bida JOURNAL

THE JOURNAL OF **THE BRITISH INTERNATIONAL DOCTORS' ASSOCIATION**
Issue No.3, Volume 31. December 2025 www.bida-online.com

Inside:

SSPHealth

NHS

We are a leading provider of primary care GP services in the UK. All practices rated Good or Outstanding

Are you a GP Partner considering your future options?

- Worsening work/life balance?
- Want to get away from the stress of running a business?
- Struggling with CQC and red tape?
- Finding it difficult to recruit new GP Partners?
- Need a solution for your property?
- Keen to reduce your hours and stress levels?
- Want guaranteed income?

What can we do for you?*

1. GP Partners Full Exit inc. Property
2. Partnership Model
3. Stree-free Outsourced Services

Contact us at ceo@ssphealth.com

*Subject to contract and T&Cs

Editorial

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

BIDA 50th Anniversary Year

2025 will always remain as a special milestone for the organisation. We have had a memorable National Conference celebrating our 50th anniversary. This edition is dedicated to them and contains the highlights of the rest of the conference. It was inspiring to felicitate our seniors who established the organisation through sheer grit and determination. They reminded us of their years of turmoil to fight for "Equality & Fairness". This fight still goes on with issues of discrimination, unconscious bias, racism, differential attainment and practice to fitness referrals to the GMC. The intricacies of MHPS trials for internal hospital investigations are often heavily biased against the doctor. BIDA will continue to raise concerns but far more important is to avoid the pitfalls and prepare our doctors by mentoring, appropriate induction, early local resolution of problems, providing access for support and advice and remediation.

I must also emphasise that we need an approach rooted in our culture, in our institutions where we belong to originally, our language and our belief in liberty and motto. That is what holds us together. What is important is how we contribute. That is what makes a difference for generations to come. We need a deep change. We don't need to keep shouting at the institutes where there is institutional racism. We need to raise our concerns but at the same time collaborate with them to set things right. We need to have this renewed purpose.

The lost tribe of doctors!

As an association, which has a large number of GPs, BIDA is alarmed by this ridiculous mismatch, when the NHS is crying out for more general practitioners to take off the enormous burden in our community. There are a number of trainees who have completed their GP training but do not have a regular job to go to. The concept of shifting care from the hospital into community for a "neighbourhood national service" is in jeopardy with the deep disengagement of these trained GPs out of work.

BIDA is extremely concerned at the vast number of ethnic minority doctors who are affected the most as they make up the large proportion of trainees who have qualified as GPs. The inability to absorb them is bound to lead to frustration and disappointment after years of training. Are they the new lost tribe of the NHS? We are at risk of losing them completely as they may move to Australia, New Zealand or Canada or end up changing their profession. These new recruits are literally being thrown into a leaking cauldron. BIDA considers this as a gross injustice.

Corridor NHS

About 74,150 patients waited at least 12 hours on trolleys in June and July, a situation almost non-existent 10 years ago. Recently a close friend, a retired consultant orthopaedic surgeon had to spend nearly 72 hours as a corridor patient. This is shameful and unacceptable in the modern NHS. Patients in corridors lack privacy, dignity, and access to essential equipment like call bells or oxygen, which can compromise their safety.

What was once a winter crisis has become a year-round disaster, with the health service buckling under pressure all year round. Every day people are put at risk by long, deadly waits with families watching helplessly as loved ones are left in agony on trolleys in A&E corridors. The North Wales doctors & patient group have initiated an action plan through their campaign "BEDS – End corridor care in A&E". Is the Heath Board taking any positive action? I don't think so.

Articles

This edition has an excellent article by a brilliant 6th Form school student. She designed a questionnaire to study the current state of the NHS and collated the current information on the challenges the NHS is facing and the measures which are essential to sustain the NHS. This is being presented to our readers in 2 parts. It makes very interesting reading.

David Brigden and his medical students have written another extremely good article on Teaching Medical students with disabilities. It presents all the facts, the challenges, support and strategies. The winning Team of the Podium presentation at the National Conference presented an excellent quality improvement project to improve the guidance for Decompensated Cirrhosis Care Bundle as advised by the British Association for the Study of the Liver.

Wishing you and your family health, happiness, and prosperity in the new year.

Prof Amit Sinha
Editor, BIDA Journal

bida JOURNAL

Instructions for Authors

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

Contents:

Editorial Address:

The Editor
BIDA Journal
Unit 4,
Swallow Mill Business Centre,
Swallow Street,
Stockport,
Cheshire
SK1 3HJ.

Telephone:
0161-456 7828

E-mail:
amitani2000@yahoo.co.in
Office@bida-online.com

Website:
www.bida-online.com

BIDA National President's Report

Dear friends and colleagues,

2025 has been the year to remember with the 50th year celebratory National Conference followed by a fantastic International Scientific Congress. It gave me immense pleasure to organise the National Conference, and I wish to thank all my colleague team members both in the North Wales Division and the central team and specially Alison Sherratt, our Office secretary for their tremendous support. It was such an honour to celebrate our anniversary by recognising the efforts and dedication of our seniors who laid the foundation of the organisation. It felt proud to felicitate the Presidents and Chairmen of yesteryears. Of course it goes without saying that there are many others in the organisation who worked with the executive team who contributed equally to establish the organisation that we have inherited today. On behalf of the organisation, I wish to pay my respects and thanks to all of them.

As the President, I have carried on attending the GMC Strategic Advisory group of the EDI Forum and the Racial Equality Forum. However, we now have other team members who have agreed to participate in turns, Dr Sai Pillarisetti, Prof Ravish Katira and Dr Anwar Tufail.

2026 will see news about BIDA conferences coming up. The first one will be the BIDA Student Wing Conference "Breaking Barriers – Building Bridges" on 17th January. The National Obesity and Oncology conferences are being planned too. You will soon be informed about the next National Conference which is going to held in the first week of October 2026 in Manchester.

At the recent ARM/ AGM meeting, a motion to increase our yearly subscription rates by a small amount was unanimously accepted. Our Treasurer, Dr Vinod Gadiyar informed the ARM committee that the subscription had not changed for several years and it was time to consider a slight increase in line with the increased cost of organising our conferences, staff salary , accountant's charges and other sundry expenses. He wishes to inform you of the new subscription rates for all our members. Please kindly make a note of the new rates from this year.

My best wishes for the New Year.

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

BIDA National Chairman's Report

Dear Friends,

A very happy new year to all our BIDA members and their loved ones. I hope that you had a great time celebrating Christmas and New Year with family and friends.

We are again in that time of year when the NHS is under tremendous pressure due to a surge in winter viruses and other seasonal illnesses. It is purely due to the hard work and dedication of our health professionals that the NHS can cope with this winter NHS crisis. Resident Doctors are still in ongoing dispute with the government and want multiple year pay erosion issue addressed. BIDA would like to urge the health secretary and the government to engage in meaningful and constructive dialogue with Resident Doctors to avoid any further strike action.

We are in the 50th year of BIDA and we have been celebrating this milestone during our BIDA National Congress, ARM/AGM in September followed by our International Congress in Mexico and Costa Rica in November. Both these events as always have been a huge success. On a personal front, being the convenor of four very successful International Conferences, I have stepped down and a new team has taken over. I am ever so grateful to all EC and BIDA members for giving me this opportunity. Please keep an eye out for 2026 International Conference announcements in coming months

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.

Dr Ashish Dhawan
National Chairman, BIDA.

BIDA Membership Fees 2026

Grade	Subscription Fees
Standard (Staff Grade & Above)	£121.00 per annum
Training grades (all training grades & trainee GP's)	£55.00 per annum
Non-Registrars (F1, F2 & Fellows)	£22.00
Spouse Membership (per couple)	£176.00 per annum
Retired Rate (only applies to fully retired)	£60.00 per annum
Sports Membership	£44.00
Life Membership	£1210.00
Life Spouse Membership (per couple)	£1760.00

BIDA Women Doctors' Forum Chair's Report

Dr Anita Sharma
GPwSI Gynaecology
Chair of Women's Doctors Forum BIDA

Dear Colleagues,

I was invited to talk about breast cancer, an event organized by UPTURN, Amana and HENNA foundation, Pink Gala Dinner, supporting Breast Cancer Awareness on 22nd October by Muzahid Khan DL.

It was attended by the Mayor of Oldham, Cllr Eddie Moores, the Mayor of Tameside, Cllr Shibley Alam, the Mayor of Warrington, Cllr Mo Hussain and the Lord Mayor of Chester, Cllr Sherin Akhtar.

October is Breast Cancer Awareness Month. One in seven women, around 56,000 women in the UK will receive a diagnosis of breast cancer. Being a GP with a special interest in Gynecology and chair and founder of Endometriosis Awareness North I talked about Breaking the Stigma of Word Breast and Word Cancer. NHS Screening (mammograms) is offered every 3 years from 50-71 years. For every 500 women screened, one life will be saved. I talked about how we need to focus on why there is poor mammogram uptake in some regions of North West of England and why there is a marked variation in various practices; with highest uptake rate of 74% as compared to lowest in some practices at 31%. The variation in uptake is because of Socioeconomic status and BAME community not coming forward for the screening process. I mentioned about the various reasons of low uptake rate – Lack of awareness, fear, phobia of pain, time off from housework, not changed the address and radiation exposure. Risks outweigh the benefit.

I am so glad to be involved with the University of Manchester developing KSS (Knowledge Support System) for primary care for early detection of self-harm in women and young girls and steps to take.

Individuals with endometriosis face a 42% higher risk of intentional self-harm, poisoning or overdose compared to matched controls. The risk is nearly double among those with no prior psychiatric history. Being the chair and founder of Endometriosis Awareness North, promoting education not only among professionals but also public, I noted the gaps in mental health support for patients suffering with Endometriosis. Harriet Cant, Research Associate in University of Manchester and Co-Principal investigator for an NIHR funded project is leading this Self Harm project.

I organized a Webinar and F2F meeting on 20th Oct focusing on Why Self harm and suicide matters in Endometriosis, recognising early signs and symptoms, what are the contributory factors, and what preventative measures should be taken by clinicians and current management.

Another BIG achievement was inviting Dr Sujata Gupta, Consultant Gynaecologist in Manchester NHS Foundation Trust and Associate Director of Medical Education, Robotic surgeon dealing with spread of endometriosis to Kidney and Bladder, attending BIDA National Conference on 20th September and talking about "Are women getting the care they deserve?"

760,000 women in UK are waiting for a gynaecological appointment. That is just the tip of the iceberg. Disproportionate toll of disability-causing conditions is much higher in women. Her presentation mentioning about increasing the investment of just £1 per woman would deliver an additional £319 million for the economy in England was an eye opener.

I am so pleased that my voice is finally being heard by the House of Commons about investing money for women's health, especially improving care of women suffering with Endometriosis. I went to House of Commons on Monday 14th July 2025 with our local MP, Mrs Elsie Jane Blundell, a patient spokesperson and my husband Dr Ravi Sharma. I did a presentation about Endometriosis affecting not only the physical but also emotional, psychological, sexual and psychosexual health.

The One and Only One way to improve the sufferings is more funding and developing One Stop Clinic for early diagnosis and early management. Finally, my voice is heard, and Emma Cox, CEO Endometriosis UK is coming to Rochdale to listen to us.

Finally, my book on Endometriosis in Primary Care: a practical guide was published in July. The money raised from the sale of the book is going to UoM multidisciplinary research team who have developed a novel bio-inspired, soft jelly-like material that delivers drugs directly to endometriosis sites which prevents endometriosis growth whilst retaining fertility.

Dr Anita Sharma
Chair, BIDA Women Doctors' Forum

What measures are essential to sustain the NHS amidst the challenges it faces?

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

This is a 2-part article. Part 1 deals with the current challenges facing the NHS and Part 2, which will be published in the next edition outlines the potential solutions for long-term NHS survival.

Introduction

The National Health Service (NHS) is one of the UK's most vital institutions, providing free healthcare at the point of use. More people work for the NHS than any other organisation in the country: 1.3 million people in England alone, that is around one in every forty people[1]. This shows the dependency of the country on the NHS, not only for health benefits but also for employment. However, in recent years the NHS has faced mounting challenges, including financial pressures, workforce shortages, an ageing population and technological advancements. As these challenges continue to grow, it raises the question of the NHS being sustainable in the modern world.

As part of this study a questionnaire was developed and was sent to a selection of doctors, junior doctors and nurses. The questionnaire can be found in Appendix 1 and the responses inform relevant sections in this report.

Current challenges facing the NHS, and how these will get progressively worse

The NHS has transformed British healthcare, yet has faced continuous financial strain, political interference and workforce shortages (Table 1). However, it has now faced an unprecedented and sustained slowdown in spending growth in recent years[2]. As the demand for healthcare services continues to rise, the funding allocated to the NHS has not kept pace with this increasing demand[3]. The lack of adequate funding puts a strain on resources, which eventually lead to longer waiting times, limited access to specialist treatments and difficulties in maintaining high-quality care. It also impacts the ability of the NHS to invest in new technologies and infrastructure improvements which are required to ensure the NHS can evolve and progress with the shifting societal expectations and needs.

In the fiscal year 2022/23 the Department of Health and Social Care's expenditure reached £181.7 billion, with £171.8 billion (94.6%) allocated to daily operational costs such as staff salaries and medications[4, 5]. This deterioration in performance, follows a decade of low spending growth before the COVID-19 pandemic. Projections from The Health Foundation suggest that in order to achieve sustained improvement, the NHS requires a 4.5% (real terms, ie taking inflation into account) funding growth over the next 5 years to recover from the pandemic and enhance services and activities[6]. The financial outlook for 2024/25 appears particularly strained, with NHS England's total revenue allocation rising by a mere 0.2% in real terms[7]. As a result, trusts are looking at identifying unprecedented levels of efficiency savings this year, well above the efficiency target of 2.2% set by the government, in some cases they are as high as 5-6%[8]. Notably, 31 out of 42 healthcare systems have submitted deficit plans for the year, resulting in a collective deficit of £2.2 billion [9, 10].

Table 1: History and evolution of the NHS

Year	Report / Act / Event	Plan	Effect
1942	Beveridge Report	Nationalised Health Service Recommendations	State Welfare System
1948	Aneurin Bevan Minister of Health	Healthcare based on needs	NHS established
1952	Introduction of New Rules due to rising costs & financial strain	Prescription charges Fees for dental treatment and Spectacles	Huge expenses for the general public
1962	Hospital Plan	Modernising the NHS Funding £570m over 10 yrs	Infant mortality dropped Eradication of polio
1990	NHS & Community Care Act under Margaret Thatcher's Conservative Government	NHS split into purchasers (GP, Health Authorities)	Competition – increased administrative costs
2000	Tony Blair's New NHS Plan	Funding from 5.2% to 8.2%	Reliance on PFI – £80 billion debt
2012	Health & Social Care Act – David Cameron's Conservative Government	Power shifted to CCGs	Fragmentation of NHS – Increased bureaucracy & Inefficiency
2023	Post-Covid		Waiting list 7.7 million
2025	Labour Government	NHS England abolished	Power centralised – DHSS

However, it is difficult to establish the impact that these financial strains are having on patient care and services. National data on NHS performance is predominantly based on acute hospital services, with little known about community-based services. Additionally, awareness tends to focus on explicit restrictions to patients' access to care – such as increased waiting times or restrictions on access to treatments (eg. IVF)[11]. Changes to the quality of care the patient receive are less visible, but just as significant.

The figure on the next page shows a simplified model of how healthcare organisations respond to financial pressures in a range of ways (Fig1)[11]. Some of these affects the patient in positive ways, however others can have negative effects even though

this isn't the intention. For example, by cutting spending per patient this may have damaging consequences on patient care as they may have reduced access to healthcare that they have the right to use. Patients may experience delays in critical treatments, worsening their conditions. This is not sustainable and poses major challenges in the future as if deficits accumulate, hospitals may exhaust reserves, leading to service cuts in the long term. Restricting access by delaying or denying care leads to poorer health outcomes and therefore leads to potentially higher emergency admissions. Diluting quality by cutting essential resources affects patient safety and satisfaction, potentially leading to higher long-term costs due to complications. If all of these outcomes progressively worsen, then this could result in some of the key principles of the NHS undermined and result in a system that struggles to meet its fundamental commitments.

