannot do justice to the individual and unable to alter the outcome. Our support and advice bring little solace to the individual concerned. We need to focus on 'Prevention'.

We need to prepare the new recruits of International Medical Graduates very early on to make them aware of what lies beyond. Working safely in the NHS is not a bed of roses. One needs to have a deep understanding of the intricacies of the hidden dangers that can affect an individual at any step. How do we inculcate the culture of self-preservation for the IMGs?

A step in this direction has already been initiated by the GMC and several Trusts by the introduction of Induction specifically directed towards the new IMG recruits. However, I feel this in no way covers the cultural and behavioural issues. It does not teach or provide a safety-net for the individuals. A much better way to cover these issues is by reaching out to individuals through 'mentoring'.

BIDA, through the efforts of Prof Romesh Gupta was the first organisation to recognise and promote the ethos of mentoring in the 90s. This way of communication and friendship, senior to junior or peer to peer is now conventional, proven and acceptable building up a buddy relationship. Unfortunately, this has not been taken up seriously by our colleagues in the context of what we are discussing. BIDA has been trying to promote and rejuvenate mentorship but much more effort is required in this direction. We need a pro-active step to reach out to as many as possible. The newcomers need to be made aware of the new culture they would be working in but also the art of non-clinical soft skills. Our BIDA Student Wing members and the Resident doctors have now taken a positive step towards achieving this goal.

BIDA is organising its 2025 annual conference this year on the theme of "Prevention through education". This should encompass every aspect of medicine from Primary care, Social Care and Secondary care. We have assembled experts from different specialities who will focus on the preventative aspects, whether it is to do with FTP referrals, complaints, health inequities or illness. The emphasis for all health leaders should be on community care which includes social care. Ideally, Public health should be brought up into the NHS mainstream. Will this ever happen? Will social care ever have sufficient funding?

**Prof Amit Sinha** *FRCS (Tr&Orth)*
*National President, BIDA.*
*Consultant Orthopaedic Surgeon.*
*Honorary Clinical Professor, Chester University.*

# BIDA National Chairman's Report

## Dear Friends,

I hope you are all enjoying the British Summer weather. As I write this report, we are into the fourth day of Resident Doctors Industrial Action. It is rather unfortunate that despite all the promises around achieving pay parity by the government, we have ended up here again. Also on the horizon is a possible Industrial action by the consultants. In an era when NHS is already stretched to its limit and waiting times are very long, last thing needed is any further industrial actions. BIDA would like to urge the health secretary and the government to engage in meaningful and constructive dialogue with doctors to avoid any further strike action.

We are in the 50th year of BIDA and we will be celebrating this milestone during our BIDA National Congress, ARM/AGM in September. I would urge members to join us in these celebrations. Preparations for our International Congress in Mexico and Costa Rica are progressing extremely well.

Whilst the EC and Office bearers remain committed to achieving and ensuring equality and fairness for all, we would also like to hear from our members. Please do write to us if you need any help, guidance or have any suggestions. We would love to hear from you.

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 G.P. Forum Chair's Report

**Dr Rakesh Sharma** MRCGP
Clinical Lead, Mental Health. Board Member, East Lancashire Clinical Commissioning Group (CCG).University of Greater Manchester.
G.P. Forum Chair, BIDA

## Dear Colleagues,

The NHS 10-Year Plan, launched with ambitious aims to modernise healthcare, promises to transform the system through digitisation, integrated care systems (ICSs), and workforce expansion. However, from the perspective of family doctors, who currently provide the backbone of primary care, the plan may inadvertently undermine the very essence of what makes general practice the most cost effective, efficient, and trusted part of the NHS.

Continuity of care, a cornerstone of British general practice, has consistently demonstrated improved health outcomes, reduced hospital admissions, and greater patient satisfaction. Yet, the 10-Year Plan largely sidelines this principle in favour of access metrics and system integration.

Under the plan, care delivery will increasingly shift from traditional GP led practices to large-scale provider organisations, often through primary care networks (PCNs) and integrated neighbourhood teams. While these structures may improve access on paper, they fragment care delivery and erode the long-term doctor-patient relationships that define continuity. This model, where patients are seen by whichever clinician is available, potentially via remote hubs, reduces the role of the named GP to a nominal figure. Such industrialised care might work for episodic issues, but it fails patients with complex, long-term conditions who benefit most from relational continuity.

General practice remains the most cost-effective part of the NHS. A patient seen in general practice costs the system a fraction of the price of a hospital encounter. 90% of patient contacts happen in general practice, yet it only receives about 8% of the NHS budget. Early diagnosis, proactive disease management, and community-based care prevent costly interventions further down the line. Yet, the plan's emphasis on employing salaried staff within large, centralised structures risks losing the efficiency inherent in the independent contractor model. GPs who run their own practices have a unique incentive to manage resources wisely. They are not just clinicians but also stewards of NHS funds.

Moving to salaried models within larger federated organisations risks bureaucratisation and inflated overheads, as we've seen with other centralised NHS initiatives. The agile, responsive nature of small GP partnerships is being lost in favour of monolithic structures with less accountability and lower productivity.

The plan may not explicitly end the independent contractor model, but its trajectory is unmistakable. With the introduction of 'integrated neighbourhood teams' and ICS commissioning powers, general practice will be absorbed into the wider NHS machinery. The language of the plan which is focused on 'population health management' and 'system-led planning' leaves little space for the autonomy and localism that make independent GP practices thrive.

Many ICSs appear to see GP partnerships as inconvenient 'obstacles' Yet, these partnerships consistently deliver more value per pound than any other part of the NHS. GP practices never post a budgetary deficit unlike hospitals, which account for most of the NHS deficit. Removing them risks killing the golden goose in pursuit of 'one size fits all'.

If the NHS 10-Year Plan continues on its current path, we may soon find ourselves with a fragmented, depersonalised, and less efficient primary care system. Patients will lose their trusted family doctors. GPs will lose professional autonomy and purpose. The system will lose one of its best value assets. It is happening without public consultation and patients will not realise until it is too late!

Rather than phasing out the independent contractor model, the NHS should be investing in its evolution, enabling partnerships to lead digital transformation, expand multidisciplinary teams, and coordinate community-based care with continuity at its heart.

Warm regards,

**Dr Rakesh Sharma** *Chairman, G.P. Forum, BIDA.*

# BIDA National Treasurer's Report

## Dear BIDA Members,

It gives me pleasure to write as your National Treasurer for BIDA. We have managed to get the BIDA finances in a healthy state due mainly to the income generated from our fixed deposits and International Congress. Our membership income is steady, but I am hoping that increased membership will strengthen our finances even better. I request all of you to spread the word and increase our membership. BIDA accounts for 2024-25 have been produced by our accountant, Amir Zahoor, and has this been presented to both the Finance Committee and Executive Committee. I am grateful to Alison from the Central Office and Amir Zahoor for their work related to this. The accounts will be presented at the forthcoming AGM in September. I hope to see many of you at the ARM and AGM.

**Dr Vinod Gadiyar** *National Treasurer, BIDA*

# The Impact of **Hospital Design** on Patient Recovery

**Sakshi Manchanda** A Mom and a Builder

## Airports, Designs and Hospitals

On one of my several air travels, our very own Bengaluru airport in India impressed me with the design, simplicity and opulence. Being in the Real Estate and Design field, the one thing that struck me the most was the design, specifically how it was human centric. It was a fully functional airport, streamlined but at the core of the layout you could see thought was given to the fact that this space was meant for the passengers – not just to facilitate their movement from one place to another but for them to rest, eat, visit, relax, and move around. Having had an eye out for the building composition and schematics my entire career, it was a pleasant surprise. At the same time, I was forced to think in terms of my most recent experience in motherhood, a little over two years back. We all get sick from time to time. Some of us dread going to the hospitals; some of us more so than others. I am in the latter category. Never having had a surgery in my entire life, when I was informed that I would be giving birth via a C-Section – you can imagine my plight. While millions of women all over the world have this surgery when due, I had butterflies in my stomach. The rational side of me kept nudging that this should not worry me as much as it did; but I have never liked hospitals, never liked how they felt, or smelt.

At the onset of my career, one of the projects that I worked on was the construction of a hospital. I was too young to have any tangible input or impact on the design and fabrication of the hospital. It is now, 15 years down the line, that if given a chance I would like to do things differently. A walk through the bustling Bengaluru airport triggered the thought as to what a hospital should look like, smell like or what would I change to make it more welcoming, make it a place of recovery and relaxation as opposed to a place where I feel anxious.

## The Bipedal Creature and Data

The story of humans is our victory over nature, a dichotomy – we are more at peace with nature, and yet we strive to live as unnatural lives surrounded by technology, the conveniences of mechanisation, and fabricated attachments. Humans over thousands of years have evolved, slowly, to adapt to our environment – except this evolution takes time. Our bodies are not developed to co-exist with our current technological and artificial environment. The earliest recognised human species is Homo habilis, also known as "handy man", who lived in Africa from about 2.4 to 1.4 million years ago [1]. The beginning of the Homo sapiens lineage is 550K - 750K years[2]. The Industrial Revolution took place a little under 300 years ago. All our technology, all our modern conveniences tracked to the age of our bodies is negligible.

We need to understand the interdependence between humans, and the environment we inhabit. We live in a data driven society; a society where the influx of data is so overwhelming that it is imperative upon us to ensure that we utilise it to best suit our requirements, our goals, to enable favourable outcomes. It is critical to invest in the amount of care and thought we put into design of spaces affecting our lives to facilitate warmth and compassion. Social spaces, our homes, our public spaces need to be reflected in our health care facilities as well. I would argue that it is more crucial in these facilities than others – as a visitor, the patient, or a stay in a healthcare facility to enable recovery, facilitate recuperation and spend as little time as possible. We need to analyse the effect of the design of hospitals – how these human elements interface with the facility and it's moveable and fixed equipment, features, and technology.

Hospital visits are not recreational, seldom optional, rarely pleasurable and almost never self-indulgent. You go into a hospital, for a specific

reason and you want the best for yourself – best doctors, top of the line diagnostics, state-of-the-art technology, and latest medicines. Not many of us think that our care and recuperation are also driven by something as unremarkable as the location of the room assigned to us. Have you ever heard a patient talk to hospital staff about which room they would like to be recuperating in? For the most, if not all, of us this is a question we never ask, or frankly even think about. Hospitals are meant to be welcoming; however, they rarely are.

Keep aside being admitted to a hospital, we have at one point or the other waited to see the doctor. How does one feel waiting for a doctor's examination. The feeling is medically described as Nosocomephobia: it is a type of specific phobia, meaning it's an anxiety disorder focused on a particular object or situation. The best example is of a patient's blood pressure which is almost always higher than the normal when it is measured in the hospital [3]. A good doctor will factor this in, however, most won't. The medicines prescribed are based on what a doctor sees, and for us to know that our readings are higher at a certain place and our medicines are based on that – shows how acceptable it is for our hospitals to be the way they currently are.

## Life is Precious

In the world of healthcare, each stakeholder's goal should be to contribute towards ensuring the most favourable outcome for the patient. One research article [4] by Ravideep Singh of CDA Architects, aptly summarises patient recovery rates to several factors including infection control, lighting in the areas of recovery, views accessible to the patient and friendly caregivers. India has taken giant strides in patient well being, hospital design and additional steps to enhance patient care. India's Hospital design guidelines focus on creating functional, safe, and patient-centred healthcare facilities.

◆ Significant data is available to assign correlation between healthcare facility design and Patient recovery. Covid19 is one of the many virus attacks on humanity, which helped define precautions and control spread of the deadly infection. Whether it is use of hand sanitizers or the safe distance between patient beds, every scientifically proven precaution has been introduced in Indian hospitals to increase patient recovery rate. However, India needs to do better to reach the level of advanced nations.

