SUSHRUTA

PROMOTING PROFESSIONAL EXCELLENCE AND LEADERSHIP

BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN

20TH ANNIVERSARY - SPECIAL EDITION

2 Decades of service in improving patient care

NOVEMBER 2016

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BAPIO
281-285 Bedford Road
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Bedfordshire
Tel: 01234 212879
Email: office@bapio.co.uk
www.bapio.co.uk

SUSHRUTA
Special Anniversary Editon

Promoting Professional Excellence and Leadership For Improving Patient safety

In this issue.....

Guest Editor
Dr Indranil Chakravorty

Managing Editor
Buddhdev Pandya MBE

Advisory Editor
Dr J S Bamrah

Advisory Editor
Dr Parag Singhal

British Association of Physicians of Indian Origin is a national voluntary organsiation establsihed in 1996 to support the doctors originating from the Indian sub-continent. Sushruta is named after one of the earliest surgeons (600 B.C.) known as 'the father of 'palsic surgery'.

BUCKINGHAM PALACE

24th October, 2016.

Dear Dr. Mehta,

The Queen has asked me to thank you for your kind letter on behalf of the British Association of Physicians of Indian Origin on the occasion of your Twentieth Anniversary, which is being celebrated at your Annual Awards Dinner on 19th November at the Park Inn Hotel, Heathrow.

Her Majesty appreciates your thoughtfulness in writing as you did, in return, sends her best wishes to all those who will be present at the event for an enjoyable evening, as you mark this most notable anniversary.

Yours sincerely,

Christopher Sandamas

Christopher Sandamas
Chief Clerk to The Queen

Dr. Ramesh Mehta.

British Association of Physcians of Indian Origin

Reflections from the President

Twenty years may not seem to be a long time in the history of an organisation in a world steeped in hundreds of years of history, but how does one gauge the impact an organisation has? Is it simply the number of years it has existed for, or is it the impact it has had on setting the direction and tone of engagement? There are many examples of single agenda movements which tailed off once the impetus was lost, and an equal number which have existed for much longer but meandered to less meaningful roles.

Reflecting on the journey so far, it is satisfying to see that a small idea discussed by a small group of friends has turned into one of the largest national organisations of doctors in the UK. No doubt it would not have been possible without the many passionate leaders who have provided stewardship, but the principles have remained steadfast in guiding us. Over the years BAPIO has constantly shown its commitment to the NHS and quality patient care, which is intricately linked to the health and wellbeing of the workforce that delivers this care. BAPIO was born to support the principle of equality and fairness, to promote professional excellence and be a beacon for promoting leadership. These guiding principles have kept us focussed and relevant over the two decades of our existence.

BAPIO has been a proactive organisation promoting professional excellence, while challenging the establishment for equality and fairness. We had the courage to stand up to the Department of Health and the Home Office in 2006, when without any consultation the visa regulations were to be changed retrospectively. The well -fought victory in the House of Lords was a significant milestone in our journey and unprecedented in the history of this nation. We have always believed in collaboration and partnership to achieve our objectives. Over the years we have managed to establish excellent relations with the NHS, GMC, Royal Colleges and Deaneries. Despite the differences, we also have ongoing fruitful collaboration with the BMA on issues of common interest.

Dr Ramesh Mehta
President

Differential attainment of BME doctors has been a major concern for us. It is not only demoralising for the doctors concerned, but also a major loss of talent for the nation. Thus, we challenged the RCGP and GMC in a Judicial Review in 2014. Although we lost the case, Mr Justice Mitting was complimentary to BAPIO and said it was a moral victory for the organisation, even as he gave the RCGP 'one last chance' to make improvements in its processes. Even though we were strongly advised to appeal, we opted to act constructively and work with the RCGP when they offered to do so after the Judicial Review. More importantly, this case shook off the inertia about differential attainment and the whole establishment is actively looking for solutions. BAPIO of course is committed to following this up and is engaged with various stakeholders

Prejudicial support for BME doctor members in difficulty from an established organisation has been highlighted to us over many years. When dialogue and negotiations did not help, we had the courage to start our own support organisation. The Medical Defence Shield (MDS), which is now well into its seventh year, has helped hundreds of its members and is both a jewel in our crown and confirmation that 'where there is a will there is a way'.