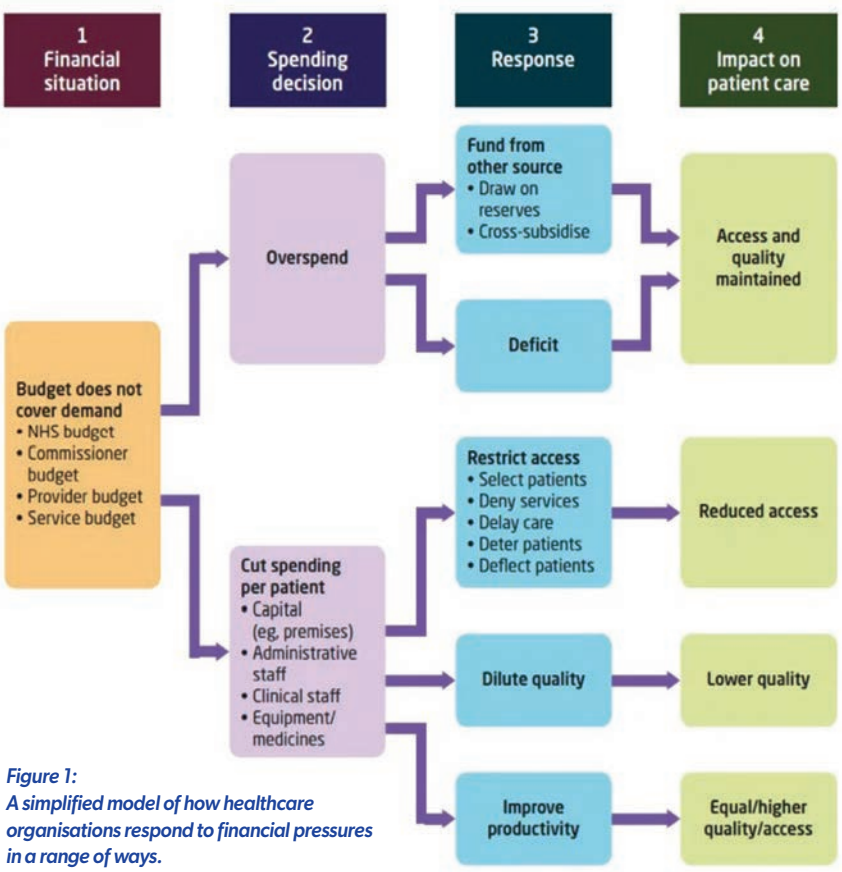


Figure 1:
A simplified model of how healthcare organisations respond to financial pressures in a range of ways.

The King's Fund carried out a study investigating the impact of financial pressures. Some of the findings from their research concluded that due to the financial constraints, care provided by some district nursing and GUM (Genito-urinary medicine) services are having to focus on the 'nuts and bolts' of diagnosis and treatment without time to address the full range of the patients' needs[11]. This highlights the fundamental challenges NHS services are facing due to financial restrictions and suggests that the NHS is moving further away from its goal of strengthening community-based services and prevention.

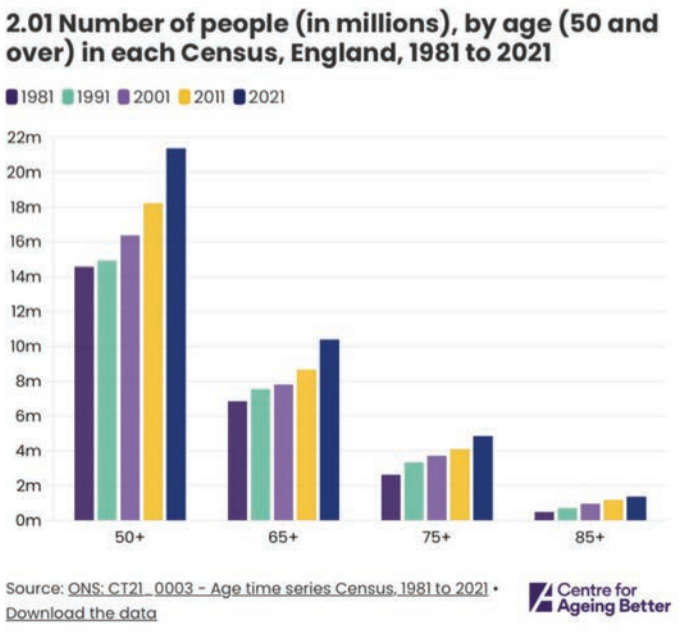
Interestingly, this challenge will continue to inflate because as the country continues to become more prosperous, the public can afford more care, and the public's expectations for quality and quality of public services rise. This is common across most developed countries, and many choose to spend more on health over time.

Ageing population

There has been a steady increase in life expectancy in recent decades[12]. In 1999, around 1 in 6 people in the UK were 65 years and over (15.8%). This increased to around 1 in 5 people in 2019 (18.5%)[13]. The ONS have projected that this is likely to rise to 1 in 4 people (23.9%) in the UK by 2039[14]. Shown by the bar chart, the number of people in England over 50 in the last 40 years has increased by over 6.8 million (a 47% increase: Fig 2)[15]. This is the result of the combination of declining fertility rates and people living longer due to better standards of health and quality of living. While living longer is a cause for celebration and shows the positive impact the NHS has had on the UK, the ageing population has major implications on the NHS such as more hospital admissions, higher medication costs and greater demand for social care support. According to my primary data, 68.9% of the respondents believed that the main factor driving increasing demand is the ageing population, and the data below demonstrates why.

As more people reach their eighties (currently 3.2 million people in the UK), the NHS must treat an increasing number of chronic conditions related to ageing such as Type 2 diabetes, frailty, arthritis and dementia[16]. For example, over 400,000 people in England have been diagnosed with dementia and 70% of people in care homes suffer from dementia or severe memory problems [17, 18]. Dementia alone is estimated to cost the UK economy over £26 billion a year and patients with the illness often having longer hospital stays than other inpatients[17]. By 2040, predicted costs are expected to treble. It is estimated that 40% of people aged over 85 will develop dementia and be in need of long-term

The number of people in England aged 50 and over has increased by almost 7 million in 40 years –four in ten of us are now aged 50 and over *Figure 2:*



care[19] . This alone presents challenges for the NHS as there will be increased demand on healthcare services which pressurise the NHS resources, staff and hospital capacity.

An ageing population places a significant financial burden on the NHS, with over two-fifths of its budget spent on those over 65. The costs associated with elderly care are considerably higher, with an 85-year-old man costing the NHS seven times more than someone in their late 30s. On average, those over 85 require £7,000 per year in healthcare compared to the overall average of £2,069[20]. Additionally, older patients account for 41% of hospital admissions, and their emergency stays tend to be longer[21]. This trend poses significant challenges for the future of the NHS as the NHS is already struggling with funding and staff shortages, and an ageing population will further exacerbate this. The challenge will continue to lie in balancing rising demand with limited funding, particularly as the working-age population that funds the NHS through taxation shrinks in proportion to the elderly population requiring care.

Another challenge regarding the ageing population is that the current NHS workforce is trained to work within a model based around single episodes of treatment[22]. However now it must deal with co-morbidities, mental and physical needs, and ensure integrated care. Older patients often require ongoing treatments, frequent GP visits and long-term care, which may require coordinated care across different NHS departments. This leads to bed shortages in hospitals, longer waiting times and increased pressure on emergency services. This not only reduces the hospital capacity but also affects patient recovery. As the ageing population rises, the number of Specialists in Elderly Medicine and social care workers will also need to increase. Currently within GPs training, there is no compulsory geriatric component, and this is a significant challenge as many doctors may lack the necessary skills to manage more complex conditions leading to more unnecessary hospital admissions which further strains the NHS resources and workforce[23]. This will result in much longer waiting times, poorer health outcomes and an over-reliance on emergency departments for conditions that could be better managed in primary care.

Older people are more likely to live in rural areas or by the coast[15]. In such locations, resources are limited, transportation links and access to advanced healthcare services can be more challenging. Rural and coastal areas often have a lower percentage of the population working in the healthcare sector so experience a shortage of GPs, geriatric specialists, fewer hospitals and longer ambulance response times[24]. In these regions social care services and residential homes are often underfunded and overstretched. This disparity in healthcare provision means that some of the most vulnerable elderly patients may experience worse health outcomes, placing further strain on the NHS and emergency services.

Technology

The NHS is increasingly focused on advancing technology to relieve pressures, but this comes with significant challenges. Keeping up with evolving software requires upgraded infrastructure, enhanced training, and additional resources[3]. While more accurate technology can improve patient outcomes, it may also increase anxiety, staff workload, and resource strain. The rapid rise of AI presents further uncertainty, as early implementation risks inaccuracies and bias. It could also impact NHS employment, potentially reducing doctor numbers, increasing burnout, or leading to the 'lazy doctor effect.'[25]

A major challenge is the NHS's outdated digital infrastructure, which struggles to keep pace with technological demands. Frequent failures, cyber threats, and IT malfunctions disrupt patient care and frustrate staff. A third of GPs say their work PC or laptop is unfit for purpose, while 56% report digital inadequacies that prevent effective information sharing with NHS trusts, leading to poorer patient care[26]. Interoperability issues worsen disparities across NHS trusts, with around 75% still relying on paper patient notes, and 4% using paper alone. Some trusts advance rapidly while others lag, creating inconsistencies in healthcare delivery[27]. Many still use outdated tools like pagers and fax machines, and older CT and MRI scanners, delaying urgent diagnoses, particularly for cancer patients[27]. Without urgent upgrades, these technological challenges will continue to impact efficiency, equality, and patient outcomes in the NHS.

NHS staff routinely complain about inadequate technology making their jobs harder rather than easer. The British Medical Association states that more than 13.5 million hours of doctors' time is being lost each year in England due to delays resulting from 'inadequate or malfunctioning IT systems and equipment' – the equivalent of almost 8000 full time doctors or nearly £1 billion (Fig 3)[28]. This is demonstrated by the figure on the right, showing the high level of delays.

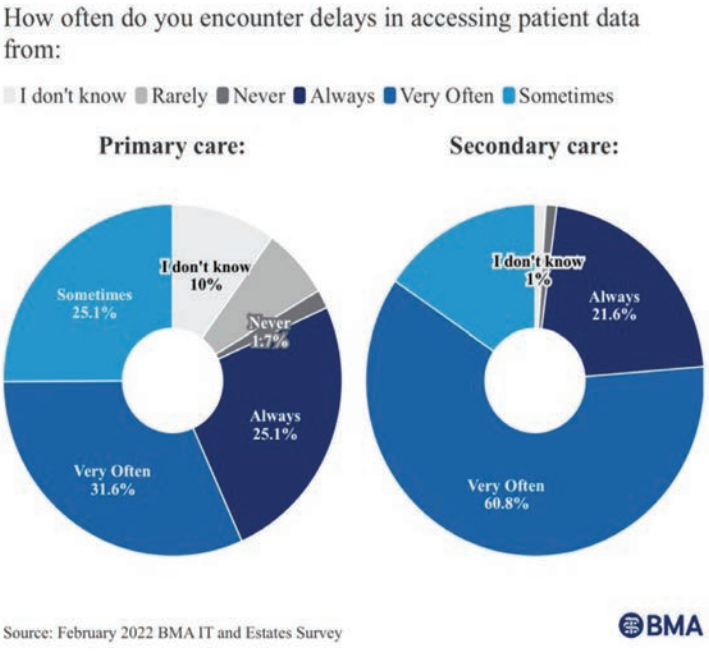


Figure 3

Healthcare staff require training to avoid digital skills gap. The trusts must ensure the technology is safe for them and also protects patients' data. This creates challenges as doctors and nurses are already under immense amounts of pressure, so additional training will have to be integrated into the working day, sacrificing patient care, and increasing waiting lists. Even when doctors had received IT training, 33% said they require more, highlighting ongoing gaps in digital proficiency and the need for further support to navigate evolving healthcare technologies[29].

Another challenge is the increase in scanning capability, resulting in earlier detection and diagnosis. Whilst this could provide

invaluable information about patients and prevent diseases from spreading earlier, potential consequences need to be identified to ensure the NHS can manage these new and emerging technologies, so it is able to sustain itself. A vast number of new scans are being developed, such as the PET (Positron Emission Tomography) scanner which is a new total-body scanner that is quicker for the patient and produces higher quality images for faster and earlier diagnosis and treatment of illnesses was unveiled by Ministers at St Thomas' Hospital. The new scanner is one of three becoming operational in the UK. It is up to 5 times more sensitive for single organ studies and up to 2-4 times faster than standard PET-CT scanners, giving quicker diagnosis and a more detailed reading of the patient's whole body[30].

Wearables are also becoming apparent in the future of scanning. Wearable medical devices aren't just monitoring heart rates and insulin levels anymore, they will be in use for radiology and diagnostic imaging. These wearables can also be developed into wearable ultrasound scanners with applications in bladder and kidney disease, breast cancer detection and more[31]. The flexible devices can be turned to take images of nearly any organ, suggesting applications in home health care, diagnostic imaging, and preventive care management thus cutting down medical appointments.

With more accurate and specialised scans, there are more likely to be false positives as they may detect harmless anomalies or variations that do not pose a real threat, leading to unnecessary concern, increased patient anxiety and potential unnecessary lifestyle changes for patients. This may result in further testing and checkups from doctors which may cause invasive procedures which aren't needed, which ultimately strain the limited resources the NHS have access to.

Despite future medical imaging devices having the potential to yield critical insights into a patient's health, it is imperative that potential challenges are identified so the NHS can effectively integrate emerging technologies and maintain long-term sustainability

Staffing Crisis

The most valuable resource the NHS has is its staff. Nonetheless, the NHS is experiencing a chronic workforce crisis, including a multitude of challenges which are primarily driven by years of insufficient investment in training new staff, inadequate workforce planning, and lack of government accountability.

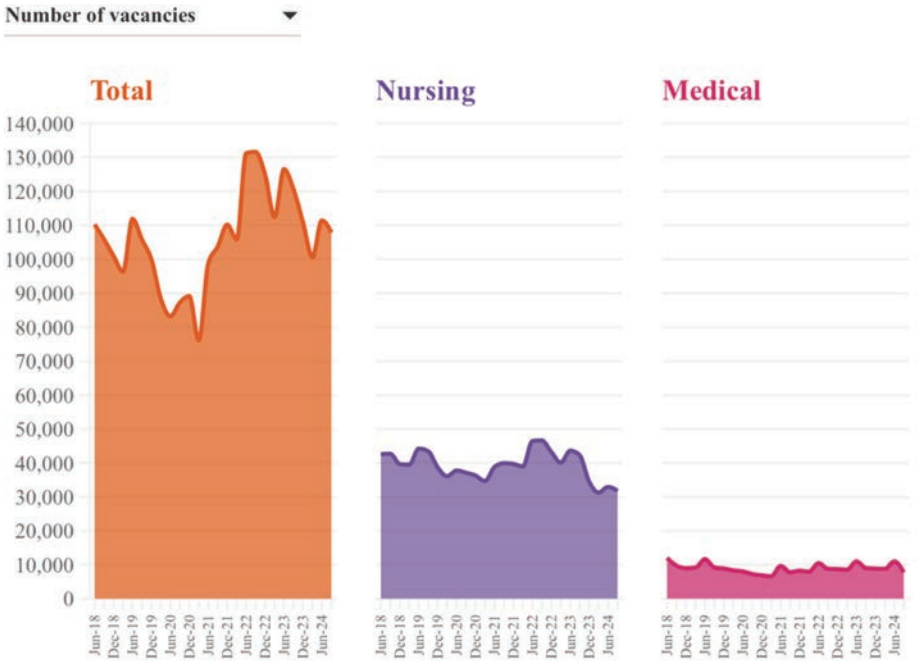
As of September 2024, there were 107,865 vacancies (7.3%) in secondary care in England with 10,165 medical vacancies amounting to 6.2% of medical posts (Fig 4)[32]. High vacancy rates create a vicious cycle: staff shortages produce environments of chronic stress, which increases pressure on existing staff and patients, causing higher turnovers and sickness absences, and in turn leading to increased patient backlogs in the NHS amongst other inefficiencies.

In addition, the NHS would not be able to function without its international workforce, on which it is highly dependent, who account for nearly one in every five people who work in the health service. Some job roles are more reliant than others on international staff – for example, international staff make up 37% of doctors compared with just over 5% of managers[33]. The UK's current immigration policy allows health and social care staff to apply for a visa to work in the UK for up to five years[34]. In the future, political and immigration policies may tighten visa restrictions and could reduce the number of overseas healthcare workers entering the UK, resulting in an insufficient number of workers to fill the vacancies which are required to run the healthcare system.

The current increase in the proportion of international staff demonstrates another issue in that the NHS is failing to attract enough local employees to become trained and work for the NHS. In primary care, the overall number of GPs has seen little growth since 2015, with the full number of GP partners experiencing significant decline over that time. Additionally, the latest data shows that, over the last year to October 2024, the NHS gained the equivalent of 7862 full-time secondary care doctors (Fig 5). This represents an increase of 5.7% for this period which is higher than the preceding year (5.2% between October 2022 – 2023)[35]. Although the overall workforce growth remains positive, it remains to be seen whether it is sufficient to cope with rising demand. This will present future obstacles for the NHS as the stagnation in GP numbers, coupled with the decline in GP partners threatens primary care capacity, which could potentially increase pressure on hospitals as more patients are referred. Additionally, regarding secondary care doctors, it remains doubtful whether this growth can keep pace with escalating demand, risking longer wait times and workforce strain.

Secondary care vacancies in England *Figure 4*

June 2018 to September 2024



Source: NHS Digital: NHS Workforce Statistics • The vacancy rate, as a percentage, is the FTE number of vacancies divided by the FTE planned workforce, multiplied by 100.

A major challenge facing the NHS workforce is rising stress, anxiety, fatigue, and burnout, all of which impact retention due to intense workloads. Although mental health issues have improved since COVID passed, it still remains very high with 30-45% of NHS staff reporting feeling unwell[2]. Mental health issues are the leading cause of sickness absence in secondary care, a trend expected to worsen as recruitment struggles, low pay, and resource shortages persist (Fig 6). Future risks include worsening mental health leading to more sick leave and early retirements, increased strikes over pay and conditions, and staff leaving for private or overseas roles. This would create a cycle of longer waiting times, lower-quality care, and mounting pressure on remaining staff.