◆ Hospital design and infection control may seem unrelated. Study suggests that strategically located hand-wash sinks and hand sanitisers (especially near patient areas) have promoted handwashing amongst the caregivers – enabling better infection control within the facility. Hospital acquired infections are not uncommon. My husband is of the strong belief we should spend the least amount of time in hospital rooms. Data does seem to support him. At any given point in time, it is estimated that 1 in 31 patients suffer from an infection that they get from the hospital [5]. This important key indicator is a direct correlation between patient care, patient recovery and hospital design,

◆ Bright Natural light, well-lit open spaces and greenery has positive affect on patient morale and psychological response to getting well soon. Optimal natural light and views have been found to stimulate patients' positive immune responses; Dingy rooms and off-colour painted walls demoralise patients and tend to negatively impact the patient's will to recover. And with this information I wonder whether the four days that I took to recuperate from the C-Section in the hospital room had anything to do with the fact that there was natural light. We had a large window – that sadly overlooked another wing of the hospital, with minimal natural light.

◆ Acoustics, stress and caregiver satisfaction affect the patient. Lack of sleep, noise, distressing environment, affects both the patient and the caregiver. Minimizing stress amongst the caregivers enables them to better focus on the patients' individual needs, eliminate medical errors, and render quality care. Employing the right materials and finishes, like sound-absorbing ceiling tiles along with strategic spatial planning can result in minimizing stress and overall patient and caregiver satisfaction. This seems like a small thing; but again, going back to my one experience being admitted for the birth of my baby, I do see gaps there. The primary care giver was my husband. He had a bed in my room that was made of rocks. The ongoing barrage of hospital staff, who came in to "check in" on things did not make thing easier. I can understand the need for regular cleaning, I cannot understand the loud doorbell or the unnecessary questions around whether the TV is working, or whether we needed food.

◆ Every colour has a soothing effect when used intelligently. Abundance of white, neutral, pastel colours, browns and green imbibe the spirit of good health and positive thinking. In children's areas, prolific use of pinks and soothing colours are used to balance between colourful and calming tones. A mix of orange and calming blue achieves the equilibrium of vivid and soothing interiors.

◆ Improving Indoor Health has become an important goal after Covid19 epidemic. Precautions around indoor health has increased with focus on paint used in the interior walls, installation of air purifiers and regular check of air vents. Healthcare designers take special

consideration for sensitive hospital environments that are more prone to infections. The indoor air has a lasting impact on patients' health and recovery.

## The Guidelines

Hospital design and care guidelines consider patient comfort, safety, and efficiency [6]. Across all studies and research in this subject, the process of designing a hospital involves a multi-disciplinary approach that balances architecture, functionality, and medical technology. Basic design guidelines universally consider the following focus areas.

- Patient areas: Have enough space for equipment and allow for easy access to nurses. This factor has been an area of concern.
- Utility areas: Keep utility areas clean and separate to minimise staff and supply movement.
- Planning: Consider how to reduce travel distances and support growth.
- Privacy: Consider how to improve privacy and dignity.

## India

Hospital building norms in India are primarily governed by the National Building Code (NBC) and related guidelines from the Bureau of Indian Standards (BIS), along with the Clinical Establishments (Registration and Regulation) Act, 2010, which sets standards for clinical facilities. These regulations cover aspects like area requirements, safety, accessibility, ventilation, and fire safety. [7]

Key aspects of hospital building norms in India:

- Area Requirements: Hospitals need adequate space per bed, with recommendations ranging from 75 sq. m in India to 150 sq. m in developed countries. Specific areas like emergency and critical care zones require larger spaces. [7]
- Ventilation: Sufficient ventilation is crucial to control infections and recycle the air, with regulations for HVAC (Heating, Ventilation, and Air Conditioning) systems that must prioritize air quality through the use of HEPA (High-Efficiency Particulate Air) filters to maintain positive pressure, adequate air changes per hour, and humidity control. [7]
- Fire Safety: Hospitals must adhere to fire prevention, life safety, and fire protection measures. This includes fire zones, building classification, and fire-resistant materials. [8]
- Accessibility: Hospitals must ensure accessibility for all, including people with disabilities, with specific provisions for ramps, lifts, pathways, and signage. [8]
- Infection Control: The Clinical Establishments Act emphasizes infection control measures, including hand hygiene, personal protective equipment, and waste management. [9]
- Open Spaces: Adequate open space around the hospital building is required for patient and emergency vehicle movement, ensuring free access for fire-fighting vehicles. [9]
- Building Height: Room heights should be between 3 and 3.65 meters, with a minimum height of 2.6 meters under beams and fixtures. [9]
- Signage and Wayfinding: Clear signage and wayfinding systems are essential for guiding patients, staff, and visitors within the hospital. [9]
- Emergency Preparedness: Hospitals must have plans for managing emergencies and disasters, including adequate evacuation routes and emergency services. [9]

## Specific Guidelines:

Indian Public Health Standards (IPHS):

- These guidelines, revised in 2022, provide detailed standards for public health institutions, including district hospitals, sub-district hospitals and primary health centres. [10]

IS 12433-2 (2001):

- This Indian Standard provides basic requirements for hospital planning, including area requirements and functional program. [11]

Hospital building regulations in India aim to ensure safe, accessible, and functional healthcare facilities that meet the needs of patients and staff. These norms are constantly evolving to incorporate new technologies and best practices, with the National Building Code serving as the primary reference point.

## United Kingdom:

In the UK, hospital building norms are primarily guided by the NHS England's Health Building Notes (HBNs) and Health Technical Memoranda (HTMs). These documents provide comprehensive guidance on the design, planning, and construction of healthcare facilities, covering aspects like circulation spaces, infection control, and environmental considerations. Additionally, the Building Regulations and the Health and Safety at Work Act 1974 play a crucial role in ensuring safety and quality. [12, 13, 14, 15, 16]

Key aspects of hospital building norms in the UK:

- Health Building Notes (HBNs): These documents provide guidance on the design and planning of new healthcare buildings and the adaptation of existing facilities. They cover a wide range of topics, including circulation spaces, infection control, and environmental considerations. [12, 14, 17]
- Health Technical Memoranda (HTMs): These memoranda offer detailed advice on the design, installation, and operation of specialized building and engineering technology used in healthcare. They focus on healthcare-specific standards, policies, and best practices. [13]
- Building Regulations: These regulations, along with Approved Documents (e.g., Approved Document F on ventilation), ensure the safety and quality of building designs and construction. [15, 16, 18]
- Health and Safety at Work etc Act 1974: This Act ensures that workplaces, including hospitals, are safe and healthy for employees. [15]
- BREEAM: This is the preferred environmental assessment and certification scheme for healthcare buildings in the UK. [15]
- Infection Control: Building design must consider and mitigate the risk of infection transmission, often involving strict national regulations, according to a study on building new hospitals published in 2006. [19]
- Procurement: ProCure23 Framework is the recommended procurement method for publicly funded capital projects over £1 million, and Principal Supply Chain Partners have developed repeatable room arrangements compliant with HBNs and HTMs. [13]
- Sustainability: Sustainability is a key consideration in healthcare building design, with guidelines emphasising the need to balance required features and standards against capital and operational costs. [19]
- Accessibility: HBNs and HTMs address the need for accessible design to ensure that all patients, staff, and visitors can easily navigate the facilities. [20]
- Acoustics: Design should address noise levels and vibration, particularly in areas where patients are at risk of disturbing others. [21]
- Patient Experience: Design considerations include patient privacy, dignity, and comfort, as well as the needs of staff and visitors. [20]
- Same-sex accommodation: HBN guidance has been reviewed to support the provision of same-sex accommodation in line with the Department of Health's Delivering Same-Sex Accommodation (DSSA) programme. [22]

## Healthcare Endgame:

In essence, the Building Safety Act and its associated reforms are a direct response to past failures, aiming to create a more robust and safer building environment in the UK. While in India, building standards while essential for safety and sustainability, have faced challenges in their implementation and enforcement. Lessons learned include the need for more robust standards and the importance of balancing safety with affordability and economic activity. Furthermore, inconsistencies in

enforcement and adherence to regulations, along with issues like illegal construction and malpractices, have contributed to building failures and tragedies, highlighting the need for improved transparency and accountability.

The phrase "we are social animals" refers to the inherent human tendency to form connections, cooperate, and engage in social interactions with others. This social nature is a defining characteristic of humans and is crucial for survival, well-being, and societal development. I think with the new age, technology and prolific use of systems in our environments understanding "the interrelationships between humans, the tools they use, and the environment in which they live and work" [(3)] is basic to any study of the design including that of a health care facility and its effect on the performance of the patients, nurses and other caregivers who interface with the facility and its fixed (e.g., oxygen and suctioning ports on the wall of a patient room) and moveable (e.g., a patient bed) equipment and technology. Humans do not always behave clumsily, and humans do not always err, but they are more likely to do so when they work in a badly conceived and poorly designed [(23)] health care setting.

One must realise that even with the best of the guidelines, with the purest of the intents, the fundamental requirement of a hospital is to heal. The interconnectedness of mind and body is a cornerstone of holistic health. We need to recognise that physical health is deeply influenced by mental and emotional states, and vice versa. Stress, anxiety, and negative thought patterns can manifest as physical ailments, while physical illness can significantly impact mood and cognitive function. True well-being requires addressing both the mind and body in a comprehensive manner. The environment plays a crucial role in shaping both our mental and physical well-being. Our social environment also has a significant impact. Supportive relationships and strong social connections promote mental and emotional resilience. Design is not just about aesthetics; it's about creating environments that support our mental and physical well-being. The mental effect on physical healing is a complex and multi-faceted phenomenon, this includes physiological mechanisms like stress responses, immune function, pain perception, and health behaviours and psychological mechanisms like sense of control, social support, meaning and purpose. By understanding the physiological and psychological mechanisms involved, and by applying these insights to healthcare design, we can create environments that promote healing and well-being. It requires a holistic approach that considers the mind, body, and spirit of the patient.

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## Sakshi Manchanda

Balancing blueprints and bedtime stories, Sakshi Manchanda is a real estate builder and hotelier by day and a mom by... well, all the other times. With a knack for turning dreams into driveways (and occasionally negotiating snack-related treaties), she brings a unique blend of construction expertise and maternal intuition to every project. She believes that a well-designed building should stand the test of time – just like a good Lego fortress. When she's not hammering out deals or singing for her toddler, you can find her working on her rooftop garden.


# Professional Voice Users Clinic (PVUC)

**Dr Anita P Sonsale** MS (ENT), FRCS (Head, Neck & ORL), MSc (Voice Pathology) Consultant ENT Surgeon

## Introduction:

Professional voice user's clinic is a clinical service with a difference, offered in the ENT department at University Hospitals, Birmingham. This specialist clinical service continues to offer a specific patient-centred clinic for professional voice users.

Professional voice users are singers, professional, semi-professionals / Professional or semi-professional singers, teachers, lecturers. This is a multi-disciplinary NHS clinic with a Laryngologist, a Speech and Language therapist and a Singing Coach present in the clinic. This unique clinic is held twice a month.

*Above: Queen Elizabeth University Hospital, Birmingham.*
*Below: The PVUC Team (left to right): Sarah Wright Owens, Anita Sonsale, Paige Bradley.*

## Aim:

Singers, teachers, lecturers depend upon their voice for their livelihood. The voice is their financial and emotional strength. The demand on their voice can be varied and for prolonged hours. Many of this cohort may even perform for many hours and hold two or more jobs. The demand may have seasonal impact. Not all singers or professional voice users are financially able to afford treatment in the private sector. The professional voice user's clinic at Queen Elizabeth Hospital is a Regional/National Referral Centre and accepts referrals from General Practitioners from different regions. The PVUC provides a multidisciplinary approach to understand voice issues in this group of patients.