We continue promoting professional excellence through education and training. With increasing demand and requirement, we decided to launch the BAPIO Training Academy in 2015. I have no doubt that in the coming years this too will develop into another feather in our cap. The treatment of whistleblowers and disputes between Trusts and their employees is an area which is a considerable drain on the resources of the NHS. On the one hand, the doctor concerned goes through a very traumatic period, while on the other there is a loss of morale and engagement from staff that inevitably leads to the poor quality of healthcare. We have developed a concept of partnership with individual NHS Trusts, and use our trained mediators to intervene at very early stages to try and nip the problem in the bud while providing support for the doctor and the Trust. Meanwhile, the Workforce Race Equality Standards (WRES) have given us an added opportunity to work with Trusts.

Even as we work very closely with stakeholders in the UK, it would be amiss not to highlight the immense partnerships we have developed within the health system in India. Our collaborations with universities, state governments, corporate hospitals and educational boards put us in a unique position where we can facilitate knowledge exchange and provide a platform for greater collaboration between these two great nations.

So, I look back on 20 years of BAPIO with immense satisfaction. The idea has taken a great shape, while the organisation remains focused, dynamic and relevant, and continues to evolve over time. I would like to thank everyone involved: our members who keep the faith and look to us for leadership; the leaders who continue to devote their time and passion to our cause; and the establishment who continue to support and engage with us to achieve our shared objectives of improving healthcare while being fair to the healthcare providers. We will continue to work towards our objectives with passion and vigour, and while 20 years have gone by in a jiffy, it has been a long time too.

Ramesh Mehta
President -BAPIO

Dr Ramesh Mehta MD, FRCP, FRCPCH, FHEA, DCH
Dr Mehta is a Consultant Paediatrician.
He is Founder President of British Association of Physicians of Indian Origin and designated President of Global Association of Physcians of Indian Origin.

Message from Guest Editor:

Dr Indranil Chakravorty
Guest Editor

It is a great honour to be invited to edit the special issue of Sushruta marking the 20th anniversary of the British Association of Physicians of Indian Origin. The association of the medical fraternities in the United Kingdom with graduates from the Indian subcontinent dates back many decades and you will see some of the articles in this journal exploring this association. Indian medical knowledge and traditions however date back several thousands of years, and at a time when we face major challenges in healthcare delivery models, systems and processes, it may be the right time to learn from this rich tradition.

Since the inception of the National Health Service, the contribution of international medical graduates has been a pillar of healthcare delivery and has helped NHS to live up to its promise of providing access that is free to all and universal. From the mines in Wales (BBC television series Indian Doctor) to Casualty the international medical graduate has rightfully become part of the mainstream fabric of the multi-cultural society that is modern Britain. Medical professionals from the Indian sub-continent have been at the forefront of this journey. What has drawn the brightest and best from the Indian sub-continent to serve the population via the UK NHS, is the belief that NHS is truly the best model of universal healthcare delivery where economic means of the individual is not a factor. Sadly, in several countries of the world, this simple human right is denied to many.

However, there have been hurdles faced by the international medical graduates, many of them have felt that their career progression, their brilliance and achievements have not been recognised as equals. There have been perceptions of glass ceilings, as is now recognised for women and other minorities in many aspects of UK professions and society. Articles in this issue will explore the role of women and junior doctors. This is where a voluntary association dedicated to recognising and channelling the contributions of this section of the intelligentsia, is needed. BAPIO has grown from a small organisation when established two decades back, to a major player in the forefront of healthcare strategy, exploring the solutions needed by the beleaguered NHS, providing innovations in patient safety and in balancing inequalities of the academic institutions.

While traditional associations have faltered to find the right balance between its ideals, rights of its members and its responsibilities to excellence in patient care, I am impressed by the commitment of the BAPIO leadership in building alliances with the regulatory and training bodies to influence change of culture and practices. The contents of this anniversary edition, reflect a huge amount of work being undertaken with some noteworthy outcomes.