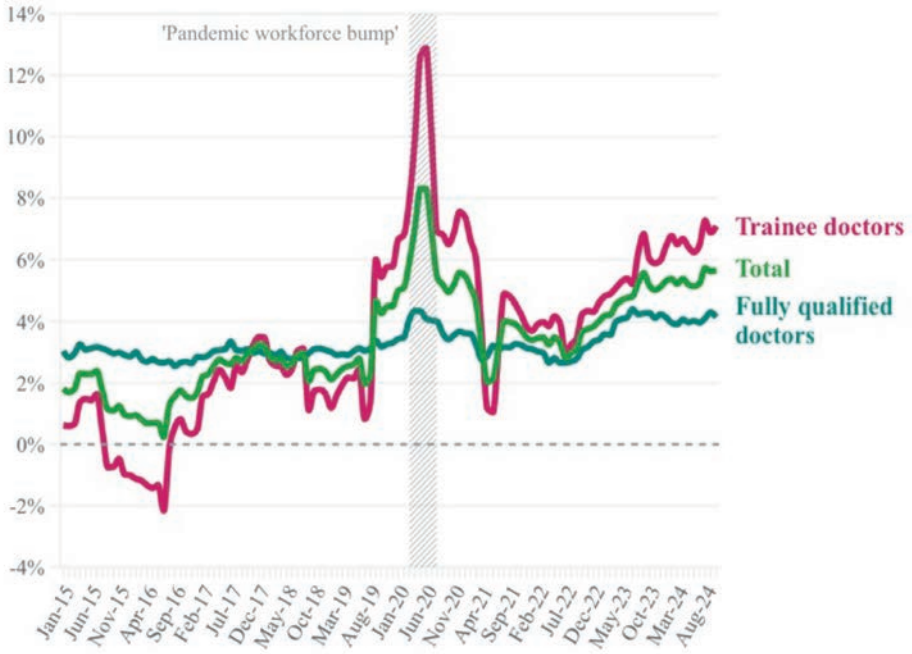
Another prevailing issue regarding the NHS workforce is reviewing the training of professionals in light of the evolving environment and expectations of the patient. This issue is being dealt with as two of England's leading doctors are to oversee a significant review into postgraduate training for newly qualified medics. National Medical Director Professor Sir Stephen Powys and Chief Medical Officer Professor Sir Chris Whitty will lead the review as part of work to address concerns raised by resident doctors. However, this creates a challenge in the future as similar reviews will be necessary for other professionals at all levels such as undergraduates[36].

Conclusion

For the NHS to survive, it must focus on strategic, long-term reforms rather than short-term political fixes. The lessons of history suggest that without these major reforms, the NHS may not survive in its current form. Therefore, significant reforms and changes in the way healthcare is delivered will be necessary if equitable healthcare for all is to continue in the UK for future generations. The second part of this article explores the issues and potential solutions for the NHS.

Rate of growth in FTE number of NHS secondary care doctors

Percentage change since 12 months prior, from January 2015 to October 2024



Source: NHS Digital: NHS Workforce Statistics

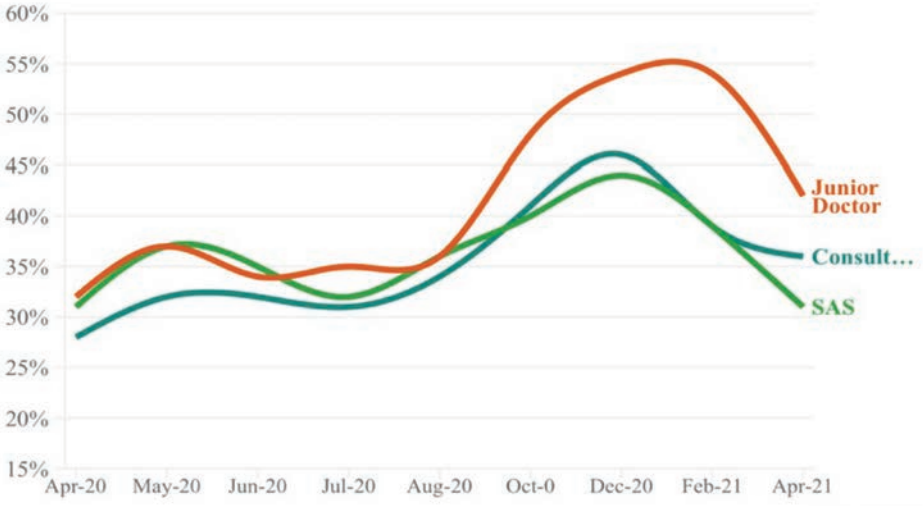
BMA

Figure 5

Figure 6

Proportion of respondents to BMA COVID-19 Tracker Surveys reporting themselves to be suffering from any of depression, anxiety, stress, burnout, emotional distress or other mental health condition relating to or made worse by their work or study

April 2020 to April 2021



Source: BMA COVID-19 Tracker Surveys

BMA

About Cara Mooney

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

Appendix 1: Primary Research

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

References:

1. NHS (2025). Step into the NHS : About the NHS. [online] www.stepintothenhs.nhs.uk. Available at: https://www.stepintothenhs.nhs.uk/about-the-nhs.
2. Dunn, Phoebe, Ewbank, Leo and Alderwick, Hugh (2023). Nine major challenges facing health and care in England. [online] The Health Foundation. Available at: https://www.health.org.uk/reports-and-analysis/briefings/nine-major-challenges-facing-health-and-care-in-england.
3. The Medic Portal (2024). Challenges Facing The NHS - The Medic Portal. [online] The Medic Portal. Available at: https://www.themedicportal.com/application-guide/the-nhs/challenges-facing-the-nhs/.
4. GOV.UK. (n.d.). Spring Budget 2024 (HTML). [online] Available at: https://www.gov.uk/government/publications/spring-budget-2024/spring-budget-2024-html#financing.
5. The King's Fund (2024). The NHS Budget and How It Has Changed. [online] The King's Fund. Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-budget-nutshell.
6. The Health Foundation (2024). How Much Funding Does the NHS Need over the next decade? [online] The Health Foundation. Available at: https://www.health.org.uk/reports-and-analysis/briefings/how-much-funding-does-the-nhs-need-over-the-next-decade.
7. Gainsbury, S. (2024). How much more money does the NHS need? [online] Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/news-item/how-much-more-money-does-the-nhs-need.
8. HM Treasury (2022). New efficiency drive to cut £5.5 billion of government waste. [online] GOV.UK. Available at: https://www.gov.uk/government/news/new-efficiency-drive-to-cut-55-billion-of-government-waste.
9. NHS Confederation. (2024). More staffing and patient care cuts likely unless government addresses growing NHS deficit. [online] Available at: https://www.nhsconfed.org/news/more-staffing-and-patient-care-cuts-likely-unless-government-addresses-growing-nhs-deficit.
10. Anandaciva, S. (2024). What Does The Autumn Budget 2024 Mean For Health And Care | The King's Fund. [online] The King's Fund. Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/autumn-budget-2024-health-and-care.
11. Robertson, R., Wenzel, L., Thompson, J. and Charles, A. (2017). Understanding NHS financial pressures [online] The King's Fund. Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/understanding-nhs-financial-pressures.
12. Vernon, M.J. (2016). NHS England» Our ageing population presents the NHS with its greatest challenge. [online] England.nhs.uk. Available at: https://www.england.nhs.uk/blog/martin-vernon/.
13. Stevenson, E. and Mutebi, N. (2024). Healthy Ageing and Care for Older Populations. [online] UK Parliament. Available at: https://post.parliament.uk/healthy-ageing-and-care-for-older-populations/.
14. ONS (2025). National Population Projections. [online] Ons.gov.uk. Available at:https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2022based.
15. Centre for Ageing Better (2024). Our Ageing Population | the State of Ageing 2023-24 . [online] ageing-better.org.uk. Available at: https://ageing-better.org.uk/our-ageing-population-state-ageing-2023-4.
16. The Medic Portal. (2021). Ageing Population. [online] Available at: https://www.themedicportal.com/application-guide/medical-school-interview/nhs-hot-topics/ageing-population/.
17. Whiterose.ac.uk. (2023). The NHS and an Ageing Population . [online] Available at: https://eprints.whiterose.ac.uk/133768/1/NHS_KIHASA_Final.docx.
18. SCIE. (2021). Care homes as a model for housing with care and support. [online] Available at: https://www.scie.org.uk/housing/role-of-housing/promising-practice/models/care-home/.
19. Science, L.S. of E. and P. (2019). Dementia care. [online] London School of Economics and Political Science. Available at: https://www.lse.ac.uk/News/Latest-news-from-LSE/2019/K-November-2019/Dementia-care.
20. Robineau, D. (2017). Ageing Britain: two-fifths of NHS budget is spent on over-65s. [online] the Guardian. Available at: https://www.theguardian.com/society/2016/feb/01/ageing-britain-two-fifths-nhs-budget-spent-over-65s.
21. Public Health England (2020). Older people's hospital admissions in the last year of life. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/older-peoples-hospital-admissions-in-the-last-year-of-life/older-peoples-hospital-admissions-in-the-last-year-of-life.
22. Imison, C. and Bohmer, R. (2013). NHS and social care workforce: meeting our needs now and in the future? Perspectives. [online] Available at: https://assets.kingsfund.org.uk/f/256914/x/bb14474d98/nhs_social_care_workforce_meeting_needs_2013.pdf.
23. Gerada, C. (2012). EnhancEd GP TrainiG: ThE EducaTional casE. [online] Available at: https://www.rcgp.org.uk/getmedia/5b5c0cb7-4345-4129-8a09-4d5ae3c0ce34/Case-for-enhanced-GP-training.pdf.
24. Green, A. and Bramley, G. (2018). Rural Workforce Issues in Health and Care. [online] Available at: https://www.ncrhc.org/assets/downloads/20181012_Rural_Workforce_Issues_in_Health_and_Care-min.pdf.
25. Siafakas N and Erini Vasarmidi. Risks of Artificial Intelligence (AI) in medicine. Pneumon 2024;37(3):40 DOI: https://doi.org/10.18332/pne/191736
26. RCGP (2024). GPs sound the alarm over 'outdated' infrastructure. [online] Rcgp.org.uk. Available at: https://www.rcgp.org.uk/news/outdated-general-practice-infrastructure [Accessed 1 Apr. 2025].
27. Dawood, S. (2024). The NHS's digital problem: how old infrastructure is slowing down healthcare services. [online] New Statesman. Available at: https://www.newstatesman.com/spotlight/healthcare/nhs/2024/08/nhs-digital-transformation-infrastructure-technology-patient-records-artificial-intelligence-waiting-lists.
28. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis
29. Fitzpatrick, P.J. (2023). Improving Health Literacy Using the Power of Digital Communications to Achieve Better Health Outcomes for Patients and Practitioners. Frontiers in Digital Health, [online] 5(1). doi:https://doi.org/10.3389/fdgth.2023.1264780.
30. Guy's and St Thomas' (2025). First patients benefit from new PET scanner. [online] Guy's and St Thomas' NHS Foundation Trust. Available at: https://www.guysandstthomas.nhs.uk/news/first-patients-benefit-new-pet-scanner.
31. Definitive Healthcare (2024). Trends in Medical ImagingIFuture of Medical Imaging. [online] www.definitivehc.com. Available at: https://www.definitivehc.com/blog/future-trends-in-medical-imaging.
32. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/medical-staffing-in-the-nhs
33. Mallorie, S. (2024). NHS workforce in a nutshell. [online] The King's Fund. Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell.
34. Gov.UK (2022). Health and Care Worker Visa. [online] GOV.UK. Available at: https://www.gov.uk/health-care-worker-visa.
35. NHS Digital (2024). NHS Workforce Statistics - NHS Digital. [online] NHS Digital. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics.
36. NHS (2025). Step into the NHS : About the NHS. [online] www.stepintothenhs.nhs.uk. Available at: https://www.stepintothenhs.nhs.uk/about-the-nhs.

From the Science Desk (1)

Clopidogrel better than aspirin for preventing heart attack and stroke in patients with coronary artery disease

Switching from aspirin to clopidogrel could reduce the risk of myocardial infarction, stroke, or death by an extra 14% in patients with coronary artery disease (CAD), a Lancet study has found. The researchers – who presented their findings at the 2025 European Society of Cardiology congress in Madrid – said that clopidogrel should be the preferred long term antiplatelet treatment for patients with CAD. The study analysed seven randomised trials comparing clopidogrel and aspirin in people with CAD, and looked at individual patient data for a total of 28,982 study participants (14,507 assigned to clopidogrel, 14,475 assigned to aspirin).

BMJ 2025; 390 doi: https://doi.org/10.1136/bmj.r1844 (Published 01 Sept 2025)

Ultra-processed foods linked to precursors of early-onset colorectal cancer

A new study led by Massachusetts General Brigham researchers, as part of the Cancer Grand Challenges PROSPECT team based at suggests an important link of ultra-processed foods to colorectal cancer. They analysed the diets and endoscopy results from almost 30,000 women. They analysed 24 years' worth of data They found that study participants who reported consuming the highest levels of ultra-processed foods had a 45% higher risk of developing adenomas, which can be precursors of early-onset colorectal cancer, compared to participants who reported consuming the lowest levels. Their results are published in JAMA Oncology.

Deaths linked to antibiotic-resistant superbugs rose 17% in England in 2024

The number of deaths linked to superbugs that do not respond to frontline antibiotics increased by 17% in England last year, according to official figures that raise concerns about the ongoing increase in antimicrobial resistance. This is one of the greatest health threats we face.

The figures, released by the UK Health Agency, also revealed a large rise in private prescriptions for antibiotics, with 22% dispensed through the private sector in 2024. The Pharmacy First scheme allows patients to be prescribed antibiotics for common illnesses without seeing a GP, raising questions about whether the shift in prescribing patterns risks contributing to the rise in resistance.

https://www.gov.uk/government/news/nearly-400-antibiotic-resistant-infections-each-week-in-2024

Educating Medical Students and Trainees with Disabilities

Tanbir Hasan 3rd Year Medical Student
Ethan Little 3rd Year Medical Student
Abhinav Yeeda 2nd Year Medical Student
Hannah Nixon 2nd Year Medical Student
David Mkwizu 2nd Year Medical Student
Humraj Singh 2nd Year Medical Student
Harold Hon 2nd Year Medical Student – All at Lancaster University
Prof David Brigden Lancaster University Medical School.
Emeritus Professor, University of Greater Manchester

Introduction:

Disability is a "physical or mental impairment that has a substantial and long-term negative impact on one's activities of daily living" as defined in the Equality Act of 2010 [1]. This act also introduced the concept of Reasonable Adjustments (RAs) to accommodate the needs of those with a disability in working environments [1].

All aspects of livelihood can be affected by disability - not just physical functioning, but also psychological and social abilities. Almost 1 in 10 medical students are afflicted by disability which can have particular consequences and implications on their education [2]. In the case of medical students and resident doctors, trainees with a disability may experience further problems with specific aspects of their education in 'the work-place'. However, with the right help and support this can be kept on track.

Medical students with a disability have already shown consider-able ability in knowledge, skills and simple durability. They have passed exams to get to medical school and possess many of the competencies and qualities desired of future doctors. Several have proceeded through their undergraduate studies, or graduated and entered the workplace to continue their training. However, in these environments, disabled doctors and medical students face constant uphill battles for support, with only 27% of doctors receiving all the necessary adjustments and only 34% of those who disclosed a disability received some improvement in support [2]. Most concerningly, 53% of doctors with a disability had considered leaving the profession due to lack of reasonable adjustments being made [2].

The effects of disability are individual and the degree of functional disability is highly context-specific. There may be certain educational and training vulnerabilities, which may in themselves be persistent or more contextual. However, despite the challenges, it is our duty to provide assistance and support to students and trainees with disabilities, for their sake, and for the benefit of patients.

Hence, in this paper we aim to:

1. Emphasize the sheer importance of educating medical students and trainees with disabilities.
2. Address the most effective ways in which support can be offered.
3. Understand and suggest methods to overcome the challenges to this notion.

How do we support students with disabilities?

Supporting medical students with disabilities requires a multi-faceted and inclusive approach that begins with early needs assessments and the provision of Disabled Student Allowance (DSA). Medical schools and healthcare organisations are also legally and ethically obliged to provide reasonable adjustments and ensure equitable distribution of resources. Some examples include: additional timing for academic tasks and examinations, more flexible teaching hours, or utilising specific technologies to aid learning [3]. Since medicine teaches compassion, it must extend that same compassion inwardly to colleagues, not just patients.

The implementation of personalised examination modalities, tailored clinical role adaptations, access to specialist counselling services, and other targeted resources can collectively foster an affirmative learning milieu wherein students are both welcomed and valued, in alignment with General Medical Council (GMC) guidance. Despite this, many students still avoid disclosing their disabilities due to stigma. It is essential to educate students on their rights, the confidentiality of disclosures, and the legal duties of institutions to protect this information - especially considering how these factors can impact patient care [3].

Promoting early disclosure, inclusive language in teaching and placements, and encouraging a culture of openness are crucial steps forward. Furthermore, the establishment of structured mentorship infrastructures and assured access to designated academic tutors can effectively mitigate experiences of social marginalisation and discrimination, by providing a safe and professionally supportive forum for articulating concerns. When coupled with comprehensive equality, diversity, and inclusion (EDI) training delivered systematically to both staff and students, these measures collectively strengthen the foundations of a genuinely inclusive medical ecosystem [4]. Once a disability is disclosed, institutions are legally mandated to make RAs on a case-by-case basis, which should undergo regular scrutiny including the evaluation of learning support plans and undertaking of clinical audits. This encourages accountability and the fostering of continuous enhancement in educational outcomes for disabled students [5].