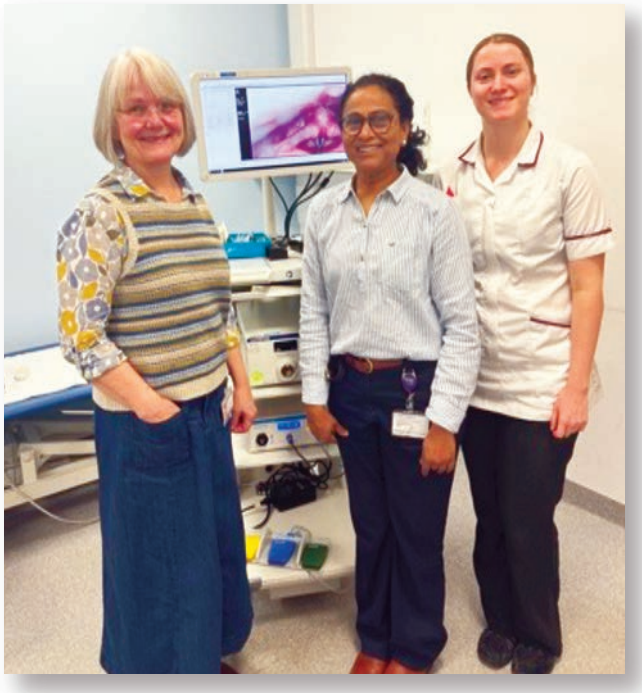
## Clinical Presentation:

The problems faced by these patients are changes in their voice, hoarseness, an inability to have the range of voice or sustain or project their voice, and many more. The problems are detrimental to the professional capabilities and have financial impact. Their livelihood is dependent on the number of performances/talks lectures. This also affects their well-being.

## Service Provision

Held twice a month, the PVUC is run by laryngologist and ENT consultant (with special interest in voice-related issues), Mrs Anita Sonsale, assisted by Speech and Language therapist Paige Bradley, and Singing Coach[1] Sarah Wright Owens. The aim of this multidisciplinary clinic is to examine, evaluate and underlying factors affecting the voice output to formulate a comprehensive plan to help.

The appointments are 30 minutes each and involves examining voice box with help of scope passing through nose, to back of throat.



## Assessment:

Patient are requested to sing/demonstrate a piece of singing with help of singing coach after warming up vocal exercises. These vocal exercises allow the voice box/larynx to stretch adequately like the physical stretch before running.

Every patient has a comprehensive assessment using a flexible scope to examine the voice box-vocal cords in action and structure (Fig 1).

The vibration on the vocal cord is examined by Stroboscopy [2]. The examination is recorded using simple vocal tasks like sustained 'eeee' and counting numbers. The patient is asked to sing or demonstrate piece of vocal task to examine the functionality of the voice box/ larynx. This allows video documentation of laryngeal structure and function. The stroboscopy is a special method to visualise the vibration of the vocal cords and biomechanics (Fig 2). The vocal cord motion is captured using a light which synchronises with the vocal function and plays back in slow motion allowing human eye to identify fine changes in vocal cord lining, function and impact of airway. Stroboscopy gives the information of pliability of vocal cords, vibrations, symmetry, movement and gap between the vocal cords.

The commonest problems seen in professional voice users are shown in Figures 3 – 6. They occur due to lack of adequate warm up, cool down exercises, overuse/misuse and optimal training of voice [3].

Video recording of the vocal function allows explanation in simple terms and identifies finer details. Visual explanation provides better insight in the function and issues of the larynx.

It gives the team to formulate plan of treatment with the patient. The patient is involved in decision making which include singing coach tips and sessions outside the clinic, session with speech therapist and surgery if needed. Surgery on vocal cords is very precise with minimum handling to avoid scarring. Any scar in the vocal cord may affect the voice negatively affecting their career [4, 5].

The patients are reviewed in the PVUC clinic after the agreed plan.

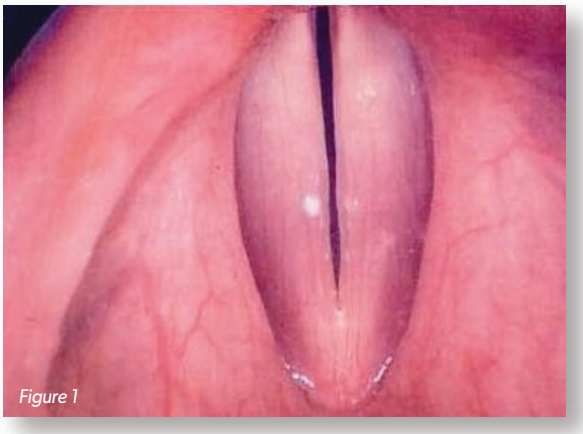
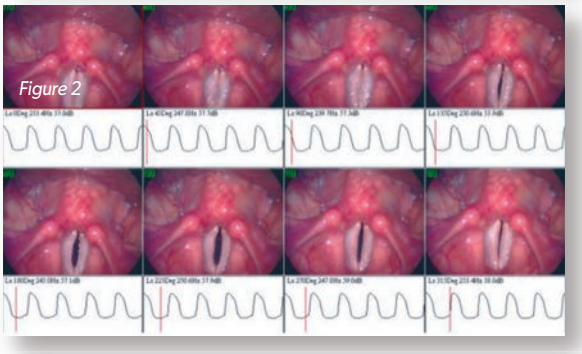


Figure 1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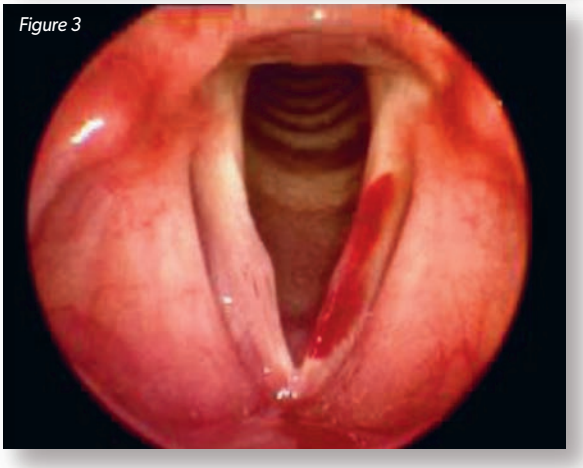
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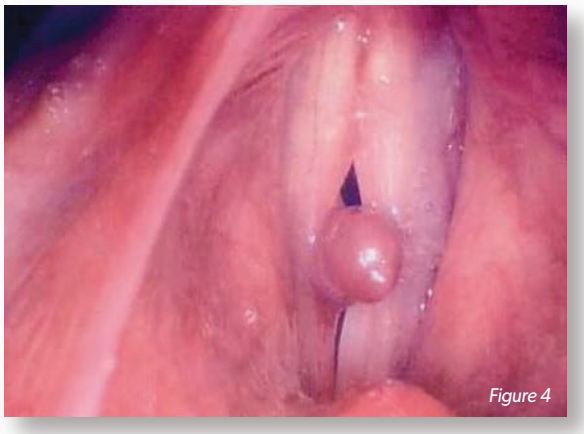
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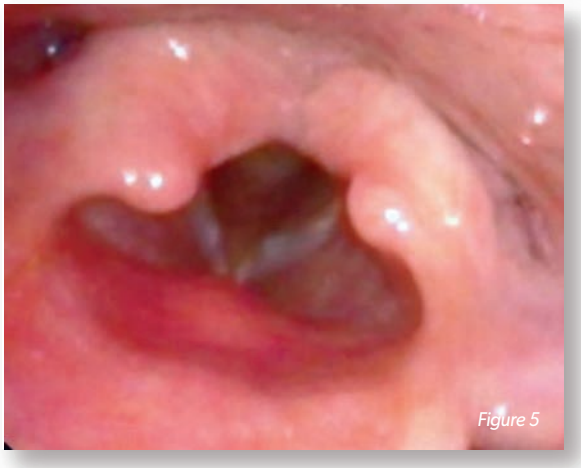
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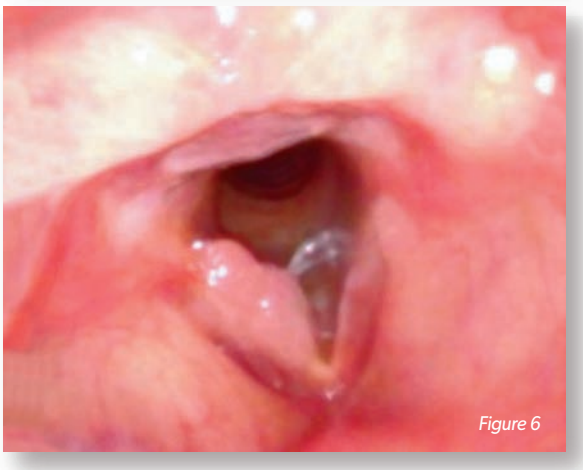
Figure 6

For further information, contact ***Teresa.prosser@uhb.nhs.uk***, secretary to Laryngologist Mrs Anita Sonsale.

*Pictured left, top to bottom:*
*Fig 1: Normal voice box /larynx*
*Fig 2: Stroboscopy*
*Fig 3. Vocal cord haemorrhage*

*Pictured above, top to bottom:*
*Fig 4. Vocal cord polyp*
*Fig 5. Vocal nodules*
*Fig 6. Vocal cord Papilloma*

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# Have you heard about Medical Examiners?

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Consultant in Acute Medicine. Service Lead Medical Examiner. Appraisal and Revalidation Lead, Oldham Care Organisation, Northern Care Alliance

**From 9 September 2024, all deaths in England and Wales are being independently reviewed, either by a Coroner where they have a duty to investigate, or by a Medical Examiner.** [1]

### Who are Medical Examiners? [3]

1. Medical Examiners (MEs) are senior medical doctors who are contracted to provide independent scrutiny of the causes of deaths not investigated by Coroners, outside their usual clinical duties.
2. They are trained in the legal and clinical elements of death certification processes.

### What are the duties & responsibilities of the Medical Examiners? [3]

Medical Examiners:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide bereaved people with an opportunity to ask questions and raise any concerns to someone not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

### What are the 3 important questions that Medical Examiners seek to answer?

1. What caused the death of the deceased and is the MCCD accurate?
2. Does the coroner need to be notified of the death?
3. Was the care before death appropriate? If the ME detects any clinical governance concerns, the ME would refer cases for further review, but do not investigate themselves as their scrutiny must be completed rapidly.

### How do Medical Examiners answer these 3 questions?

Medical examiners answer these by providing independent scrutiny, with 3 elements:

1. a proportionate review of relevant medical records
2. interaction with the Attending Practitioner (AP) completing the Medical Certificate of Cause of Death (MCCD)
3. interaction with a bereaved person, providing an opportunity to ask questions and to raise concerns

### Are you interested in becoming a Medical Examiner?

### Q: Who can be a medical examiner? [1]

Section 19 of the Coroners and Justice Act defines the requirements for medical examiners: "A person may be appointed as a medical examiner if, at the time of the appointment, he or she:

a) is a registered medical practitioner and has been throughout the previous 5 years, and

b) practises as such or has done within the previous 5 years."

The National Medical Examiner recommends that medical examiners should be:

- Consultant grade doctors of any specialty OR

- Other senior doctors from a range of specialties (including GPs) with an equivalent level of experience.

### What training do I need if I want to be a Medical Examiner? [3]

The Medical Examiners (England) Regulations 2024 and The Medical Examiners (Wales) Regulations 2024 require that:

(a) Medical Examiners complete 24 core e-learning modules before starting work and

(b) also complete face-to-face/virtual training provided by the Royal College of Pathologists within 6 months of starting work.