I hope you will join me in recognising the vision of BAPIO's founding members and those successive leadership team for their collective efforts in sustaining BAPIO in the mainstream, that is growing in strength and influence. I hope that you would find this issue interesting and an insight to BAPIOs' track record for the past two decades.

Dr Indranil Chakravorty

Dr Indranil Chakravorty MBBS PhD FRCP
Consultant Physician
St Georges University Hospitals NHS Trust
London
Trust Liaison Dean
Health Education England, London & South East
Indranil.chakravorty@stgeorges.nhs.uk

BAPIO

A Journey of Two Decades

Conceptions, Birth and The First Steps of the Baby

Dr Raj Kathane
Founder Secreatry

Unlike the Immaculate Conception or that of Brooklyn Beckham, it is often difficult to determine exactly when the conception took place, especially if it is an idea! We have often tried to pinpoint such a date for BAPIO; the nearest we could narrow it down to was perhaps the summer of 1994. And it certainly was not done at the first attempt!

A group of us, some 10 or 12, used to sit around informally (not in smoke-filled rooms) to discuss many issues that affected doctors of all different types: GPs, junior doctors, middle grade doctors, consultants, etc. It was becoming clearer that there was growing frustration and exasperation within the doctors who came to the UK from other countries. There was a perception at that time that there was a greater chance that if you were an immigrant doctor you were more likely to be complained against, be referred to the GMC for wrong-doing and be punished, than if you were not of immigrant heritage.

There was frustration amongst the immigrant doctors that the established system may not always come to the assistance and rescue fully, and thus the outcome was often compromised and less than satisfactory. Being Indian, we started to narrow down the remit of such discussions to this context.

There were of course some organisations that did help the immigrant doctors, but the names tended to suggest that these were for foreign and overseas doctors in general, rather than the specific context of being British, working in Britain and being of Indian origin. Indian origin, again, is a broad brush, comprising of people from India, Pakistan, Bangladesh, Nepal and Sri Lanka who have the same or comparable colour and morphology, with it often proving difficult to locate where one person may have come from. Thus, there was perhaps a need for such doctors to 'belong' to a specific group.

Ramesh Mehta, for if there is a born leader, that is him (I have known him since 1966 from our medical school days as we were classmates, and I have personally seen many examples of his strong and skilful leadership), got thinking harder about such issues more than the others.

News came that in the USA there was such an organisation for doctors of Indian origin, the American Association of Physicians of India (AAPI). It was financially very rich, politically very active and had great clout. One of their annual conferences was graced by President Bill Clinton. So here was the outline of the vision and the challenge for Ramesh!

The discussions began to crystallise with action plans. That would have been around 1995. A name began to emerge; many variations were suggested and great discussion took place, before finally the current name was settled upon. A small sub-group worked on the logo. Finally, the British Association of Physicians of Indian Origin (BAPIO) was launched at a dinner meeting at a local Indian/Bangladeshi restaurant. That was Friday the 17th of May 1996.

Much background work was still going on, and finally it was time for the national launch of the organisation. By now there was a change in government with Tony Blair as Prime Minister and Tessa Jowell as the Health Secretary; the latter was invited and accepted to inaugurate the Association, a function that took place in the Harpur Suite, Corn Exchange, Bedford.

A Journey of Two Decades

BAPIO

Consolidation

Buddhdev Pandya MBE
Director of Policy and Promotion

It is fair to say that since its formation BAPIO has never looked back, while embarking on a journey that has proactively highlighted several issues affecting the careers of Black and Ethnic Minority (BME) doctors working in the NHS.

In 1998, while formally launching BAPIO Ms Tessa Jowell, the Minister of State for Health, acknowledged that ethnic minority doctors have made an excellent contribution to the NHS since its inception. She also confirmed that the NHS had signed up to the Commission for Racial Equality's 'Leadership Challenge' and had pledged to tackle discrimination and promote the equality of opportunity. Yet, after almost two decades the situation remains the same for many international medical gradates.

In a message in 2014, almost 16 years later, the former Prime Minister Rt Hon David Cameron MP wrote, "I have huge respect and admiration for the doctors and nurses of Indian heritage who serve the National Health Service day in day out with such relentless dedication, skill and care.