Why should we support students with disabilities?

Educating and empowering medical students and trainees with disabilities is not only a matter of equity, but a pathway to stronger, more compassionate healthcare and improved clinical practice. Professionals with lived experience of disability bring unique insights that enrich patient care; offering empathy, nuance, and authenticity when caring for patients facing similar challenges. This aligns with the social model of disability, which identifies systemic and environmental barriers not individual impairments as the true obstacles to inclusion [6].

The presence of disabled students within healthcare education reminds peers and institutions of the importance of diversity, respect, and equity within the medical profession. From the standpoint of the rights-based model, supporting students with disabilities also strengthens institutional accountability, ensuring that the principles of justice and fairness enshrined in the Equality Act are actively upheld rather than being simply acknowledged [1,7].

Disabled doctors possess a personalised understanding of disability which brings a unique insight to the multidisciplinary team, resulting in a more inclusive and holistic standard of care. Furthermore, trainees with disabilities may find it easier to empathise and relate to people with disability, improving their ability to communicate with patients. Finally, inclusion of disabled colleagues contributes to team resilience: learning to adapt together encourages creativity, problem-solving, and solidarity, all of which are essential traits for effective multidisciplinary healthcare teams.

What are the challenges faced by students with disabilities?

Disabled medical students and trainees often have to negotiate a culture of stigma and prejudice that discourages disclosure and seeking help. In one UK qualitative study, students reported delaying or hiding health-related disclosures - especially to university services - because they feared that to do so would compromise their future fitness to practise and professional careers [8]. Even when students report their disabilities, the BMA Disability Report revealed only 55% of disabled doctors and medical students received the RAs they are entitled to.[9] Understanding why such a large gap exists in those who do and do not get their adjustments is a key issue, and logistics is a significant obstacle in this.

Even when trainees overcome these barriers, they often experience repeated accessibility issues. Clinical learning spaces are often physically inaccessible for wheelchair users, and hospital apparatus can lack the required adaptations for impaired learners (e.g., adjustable examination couches or accessible simulation rooms); while many digital platforms and patient-management systems do not incorporate features required by sensory-impaired learners.

Educators and regulators also struggle with reconciling patient safety and the need to include disabled learners. The GMC reaffirms that patient safety cannot be compromised by the learning environment in any way. This leads to concerns regarding prolonged procedural times or alternative assessment

formats can prompt some supervisors to query the feasibility of particular accommodations within busy clinical services [10].

At an institutional level, oversight of disability support is frequently dispersed across undergraduate medical schools, postgraduate deaneries, and NHS Trusts, generating delays and gaps in accountability. The Medical Schools Council's 2022 guidance demands streamlined processes and more explicit institutional commitment to disabled applicants and students, yet uptake remains patchy across the UK [11].

The Consequences of Neglect - Case Studies

There are stark consequences for failing to uphold basic liberties for disabled students and trainees. Historically, in 2001, the Daksha Emson case opened the floodgates for many more cases to come forward pertaining to systemic failures in the provision of support [12]. In 2015, Dr Wendy Potts, a GP with bipolar disorder, died by suicide after facing suspension from clinical practice following disclosures about her condition on a personal blog [13]. More recently in 2025, the story of Francesca Nnamchi, a disabled medical student in the UK, demonstrates how barriers to accessibility still persist in education today. Her struggle for basic accommodations and the dismissive institutional responses she received underline the hypocrisy of healthcare and academic institutions that claim to value inclusivity while continuing to marginalise those with lived experience of disability [14].

If we fail to reflect on these legacies, we risk repeating their outcomes with today's trainees. Respecting the principles of the Equality Act and the social model of disability is not simply best practice; it is a moral imperative, vital to building a safe, inclusive, and truly caring medical workforce.

Institutional Challenges:

The GMC's 'Welcomed and Valued' guidance affirms that no disability diagnosis "automatically prohibits an individual from studying or practising medicine" with schools being obligated to consider support on a case-by-case basis [3]. It gives guidance to medical schools to create a holistic and inclusive environment, where all students feel safe and supported.

Despite this, a common issue seen is that institutional implementation lags behind in practice as regulation of the placement environment is challenging for medical schools, for it is in control of individual trusts rather than the school itself. Thus, the oversight of disability support can be fragmented across universities, trusts and deaneries, leading to the inconsistent provision of students.

Advertising of support services such as Disability Champion or Disability Network is poor, with the 2020 BMA report revealing only 26% of medical students are aware of such resources. Worse yet, dedicated disability advisers, occupational health services and support networks are often critically understaffed or siloed [3, 10]. Half a decade later, interim findings from the 2025 survey revealed 73% hadn't received all their required adjustments, with 43% paying out of pocket; despite the statutory duty to provide such help [15]. Furthermore, less than half of organisations even possess reasonable adjustments policies, with less than a fifth implementing an official budget for providing these [10].

These gaps collectively suggest persistent systemic shortfalls in funding, administration and engagement from the institution, contributing to the formation of a discriminative culture that can push disabled doctors out of the profession [2]. Considering the cost of replacing an NHS doctor, potentially exceeding £300,000 it's paramount we provide adequate support to medical students now in an effort to retain them in the future [17].

Educator training and awareness:

Medical schools should endeavour to make conditions for work as inclusive as possible for staff and students, based on Active Inclusion guidance, as a way to reduce stigma and improve understanding of RAs [15].

This can be through the promotion of structured programs, such as student involvement in reverse mentoring, dedicated committees and training sessions on EDI, however implementation in trust-governed placement is once again limited for the reasons mentioned above. The establishment of an MSC EDI alliance signifies a reinvigorated commitment to education for disabled students: leads from countrywide medical schools collaborate together, with the aim to tackle barriers faced by these students, as well as fostering a more positive culture and change [15].

If we are to see change, the BMA's recommendations from the 2020 Disability in the Medical Profession report must be heard. This involves actions like: centralising the reasonable adjustment process for both medical schools and hospitals, while also being more flexible for training/working options and shifting the culture around how disability is perceived is vital to ensure the placement environment adequately supports disabled students and trainees [16].

What can we do? Strategies for Success:

Health Passports

One way in which RAs can be implemented is through "Health Passports". Typically, these are utilised in a hospital setting for patients who have special needs to enhance their quality of care. This often notes adaptations necessitated for an individual patient such as communicative or sensory requirements.

Applying this concept in the context of medical students and trainees, Health Passports can provide a domain to communicate their needs to their respective stakeholders (e.g. the medical school, the trust in which they work, or their clinical team) and thus allow for adaptations to be made. This reinforces a clearer line of communication between medical trainees and their teams, whilst respecting transparency and autonomy [18].

Communication of these health needs opens lines to what adjustments can be made for the trainee. According to the University of St Andrews Medical School Handbook, notifying the institution of any disability or impairment allows them to understand what impact it has on the student (e.g. on placement or in academia) and thus allowing the student to flourish to the best of their abilities. [19]

Therefore, a Health Passport will streamline the complexity of RAs, by providing a more consistent method for stakeholders to understand the needs for trainees, without having to communicate with an excessive number of parties, reducing miscommunication. In addition, this aids in the delivery of RAs, improving the logistics behind them, allowing for quicker and more effective implementation.

Pedagogical Reform

Universal Design for Learning (UDL) is a framework that focuses on creating a diverse and inclusive curriculum, expecting that it will be accessed by learners with varied skills, attributes and methods [20]. By doing so, it reduces the burden on learners to adjust independently, providing a fairer, more equitable method for not just neurodivergent learners, but all learners as a whole. Applying this to medicine, this could translate to:

- Accessibility to learning experiences
- Support for learners through different elements of their training
- Executive functioning, which refers to managing learning through setting aims, categorising/organising learning, and understanding learning strategies [21].

The key issue with RAs is that they have to be requested by the learner, which places a burden upon themselves to access any accommodations that they require. Especially when considering neurodivergence, this can range from having a minimal impact on the learner whereby they can easily ask for help, to conditions such as ADHD where poor executive functioning can become an insurmountable obstacle for securing support [22]. Other factors, such as stigmatisation of their condition, combined with inadequate support, could contribute to this eschewment of RAs [21].

Neurodivergent individuals face complex challenges in adapting to the cultures and norms of medicine – poor support and social stigmata makes transparency and openness difficult (22). Exposing medical students to disabled communities can help reduce labelling and stereotyping for neurodivergent individuals. The need for this is seen in McVey's paper, where it mentions fellow doctors generalising and labelling neurodivergent doctors, as quoted *"the sooner this obsession with being diagnosed with neurodiversity ends, the better"* [22].

UDL also promotes effective teaching strategies to aid students in an equitable fashion, presenting content in different ways depending on the learning style that works best for them [17]. Those on a neurodivergent spectrum have different attributes depending on their condition. For instance, those with dyslexia have greater visual-spatial skillsets which can be evoked through UDL [18]. Visual learning, as well as activities that focus on pattern recognition, may aid in reducing barriers to these groups. It is paramount to note that the skillsets neurodiverse individuals possess are highly attractive to medicine – through their observational skills and diagnostic abilities – further reinforcing the benefits of utilising specific teaching strategies.

Key Summaries:

- Student-centred support is crucial to ensure that students with disabilities are, not only included in medical education, empowered to burgeon and prosper.
- Students have a right to a stigma-free environment that actively supports and safeguards the disclosure of disabilities.
- Personalised reasonable adjustments are a legal and moral obligation.
- Lived experience from disabled doctors, fosters a unique and enriching environment of empathy, resilience and patient-in-sight to healthcare.
- Institutional gaps in the accessibility of reasonable adjustments and other support can have a devastating impact on medical students and trainees.
- Improvements in ED are not enough to make up for shortfalls in funding.
- Health Passports can more clearly convey a medical student or trainees need for support from medical schools and hospitals.
- Universal Design for Learning (UDL) offers a proactive framework that reduces the burden on individuals by embedding inclusivity into the structure of medical education itself.

References:

1. UK Government. Equality Act 2010. London: The National Archives; 2010. Available from: https://www.legislation.gov.uk/ukpga/2010/15/contents
2. British Medical Association. Disability and neurodivergence in the medical profession: survey findings. London: BMA; 12 Jun 2025. Available from: https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/disability-equality-in-medicine/disability-and-neurodivergence-in-the-medical-profession
3. General Medical Council. Welcomed and valued: Supporting disabled learners in medical education and training. London: GMC; 2021. Available from: https://www.gmc-uk.org/-/media/documents/welcomed-and-valued-2021-english_pdf-86053468.pdf**
4 Mogensen L, Hu W. "A doctor who really knows ...": a survey of community perspectives on medical students and practitioners with disability. BMC Med Educ. 2019;19:288. doi:10.1186/s12909-019-1715-7.
5. Revell, K., & Nolan, H. (2022). Do medical students with a disability experience adverse educational outcomes on UK medical courses? Medical Teacher, 45(4), 388–394. https://doi.org/10.1080/0142159X.2022.2136518
6 Oliver M. The Politics of Disablement. Basingstoke: Macmillan Education; 1990. Available from: https://www.palgrave.com/gp/book/9780333373266
7. Degener T. A human rights model of disability. In: Blanck P, Flynn E, editors. Routledge Handbook of Disability Law and Human Rights. London: Routledge; 2017. p. 31–49. Available from: https://doi.org/10.4324/9781315612881
8. Shahaf-Oren B, Madan I, Henderson C. Disclosure and help-seeking decisions by medical students with health problems: a qualitative study. BMC Med Educ. 2021;21(1):599. Available from: https://pubmed.ncbi.nlm.nih.gov/34865636/
9. Tonkin T. Disabled doctors do not receive required support, finds survey. The Doctor [Internet]. 2024 Dec 3 [cited 2025 Sep 27]; Available from: https://thedoctor.bma.org.uk/articles/doctors-wellbeing/disabled-doctors-do-not-receive-required-support-finds-survey/
10. Medical Schools Council. Supporting and encouraging applicants with a disability – a guide for medical schools. London: MSC; 08 Apr 2022. Available from: https://www.medschools.ac.uk/latest/publications/supporting-and-encouraging-applicants-with-a-disability-a-guide-for-medical-schools/
11. General Medical Council. Welcomed and Valued: Supporting disabled learners in medical education and training. London: GMC; 2012. Available from: https://www.gmc-uk.org/-/media/documents/dc11872-pol-welcomed-and-valued_pdf-78449815.pdf (cant find this one)
12 Emson R, North East London Strategic Health Authority. Independent Inquiry into the Care and Treatment of Dr Daksha Emson and Her Daughter Freya. NHS; 2003. Available from: https://www.hundredfamilies.org/wp/wp-content/uploads/2013/12/DAKSHA_EMSON_LON_10.01.pdf
13. General Medical Council. Inquest into the death of Dr Wendy Potts. London: GMC; 2017. Available from: https://www.gmc-uk.org/news/news-archive/inquest-into-the-death-of-dr-wendy-potts
14. Nnamchi F. My struggle for access: A disabled medical student's fight for accessible higher education. Crip Life™; 2025. Available from: https://criplife.co.uk/my-struggle-for-access-a-disabled-medical-students-fight-for-accessible-higher-education/
15. Medical Schools Council. Active inclusion: Challenging exclusions in medical education [Internet]. London: Medical Schools Council; 2021 Dec 8 [cited 2025 Sep 27]. Available from: https://www.medschools.ac.uk/latest/publications/active-inclusion-challenging-exclusions-in-medical-education/
16. British Medical Association. Disability in the medical profession: Survey findings 2020. London: BMA; 2020. Available from: https://www.bma.org.uk/media/2923/bma-disability-in-the-medical-profession.pdf
17. British Medical Association. When a doctor leaves: Tackling the cost of attrition in the UK's health services. [Internet]. London: BMA; 2025 [cited 2025 Sep 27]. Available from: https://www.bma.org.uk/
18 University of Leeds. Guidance for clinical placements on reasonable adjustments [Internet]. 2024 [cited 2025 Oct 5]. Available from: https://placements.leeds.ac.uk/wp-content/uploads/sites/58/2024/09/Guidance-for-clinical-placements-on-reasonable-adjustments-and-Health-Passports.pdf
19. Med Handbook - Medical Students - Health, Disability and Reasonable Adjustments. University of St Andrews; 2023 [cited 2025 Oct 5]. Available from: https://medhandbook.st-andrews.ac.uk/
20. Luke K. Twelve tips for designing an inclusive curriculum in medical education using Universal Design for Learning (UDL) principles. MedEdPublish [Internet]. 2021;10(1):118. Available from: http://dx.doi.org/10.15694/mep.2021.000118.1
21. Doyle AJ, O'Toole M, Cassidy D, Condron CM. Universal Design for Learning (UDL) in simulation-based health professions education. Adv Simul [Internet]. 2025;10(1):33. Available from: http://dx.doi.org/10.1186/s41077-025-00361-3
22. McVey C. Neurodiversity in doctors and its impact on their profession. [cited 2025 Oct 5]; Available from: https://www.rcpsych.ac.uk/docs/default-source/members/faculties/general-adult-psychiatry/mcveyc-'neurodiversity-in-doctors-and-its-impact-on-their-profession'.pdf?sfvrsn=aca38d1b_5

Comparative Effectiveness and Safety of Direct Oral Coagulents in Elderly Patients with Atrial

Hafsa Aman Fairfield General Hospital NCA NHS **Sangeen Khan** Fairfield General Hospital NCA NHS

Introduction

Atrial fibrillation (AF) is the most common sustained arrhythmia in the elderly. It increases risk of cardioembolic stroke particularly in age > 65 years.
In elderly patients age related changes and comorbidities increases both stroke risk and treatment side effects making effective anticoagulation essential for prevention.
VKAs particularly warfarin, proven efficacy but require INR monitoring and have dietary/drug interactions with narrow therapeutic window. DOACs offer fixed dosing, predictable pharmacokinetics, and fewer interactions.
This systematic review evaluates comparative effectiveness and safety of DOACs vs VKAs in elderly AF patients.

Methods

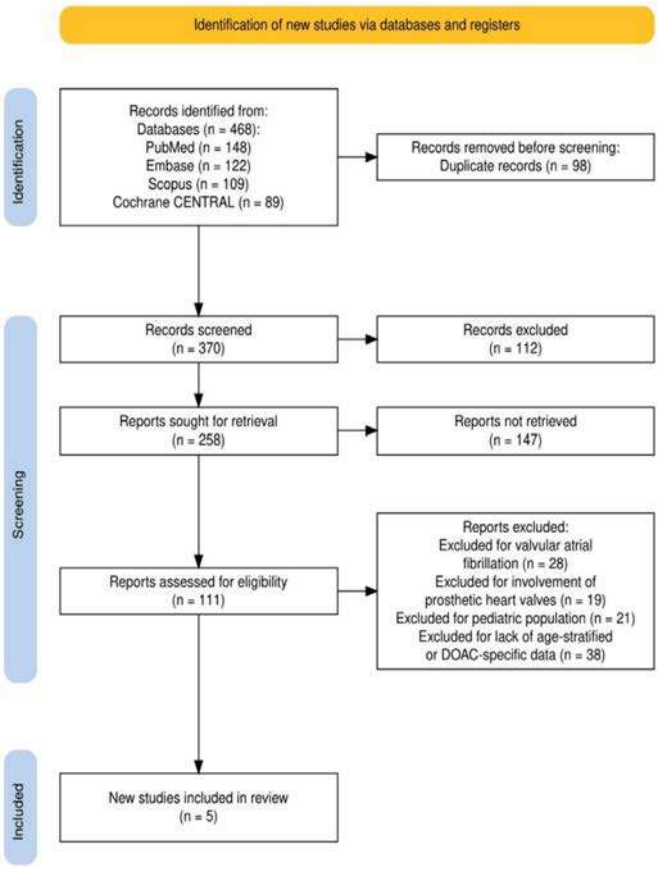
A systematic review was conducted in accordance with PRISMA guidelines.