- In addition to the 24 core modules, there are 61 other e-learning modules. Their completion is not a mandatory requirement but will help medical examiners in performing their role.
- Once appointed, medical examiners should undertake continuing professional development (CPD) activities relevant to their role.

### What is the job description for medical examiners? [1]

1. The Medical Examiners (England) Regulations 2024 and The Medical Examiners (Wales) Regulations 2024 set out the requirements for medical examiners' terms and conditions.

2. The Royal College of Pathologists has published a model job description.
3. Medical Examiners must be appointed by NHS bodies in England and Wales and are employed by NHS trusts in England and by NHS
   Wales Shared Services Partnership (NWSSP) in Wales.
4. The medical examiner role is classified as an additional responsibility.
   -) It either replaces a direct clinical care (DCC) programmed activity or is an addition to this in an existing job plan, depending on what is manageable for the individual.
   -) The role must not be undertaken in SPA (supporting professional activities) time.

## How many sessions does a Medical Examiner work?

Medical Examiners normally work for 1 or 2 sessions per week.

## Can I be a Medical Examiner after I've retired?

Medical examiners who are appointed after retirement can continue to work as MEs for as long as they remain a registered medical practitioner with a licence to practise.

## What is the medical appraisal/revalidation requirements for Medical Examiners?

1. The Royal College of Pathologists has published information to support appraisal and revalidation of medical examiners.

- Medical Examiner duties must be covered in their whole practice appraisal.
- In both England and Wales, medical appraisal and revalidation for medical examiners will be governed by the usual General Medical Council (GMC) guidance.
- Appraisal will be undertaken by an appraiser approved by the relevant Responsible Officer.

## How are Medical Examiners managed? [1]

The responsibilities of medical examiners are governed by the Coroners and Justice Act 2009, the Medical Examiners (England) Regulations 2024, the Medical Examiners (Wales) Regulations 2024 and the Medical Certificate of Cause of Death Regulations 2024.

- Medical Examiners (MEs), supported by Medical Examiner Officers (MEOs), are based in local Medical Examiner Offices.
- In England, each Medical Examiner Office has a Lead Medical Examiner providing overall leadership to the office, and in Wales the Lead Medical Examiner for Wales has this role.
- In addition, NHS England employs Regional Medical Examiners to provide regional leadership and guidance.
- Day-to-day management and oversight of medical examiners operates through local line management arrangements with the employing NHS body.

## Are Medical Examiners independent?

The Medical Examiners (England) Regulations 2024 and The Medical Examiners (Wales) Regulations 2024 set out requirements for the independence of medical examiners.

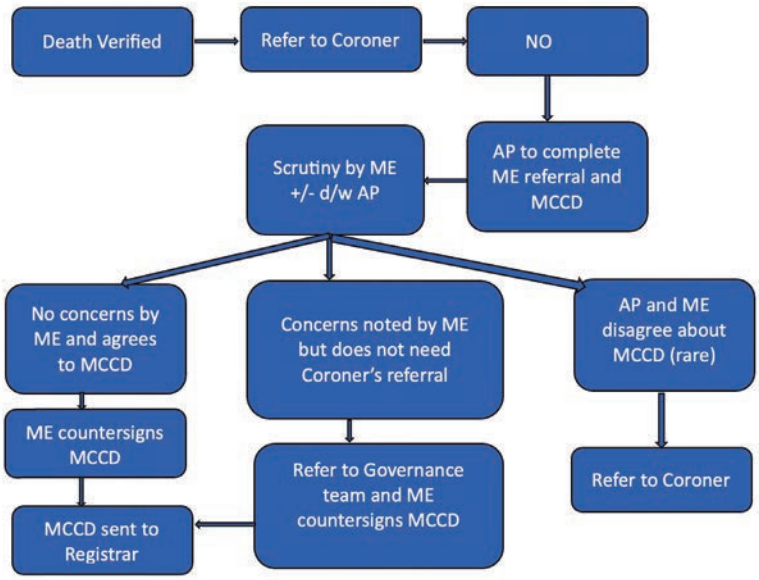
(a) medical examiners must not have provided care for the deceased person or be part of the team that provided care

(b) they must not be related or closely related to the deceased person or to the attending practitioner or to any relevant medical practitioner, either personally or professionally

(c) they must not have a financial interest in the estate of the deceased person or have another other connection with them that could give rise to reasonable doubt about their objectivity.

## What are the major benefits of the Medical Examiner Service?

1. A key feature of the ME service is that it has improved support for bereaved people.
2. The experience of bereaved people has further improved by the changes brought in by the Death Certification Reforms which affect other parts of the death management process such as the work of Attending Practitioners, Register Offices, Coroners and Cremation services.




*Above: A chart showing the overview process for death certification.*

## How to complete an accurate MCCD?

Cause of death has 2 parts:

*Part 1:*

the immediate, direct cause of death including the sequence of events or conditions that led to death

1a: disease or condition leading directly to death

1b: other disease or condition, if any, leading to 1a

1c: other disease or condition, if any, leading to 1b

1d: other disease or condition, if any, leading to 1c

*Part 2:*

Other significant conditions contributing to death but not related to the disease or condition causing it

## Tips:

- 1a: start with the immediate, direct cause of death
- 1b to 1d: go through the sequence of events or conditions that led to death on subsequent lines b to d until you reach the condition that started the fatal sequence.
- So, the condition on the lowest completed line of part 1 will have caused all of the conditions on the lines above it. This initiating condition, on the lowest completed line of part 1, will usually be selected as the underlying cause of death, following ICD coding rules.
- The conditions mentioned in part 2 must be known or suspected to have contributed to the death, not merely be other conditions which were present at the time.
- Wherever possible, you should provide the duration of each disease or condition, referred to as the 'approximate interval between onset and death' on the MCCDs, although the medical record may not always support this.

**Example 1:**

| | Disease or Condition | Duration |
|---|---|---|
| 1a: disease or condition leading directly to death | Myocardial infarction | 2 Days |
| 1b: other disease or condition, if any, leading to 1a | Ischaemic heart disease | 5 Years |
| 1c: other disease or condition, if any, leading to 1b | Coronary artery atheroma | 10 Years |
| 1d: other disease or condition, if any, leading to 1c | Hypercholesterolaemia and tobacco smoking | 15 Years |
| 2: other significant conditions contributing to death but not related to the disease or condition causing it | Non-insulin dependent diabetes mellitus | 20 Years |

In some cases, a single disease may be wholly responsible for the death.

**Example 2:**

| | Disease or Condition | Duration |
|---|---|---|
| 1a: disease or condition leading directly to death | Meningococcal septicaemia | 5 Days |
| 1b: other disease or condition, if any, leading to 1a | | |
| 1c: other disease or condition, if any, leading to 1b | | |
| 1d: other disease or condition, if any, leading to 1c | | |
| 2: other significant conditions contributing to death but not related to the disease or condition causing it | | |

**Is Old Age acceptable as a cause of death:**

1. Avoid 'old age' alone
2. Old age or 'frailty of old age' should only be given as the sole cause of death where all the following circumstances apply:

- the deceased was over 80 years old
- you have personally cared for the deceased over a long period - this is difficult to define, but we would suggest at least several months
- you have observed a gradual decline in your patient's general health and functioning
- you are not aware of any identifiable disease or injury that contributed to the death
- you are certain that there is no reason that the death should be reported to the coroner

3. You may mention old age or frailty as a contributory cause in 2, especially if it explains the severe effect of a condition that is not usually fatal.

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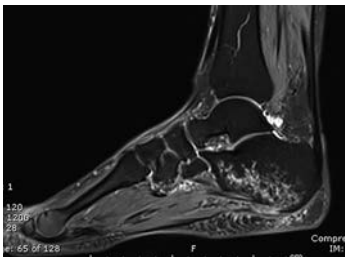
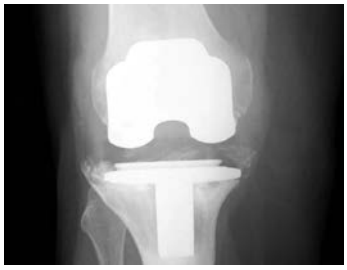
# BIDA Radiology Quiz

*Answers on Page 25*

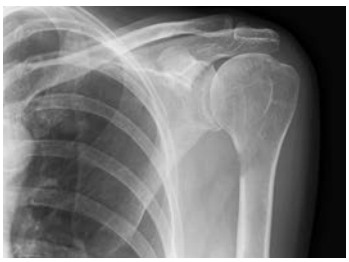
**1** A 61-year-old lady of African descent has returned from a month long trip to her village in Ghana. Since her return 2 weeks back she has been complaining of increasing pain in her right heel. A week prior to her return to the UK, she had an injection given to her right heel by a village quack doctor for a possible diagnosis of plantar fasciitis. The heel is now swollen and tender. Systemically she was well. She can't bear weight on her heel. She is a diabetic and also suffers from Sickle cell disease. Plain X-rays were normal. Blood tests showed mildly raised White cell count and CRP. What do you see on MRI scan? What is the diagnosis?



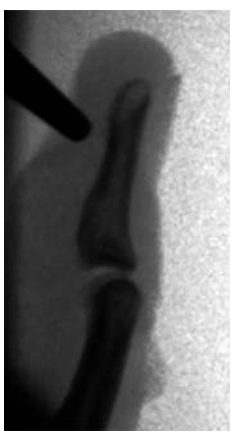
**2** An 81-year-old gentleman had a total knee replacement 17 years ago. Recently suffered from significant dental sepsis. There some delay in seeing the NHS dentist. For the past 2 months he has been complaining of pain in his right knee, which is now swollen. He looks tired. His mobility is reduced. Knee movements are now restricted. He has IHD and hypertension. What do you see on Plain X-rays? What is the diagnosis?



**3** A 76-year-old lady complaining of vague pain in her left shoulder. It's a dull ache all the time even at night. Pain is occasionally aggravated when she attempts to do any overhead activities. Systemically she remains well. There is no history of any recent injury or infection. There is generalised mild tenderness all over her left shoulder. Axillary lymph nodes are not palpable. She has a history of diabetes and high blood pressure, both of which are well controlled. Blood tests are normal. What do you see on Plain AP view of her left shoulder? What is your differential diagnosis? What other tests are required here?



**4** A 19-year-old attended ED with painful left middle finger after he sustained an open dislocation of the DIP joint during a rugby tackle. He relocated the finger himself. He is otherwise fit and healthy. The open wound is on the dorsum of the DIP joint. The exposed extensor tendon is partially ruptured. The image is after repair of the tendon and attempted manipulation of the finger. What do you see on the X-rays? What is the diagnosis?



# Writing for Publication

**Prof David Brigden** Lancaster University Medical School Emeritus Professor, University of Greater Manchester

### Introduction:

As the number of medical students increases, the competition for foundation and specialist training posts becomes more intense. One way to strengthen your application is to show the selection committee that you have written articles that have been peer reviewed and published in respected journals. This article is intended to guide you through the process of writing for publication

An article may take many forms. Your article may describe some original research work carried out by you or by others; alternatively, it may provide advice which will be of relevance to your audience. For example, medical students will often be interested in case reports, educational articles and career advice.

Whatever you decide to write about, it must always be informative, but if you can make it engaging, then so much the better.

This article will show you how to present your ideas in an appropriate manner before submitting work for peer review. The article is split into 4 parts. The first part deals with searching the literature and developing your idea. It then describes how to plan the structure of your article. The third part offers instruction on how to go about writing your first draft. The final part addresses the process of writing in good English and editing your work.