Doctors from India, Pakistan, Bangladesh, Sri Lanka and Nepal have been here since the very beginning of the NHS and today there are over 40,000 of you helping to deliver a world-class health service for all". He added, "The British Association of Physicians of Indian Origin has a vital role in supporting doctors of Indian origin when they come to the UK".

The current Secretary of State for Health, the Rt Hon Jeremy Hunt MP, commented, "BAPIO has done sterling work since its foundation and I pay tribute for the excellent work it does to champion international medical graduates as providers of world-class, comprehensive care".

These complements perhaps come following a sustainable strategic approach to pursue our goals. Most proactive groups are issue-bound campaigners, although BAPIO has had a long-term view on tackling the persistent challenge of the unfair treatment of BME doctors in the NHS.

Unfortunately the institutions, both employers and the regulatory bodies, have often been insensitive to the cultural diversity that exists in the NHS. The policies, often well-meaning, are left as 'soundbites' when it comes to implementation and monitoring at the grassroots level.

There were those who preferred to live in a world of apathy, often believing that 'it has nothing to do with me'. But this approach only lasted until the troubles came to rest at their own front door, threatening their own career. Thus, BAPIO has become a lifeline and a career saver. However unfortunate this could be, a large number of IMGs across many communities have welcomed BAPIO and appreciated its activities.

With most of the management committee members being busy in their clinics and surgeries, during the early decade there was substantial but patchy work carried out on an ad-hoc basis. The Association provided social, cultural and sports activities that helped expand networking opportunities.

During the journey, BAPIO has tried to reach out to other similar organisations within the specialty and alumni groups across Britain. This was a trying period and it proved to be an uphill struggle to get accepted by the powerful lobbies of the policy makers. We are grateful to a number of individuals for their contribution during this period: Dr Raman Lakshman, Dr Satyanarayan Hegde, Dr Satheesh Mathew, Dr Sajayan, Dr Joydeep Grover, Dr Rehman Khan, Dr Romesh Gupta and many others who assisted the Executive in formulating many responses.

By the end of the first decade BAPIO had grown in influence and strength, with its presence felt in many of the regions through its dedicated teams.

Choosing a Strategic Direction

Central to our approach was the issue of fairness. It was obvious that career progression was proving a major barrier for the IMGs.

Discrimination, largely practised in a most sophisticated and subtle form, was subjecting many of our skilled professionals to disciplinary processes that could have been prevented by fairer management and training support.

While the NHS has been in a continual state of reform in the name of modernisation, many reports have highlighted a plethora of cases of bullying and harassment, endured by BME doctors in silence. Even today in 2016, we clearly see the 'snowy peaks' across the NHS. Thus, our work has been cut out in addressing many of these issues over the past two decades.

Vision & Mission

BAPIO executive committee members have had regular deliberations and 'think tank' exercises to reflect on the issues and challenges facing BME doctors.

In December 2009, after reflecting for two days, our vision and mission was revised as follows:

Vision:

Empowering doctors and dentists of Indian heritage to be beacons of leadership and professional excellence.

Mission:

BAPIO aims to provide a forum for a diverse group of doctors, dentists and medical & dental students of Indian heritage, along with all others, to contribute to improving patient care by promoting:

- Practical leadership skills & capabilities
- Professional excellence in patient care
- Awareness in diversity and inclusion that supports fairness & equality
- Access to better healthcare globally and assistance in responding to natural disasters around the world.

In a pragmatic approach, we felt it would be prudent to prioritise our work under four strategic pillars that run through the central theme of promoting professional excellence and leadership to enhance patient care:

- Policy influence
- Education and training
- Advice and support to individuals
- International healthcare & charity
- Leaders, Divisions and Units

Over the years BAPIO has attracted many high quality national leaders who have served in senior positions. These include Prof. Romesh Gupta, Prof. Raman Bedi, Prof. Rajan Madhok and Dr JS Bamrah as chairs. Vice chair positions have been occupied by Dr Satheesh Mathew, Dr Umesh Prabhu, Dr Rehman Khan and Dr Raman Lakshman. Meanwhile, we have had active secretaries in Dr Raj Kathane, Dr Sanjiv Manjure and Dr Parag Singhal.