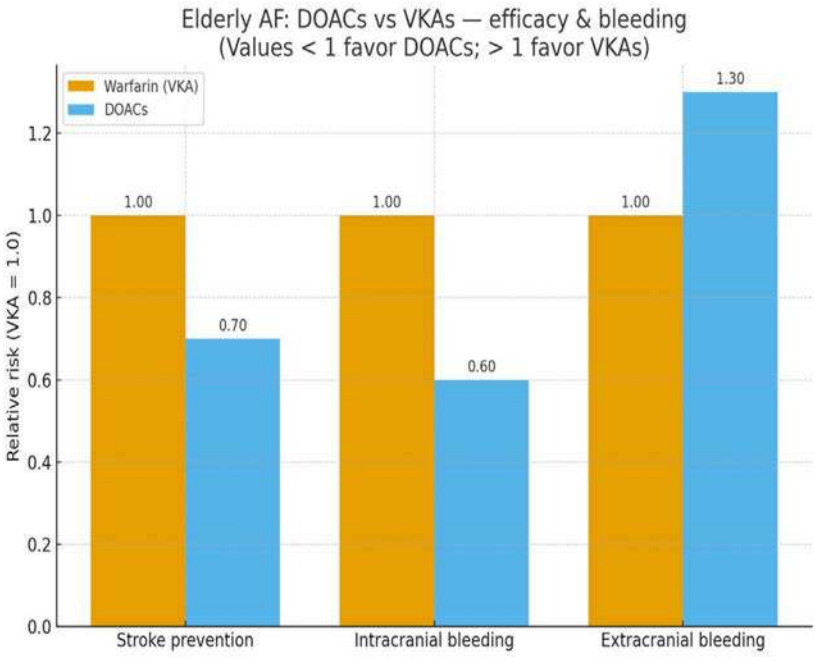
Databases searched: PubMed, Embase, Scopus, and Cochrane CENTRAL.

Inclusion criteria: Randomized controlled trials (RCTs) of elderly patients (≥70 years) with non-valvular AF.

Primary outcomes: Stroke or systemic embolism, major bleeding, cognitive outcomes.

Risk of bias assessment: Cochrane RoB 2.0 tool was used.





vs Vitamin K Antagonists

Fibrillation: A systemic Review

Results

Five high-quality RCTs included:

- Dabigatran (RE-LY, Lauw 2017): Effective stroke prevention; higher incidence of extracranial bleeding(GI bleeding with higher doses) in ≥80 yrs.
- Rivaroxaban (ROCKET AF, Halperin 2014): Non-inferior to warfarin; similar bleeding risk.
- Edoxaban (ENGAGE AF-TIMI 48, Yamashita 2016): High dose superior for stroke prevention and major bleeding; low dose non-inferior for stroke and lowest bleeding risk.
- Dabigatran vs Warfarin (GIRAF, Caramelli 2022): No significant difference in cognitive decline over 2 years.
- Dabigatran (Eikelboom 2011): Lower intracranial bleeding at all ages but higher extracranial bleeding in ≥75 yrs with dose 150mg.

Overall: DOACs = effective, safer for intracranial bleeding; extracranial bleeding risk rises in very elderly.

Trial	Population	DOAC	Comparator	Key Findings
RE-LY (2011, 2017)	≥75 yrs	Dabigatran 110/150 mg	Warfarin	Stroke prevention strong, extracranial bleeding ↑ ≥80 yrs
ROCKET AF (2014)	≥75 yrs	Rivaroxaban 20/15 mg	Warfarin	Non-inferior for stroke, similar bleeding
ENGAGE AF-TIMI 48 (2016)	≥70 yrs (East Asians)	Edoxaban 60/30 mg	Warfarin	High dose better stroke /bleeding, low dose safest
GIRAF (2022)	≥70 yrs	Dabigatran 110/150 mg	Warfarin	No cognitive difference vs warfarin
RE-LY Subgroup (2011)	≥75 yrs vs <75 yrs	Dabigatran 110/150 mg	Warfarin	Less intracranial bleeding safer in <75 years, extracranial ↑ in >75 years with 150mg

Discussion & Conclusion

DOACs offer comparable or superior stroke prevention and markedly reduce intracranial haemorrhage compared with VKAs (warfarin). However, in elderly (>75 years), DOACs carry an increased risk of extracranial bleeding, especially GI bleeding, particularly at higher Dabigatran doses. These findings stress the need for individualized dosing and careful monitoring in older adults, balancing efficacy with safety.

Lower dose options(e.g., dabigatran 110mg) may help balance safety and efficacy in very elderly or renally impaired patients.

Role of DOACs in cognitive protection remain uncertain but area of growing interest .These findings are relevant for clinicians managing long term anticoagulation in older adults.

Conclusion: DOACs are generally safer and effective in elderly AF patients; caution required in very elderly..

Clinical Recommendations

- DOACs should be considered first-line in elderly AF.
- Intracranial bleeding risk is lower vs VKAs.
- Extracranial bleeding risk increases in ≥80 years
- Dose adjustment and individualized therapy considering age , renal functions and bleeding risk are crucial.
- Shared decision-making is recommended.

Improving adherence to the BASL decompensated cirrhosis care bundle: A three-cycle quality improvement project at North Manchester General Hospital

Kitcher, A Senior Clinical Fellow, Salford Royal Hospital. *Joint First Author.*
Harris, E Department of Gastroenterology & General Medicine, North Manchester General Hospital. *Joint First Author.*
Niaz, A Department of Gastroenterology & General Medicine, North Manchester General Hospital. *Joint First Author.*
Ali, S Department of Gastroenterology & General Medicine, North Manchester General Hospital.

WINNER, Best Podium Presentation, BIDA National Conference 2025

Abstract:

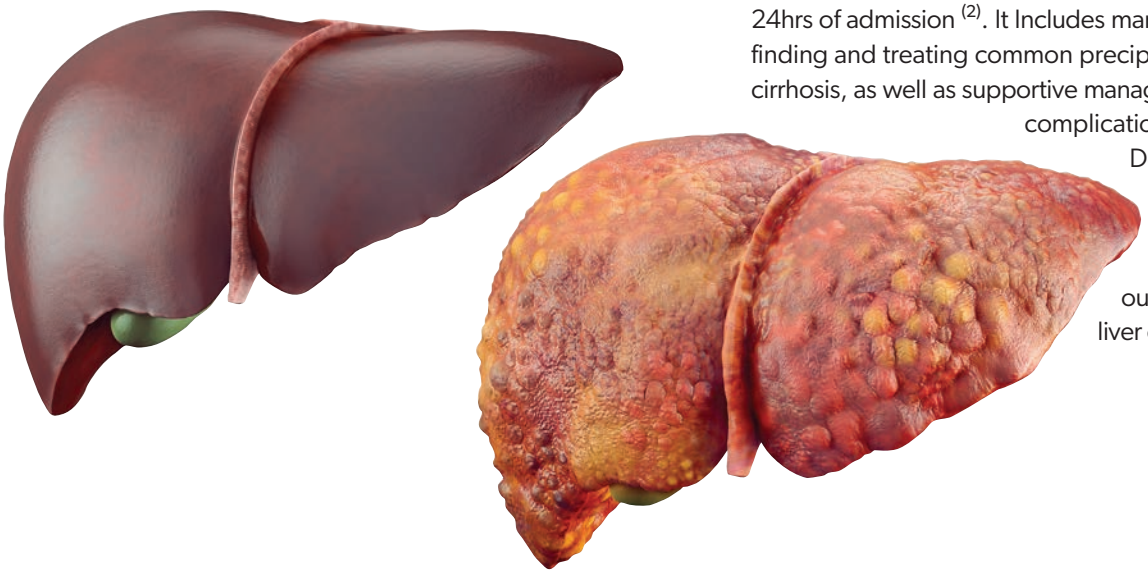
Decompensated liver cirrhosis is a frequent cause of hospital admission and is associated with high mortality. Adherence to the British Association for the Study of the Liver (BASL) Decompensated Cirrhosis Care Bundle has been shown to improve outcomes. This three-cycle quality improvement project, conducted at North Manchester General Hospital, evaluated and enhanced compliance with the bundle. Interventions included email reminders and posters (Cycle 1), a structured teaching session (Cycle 2), and the introduction of a "smart phrase" within the electronic health record (Cycle 3).

Baseline analysis highlighted key barriers to adherence, including limited procedural confidence (particularly in ascitic paracentesis), loss of alcohol liaison support, and the absence of a dedicated gastroenterology ward. Subsequent cycles demonstrated progressive improvement in compliance, with the greatest impact following face-to-face teaching. Targeted education supported by electronic prompts resulted in more consistent completion of complex investigations and management steps.

This project demonstrates that combining focused teaching with simple digital tools can drive meaningful improvement in adherence to evidence-based care bundles. Embedding structured training and electronic prompts into routine practice may support safer, standardised care for patients with decompensated cirrhosis.

Introduction

Decompensated liver cirrhosis is defined as a patient with known liver cirrhosis who presents with an acute deterioration in liver function. It is a frequent cause of admission, and can present with jaundice, ascites, encephalopathy, renal impairment, gastrointestinal bleeding and sepsis [1, 2]. There are a wide range of precipitants, including infection, gastrointestinal bleeding, drug-induced liver injury, thrombosis in the hepatic/portal system, dehydration and constipation [1, 2]. Complications include ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, coagulopathy, gastro-oesophageal varices (and sequelae), and hepatorenal syndrome [1, 2]. Decompensated liver cirrhosis is associated with high mortality (10-20% in hospital mortality). A study published by Crisp et al. revealed that, amongst non-communicable diseases in the UK, the commonest cause of premature deaths is liver disease [1]. Following the Covid 19 pandemic, the burden of liver disease has increased significantly, with mortality rates having increased by 25% in 2024 compared to 2019 [1]. Early intervention with evidence-based treatments for patients with decompensated liver disease can save lives [1, 2]. The BASL (British Association for the Study of the Liver) care bundle was introduced to provide standardised, evidence-based approach to management of patients with DC in the first 24hrs of admission [2]. It Includes many investigations aimed at finding and treating common precipitants of decompensated cirrhosis, as well as supportive management to avoid and treat complications. Adherence to the Decompensated Cirrhosis Care Bundle has been shown to reduce mortality and lead to improved outcomes for patients with liver cirrhosis [2].



1. Investigations							
a)	NEWS❑	FBC ❑	U/E ❑	LFT ❑	Coag ❑	Gluc ❑	Ca/PO_4/Mg ❑
b)	Blood cultures ❑			Urine Dip/ MSU ❑	CXR ❑	Request USS abdo ❑	CRP ❑
c)	Perform ascitic tap in **all patients with ascites** using green needle **irrespective of clotting parameters** and send for ascitic PMN/WCC, culture and fluid albumin					Done **Y N**	N/A ❑
d)	**Record recent daily alcohol intake**			..... Units			
2. Alcohol - if the patient has a history of current excess alcohol consumption (>8 units/day Males or >6 units/day Females)						**N/A** ❑	
a)	Give IV Pabrinex (2 pairs of vials three times daily)					**Y N**	
b)	Commence CIWA score if evidence of alcohol withdrawal					**Y N N/A**	
3. Infections - if sepsis or infection is suspected						**N/A** ❑	
a)	What was the suspected source?.....						
b)	Treat with antibiotics in accordance with Trust protocol					**Y N**	
c)	If the ascitic neutrophils >0.25 x 10^9/L (>250/mm^3)(i.e. SBP) then give:					**Y N**	
I)	Treat with antibiotics as per trust protocol					**Y N NA**	
II)	IV albumin (20% Human Albumin solution) 1.5g/kg (20g of albumin in 100ml of 20% Human Albumin Solution)					**Y N NA**	
4. Acute kidney injury and/or hyponatraemia (Na <125 mmol/L)						**N/A** ❑	
AKI defined by modified RIFLE criteria	1: Increase in serum creatinine ≥ 26µmol/L within 48hrs ***or***						
	2: ≥50% rise in serum creatinine over the last 7 days ***or***						
	3: Urine output (UO) <0.5mls/kg/hr for more than 6 hrs based on dry weight ***or***						
	4: Clinically dehydrated						
a)	Suspend all diuretics and nephrotoxic drugs					**Y N NA**	
b)	Fluid resuscitate with 5% Human Albumin Solution or 0.9% Sodium Chloride (250ml boluses with regular reassessment: 1-2L will correct most losses)					**Y N**	
c)	Initiate fluid balance chart/daily weights					**Y N**	
d)	Aim for MAP>80mmHg to achieve UO>0.5ml/kg/hr based on dry weight					**Y N**	
e)	At 6 hrs, if target not achieved or EWS worsening then consider escalation to higher level of care					**Y N NA**	
5. GI bleeding – if the patient has evidence of GI bleeding and varices are suspected						**N/A** ❑	
a)	Fluid resuscitate according to BP, pulse and venous pressure (aim MAP >65 mmHg)					**Y N**	
b)	Prescribe IV terlipressin 2mg four times daily (caution if known ischaemic heart disease or peripheral vascular disease; perform ECG in >65yrs)					**Y N NA**	
c)	Prescribe prophylactic antibiotics as per Trust protocol (cefuroxime unless contraindicated)					**Y N**	
d)	If prothrombin time (PT) prolonged give IV vitamin K 10mg stat					**Y N NA**	
e)	If PT> 20 seconds (or INR >2.0) – give FFP (2-4 units)					**Y N NA**	
f)	If platelets <50 – give IV platelets					**Y N NA**	
g)	Transfuse blood if Hb <7.0g/L or massive bleeding (aim for Hb >8g/L)					**Y N NA**	
h)	Early endoscopy **after** resuscitation (ideally within 12 hours)					**Y N**	
6. Encephalopathy						**N/A** ❑	
a)	Look for precipitant (GI bleed, constipation, dehydration, sepsis etc.)					**Y N**	
b)	Encephalopathy – lactulose 20-30ml QDS or phosphate enema (aiming for 2 soft stools/day)					**Y N**	
c)	If in clinical doubt in a confused patient request CT head to exclude subdural haematoma					**Y N N/A**	
7. Other							
a)	Venous thromboembolism prophylaxis – prescribe prophylactic LMWH (patients with liver disease are at a high risk of thromboembolism even with a prolonged prothrombin time; withhold if patient is actively bleeding or platelets <50)					**Y N NA**	
b)	GI/Liver review at earliest opportunity (ideally within 24 hrs)					❑	

Figure 1: BASL decompensated cirrhosis care bundle [2]

During our time working with the gastroenterology team at North Manchester General Hospital (NMGH), a busy district general hospital, we noted a high frequency of referrals to the team for advice regarding the management of decompensated liver cirrhosis. We became aware anecdotally that many of these were not receiving appropriate investigations and management within 24 hours as per BASL decompensated cirrhosis guidelines [1]. There appeared to be a delay in recognition of decompensated cirrhosis and unfamiliarity with how to manage this condition. Thus, we observed a subsequent delay in appropriate investigations and management. Therefore, we sought to audit compliance with the care bundle proposed by BASL. On confirming compliance to be poor we would set about initiating interventions to improve the care received by this patient cohort.

Aim

Our specific objectives included:

1. To evaluate of compliance with the BASL decompensated cirrhosis care bundle for patients admitted with decompensated liver disease within the first 24 hours.
2. To assess whether essential investigations, including blood tests, an ascitic tap, and appropriate imaging were completed within 24 hours of admission.
3. To determine if timely management interventions, such as antibiotics for suspected infections, diuretic adjustments, and lactulose for hepatic encephalopathy, are initiated as per the care bundle guidelines.
4. To identify areas of poor compliance, and common reasons for these delays or omissions in investigations and management in the first 24 hours.
5. Based on these findings, to provide targeted and effective interventions for improving adherence to the BASL care bundle, and subsequently enhance the quality of care and improve outcomes for patients presenting with decompensated cirrhosis.

We constructed a project aim using the 'SMART' tool (specific, measurable, achievable, relevant, time-bound):

"100% of patients admitted to NMGH with decompensated liver disease to have appropriate investigations and management implemented within 24 hours of admission, in accordance with the BASL decompensated cirrhosis care bundle."

Materials and Methods

Three PDSA (Plan, Do, Study, Act) cycles were carried out between August 2024 and April 2025. PDSA methodology is widely used in NHS quality improvement work as it allows iterative testing of interventions in real clinical settings with rapid feedback and refinement [3]. Adult admissions coded as 'decompensated cirrhosis' in the electronic patient record at NMGH were identified. End-of-life patients were excluded. Some cases may have been missed if coding was inaccurate.