### Literature Searching and Developing Your Idea.

A proper literature search involves a systematic exploration of relevant material already produced on a particular topic. There may be reasons to undertake the literature search:

- Discover what exists on a topic
- Increase your knowledge of the topic
- Use earlier work as a foundation or springboard
- Find gaps, errors or inconsistencies in previous work
- Generate ideas for your own work
- Avoid duplication of previous work
- Justify and lend authority to your work

Keep a record of all the potentially useful articles you discover. Make sure you record all the details necessary for the reference section. that will form the end of your article. It is a good idea to document these details thoroughly and consistently as you go along to avoid hours of painstaking work at the end; above all make sure your references are accurately reported in your finished article.

Be sure to know when to stop. It is easy to go on searching for new material, ending up with too many references that do not add anything to your arguments. It is much better that you provide only necessary references that support your arguments without overwhelming or confusing the reader. A large number of cited references does not necessarily mean your article will be well received by the peer reviewers.


The type of article you reference is also important. Many writers like to start a literature search with the internet. However, it is always worth cross-checking web-based information against traditional sources; the internet is quicker, but the material is often less reliable. It is better to concentrate on primary and published research articles (where possible) when getting to grips with the current literature on your topic of study. Using non primary published articles should be the exception rather than the rule.

In summary, you should ensure that your references are:

- accurate
- appropriate (not too many)
- primary and published where possible.

Once you have established your idea, use it as a focal point for a mind map. From this mind map begin to consider different areas you wish to cover and use them as your initial headings. Write any thoughts under your headings and begin to create a visual picture of how the various elements can be connected. Bounce your ideas off others; ask for their comments about whether or not they think anyone would be interested in the topic you have in mind. They may point you in a different direction or you may realise that there is still a great deal of work to be done. Your mind map and initial thoughts form the skeleton of your article; you now need to begin to add the flesh!

An article is no different from any other piece of written work in that if it is going to succeed, it must be well planned. Your plan is how you intend to structure your article and guide your audience from start to finish. First you need to break the article down into 3 parts:

- introduction
- body (methods, results, discussion)
- conclusion

Each part needs to be carefully considered, with your main points running as a continuous theme throughout. Details can be refined when writing your first draft. Time spent on planning is never wasted.

Once you have your plan, you can start to write in more depth, expanding on your main points.

### Writing your first draft

Remember the three basic parts previously mentioned, you need to star with a concise introduction that defines the topic that you are going to be writing about. It is essential to highlight the most important points you are going to cover in order to give the reader a good idea of what the article is about. Writers often struggle with their introductions because they think it must be pithy and witty otherwise, they will immediately lose the reader's attention. The introduction can be the hardest part to write, so it is sometimes better to put off writing it until the end. Apart from anything else the final version may not resemble the first draft, so if you write your introduction last, you will have the advantage of knowing exactly what is in your article.

You need a middle section, which forms the main body of the article. This is where your main points will be discussed in detail and the majority of your work will be presented. Keep your paragraphs short and restrict each one to a single point. Draft out the order in which you think they should be arranged. The paragraphs may fall into some sort of chronological order or you may decide that they should be arranged in a hierarchy of importance. Ensure that your paragraphs flow naturally and do not read as a series of disjointed points.

Finally, your ending should reiterate your main points to the reader. Make sure these are clear before finishing with your conclusions and opinions. There is a saying that is applicable to both giving a presentation and to writing: 'Tell them what you are going to tell them, tell them, then tell them what you have just told them'.

### Good English must be clear, concise and correct.

Doctors do not need to be good writers to be good clinicians, but if your idea is ever going to be published then you must be able to write well. It is therefore vital to have a good understanding of the structure of the English Language. Essentially 'good' English should be clear, concise and correct. The final part of this article deals with writing good English, editing and redrafting. It highlights some of the basic rules of English grammar and punctuation and outlines a strategy for editing.

In a vain attempt to impress the reader, some authors construct long sentences made up of clauses, sub-clauses and phrases, all of which are separated by commas. It is better to have a number of short sentences than one long sentence. This makes sure that the meaning is not obscured by overuse of commas. You should avoid superfluous words and phrases (e.g. 'at the present time' instead of 'now'), as they serve no other purpose than to waste time and distort meaning.

Ambiguity is the sign of poor writing and can be caused by 3 things:

- poor syntax
- incorrect or overuse of punctuation
- overuse of pronouns

The arrangement of words and phrases to create grammatically correct sentences is known as syntax. The normal word order is subject, verb, object, dependent clause. You are less likely to make syntactical errors if you restrict the length of your sentences, but too many short sentences will make the article seem disjointed. To avoid this, you should try to vary the length of your sentences to help retain the reader's attention.

Reading anything that is littered with punctuation is difficult. As a general rule leave out all punctuation except full stops in the first draft, and only insert commas, semicolons and colons later where they are absolutely necessary to the meaning and sense. A full stop is used to mark the end of a sentence. However, it is acceptable to separate a series of short sentences using semicolons or commas. Modern writing tends to omit full stops after initials or abbreviations for example 'B.M.J.' is better written as 'BMJ'. Colons are used in front of a list, or to divide a sentence where both parts are grammatically complete in themselves. Semicolons are generally used to separate items in a list where each item could form a sentence in itself. A comma is used in complex sentences to separate clauses. The apostrophe is a much-abused punctuation mark. It serves one of two purposes: it shows that a letter has been omitted, for example 'it's' meaning 'it is'; or that something belongs to someone or something, for example, Dr |White's office.

In short, you should ensure every sentence is syntactically correct and punctuated appropriately; be consistent with the use of your punctuation. It is also much better to make the subject of a sentence clear by using their name rather than repeatedly using pronouns.

Every writer has their own method of editing their written work. The purpose of editing is to prepare the article for publication by correcting, shortening, improving it. Once you have your first draft, read the article through checking for spelling mistakes and syntactical errors. Don't forget to check factual information, such as names. It can also be useful to get someone else to read through it, to check again for anything you may have missed.

### Conclusions:

Writing for publication is a skill which must be developed through practice. Writing can be a complex process because of its very personal nature, but it can be simplified by approaching it in a methodical way as has been suggested here.

Once you have formed your initial idea you need to carefully think about how to develop it. Consider your initial framework and areas you wish to cover, before analysing your thoughts in depth. Then begin to put your ideas onto paper, as a first draft. Ensure all of your main points are covered before dealing with the important issue of grammar and clear writing. Once you have edited and are happy with your work, submit for publication.

### Take home messages:

- writing publications can strengthen a candidate's application for a training post
- this article explains how to write successfully and get published, and gives tips on how to negotiate the peer review process
- mind mapping can help generate ideas for publication
- good grammar will create the right impression with journal editors.

# Teaching Ethics to Medical Students and Junior Doctors

**Prof David Brigden**
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**Abhinav Yeeda, Ethan Little**
2nd Year Medical Students (Lancaster University)
**Humraj Singh, Hannah Nixon, David Mkwizu** 1st Year Medical Students (Lancaster University)

## Introduction:

Traditionally, doctors learned about ethics on the job. When faced with problems in clinical practice that challenged their moral beliefs, they were mandated to adopt new ethical reasoning and realign their emotive responses.

Learning of this kind will always be a component of professional development but nowadays there is a trend towards the formal teaching of ethics in all undergraduate medical curricula. This is because :

- Learning ethics is part of general education – the capacity to go beyond mere opinion, prejudice and 'gut reaction' and support ethical positions with reasoning informed by ethical theory.
- Ethical awareness is part of being a critical and reflective medical practitioner.
- External pressures on medicine from Government and other Regulatory Bodies have created a need for doctors to demonstrate accountability for ethical reasoning and decision making.

## The Four Pillars

Overarching the entirety of ethical pedagogy, the four pillars of medical ethics were first formally outlined in the influential 1979 book Principles of Biomedical Ethics by Beauchamp and Childress [1]. Since then, these principles (autonomy, beneficence, non-maleficence and justice) have become inherent to the initial teaching and comprehension of vital ethical concepts relating to healthcare. Medical and healthcare students are encouraged to apply these principles when navigating both theoretical and real-life ethical dilemmas.

Tschudin's 2003 work, *Approaches to Ethics: Nursing Beyond Boundaries* builds upon this foundation by incorporating broader ethical perspectives, particularly the concept of relational ethics [2]. This approach emphasizes that ethical practice is rooted in the relationships between healthcare professionals and those in their care, urging practitioners and students to deeply consider the individual needs and perspectives of patients. Teaching such frameworks to medical students is essential in response to the nuanced realities of patient care, and to prepare students to adapt and expand their ethical reasoning.

## Current Ethical Debates

Ethical debates endlessly course through the healthcare sector, often influenced by - and influencing - the moral paradigm of professional practice.

### GPs allocation of time in surgery

The allocation of time in GP surgeries raises several ethical considerations across the four pillars.

- Justice may be compromised when time constraints result in unequal care, being particularly disadvantageous to vulnerable groups such as non-native speakers, the elderly, and those with mental health conditions.
- Autonomy can be undermined if patients are rushed through appointments, leaving little opportunity to voice concerns or make fully informed decisions.
- Beneficence is challenged when limited time prevents thorough assessments, reducing the quality and effectiveness of care.
- Similarly, non-maleficence is at risk, as time pressure increases the likelihood of errors or missed diagnoses, especially in complex cases [1].

Beyond these core principles, relational ethics are also affected: brief, impersonal consultations can weaken the doctor–patient relationship and erode trust. In such environments, GPs may face moral distress when systemic pressures prevent them from delivering the care they deem necessary [2].

### Decisions on providing child contraception

A key ethical dilemma for students and junior doctors is whether to provide contraception or abortion advice to children under the age of 16 without parental knowledge. As per UK law, children under 16 can consent to treatment if deemed competent under the Fraser Guidelines, which assess their comprehension of medical advice and the risks involved [3]. This is part of the broader Gillick competence framework [4]. Although parental views matter, clinicians must prioritise the child's best interests, while maintaining confidentiality - a balance requiring careful ethical and legal judgement.

### Challenges with Consent

Ethical issues surrounding consent are ramified by past scandals such as the Alder Hey Inquiry , where children's organs were retained without parental consent nor knowledge. This led to the ratification of the Human Tissue Act 2004, which enshrines informed consent as a legal requirement. Ethical teaching should empower future doctors to navigate debates on capacity, best interests, and presumed consent while preserving patient dignity at life's end.

## Teaching Ethics

Ethical teaching is an intrinsic aspect of professionalism that is inseparable from the flow of clinical practice: there is an unlimited scope for learning. This teaching is a prudential system of quasi-legal rules that doctors must know and be proficient in applying to their clinical practice.

The discipline of ethics draws on the theories of anthropology, philosophy and social psychology. These theories can be made relevant to clinical practice by introducing selected cases as illustrations. Alternatively, ethical theories and their potential insights may be extrapolated from the critical reflection and dialogue that doctors engage in on a daily basis.

Prudential teaching tends to be prescriptive, delivering required knowledge, an understanding of procedures, and typical applications possibly set out as a Code of Ethics or predefined standards. This teaching tends to be didactic (e.g. lectures), whereas a more open approach, as used in Problem-Based Learning (PBL) / Case Based Learning, may be to 'brainstorm' ideas and produce a 'mind map'.

In PBL, small groups are confronted by cases or problems that, though often paper based, may represent something of the authenticity and complexity of ethical issues arising in clinical practice. Here is an opportunity to introduce the subtleties of ethics in professional practice without undue simplification or caricature. Clinical aspects of the problem may be developed first through the PBL cycle of problem formulation, objective setting, research, discussion and arrival at interim outcomes before the time is right to inject an ethical dimension to the problem. Learners may then proceed to deepen their ethical awareness and powers of justification developed in PBL using the reflective space of a learning journal or portfolio.