Data on investigations and management completed within the first 24 hours were extracted from electronic clinical notes and investigation records. The sample size for each cycle was modest, with 15 patients in Cycle 1, 16 in Cycle 2 and 13 in Cycle 3. Audit criteria were matched directly to components of the BASL Decompensated Cirrhosis Care Bundle (Figure 1). Compliance percentages were calculated in Microsoft Excel, with separate analysis for investigations and management components. Mean compliance for each bundle element was presented in table format. Each PDSA cycle introduced a targeted intervention informed by the main barriers identified (Figure 2).

In Cycle 1, awareness was raised via an email reminder to clinical staff and posters summarising the care bundle were placed in key clinical areas, supported by a QR code link to the guideline. In Cycle 2, a face-to-face teaching session was delivered at departmental medical teaching to emphasise early management and highlight gaps from interim audit data. Cycle 3 focused on embedding guidance into everyday workflow through the addition of a BASL "smart phrase" within the electronic record system, allowing clinicians to insert bundle prompts directly into documentation during admission clerking.

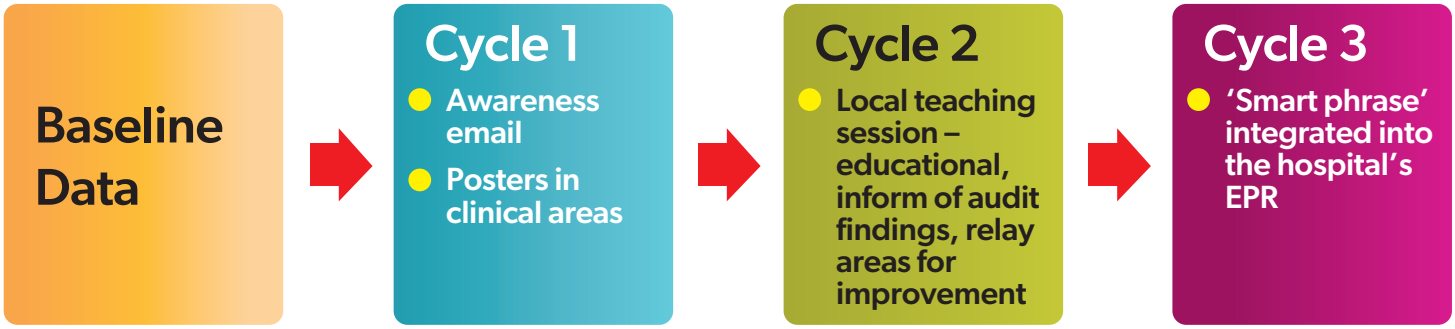


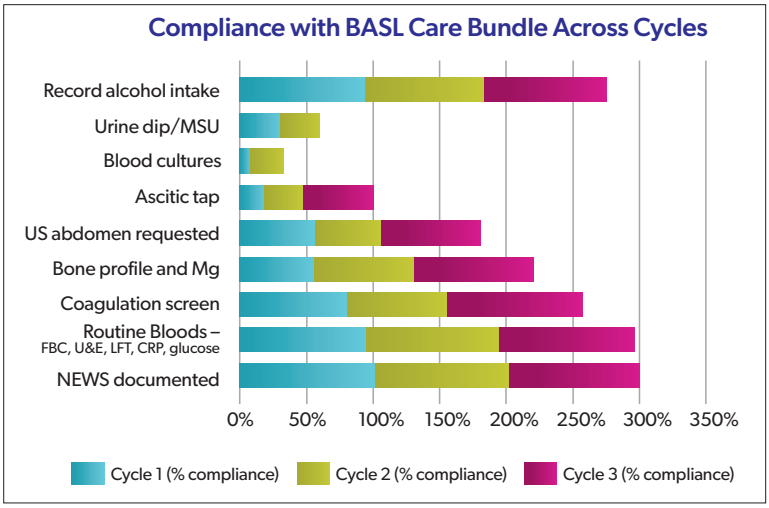
Figure 2: Interventions introduced across all three PDSA cycles

Results:

Baseline compliance was high for routine blood tests (>90%), NEWS documentation (100%) and referral to the local specialist gastroenterology service (87%). Poor initial compliance was seen for sepsis screening (represented by blood culture and urine dip/MSU sampling, 7 % and 27% respectively), abdominal imaging requests (60%), ascitic sampling (20%), investigation/management of encephalopathy (40-60%), and management of fluid balance (60-80%). Notable improvements occurred across cycles for coagulation screens (80% ⇢ 100%), bone profile/magnesium screening (60% ⇢ 92%), ascitic sampling (20% ⇢ 58%), diuretic suspension in AKI (80% ⇢ 100%) and management of encephalopathy (reaching 100% in all components) as shown in Table 1& 2. However, compliance with sepsis screening, fluid balance charting and abdominal imaging all remained poor. Teaching interventions yielded the greatest positive shift in data when compared to email and poster prompts.

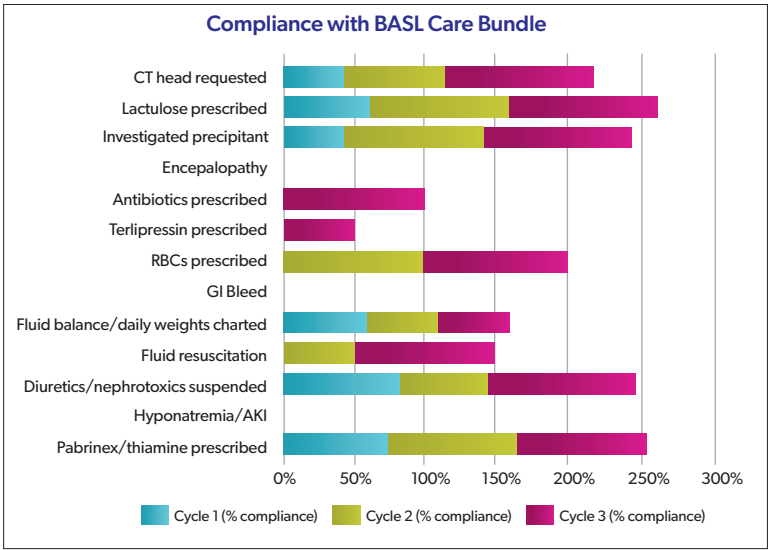
Investigation	Cycle 1 % compliance	Cycle 2 % compliance	Cycle 3 % compliance
NEWS documented	100%	100%	100%
Routine Bloods – FBC, U&E, LFT, CRP, glucose	93%	100%	100%
Coagulation screen	80%	76%	100%
Bone profile and Mg	60%	71%	92%
US abdomen requested	60%	47%	75%
Ascitic tap	20%	23%	58%
Blood cultures	7%	24%	0%
Urine dip/MSU	27%	29%	0%
Record alcohol intake	93%	88%	92%

Table 1: Demonstrates the compliance with multiple aspects of the decompensated liver disease bundle across 3 cycles. Significant improvement seen in requesting bone profile.



Alcohol	Cycle 1 % compliance	Cycle 2 % compliance	Cycle 3 % compliance
Pabrinex/thiamine prescribed	75%	90%	88%
Hyponatremia/AKI	**Cycle 1 % compliance**	**Cycle 2 % compliance**	**Cycle 3 % compliance**
Diuretics/nephrotoxics suspended	80%	67%	100%
Fluid resuscitation	0%	50%	100%
Fluid balance/daily weights charted	60%	50%	50%
GI Bleed	**Cycle 1 % compliance**	**Cycle 2 % compliance**	**Cycle 3 % compliance**
RBCs prescribed	n/a	100%	100%
Terlipressin prescribed	n/a	0%	50%
Antibiotics prescribed	n/a	0%	100%
Encephalopathy	**Cycle 1 % compliance**	**Cycle 2 % compliance**	**Cycle 3 % compliance**
Investigated precipitant	40%	100%	100%
Lactulose prescribed	60%	100%	100%
CT head requested	40%	75%	100%

Table 2: Demonstrates the compliance with decompensated liver disease bundle across the 3 cycles



Discussion:

Good compliance was observed from the outset for routine blood investigations sent within the first 24 hours, and VTE assessment. This can likely be attributed to these investigations forming part of the standard triage blood tests performed on all patients undergoing phlebotomy on arrival to A&E. Conversely, poor compliance was seen for non-standard blood tests such as bone profile and magnesium (important blood tests often correlating with nutritional status) and coagulation screening (an important for monitoring synthetic liver function). From cycle 2 to 3 a significant improvement was seen in sending bone profile, magnesium and coagulation screens.

Requesting blood cultures and other components of a septic screen (such as urine cultures) remained poor across all cycles despite our interventions. This may reflect a lack of awareness of infection as cause of liver decompensation, especially given patients with poor synthetic liver function may not mount a CRP or febrile response to infection. In cycles 1 and 2 ascitic taps were very underperformed, possibly due to underlying lack of confidence and training in procedural skills amongst more junior medical resident doctors. However, by cycle 3 a significant improvement has been seen in sending off ascitic samples for analysis, though the percentage compliance remains low at 58%. There may be limited ability to improve this given the technical difficulty in aspiration in the absence of radiological guidance where ascites is mild or even moderate. With respect to radiology, abdominal ultrasound imaging requests remained static at 75% in cycle 3 from 60% in cycle 1.

In the care bundle, BASL advises investigations/management for decompensated liver disease patients presenting with specific complications. From cycle 1 to 3, compliance increased in all aspects of management recommended for patients with encephalopathy, possibly reflecting better recognition of encephalopathy as a facet of the broader syndrome of decompensated liver disease, following our teaching session. Whilst throughout all 3 cycles, the recording of alcohol intake has been consistently done, compliance with documenting alcohol withdrawal scores (CIWA) and prescribing vitamin supplementation (prophylaxis for Wernicke's encephalopathy) was variable, conforming to no trend despite interventions. One reason proposed for this is the current lack of alcohol clinical nurse specialist at NMGH.

In the acute kidney injury (AKI) and hyponatremia cohort of patients, suspension of prescribed diuretic/nephrotoxic agents and initiation of fluid resuscitation has greatly improved. From our session with the general medical team, initial barriers to compliance included a lack of confidence in selecting an appropriate resuscitation fluid (crystalloid vs colloid) and approaching the ascites/hypotension conundrum in this cohort of patients. Unfortunately, monitoring of fluid intake and output has remained poor, with one possible reason being that multiple staff report this is difficult to record in the HIVE

system. In the gastrointestinal bleed cohort of patients, compliance has been difficult to assess due to a small sample size (0-2 in each cycle).

In general, the biggest improvement in compliance with completion of the care bundle was seen from cycle 2 to 3. This followed the local presentation during General Medical weekly teaching, attended by colleagues of a variety of grades and specialties within internal medicine. This supports the notion that face-to-face, interactive encounters involving education on the theoretical and evidence-driven basis for a policy, can be effective in motivating a sustainable change in practice. This appears more effective than the earlier interventions which involved raising awareness through emails and posters. These strategies are potentially more easily lost due to the vast volume of circulating emails in hospital trusts. They also require more 'activation energy' to read and digest the information in contrast to passively absorbing information, and subconsciously changing practice through a presentation. However, it is hard to ignore one confounding variable which occurred between cycle 2 and 3, being the shift in the hospital's gastroenterology service from an 'in-reach' service to the team being based on their own wards with more ownership of patients referred to them. This may have led to improved care received by decompensated liver patients under gastroenterology, now under more regular review by specialists and from an earlier point in their hospital journey.

In the last cycle, we introduced a 'smart phrase' which serves as a quick reference for the required investigations and management steps, making it easier for clinicians to follow the care bundle during patient admission. It is unclear yet the extent to which this will manifest in real improvements seen in care delivered. Future opportunities to intervene which we have considered include pop-up alerts on our electronic patient record to initiate the bundle when selecting a patient with decompensated cirrhosis on their problem list. The drawback to this approach is adding to the aforementioned 'alert fatigue' which already renders pop-ups as less effective, with many health professionals clicking through these to get to the information they are searching for at that moment in time. Additionally, we plan to liaise between the general medicine and gastroenterology teams to arrange teaching sessions on ascitic taps to allow such procedures to be performed on the front door. Finally, involving specialist liver nurses in A&E or on AMU may be beneficial in engaging the wider MDT earlier in the patient's hospital journey.

To support the longevity of these improvements, it will be important to build them into everyday clinical processes rather than relying on isolated initiatives. Retaining the BASL smart phrase within the electronic health record should offer a consistent and easily accessible prompt, helping to standardise decision-making even as staff rotate. Likewise, incorporating teaching into regular induction and departmental education can help maintain awareness and confidence among clinicians, particularly given the frequent turnover of junior doctors. Embedding these elements into routine practice provides a more reliable foundation for sustained behavioural change and should help preserve adherence to the care bundle in the long term.

Recommendations

1. Regular local teaching sessions are incorporated into the General Medical Teaching rota.
2. Prompt assessment of patients by the Alcohol Care Team in E.D or AMU
3. Liver nurse specialist involvement in AMU.
4. Where electronic patient records exist, integrate the decompensated cirrhosis care bundle into the system.
5. Workshops for resident doctors on ascitic sampling.

Recommendation	Rationale
Incorporate regular local teaching into departmental rota	Teaching produced the greatest increase in compliance compared to posters/emails
Reinstate alcohol liaison input at admission stage	Alcohol-related lack of support identified as a barrier to bundle completion
Earlier involvement of liver nurse specialists in ED/AMU	Specialist input may improve recognition and early management
Embed BASL care bundle into electronic patient record	Smart phrase improved access but further system integration could streamline use
Deliver practical ascitic tap workshops for junior doctors	Procedural confidence was a key limiting factor in ascitic sampling compliance

Summary of key recommendations

Key finding	Interpretation / Discussion
High baseline compliance with routine blood tests and NEWS documentation	These are embedded in standard triage workflows, suggesting established habits improve adherence without additional interventions.
Persistently low compliance with sepsis screening and ascitic sampling	Indicates lack of procedural confidence and awareness of sepsis as a precipitating factor in liver decompensation. Training rather than reminders alone appears necessary.
Improvement in bone profile, magnesium, and coagulation screening after teaching intervention	Teaching was more effective than passive strategies (email/posters), highlighting the importance of active engagement in changing clinical behaviour.
Greatest improvement observed between Cycle 2 and 3, coinciding with face-to-face teaching and service restructuring	Suggests cultural and structural factors (e.g., ward ownership and specialist presence) influence bundle adherence alongside education.
Smart phrase improved access to guidance but limited impact on complex tasks like ascitic taps	Digital prompts support recall but do not replace hands-on procedural training or MDT support.
Alcohol liaison and specialist nurse absence noted as barriers	Highlights the role of multidisciplinary involvement in improving care quality beyond medical interventions alone.

Summary of key findings and discussion points

References:

1. Crisp, H., Tavabie, O., Enever, Y., Allen, R., Silverman, M., Acevedo, J., Chauhan, A., Hogan, B., Patel, V., Mookerjee, R. and Wright, G. (2024) 'Decompensated Liver Cirrhosis Research Network (UK-CLIF): Building consensus for hepatology trials in the UK', NIHR Open Research, 4, p. 69.
2. McPherson, S., Dyson, J., Austin, A. and Hudson, M. (2016 'Response to the NCEPOD report: development of a care bundle for patients admitted with decompensated cirrhosis – the first 24 h', Frontline Gastroenterology, 7(1), pp. 16–23. doi: 10.1136/flgastro-2014-100491.
3. NHS England (2023) Quality, Service Improvement and Redesign (QSIR) Framework. London: NHS England.

BIDA National Conference 2025

Doubletree by Hilton Hotel, Chester. 20 September 2025

Prof Ravish Katira Organising Chairman, BIDA National Conference 2025

Bridging the Gap: Prevention through Education

BIDA National Conference was held on 20th September 2025 at Double Tree by Hilton Hotel in Chester. We had 110 attendees for the conference. The programme kicked off with Chairman's address, President's address and welcome address by Conference Chairperson.

The keynote speaker was Dr Mumtaz Patel, President of The Royal College of Physicians, London. This session was timely and poignant, and was very well received.

Session 1 was on governance and accountability in the NHS and was ably chaired by Professor Sanjay Arya and Dr. Shikha Pitalia. Dr Shanu Datta was one of the panellists. Ms.Tista Chakravarty-Gannon, Head of Outreach Operations GMC spoke about prevention of GMC referrals. Thereafter there were sessions by Dr Chaand Nagpaul, Chair of BMA Forum for Racial and Ethnic Equality who spoke about the NHS 10-year plan – "from hospital to community". Thereafter, Mr R Balasundaram, Planned Care Lead of BCUHB, discussed accountability in the NHS, and he was followed by Mr Gurpreet Singh, Non-Executive Director of Southport & Ormskirk Hospital NHS Trust talking about "How to Stay Out of Trouble". All of these sessions were very well received, and feedback was excellent. However, the panel discussion was felt to be somewhat lengthy.

Session 2 focused on medical education; Dr M Patel spoke on "Differential Attainment: challenges and solutions". Thereafter Dr Richard Vautrey, President of The Royal College of General Practitioners discussed the role of RCGP in Medical Education. This was followed by Professor Arpan Guha, Dean of University of Greater Manchester talking about "Educating Doctors of the Future: Fit for Purpose?". These sessions generated a lot of discussion from the audience who were actively engaged. This was ably chaired by Prof. Sanjoy Bhattacharyya and Dr Vinod Gadiyar. However, we have issues with time keeping and there were lengthy panel discussions.