## Constructivist Approaches

Constructivism posits that learners construct knowledge by processing new experience through prior cognitive schemata rather than by receiving facts passively [5]. In medical education, this philosophy is manifest in PBL. When

such situations are deliberately - or even subtly - embedded with moral dilemmas, students learn to recognise and articulate ethical issues within the intricacies of biomedicine [6].

Learning then moves beyond the classroom via structured reflection. Journals and e-portfolios foster Schön's *"reflective conversation with the situation"*, enabling students to examine where personal values intersect with professional norms, a process that promotes metacognition, encourages epistemic humility, and evidences progress towards the General Medical Council's "professionalism and trust" outcomes [7]. So the teacher's role shifts from that of prescriptive expert to facilitator - developing psychological safety, posing provocative Socratic questions, and modelling a rigorous but non-directive approach to ethical analysis [6]. By collaborative inquiry, use of real-world contexts, and critical reflection, constructivist approaches mirror the moral ambiguity of clinical practice and enable practitioners to address ethical challenges directly with discrimination, informed judgment, and professional integrity.

## Socratic Questioning

Another approach could be to use Socratic questioning as a whole class strategy. Socrates, a 5th century philosopher, was renowned for challenging his interlocutors to define a controversial term such as justice. He then proceeded by critically questioning them, forcing them to qualify their initial definition, reveal assumptions behind it and admit inconsistent or absurd conclusions. In the medical arena when addressing the question 'what do we mean by patient consent?' learners may first venture definitions before being led to consider standard protocols and how far they apply.

### Organ Donation by an Unconscious Patient

For example, let us consider the circumstance of organ donation by an unconscious patient. Firstly, we must socratically analyse our initial statement and implore students to define key terms: what do we mean by 'organ donation'; what do we mean by 'unconscious'; and what do we mean by 'patient'?

In this specific scenario, the important concept to discuss is 'unconscious', of which there are many different levels. Although organ donation is usually only considered after a patient's death, there are some calls, not without substantial ethical friction, for patients in a permanent vegetative state (PVS) to be considered as potential donors [8]. Perhaps there will be a reignition of this discussion as the Terminally Ill Adults Bill continues through UK parliament [9].

In the case of post-mortem organ donation, a patient is only physically eligible to donate their organs if they are clearly brain-dead and their heart has stopped beating; and they have not previously 'opted out' of the organ donation system [10]. But how can we tell if a patient is brain dead? Are 'brain-death' and 'death' synonymous? What is death? Socratic questioning can rapidly cascade into discussions of fundamental, yet sometimes unknowable, truths; but these are the truths that garrison a student's ethical and judicial artillery.

## Social and Emotional Contexts

### Reflective Diaries

Engagement with ethics in the healthcare system is frequently emotionally charged, especially for medical students who are encountering it from a position of inexperience. Medical students may be faced with distress, confusion, and moral unease when confronting real ethical dilemmas. It may necessitate the need for intrinsic approaches to tackle the personal conflicts, stresses and turmoil.

Reflective tools can often provide a safe outlet for individuals to gain some perspective on the emotional 'heat' of their ethical issues [11]. It can be as simple as maintaining a diary or journal, that serves as a structured means for students to externalise and later examine these internal conflicts. This method encourages students to assess the ethical situations from a critical distance and develop a more mature ethical identity. It helps cultivate ethical and moral resilience, which are key attributes in clinical practice.

### Role-play simulation

Drama and role-play are commonly adopted classroom strategies used to confront ethical dilemmas. Actors are a practical way to present realistic ethical scenarios in medical practice, in a controlled and supportive environment. This can spur discussion and debates whilst drawing out learning outcomes.The actor/supervisor may temporarily come out from their role to assist with the debate, allowing for the introduction of new perspectives. Alternatively, students themselves can role play an ethical dilemma. Peer-led simulations can potentially be more congenial, while placing more focus on collaborative reflection. Such simulations can give learners a vicarious experience of the modes of ethical rea in soning to manage the emotional-complexity of empathising with the patient's perspective.

## Conclusions

When approaching any ethical situation, it is not just students' medico-legal knowledge being challenged, but their entire belief system. By combining constructivist, Socratic, and social and emotional approaches, students develop a comprehensive appreciation of ethical concepts:

- Constructivist learning engages students in the active process of identifying ethical dilemmas, and directly building their own knowledge from scenarios and examples, while applying their foundational beliefs.
- Participating in Socratic dialogues leads to students reevaluating the bedrock assumptions that they refer to in providing ethical justifications.
- Tools like role-play scenarios and reflective diaries can be indispensable in terms of focusing on ethical and moral reflection.

Following this, the students would substantially benefit from a guided meta-reflection, involving the analysis of the ethical frameworks underpinning their mode of reasoning used during the discussion (e.g. consequentialist, deontologist, virtue-based or others).

Understanding these frameworks permits the refinement of students' moral intuitions and reasoning patterns when confronting ethical dilemmas. Seedhouse Ethics emphasises that a person's ethical reasoning is deeply influenced by personal and cultural values [12]. It suggests that a coherent professional ethical basis can be better developed by reflecting on these values.

## Take home messages:

- Respect for the foundational ethical principles such as the four pillars; patient's best interests; capacity; and consent are crucial for medical practice.
- Ethical reasoning is a critical groundwork to good medical practice as it reflects the values that are expected of healthcare professionals.
- Prudential ethics teaches the legalities surrounding ethics, whereas constructivist approaches cultivate deeper ethical thinking and reflection.
- Integrating ethics in Problem-Based Learning and seminar group sessions is a puissant method to facilitate professional growth and moral development.
- Reflective writing tools, Role-play and Socratic Questioning are invaluable assets in strengthening critical thinking on an ethical basis in clinical settings.
- Education about ethics does not involve the prescription of 'right answers', but nurturing a mindset of critical inquiry, professional values and compassion.

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# Conquering Mount Kilimanjaro: A journey beyond the Summit

**Dr Poonam Singh** Fellow of the American College of Physicians (FACP).
**Dr Amar Singh** Fellow of the American College of Physicians (FACP).

Board-certified by the American Board of Internal Medicine and the American Board of Obesity Medicine. Specialising in preventing, treating, and reversing chronic diseases using an evidence-based holistic approach. Specifically interested in weight management, hormone re-balancing, and longevity.

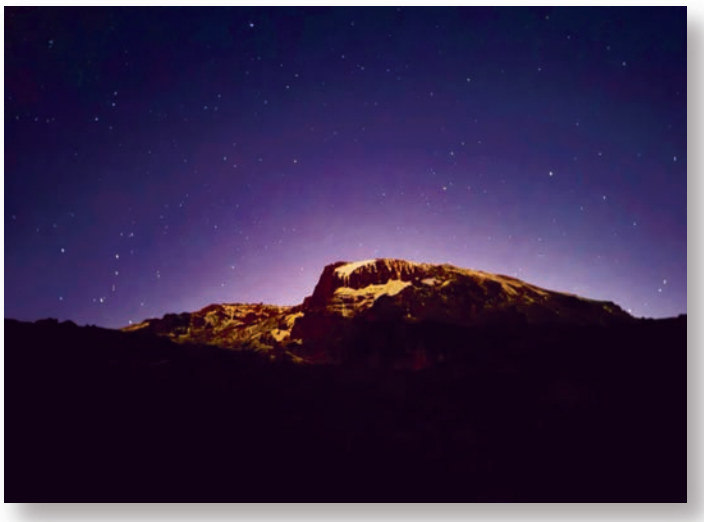
***On Monday, June 23rd, 2024, we summited Uhuru Peak, the highest point of Mount Kilimanjaro. Standing at 19,340.55 feet above sea level, the Journey to the top was a physical challenge and a profound experience of self-discovery and personal growth. Here's what we learned from our adventure.***

## Embracing the Journey

Hiking is not merely a physical activity; it's a journey of self-discovery and personal growth. Each trail uncovers the beauty of the world and the depth of our spirits. The wilderness invites us to shed our inhibitions and embrace our true selves. Away from the constraints of daily life, nature becomes a mirror, reflecting our inner strength and resilience. Every step in nature is a step towards a greater understanding and appreciation of the world around us.

## The freedom of the wilderness

In the wilderness, we find the freedom to be unapologetically ourselves. Nature's raw beauty acts as a mirror, reflecting our inner strength and potential. The Journey is not defined by the destination but by the courage



to embark on it. Each mountain climbed leaves us with a clearer view of our potential. Hiking teaches us that it is not about escaping life but discovering it in its purest form.

On the slopes of Kilimanjaro, we experienced a true sense of freedom. There were no messages to answer, no meetings to attend, and no distractions from the outside world. It was just us and the mountain. 8 days with no running water and electricity. This simplicity was liberating. We could focus entirely on the task at hand and our inner thoughts. Every step was an opportunity to reflect and connect with our true selves.

## Lessons from the trail

### *Patience and persistence*

Hiking challenges us to be patient, persistent, prepared, and present. The trail, much like life, is unpredictable and full of surprises. It takes twists and turns, presenting obstacles that test our limits. Every step, even the tough ones, shapes who we are, revealing our true strength.

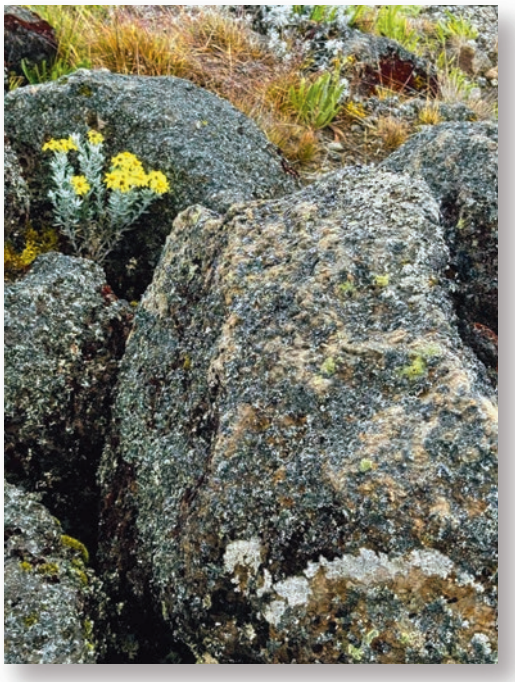
Patience and persistence were vital in Kilimanjaro. The climb is long and arduous, with varying terrains and unpredictable weather. We got caught in torrential rain and wind. There were dark and cold moments when the path seemed endless, and the summit appeared unreachable. However, we learned that progress is made one step at a time. It taught us to adapt and accept uncertainties, focus on what we can influence, and let go of what we can't change. Each small victory, whether reaching a campsite or overcoming a steep ascent, was a testament to our perseverance.

### *The Joy of New Experiences*

John Muir once said, *"The world is big, and I want to have a good look at it before it turns dark."* Hiking allows us to see the world in its full glory. The core of a person's living spirit is their passion for adventure. The joy of life comes from our encounters with new experiences; hence, there is no greater joy than having an endlessly changing horizon and a new and different sun each day.

Climbing Kilimanjaro exposed us to new daily experiences, each bringing different challenges and rewards. We trekked through lush rainforests, rocky paths, and barren alpine deserts. The ever-changing

landscape was a constant reminder of the beauty and diversity of our planet. Every sunrise and sunset on the mountain was a unique spectacle, a reminder of life's fleeting yet precious moments.



### *Conquering Mental Mountains*

Hiking isn't just about conquering mountains; it's about conquering our minds' limitations. With every step on the trail, we learn to let go of what weighs us down and embrace the freedom of the journey. It's a lesson in being strong and determined, showing us that we should keep going, even when the path becomes difficult.

The mental challenges of climbing Kilimanjaro were as significant as the physical ones. At times, fatigue and altitude sickness made us question our ability to continue. However, we discovered that mental strength often differentiates between giving up and pushing forward. Positive self-talk, mental fortitude, and each other's support helped us overcome these hurdles.

### *Hope*

We were welcomed by a natural garden of flowers growing on rocks and in the alpine desert. Seeing flowers growing on rocks on a mountain symbolises hope by unveiling resilience and beauty in adversity. These flowers thrive despite harsh conditions, representing the ability to overcome challenges. Their unexpected presence highlights the potential for positive outcomes and new beginnings, even in the most unlikely places, reminding us that hope and growth can emerge in any situation.

### *Abundance and growth*

We walked through forests and witnessed how they are self-sustaining ecosystems that embody abundance, rebirth, and recycling. Their dense, vibrant foliage and diverse wildlife illustrate nature's generosity and thriving life. Forests undergo continuous cycles of decay and regeneration, symbolising rebirth and the perpetual renewal of life. This process mirrors human experiences of growth and transformation as we go through phases of change, shedding the old to make way for the new. Just as forests recycle nutrients to sustain themselves, humans recycle experiences and knowledge, continuously evolving and adapting in our journey through life.

### *Deceptive stability*

In human life, appearances can be deceptive, much like the seemingly solid rocks and logs we encountered on our hike. Just as those surfaces proved slippery and weak, people and situations that appear reliable at first glance can often reveal hidden flaws and instability. This experience teaches us the importance of being cautious and not taking things at face value. It's crucial to look beyond the surface, seeking deeper understanding and true stability before placing our trust and making decisions.

### *Bonding through shared adventure*

Hiking allows us to develop a unique bond that only comes through a shared adventure, pushing through discomfort together. Each hike is a journey of self-discovery, a chance to learn more about who we are and what we are capable of. The beauty of nature becomes a mirror reflecting the strength in us. The journey is not about reaching the destination but about having the courage to embark on it.

Our Journey up Kilimanjaro brought us closer together. The shared experiences of struggle and triumph strengthened our bond. We encouraged each other during difficult times and celebrated each milestone together. The camaraderie and mutual support were invaluable. We learned that we could overcome any obstacle together, a lesson extending beyond the mountain.

### *Trust*

Just as our seasoned guide led us safely to the summit of Mount Kilimanjaro with simple and accurate advice grounded in years of experience, doctors provide essential guidance to improve our health and well-being. Their recommendations are rooted in medical knowledge and practical expertise, ensuring that each step is toward better health. By following their advice, patients can confidently navigate the complexities of their health journey, just as climbers trust their guide to reach the peak safely. Trusting your doctor's advice is like trusting your guide on a challenging climb – both are vital for achieving the best possible outcomes.

### *So near, yet so far*

The mountain peak appeared tantalizingly close, its jagged outline seemingly within an arm's reach, glistening with the promise of achievement. Yet, as the trek began, the true distance became apparent, with hidden valleys and unexpected obstacles turning the climb into a test of endurance and willpower. This mirrors the human experience, where our goals and dreams often seem within grasp, yet the journey to achieve them is fraught with challenges and perseverance. Just as climbers must navigate the rugged terrain, facing moments of doubt and exhaustion, individuals must overcome life's hurdles and setbacks to realize their aspirations, discovering the strength and resilience they never knew they possessed along the way.

### *Appreciate little things*

Taking moments to appreciate the little things – like the beauty of a wildflower growing in a crevice or the serene sound of a distant waterfall – can be profoundly important. These small yet significant experiences offered us a chance to pause, reflect, and reconnect with the natural world, providing mental and emotional rejuvenation amidst our physical challenges. This practice of 'smelling the roses' enriched the journey and mirrored an essential philosophy for daily life. Just as climbers find meaning in these small wonders, individuals can enhance their everyday lives by noticing and appreciating the simple joys around them, such as a child's laughter, the warmth of the sun, or a kind gesture from a stranger. This mindful appreciation helps foster a sense of gratitude, reduces stress, and enhances overall well-being, making life's journey more fulfilling and balanced.

### *Inner Serenity*

Hiking is more than just moving through rugged terrain; it is the ultimate Journey to inner serenity, challenging us to our core and revealing our true strength. In nature, one finds the most authentic version of oneself.

The serenity we found on Kilimanjaro was unparalleled. The mountain demanded our complete presence, pushing us to let go of external worries and focus on the moment. This deep sense of presence allowed us to connect with our inner selves. We realized that true peace comes from within, and the Journey of self-discovery is a lifelong adventure.

### *Reflections from the Summit*

Reaching the summit of Mount Kilimanjaro was a moment of triumph, but it also brought a new perspective. Nature's sheer vastness was overwhelming. Standing there, we felt smaller than a speck of dirt against the immensity of the world. This moment reminded us that no matter our perceived significance, we are but specks in the grand scheme of the universe. It was a humbling lesson to forgo our egos and embrace our place in the grand mosaic of existence. Standing at Uhuru Peak, we felt immense gratitude – not just for the breathtaking view but for the journey itself. The panoramic vista of clouds below us, the glaciers, and distant landscapes were indescribable. The summit represented the physical peak and the culmination of our efforts, determination, and growth, filling us with a genuine appreciation for the experience. The view from the top was breathtaking, a reminder that every peak was once a challenge. Mountains teach us that reaching the top rewards taking one step at a time. This mirrors life's Journey, where handling challenges gracefully leads to a fulfilling experience.


## About us

Dr. Poonam Singh, MD, and Dr. Amar Singh, MD, are board-certified by the American Board of Internal Medicine and the American Board of Obesity Medicine. They specialise in preventing, treating, and reversing chronic diseases using an evidence-based holistic approach. They are specifically interested in weight management, hormone re-balancing, and longevity. The American College of Physicians has recognised them as Fellows, FACP, for their excellence and contributions to medicine and the broader community. They enjoy teaching, volunteering, and advocating for their patients. Their mission is to share simple, effective, proven strategies leading to meaningful, sustainable, and long-lasting well-being.

### *Bottomline*

Our Journey to Uhuru Peak was unforgettable, blending physical endurance, mental fortitude, and spiritual awakening. We returned with a clearer view of our potential and a deeper appreciation for the beauty of life. As John Muir aptly put it, *"In every walk with Nature, one receives far more than he seeks."* Hiking is not about escaping life but discovering it in its purest form.

Climbing Kilimanjaro was more than just a hike; it was a transformative experience that taught us valuable lessons about ourselves and the world. Life is much like a hike – full of ups and downs, twists and turns – and learning to find joy in the journey is key to living a fulfilling life. We hope our Journey inspires you to seek out your adventures and embrace the growth that comes with them. Whether it's a mountain, a new hobby, or a personal challenge, remember that the Journey is as important as the destination. Keep exploring, keep pushing your boundaries, and keep discovering the beauty and strength within you. We want to leave you with a short open-verse poem penned by us:

## The edge of resolve

*I kept going, not because I wanted to,*
*But because I yearned to taste the edge of resolve,*
*To feel the weight of persistence,*
*And hear the whispers of a weary soul.*
*With each step, a reluctant sigh,*
*Yet curiosity burned beneath fatigue,*
*What lies beyond the valleys of doubt?*
*What echoes in the halls of tenacity?*
*The trail was never gentle,*
*Its stones sharp, its winds unkind,*
*But within the struggle, a quiet question,*
*What if I did not turn away?*
*In the heart of the storm, I found it,*
*Not the end but the essence of the journey,*
*A strength born not of desire,*
*But of the hunger to know*
*The power of not giving up.*

# Progress addresses women's health inequalities

**Dr Anita Sharma**
GPwSI in Gynaecology. Chair, Women's Doctors Forum, BIDA.

**Broadcaster Naga Munchetty's new book "It's Probably Nothing" marks a turning point in the month of March to beat medical misogyny and at last advance knowledge and treatment of conditions such as endometriosis.**

I am hoping that my own book ***Endometriosis in Primary Care: A Practical Guide***, released on 12th July this year will build on this and enlighten GPs on the symptoms and need for a holistic approach to reduce the current ten-year wait for a diagnosis.

With endo and its cruel cousin Adenomyosis making headlines – and I thank the team of my charity Endometriosis Awareness North for helping to achieve that – discrepancies in women's health are at last coming to the fore.

I actually use the word, "charity" with great pride. Becoming a registered good cause is no easy ride (nor should it be) but my team has achieved this significant goal, recently. It means we can access new funding streams and campaign with ever more confidence, raising monies to support endo sufferers and hopefully even invest in research for a cure.

Anything raised will also help us continue with our free webinars and I would like to sincerely thank BIDA members for contributing their expertise to events on areas such as pain management.

Word of mouth marketing continues to be one of the strongest ways to push our awareness message. Our endometriosis walks have brought extra brightness to some of the most popular and picturesque areas of Greater Manchester. Liveried in daffodil yellow, our pounding volunteers are helping to establish this as the colour of endo awareness – as pink has become for breast cancer.

There are some very exciting developments in the pipeline, too. Following a presentation to Media and Creative Arts students, a West Yorkshire sixth form college is about to become our first, "Endo Awareness College."

Other social events including coffee mornings have both raised knowledge and money to advance our battle. A hugely pleasing side effect has been the swapping of experiences and building of friendships these gatherings have brought. *"You are not alone"* has indeed become their mantra.

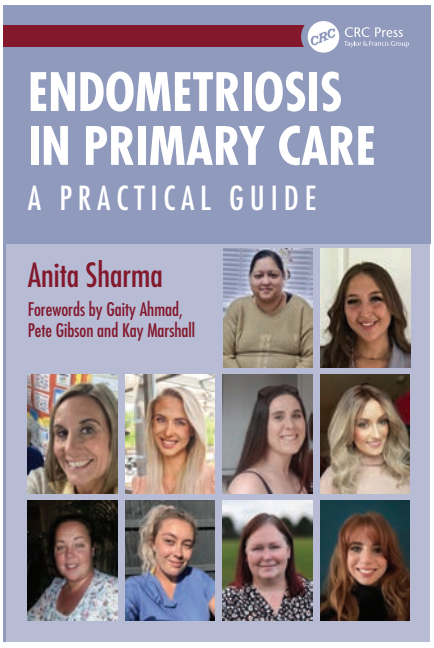
But while this progress is pleasing, we still need to see the demonstrable change required to close the inequality gap between men's and women's health. Endometriosis is by no means understood fully by society, decision-makers and more alarmingly, medics. There are still far too many women being fobbed off by emergency departments and in GP appointments for having what Naga describes brilliantly as "Probably nothing."

BIDA, like Endometriosis Awareness North, can be leaders in this continuing campaign. Our unique place as the representatives of the UK's overseas doctors means we can educate and persuade. And our verve for equality, should make us natural advocates for the equitable treatment of women, everywhere.

**Dr Anita Sharma is the founder of the Endometriosis Awareness North charity. Learn more about them at https://www.endometriosisawarenessnorth.com**


*Far left: Anita Sharma with Mrs Elsie Blundell, M.P. for Heywood and Middleton North, at the launch of Endometriosis in Primary Care, which took place at Norden Social Club on 12th July (below)*

*Left: Anita Sharma with BIDA National President Prof. Amit Sinha, at the book launch.*



# From the Science Desk

## The changing face of Lung Cancers

Lung cancer has undergone a startling demographic shift. In recent years, oncologists and researchers have observed an alarming number of non-smokers are now being diagnosed with lung cancers According to the American cancer society up to 20% of lung cancer cases in the United States now occur in non-smokers. In some regions of Asia, this figure rises to nearly 50%, especially among women. The following risk factors have been incriminated [1].

### 1. Air pollution

Long-term exposure to fine particulate matter PM2.5 is strongly linked to the development of lung cancer [2]. Air pollution triggers pre-existing mutations in lung cells, which acts like a catalyst for development of cancer.