Session 3 was ably chaired by Dr Shamim Rose on preventive medicine. Dr Sakthi Karunanithi spoke about the NHS recovery plan and Professor Thara Raj discussed embedding prevention and healthy qualities approach within the hospital setting.

Thereafter, BIDA's 50th Anniversary celebration felicitations took place, where 9 previous senior office bearers, Past Presidents and Chairmen of BIDA were honoured. Presentations were given by Past President, Dr Surendra Kumar, Dr Sai Pillarisetti, BIDA Secretary and Paarth Gupta, President of BIDA Student Wing.

The women's health session was ably chaired by Dr Anita Sharma and Dr Marguerite O'Riordan. Miss S Gupta spoke about bridging the gap in gynaecology waiting lists in the UK and Dr Sharma discussed about menopause.

Session 4 was dedicated to resident doctors with podium and poster presentations. These were very well received.

Session 5 was chaired by Dr Rakesh Sharma and Professor Ravish Katira. This session on medical management of obesity by Professor Franklin Joseph. This generated a lot of discussion and learning points.

The last session was on prevention is better than cure on cardio-vascular issues was ably chaired by Dr Ashish Dhawan and Dr Suresh Chandran. Dr Chetan Upadhyay spoke about "Can I prevent that heart attack?" and Dr Yee Ping Teoh discussed Statin intolerance and its practical considerations. These were very well received.

The last talk of the day was on finance and pension delivered by Veronica Trott of Quilter.

A vote of thanks was proposed by Dr Sai Pillarsetti National Secretary of BIDA.


NHS
BRITISH INTERNATIONAL DOCTORS ASSOCIATION

National Conference 2025 Sponsors

BIDA would like to acknowledge the invaluable support received from these organisations towards this Conference.

Quilter Financial Advisers

General Medical Council

Daiichi-Sankyo

GTEC Global Training and Education Centre at WWL

bolton travel

Pall Mall all your healthcare needs

VIATRIS

SSPHealth

BIDA North Wales Division Conference

The Doubletree by Hilton Hotel, Chester. Friday 19 September 2025

The 50th Anniversary Year Celebration commenced with a very special conference evening. With nearly 115 delegate guests the conference hall was packed, buzzing with enthusiasm and cheers. Dr Jay Nankani, Chair of BIDA North Wales Division welcomed everybody and initiated the proceedings.

Rt Hon Sir Mark Tami, MP for Alyn & Deeside and our Chief Guest, gave a scintillating lecture on his contribution and his personal experience with the NHS. The educational lectures were given by Dr Yee-Ping Teoh, Consultant Chemical Pathologist who gave a brilliant lecture on The Management of LDL explaining the role of statins, which was followed by Mr Ram Prasad, Consultant Breast & Aesthetic Surgeon who steered into the world of cosmetic surgery Navigating into the modern aesthetic landscape. Both lectures kept the audience captivated and brought up several questions.

The final show was the special felicitation of Prof Bim Bhowmick OBE, retired Consultant Physician from Glan Clwyd Hospital and Associate Dean at Cardiff University who is so well known to the vast majority as the doyen of education and an enterprising leader. His numerous contributions have left an ever-lasting impression, which nobody can ever match. His humble words brought back memories to several of us who have worked with him and seen him tirelessly make those changes to improve and enhance the working lives of doctors in Wales. It was a pleasure and honour to welcome him in our midst.

Left: BIDA North Wales Division Chairman Dr Jay Nankani welcomes delegates to the Conference.

Right, top: Rt. Hon. Sir Mark Tami MP.

Right, centre: Dr Yee-Ping Teoh pictured with Mr Nikhil Kaushik.

Below: Prof Bim Bhowmick OBE (centre) receives a special felicitation from BIDA National President Prof. Amit Sinha (left) and North Wales Division Chairman Dr Jay Nankani.

BIDA A.G.M. / A.R.M. 2025

The Doubletree by Hilton Hotel, Chester 21 September 2025

ARM Motions 2025

Motion 1:
Proposer: Dr Sai Pillarisetti, BIDA National Secretary

This ARM notes that the GMC and BIDA, alongside the Centre for Remediation, Support and Training (CRST), have co-developed an innovative "early resolution" intervention involving cultural intelligence training for trusts and primary care networks, aiming to tackle disproportionate referrals of international and BAME doctors.

This ARM resolves that BIDA will:

(i) Formally endorse and champion the GMC early resolution training programme among NHS trusts and primary care networks.
(ii) Encourage any members or regions interested in hosting local workshops

Result: Both motions were carried over unanimously

Action: SP is already underway with the proposals in this motion. Workshops have already been arranged in Bolton and Liverpool. Next on the list are Preston, Wigan and other Northwest Trusts. After Easter time the plan is to make this a national initiative, the Royal College of Surgeons are supporting. Amit S is planning a meeting with the Countess of Chester Hospital and then hopefully North Wales (the Medical Director and HR lead have been written to).

Motion 2:
Proposer: Professor Amit Sinha, BIDA National President

That this conference is extremely concerned that the workforce plan for UK medical graduates for several years has miscalculated the numbers and created an imbalance in every :er of training leading to Consultants or General Practitioners.

We call upon the government to:

(i) Proportionately increase the number of specialty training programme posts available for all doctors in training to match the increase in UK medical school places.
(ii) Consider Consultant expansion to accommodate freshly CCT qualified trainees
(iii) Increase funding to General Practice so that the practices employ newly qualified GPs.

Result: All three motions were carried over unanimously

Action: Amit S stated that previously we have teamed with APPNE to write to the relevant bodies to raise our concerns, the plan now is to write a letter from BIDA alone and do our best to keep raising these issues on all our social media platforms.

Motion 3:
Proposer: Dr Ashish Dhawan, BIDA National Chairman

That this conference is alarmed that there are around 15,000 doctors who after passing PLAB 2 remain unemployed because there are not enough training posts in the NHS:

(A) We call upon the Department of Health Workforce Planning to:
(i) match the availability of jobs in the NHS with the number of doctors who pass the PLAB examination

(B) This conference calls upon the BIDA Executive team to join hands with all sister organisations and campaign for the GMC to:
(i) raise awareness of the current job scenario in the UK when applying for PLAB examination
(ii) reduce the number of PLAB examinations in the year

Result: Against 1, Abstain 1. Motion carried over

Action: Summarise motion 2 & 3 together and work to contact the DOH and GMC to work towards a better workforce plan for both UK graduates and IMG's and to raise awareness of the current job scenario in the UK when applying for PLAB examination and lower the number of exams being taken and match the number of successful candidates according to the job availability.

Motion 4:
Proposer: Dr John Raj,
BIDA Public Health & Community Health Forum Chair

This meeting notes the increasing prioritisation of UK medical graduates in recruitment to Foundation Programme and postgraduate training posts, often at the expense of highly qualified international medical graduates (IMGs). This meeting believes that such policies risk exacerbating NHS workforce shortages and discrimination against IMGs.

This ARM resolves that BIDA should:

(i) Lobby NHS England, the GMC, and Health Education England equivalents to ensure transparent and fair recruitment processes.
(ii) Call for equal treatment of IMGs in allocation of training posts, especially where vacancies remain unfilled
(iii) Publish a policy paper on the impact of "UK graduate first" approaches on NHS workforce sustainability.

Result: 4i) 3 Abstained, 4ii) 3 Abstained. Motion carried over

Action: AD feels this motion is already covered in motions 2 & 3

Motion 5:
Proposer: Dr Shamim Rose, Merseyside & Cheshire Division

The introduction of ARRS GPs has created a 'multi-tier' system of GPs, due to the restrictions associated with employing ARRS GPs.

That this Conference:
(i) Deplores the crea:on of this lower tier of GP
(ii) Calls for all GP ARRS funding to be moved into core funding
(iii) Calls for all ARRS GPs to be treated no differently to GPs directly employed by GP practices

Result: Motion carried over unanimously

Action: SR and RakS to write to the DOH and copy in the GMC and BMA to make it clear BIDA are totally against the creation of the 'multi-tier' system of GPs.

Motion 6:
Proposer: Professor Ravish Katira, Southport & Ormskirk Division

Until recently, the NHS has expanded international recruitment to fill gaps in critical roles such as nursing, midwifery, doctors, and allied health professionals.

That this conference requests NHS employers:
(i) to come up with innovative strategies of recruitment focussing on ethical and sustainable recruitment
(ii) follow the Department of Health and Social Care's Code of Practice (based on WHO guidelines) to prevent recruitment from nations facing severe health workforce shortages such as the "red-list" countries

Result: 6ii) 2 Abstained. Motion carried over

Action: RK; a letter is already being drafted, just discussing with AD and Amit S whether to collaborate with our sister organisations or just to send from BIDA.

Motion 7:
Proposer: Dr Murthy Motupalli, Blackburn Division

This ARM notes that there should be PCN involvement in 10 year planning.

The ARM suggests that BIDA should:
(i) Ask NHS to allow the PCNs to bid for community services, mental health and secondary care services

Result: No one to present so moved on to next motion

Motion 8:
Proposer: Dr Anita Sharma, Women's Forum Chair

BIDA is committed to its Women's Health Strategy. We aim to ensure consistent, evidence-based primary care provision across practices, reduce regional inequalities, and improve long-term outcomes in women's health.

This ARM urges the government to:

(i) introduce a Quality and Outcomes Framework (QOF) specifically for Women's Health, covering key priority areas such as:
- menstrual health and heavy menstrual bleeding
- menopause care
- contraception and reproductive health, and
- screening for common women's health conditions

Result: 2 Abstained. Motion carried over

Action: AnitaS was unable to attend the EC today, RavS briefly explained that AnitaS is already actioning this motion, she has met with her local MP and been to parliament – she will be able to elaborate further in the next EC.

Motion 9:
Proposer: Dr Sai Pillarisetti, BIDA National Secretary

This ARM notes that international medical students in the UK face unique academic and socio-cultural challenges – including those relating to belonging, academic transition, financial stress, and limited inclusion in research opportunities – which are under-explored in current literature.

This ARM resolves that BIDA will:
(i) Support and promote a research programme within the BIDA Student Wing, including workshops, peer mentorship, and collaborative projects
(ii) Collaborate with academic institutions to facilitate intercalated or elective research opportunities for international students
(iii) Encourage publica:on and dissemination of student-led findings in academic forums or medical student conferences

Result: 1 Abstained to (i,ii,iii). Motion carried over

Action: SP Already actioning the points in this motion and the content will feature in the SW conference. A questionnaire is also being developed.

Motion 10:
Proposer: Dr Vinod Gadiyar, BIDA National Treasurer

That this ARM agrees to:
(i) increase the annual subscription rate for BIDA members by 10% for all categories of subscription.

Result: Against 4, Abstain 2. Motion carried over

Action: VG The increase in membership rates was passed, we just need to publish the new rates ready for 2026.

Motion 11:
Proposer: Dr Jay Nankani, North Wales Division

That this conference remains apprehensive about overcrowding in Emergency Departments and corridor care, which is now occurring all the yearlong in all hospitals.

We urge the government to:
(i) Urgently tackle the issue of underfunding, and understaffing in EDs
(ii) Promote Intermediate Care facilities in the community
(iii) Increase social care provisions so that patients are fit for discharge from the hospital in the predicted time

Result: Motion carried over unanimously

Action: AD feels this topic is already being exposed and covered by the media; however we should ask the proposer Dr Jay Nankani to draft a letter to DOH.

Motion 12:
Proposer: Dr Jay Nankani, North Wales Division

That this conference recognises the importance of controlling obesity through drugs like Mounjaro. We raise the issue that the access to weight loss drugs via their GPs is not working. Less than half (18 out of 42) of the commissioning bodies in England have confirmed that they have started prescribing.

Continued overleaf...

That this conference asks the government to:
(i) Act quickly to ensure that this NHS roll out becomes fit for purpose
(ii) Ensure that they tackle the 170% price hike the company is planning to impose for private prescriptions

Result: Against 3, Abstain 1. Motion carried over

Action: There was a discussion around this topic and some of our GPs present today gave an overview on just how hard it's becoming to prescribe weight loss drugs to many patients who would clearly benefit and solve more than one health issue at the same time. It was concluded that we request Dr Jay Nankani (the proposer) to write a letter to DOH.

Motion 13:
Proposer: Dr John Raj,
BIDA Public Health & Community Health Forum Chair

Doctors face unprecedented workload pressures due to the current state of the NHS. Burnout affects not only doctors' wellbeing but also patient safety, staff retention, and NHS sustainability.

That this ARM urges the government to:
(i) create systemic NHS reforms which can improve the current state duress for doctors
(ii) launch a confidential mental health support programme for resident doctors
(iii) organise training and workshops on resilience, wellbeing, and workload management

Result: Abstain 1 (ii). Motion carried over

Action: AD gave an overview as JRM was on call and had to leave the meeting. AmitS pointed out that BIDA have raised these concerns numerous times with the Government, Health board and Trusts and had no response. It was decided that with the help of RakS, JRM to write to the health boards.

Motion 14:
Proposer: Dr John Raj,
BIDA Public Health & Community Health Forum Chair

Sleep is a neglected pillar of public health, despite strong links with chronic disease, mental health, and workplace productivity. Greater awareness and training in sleep medicine can support prevention and promote overall health and reduce long-term NHS burden.

That this ARM asks the NHS to:
(i) Develop an educational initiative for medical professionals and the public
(ii) Partner with relevant bodies, sleep charities, and academic centres
(iii) Integrate sleep health messages into wider preventive health campaigns

Result: Abstain: 1(i), 1(ii), 1(iii). Motion carried over

Action: To be included in the action for Motion 13.

Motion 15:
Proposer: Dr Fareed Al Qusous, EC Member

This meeting notes the UK Government's awarding of major NHS data contracts to Palantir to run the Federated Data Platform raise concerns around transparency, governance, and public trust.

This meeting believes that entrusting sensitive NHS patient data to a private firm with controversial associations risks undermining clinician and community confidence in the NHS.

This meeting resolves that BIDA will:
(i) Campaign for transparent oversight of NHS data partnerships
(ii) Call for independent audit and accountability mechanisms for Palantir's role
(iii) Advocate for NHS-controlled, clinician-informed alternatives to manage patient data

Result: No one to present so skipped.

BIDA Awards 2025

BIDA Special Award 2025

Prof. Mumtaz Patel

It was a great pleasure to honour Professor Mumtaz Patel with the BIDA Special Award at our National Conference on 20th September 2025. She is the first woman of Indian origin to become the President of the Royal College of Physicians, London. She is a Consultant Nephrologist at Manchester Royal Infirmary. She is also NHS England Post-Graduate Associate Dean in the North-West, a post she's held since 2016, and the RCP's Senior Censor. Between 2020 and 2023 she was the RCP's Global Vice President and Vice President for education and training between 2023 and 2025. In 2022, she launched the Global Women Leaders Programme, which aims to support female doctors in achieving leadership positions. The programme has run paid workshops in Hong Kong, India, Iraq, Jordan, Pakistan, and Sri Lanka.

Her educational research interests include Assessment, Doctors in Difficulty, Fairness in Education and Differential Attainment which she leads on nationally.

At the 2025 BIDA National Conference she delivered a keynote speech on the Future perspective of Medical Education & Training, and also went on to share her thoughts on the Challenges and solutions of Differential Attainment.

BIDA is proud of her accomplishments and congratulates her in achieving the Presidentship of the Royal College of Physicians, London.

BIDA Fellowship Awards 2025

Dr Ashish Dhawan

Dr Dhawan is a graduate from Punjab University in 1996. After completing his post-graduation in medicine, he came to the UK in 2003. He successfully completed his Specialty training and subspecialty training in Electrophysiology and Devices. He is now a Consultant Cardiologist and Electrophysiologist at Wigan, Wrightington & Leigh NHS Foundation Trust. Within 10 years under his leadership, WWL trust has become the leading implanter of Complex devices amongst the three trusts that share the complex devices sector lab (Bolton, Wigan and Salford) with himself as the leading implanter amongst all operators. He is the Clinical lead of cardiology unit at WWL NHS Trust, Clinical Governance lead, appraiser and a trainer.

He has made tremendous contributions to BIDA. He has been an active member of the EC for several years. He served as National Secretary (2017- 2021) and is the current National Chairman. He been a Member of BIDA Journal editorial board for the last sixteen years having also been a co-editor for four years. He has been a Co-convener of 4 hugely successful BIDA international congresses in Bali 2018, Vietnam and Cambodia in 2023 and Zanzibar and Tanzania in 2024 and the recent one to Mexico. He has organised and convened BIDA ARM/AGM and National Conference for Wigan Division in 2023. As General Secretary and Chairman of BIDA he has successfully lead various campaigns to uphold BIDA's principle of Equality and Fairness.

Dr Praveen Govind

Dr Govind graduated from Bangalore Medical College in 1995. He started his training in the UK in 1998 and following Higher Specialty training in Radiology, he was appointed to the post of consultant Radiologist in Wrexham Maelor Hospital in September 2007. His main responsibilities are towards Neuroimaging. He is the lead Radiologist and supports Musculoskeletal, and Head and Neck Radiology Multi-disciplinary meetings. He is the current clinical Lead for Wrexham Maelor Radiology department and the Radiology representative in planning and supporting Neuroimaging throughout Betsi Cadwaladr University Health Board.

He is a great supporter of all the social, educational, and sporting activities that bring a vast array of colleagues together within the United Kingdom. His talent is playing cricket. He was part of a strong North Wales Team when they won the Presidents Cup a few times. In the last few years, under his captaincy, his team reached the finals in 2002. He is still actively involved in the planning and organisation as well as playing BIDA cricket tournaments. He is also the secretary of Westminster Park Cricket Club, currently playing in Cheshire league Division 1 and a coach for his juniors.

He also plays badminton and squash, He also enjoys playing the acoustic and electric guitars. He is indeed a man of many talents.

An interview with
Prof. Shiv Pande M.B.E. D.L. J.P. F.R.C.G.P. M.S.

After completing his MBBS in 1962 and a master's degree in surgery from Vikram University, Indore, Dr Pande spent nine years in surgery in various medical colleges before travelling to the UK to train in surgery for two years.

After initially working in A & E at the Royal Albert Infirmary, Wigan he then secured a position as a registrar in cardio-thoracic surgery at the London Chest Hospital. Subsequently, he obtained placements at Broadgreen Hospital and Fazakerley Hospital, Liverpool. Dr Pande's two-year plan extended to four and he therefore decided to remain in the UK.

Dr Pande became a GP in 1975 and retired in 2005 after 30 years in general practice.

Dr Pande was awarded an honorary fellowship by the University of Central Lancashire in recognition of his contribution to the community. In 1989, he received an MBE. In 2004, Dr Pande received the Lloyds TSB lifetime achievement award. 10 years later he was awarded the RCGP's "Lifetime achievement award".

In 2016, Dr Pande was appointed Visiting Professor in ethics and leadership at Gauhati University, India. A year later, he was appointed Visiting Professor at the University of Greater Manchester, Bolton.

What was your best career move?

Despite applying for several Senior Registrar roles and being more than qualified I found I just couldn't 'break the glass ceiling' to secure a role. By then my children were settling into secondary school so I had to make a decision to either return to India or remain in the UK and change the direction of my career.

By 1975 there were increasing job opportunities in general practice, I completed my one-year (non-compulsory) vocational training in Liverpool and whilst job searching, worked as a GP locum prior to being taken on as a partner.

What was the best decision you made for your career?

Despite my initial reservations, moving into General Practice turned out to be the best career decision and opened up so many other opportunities to work with the general public both locally and nationally and internationally.

What motivated you to promote "Mother Teresa Charity"?

Mother Teresa's charity were raising funds for the orphans of the Bhopal gas disaster, I came up with the idea of forming a combined India-Pakistan XI cricket team to play against "the rest of the world". The match was held on 28 August 1985, at Old Trafford Cricket Ground and was televised by Granada TV. The event raised over £20,000 and I was able to personally present the funds raised to Mother Teresa and the then prime minister of India, Shri Rajiv Gandhi.

What is your view on work-life balance?

My view is 'a change is as good as a rest'. Although my passion was working in medicine a sidestep into media proved to be very productive and helpful for the wider Asian Community. I feel that for fulfilment there has to be change.

What single change or technology/ development would you like to see made to the NHS?

We are currently in an era of rapid technological advancement; we have all had to learn how to adapt (I adapted to online banking and other similar time and paper saving advancements).

I would like to see the adaption to digitalisation throughout the NHS as a whole happen at a much faster pace.

What is your contribution to BIDA?

I am a lifetime member and 'Fellow' of BIDA. I was involved right from the early days when ODA was formed. I joined ODA in 1977 and was the Founding member of Merseyside/ Cheshire ODA. I have served as the Chairman of BIDA as well many other senior office bearer roles on the Executive Committee. I initiated in establishing PLAB Part 1 exams in India.

I was felicitated at BIDA's 50th Anniversary National Conference in September 2025.

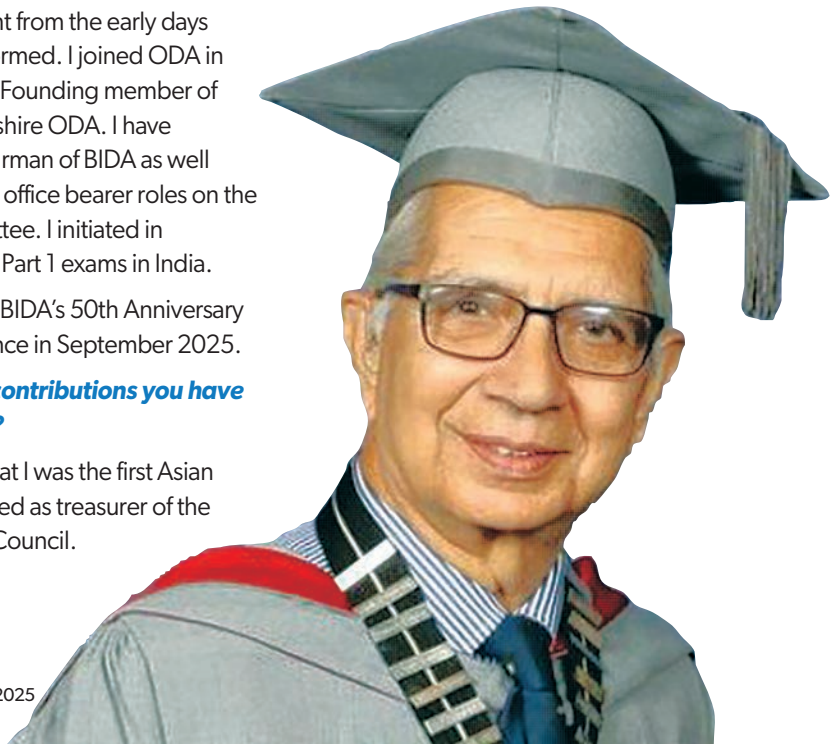
What are other contributions you have made to society?

I am very proud that I was the first Asian doctor to be elected as treasurer of the General Medical Council.

I became involved in television programmes for Asian people, hosting a citizens' rights programme 'Aap Kaa Hak'. This was broadcast by Granada TV from 1980 for 14 years. The show was founded on the principles of the English Language TV programme 'This is your right'. In a similar manner to the original programme format , I would respond to queries about health and welfare in Hindi and Urdu, whilst my Pakistani barrister friend answered the legal queries.

The show introduced me to numerous allied health professionals including dieticians and social workers, and I extended their services to my own practice, providing "children's health checks, vaccinations, and family-planning clinics"

In 1996, I initiated and oversaw the pilot of the first part of the Professional and Linguistic Assessments Board (PLAB) test to be held



in India. The innovation allowed thousands of young Indian doctors to sit the exam in their home country, rather than in Britain.

I also worked as a broadcaster for the BBC Northwest TV and BBC Radio Merseyside.

For 24 years I have been a Justice of Peace on the Liverpool bench. In 2002, I was appointed a Deputy Lieutenant of Merseyside.

What advice would you give to your medical colleagues, who plan to retire from the NHS now?

Keep your eyes and ears open all the time, stay feeling young by keeping your curiosity alive (as you did when you were young). I may have retired from medical practice, but I still try to keep myself involved in medicine, for example, I am still helping UCLAN medical college. I find this involvement keeps my faculties sharp and is a fulfilling way to give back and share my knowledge.

What is your favourite book?

Wings of fire, an autobiography by Dr. A.P.J. Abdul Kalam

What makes you really happy?

Meeting people, especially younger ones – they are so full of enthusiasm and ideas.

Do you ever get stressed? If you do how do you deal with it?

I do get stressed, my way of dealing with it is to analyse the reason rather than react to it. Talk to your friends about what is stressing you, often the best solutions come from them. My best friend is my wife Kala, and she is also my greatest critic.

Where is your favourite destination in your travels and why?

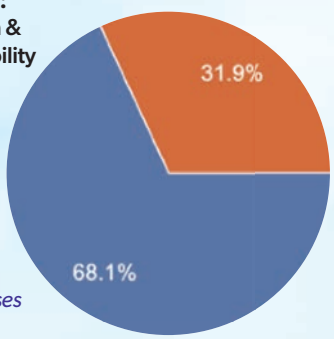
India is still by far my favourite destination. I have still not had chance to visit the North East of India yet but would dearly love to.

BIDA National Conference Feedback

How satisfied were you with the CONTENT & DELIVERY of this session?

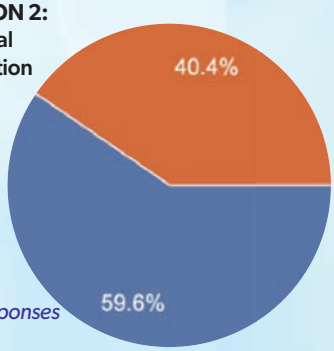
- Very satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very dissatisfied

SESSION 1: Regulation & Accountability in the NHS



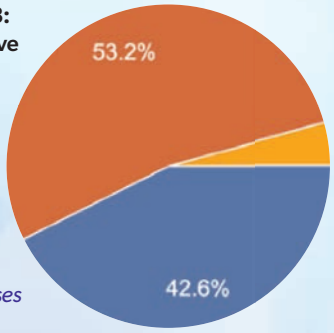
47 Responses

SESSION 2: Medical Education



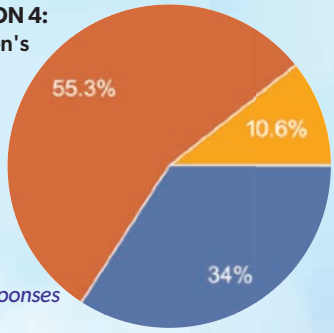
47 Responses

SESSION 3: Preventative Medicine



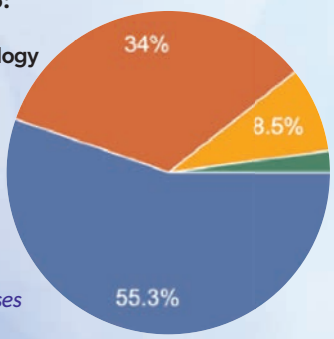
47 Responses

SESSION 4: Women's Health



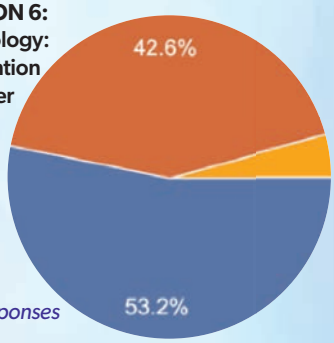
47 Responses

SESSION 5: Diabetes/ Endocrinology



47 Responses

SESSION 6: Cardiology: Prevention is better than cure



47 Responses

Comments

1. *Excellent organisation and very informative programme covering a wide variety of subjects.*
2. *The felicitation of Prof Bim Bhowmick & senior BIDA personalities was really great.*
3. *Listening to the founding members was inspiring and what hurdles they faced but still they came out of the short dark period.*
4. *I think all speakers were of such high calibre, and the content of their presentations so interesting, that it was over-ambitious to have the number of presentations that there were. The Conference ran very behind time.*
5. *Better advertisement to a wider audience would make a difference.*
6. *Personally, I would have preferred fewer speakers with more generous time for themes to be developed and more opportunity for discussion.*
7. *The panel discussion would benefit from being more focused and again keeping questions limited so keep better to time.*

It is essential to keep these comments and incorporate the positive suggestions for planning of future national conferences.

Remembering...

Dr Ashok Kakkar

Dr Ashok Kakkar, a much-loved GP, devoted family man and respected colleague, passed away recently after a life defined by kindness, compassion and service. Ashok dedicated his professional life to caring for others and leaves behind a legacy that will be felt by patients, colleagues, friends and family alike.

Born in Gwalior, India, Ashok grew up in a close and loving family, where his intelligence, curiosity and warmth were evident from an early age. Drawn to medicine and guided by a strong sense of purpose, he moved to the UK in the early 1970s to pursue a medical career. What followed was a lifelong commitment to the care of others, shaped by empathy, wisdom and a genuine love of people.

Ashok began his medical career in Yorkshire before settling in Manchester in the early 1980s. There, he went on to establish and run a single-handed GP practice in Fallowfield, serving his community with dedication for many years. He was proud to work within the NHS and remained deeply committed to its values throughout his career. Patients and colleagues remember him as a doctor who listened carefully, treated everyone with respect, and placed compassion at the heart of his practice.

Alongside his clinical work, Ashok was a passionate supporter, mentor and advocate for overseas doctors. He gave significant time and energy to professional organisations supporting internationally trained clinicians and was proud to be a member of the Overseas Doctors Association (ODA), now the British International Doctors Association (BIDA). He served the organisation with distinction, holding the roles of General Secretary and Treasurer. His work reflected his belief in fairness, inclusion and mutual respect, and he was widely admired for his integrity and generosity of spirit.

Even after retiring from general practice, Ashok's commitment to medicine did not end. He continued to offer his time and expertise through charitable clinic work in India, ensuring his skills could benefit others. Caring for people was not simply his profession; it was central to who he was.

In 1983, Ashok married his wife Poonam, with whom he shared 42 years of a loving and supportive partnership built on friendship, laughter and mutual respect. Together they raised two sons, Vishal and Varun, both of whom he inspired and supported as they followed him into medicine – a source of great pride for him. As well as all his professional activities, nevertheless he was a loving family man, especially cherishing his time with his beloved granddaughter, Lara, who brought him immense joy.

Outside medicine, Ashok embraced life fully. He was a passionate sports enthusiast, particularly devoted to cricket (he failed the Tebbit test, being a childhood supporter of the Indian cricket team) and tennis, a lifelong Manchester United supporter, and a keen walker. He enjoyed good food, poetry, music and conversation, and was known for his warmth, humour and generosity.

Ashok was one of life's good people. Wise, gentle and joyful, he touched countless lives through his care, advocacy and example. He died suddenly at home after a short cardiac related illness. He leaves behind his wife, two sons, daughters-in-law Harpal and Rute and granddaughter, along with a legacy of compassion and service. He will always be deeply missed and fondly remembered.

Dr Vishal Kakkar *(Ashok's Son).*

Specialist Registrar (Rheumatology)
Honorary Clinical Research Fellow
Mid Yorkshire NHS Foundation Trust / University of Leeds

From the Science Desk (2)

Epstein-Barr virus appears to be trigger of lupus disease, say scientists

Lupus, which affects about 69,000 people in the UK, is a chronic autoimmune condition in which the immune system creates antibodies that attack the body's own tissues. The causes have not been well understood and there is no known cure for the condition, which can cause joint and muscle pain, extreme tiredness and skin rashes.

The study from Stanford University suggests that Epstein-Barr virus (EBV), which for most people is harmless, can cause immune cells to "go rogue" and mistakenly attack the body's own tissues. The team behind the work said that uncovering the cause of lupus could revolutionise treatments. The lead author believes that it applies to 100% of lupus cases.

(Younis S et al. Epstein-Barr virus-mediated B-cells as antigen-presenting cells in systemic lupus erythematosus. Science Translational Medicine 12 Nov 2025)

BIDA Golf Day

Prof Iqbal Shergill & **Dr Ravi Adapala**

North Wales Division were proud to welcome members to the 3rd Annual BIDA Golf tournament at Clays Golf Club, Wrexham, on Sunday 21st September 2025. This followed the conclusion of a successful 75th Anniversary meeting over the weekend. The competition has gradually increased its profile such that 20 golfers teed off, including for the first time this year, a lady competitor and also an under 16 player – highlighting the inclusivity of this event. All were welcomed to the course in beautiful sunny conditions with amazing blue skies – a far cry from the previous 24 hours which had seen an incessant rain deluge in the North West, putting the event in jeopardy.

On arrival a light breakfast of pakora and spring rolls plus authentic Indian tea was served before the first group got under way. After 4 hours on the course, the troops returned to a well earned drink and sumptuous desi meal in the "19th Hole"! Regarding the results, it was case of "Singh is King" with Mr Gurpreet Singh the overall winner and Dr Amrit Singh winner of the under 18 Handicap category. Congratulations. Further winners included Mr Nader "Noddy" Rehmatullah who won the £20 cash prize, donated by our benevolent guest, Mr Ajmer Singh Rai, for "nearest the pin" on hole 5. Mr Amit Sinha, President of BIDA kindly presided over the presentation after the event. Of course, the event could not have been possible without support of North Wales BIDA Chair, Dr Jay Nankani, and our new Sports Secretary, Mr Ravi Badge. Many thanks to all who played and supported the event including Lakhy Singh (Caterers) and Clays Golf Club for their hosting of the event. Finally, we look forward to inviting all those interested for 2026 BIDA golf tournament. Happy golfing!

Prof Iqbal Shergill
Dr Ravi Adapala *Local Organisers*

Below: BIDA 2025 Golf Tournament Winners (l to r) Mr Gurpreet Singh (Winner), Dr Amrit Singh (Winner, Under-18 handicap category) and Chief Guest Mr Ajmer Singh Rai with BIDA National President Prof. Amit Sinha.

Bottom: The competitors before the start of the tournament.

Together, we are stronger!

The British International Doctors' Association (BIDA) is a professional doctors' association. Its sole objective is promoting equality and fairness for all doctors and dentists working throughout the United Kingdom.

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

50th ANNIVERSARY

BRITISH INTERNATIONAL DOCTORS' ASSOCIATION

If you believe in this mission, join us!

If you are interested in joining BIDA, or would simply like to know more about us, please either write to **BIDA, Unit 4, Swallow Mill Business Centre, Swallow Street, Stockport, Cheshire SK1 3HJ U.K.**
E-mail us at **Office@bidaonline.co.uk**,
or contact us through our website at **www.bidaonline.co.uk**.