### 2. Radon Gas Exposure

Radon is an odourless, colourless radioactive gas that occurs naturally from decay of uranium in rocks and soil. It can seep into homes through cracks in foundations or walls particularly in poorly ventilated basements. It is the commonest cause of lung cancer in the US in non-smokers.

### 3. Second hand smoking

Inhaling smoke from someone else's cigarettes exposes non-smokers to the same carcinogens. Children and spouses of smokers are at the highest risk due to prolonged exposure.

### 4. Genetic Predisposition

Certain mutations in the EGFR (epidermal growth factor receptor) are common in non-smokers who develop lung cancer. These are prevalent among Asian women and younger patients.

### 5. Indoor pollution and fumes

Cooking with biomass fuels (like wood, charcoal, or dung) in poorly ventilated houses exposes individuals to harmful gases. Oil fumes from high temperature frying and Polyaromatic Hydrocarbons (PAHs) produced during frying are carcinogens.

### 6. Infections and viruses

Certain strains of human papillomavirus (HPV) and Epstein-Barr virus (EBV) have been detected in lung tumour samples, particularly in patients with no history of smoking. It is hypothesised that viruses can cause cellular changes leading to tumour formation.

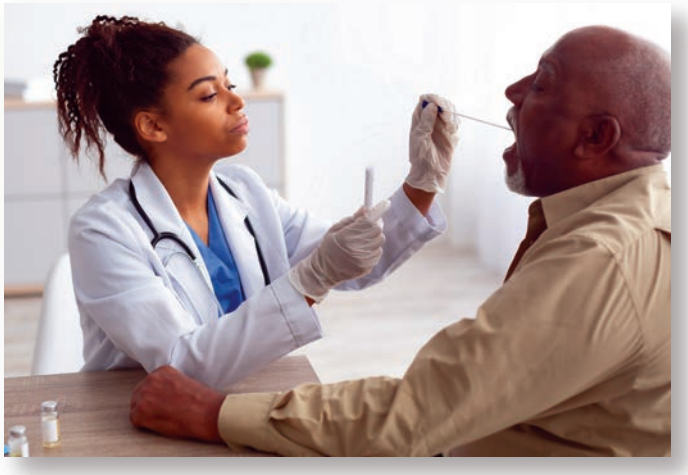
*References:*

*(1) Lung Cancer Research Foundation*

*https://www.lungcancerresearchfoundation.org/for-patients/lung-cancer-facts/#:~:text=Facts%20about%20lung%20cancer,2*

*(2) Chen Chi-Yuan et al. The role of PM2.5 exposure in lung cancer: mechanisms, genetic factors, and clinical implications. EMBO Mol Med. 2024 Nov 22;17(1) 31–40. doi: 10.1038/s44321-024-00175-2*

# Swab test for Parkinsonism



Parkinsons disease can be identified in its earliest stages by detecting distinctive biomarkers found in sebum. Researchers at Manchester University, in collaboration with Salford Royal NHS Trust and the University of Innsbruck, analysed skin swabs from people with Parkinson's disease, healthy volunteers, and those with a sleep disorder called isolated REM Sleep Behaviour Disorder (iRBD). The results showed that people with iRBD had distinct chemical profiles in their sebum that were different from healthy individuals, but not yet as pronounced as those with established Parkinson's disease. This supports the idea that Parkinson's disease leaves a detectable trace on the body well before physical symptoms appear. They found patterns that suggest this method can also be used to map the progression of the disease, refine treatment options and improve patient outcomes.

A simple, non-invasive skin swab could help identify people at risk before symptoms arise, allowing for earlier intervention and improved outcomes. The researchers plan to develop and improve the sebum-based testing to eventually use as a practical tool in real-world clinical settings.

*Reference:*

*https://www.manchester.ac.uk/about/news/parkinsons-breakthrough-can-diagnose-disease-from-skin-swabs-in-3-minutes/*


# Australian Doctors use A.I.

AI stands for Artificial Intelligence. It refers to the field of computer science and engineering focused on creating systems or machines that can perform tasks that typically require human intelligence. These tasks include things like: Learning (improving performance based on experience) Reasoning (making decisions or solving problems) Understanding natural language (interpreting spoken or written language) Perception (seeing, hearing, and interpreting sensory input) Planning (setting and achieving goals) Creativity (generating new ideas, designs, or content) AI can be narrow (or weak) — designed to perform a specific task (like facial recognition or language translation), or general (or strong) — capable of understanding and learning any intellectual task that a human can do (though this level of AI does not yet exist).

*Chat GPT definition of AI*

# BIDA Sports Update

**Dr 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 Co-Ordinator, BIDA.

## The BIDA Cricket President's Cup 2025

has now reached the knockout stage, with two exciting semi-final fixtures lined up:

- ***Stoke vs North East***
- ***Wigan vs Wolverhampton***

Both matches will take place on Sunday, 17th August at Moddershall & Oulton Cricket Club, Staffordshire.

This year, following feedback from divisional representatives, we transitioned from our traditional 30-over format to a T20 format and increased the number of matches per team. This new structure has been well received, with teams thoroughly enjoying a vibrant summer of cricket.

Unfortunately, the Blackburn division was unable to continue due to player availability. However, in the true spirit of inclusivity, all remaining divisions have generously agreed to integrate the Blackburn players into their squads, ensuring everyone would have the chance to participate.

As the cricket season draws to a close, preparations for the Annual Golf Day are well underway. The event is scheduled for 21st September at Clays Golf Course in Wrexham and promises to be another great occasion.

A heartfelt thank you to all individuals who have helped coordinate both these events and to everyone involved across the divisions for their support and enthusiasm.

**Dr Ravi Badge**
*National Sports Co-Ordinator, BIDA.*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## 3rd Annual BIDA Golf Tournament

**Clays Golf Club**
**Bryn Estyn Road, Wrexham, LL13 9UB**
**Sunday 21st September 2025**

Registration and Breakfast 1030
First Tee time 1200
Followed by Dinner & Presentations

Division 1 (Handicap ≤ 18.0)
Division 2 (Handicap ≥18.1)

# Radiology Quiz Answers

**1** The MRI scan shows widespread signs of inflammation (Fluid) in the calcaneus suggestive of infection.
**Diagnosis: Osteomyelitis of Os Calcis**

**2** The plain X-ray shows a clear cystic shadow underneath the tibial plate on the medial side and also along the peg. This is sign of loosening due to infection
**Diagnosis: Deep infection of the TKR**

**3** X-ray of the proximal humerus shows a break in the medial cortex below the humeral neck. **Differential diagnosis: Metastasis in the proximal humerus/ Primary Tumour/ Infection**
It is unlikely to be any infection as she is systemically well with a normal blood picture. X-rays do not show any periosteal reaction. A metastasis is commoner than a primary tumour. A full systemic examination and radiological investigation (Skeletal survey/ CT Scan/ Specific blood tests) is required to find the primary.

**4** Repeated attempts have failed to reduce the dislocation. **Diagnosis: Rupture of the volar plate of the DIP joint, which is stuck in the joint.**

# Remembering...

## Dr Basanta Kabi A life of care, dedication and passion.

**It is with deep sadness that we announce the passing of Dr Basanta Kabi, who died peacefully on March 19th, 2025. Dr Kabi is survived by his beloved wife, Tracy.**

For over 30 years Dr Kabi served his community as a dedicated General Practitioner retiring from the practice in Huyton, near Liverpool. His unwavering commitment to his patients' well-being left an indelible mark on countless lives, earning him the respect and affection of all who knew him. Beyond his practice, Dr Kabi was a long-standing and active member of British International Doctors' Association contributing to the broader medical community for over 3 decades.

Outside professional life, Dr Kabi was a passionate supporter of Liverpool Football Club. He followed his team with enthusiasm and joy, sharing in their triumphs and standing by them through every season.

Dr Kabi's kindness, dedication, and warm spirit will be profoundly missed by his family, friends, former colleagues, and the many patients whose lives he touched.

## Dr Bharat Bhooshan Bhasin

**It is with great sadness that we announce the passing of Dr Bharat Bhooshan Bhasin, who at the age of 86, died very peacefully at home surrounded by family on 12th May 2025.**

Born in Bharatpur, Rajasthan, India in 1939, as one of six siblings, he graduated as a Doctor from SMS Medical College, Jaipur, before moving to England in 1966 and marrying Priti that year, having known her since they were both 9 years old.

Bharat initially worked as an Orthopaedic Surgeon, but then changed to the discipline of General Practice and settled in Milnsbridge, Huddersfield in 1976. He dedicated himself to serving the community as the sole GP in that area for 29 years, retiring in 2005. He continued his interest in orthopaedics, being a clinical assistant at the Huddersfield Royal Infirmary.

In addition to the compassionate care he provided to his patients, he was also a leader in the medical community, being chair of the Local Medical Committee, amongst other numerous medical and community roles such as leading the Yorkshire Indian Society.

He was passionate in supporting other international colleagues and ensuring their fair treatment and was the president and one of the founders of the Huddersfield division of the Overseas Doctors Association. Bharat then was involved at a national level with the transition to the British International Doctors Association and was the National Sports Co-ordinator, leading the national cricket tournament and his local team, bringing people together. Bharat also maintained his love of cricket playing for Broad Oak.

A true gentleman, he was full or energy, laughter and joy. Bharat leaves his wife, Priti 3 children, and 8 grandchildren.

The funeral service was held at Huddersfield Crematorium and donations were invited to The Kirkwood Hospice or Marie Curie.

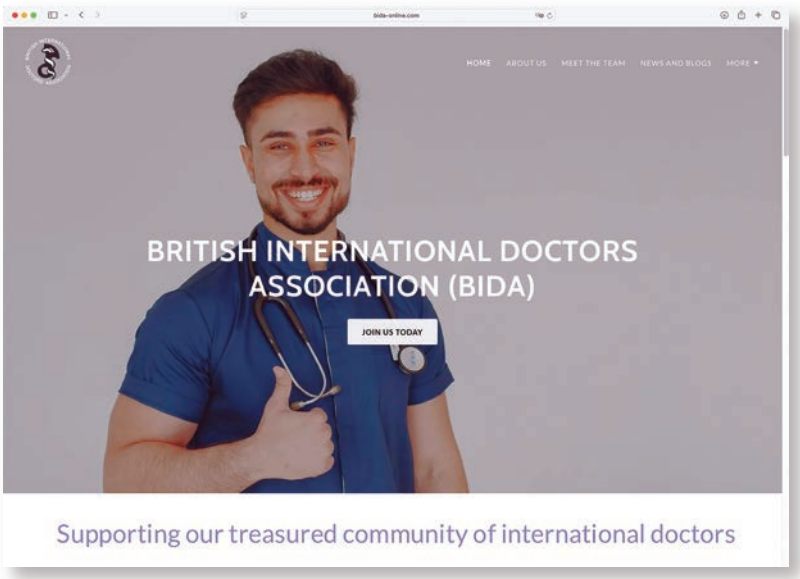
# Our new website

**To coincide with our 50th Anniversary, BIDA has recently commissioned a redesign to our website, which will be 'going live' any day now.**

Featuring up-to-date information about the Association and its history, mission and team, the new website is the place to go to in order to find out about forthcoming meetings, the International Congress and ARM / AGM, news and blog articles by BIDA members, BIDA Sports, Fellowship Awards, and how to get in touch with us.

While we continue to be a great social network for doctors in the U.K., BIDA now also campaigns to raise awareness of issues such as racism and misogyny in the workplace. BIDA also allows its membership to share expertise, and keep up with the fast paced, ever-changing nature of the healthcare profession in the UK.

Find out more about the Association today by visiting our updated website. Any suggestions are most welcome!

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