BAPIO's work has gradually expanded nationally, and now we have 11 divisions all over the country. Leaders who have actively contributed in forming divisions include Dr Prakash Sahay, Dr Ravi Madhotra and Dr Sajayan (West Midlands); Dr Raghu Ramiah (East Midlands); Dr Rajeev Gupta (Yorkshire); Dr Raj Verma, Mr Shyam Kumar and Dr Sekar (North West); Dr Meena Virdi and Dr Nitin Gambhir (Scotland); Dr Mukesh Chug (Northern Ireland); Mr Keshav Singhal, Dr Hasmukh Shah and Dr Victor Babu (Wales); Dr Parag Singhal (South West); Dr Anand Deshpande (London); Dr RK Rao (Eastern); Dr Umesh Dashora and Mr Kalidasan (South East).

Forums

BAPIO has developed various speciality forums to engage members with special interests in a range of activities under the BAPIO umbrella. Many leaders have helped in developing these fora.

- Medical Students' Forum: Nikila Patil
- Young Doctors' Forum: Dr Abrar Hussain and Dr Ankur Khandelwal
- Women's Forum: Dr Vinita Manjure and Dr Uma Gordon
- SAS Doctors' Forum: Dr Hemadri and Dr Victor Babu
- Paediatric Forum: Dr Sunil Sinha, Dr Amit Gupta and Dr Arvind Shah
- Patient Safety Forum: Mr Sham Kumar and Dr Suresh Rao
- GP Forum: Dr Satwinder Basra
- Indigo Forum: (An online discussion forum with over 5,000 members) Dr Raman Lakshman, Dr Nand Kumar, Dr Hemadri and Dr Joydeep Grover

A Journey of Two Decades

FOUR PILLARS: Policy

Dr Satheesh Mathew
Vice President

The BAPIO leadership has been committed to the principle of providing high quality patient care through the National Health Service.

Unfortunately, all BME doctors have experienced some form of discrimination during their career in the NHS. The majority have faced a subtle form of unfair disadvantage, most suffering in silence. Under the leadership of President Dr Mehta, a team was established to evaluate and respond to the many policy and regulatory issues.

Within the first five years of its formation, BAPIO began attracting many committed academics and clinicians. Amongst them was Dr Satheesh Mathew, a consultant paediatrician with an active interest in the welfare of the workforce. Others including Dr A Sajayan, Dr Hemadri, Dr Rajeev Gupta, Dr Abrar Hussain and Dr Raj Verma, supported by Mr Buddhdev Pandya, brought new vigour to the debate and helped in decoding the mismanaged practices in hospitals and training institutions.

BAPIO's approach to problems was simple. Open a discussion with the establishment through a friendly collaborative dialogue and encourage equality and fairness. This worked most of the time with the General Medical Council, the Royal Colleges, NCAS, PMETB, Department of Health, CQC and BMA. However, there have been times when BAPIO decided to stand up to the establishment and challenge their authority.

Judicial Review: Immigration rules

BAPIO was shocked when the Department of Health announced on the 7th of March
2006 that the rules were to be changed on the 3rd of April 2006.

Effectively, this would have ended equal opportunities for doctors from outside the European Union. This ruling was introduced with no consultation and applied retrospectively.

The impact would have been much graver for many doctors who were already in the middle of their training, as they would not have been able to continue training and would have been expected to leave the country. Doctors who had come to the UK after passing the PLAB and were waiting for jobs would only find their troubles multiplied if the new rules were applied.

BAPIO led a peaceful protest, probably the first time in the history of the NHS where a group of over 600 doctors stood in solidarity before Richmond House in Whitehall, London. On the 21st of April 2006, a petition signed by over 6,500 doctors was submitted by the BAPIO delegation to the Department of Health.

On the 7th of June 2006 BAPIO filed a case in the High Court for a judicial review, requesting the court declare the abolition of PFT unlawful. Mr Rabinder Singh QC, one of the most able barristers, represented BAPIO. BAPIO lost this review but appealed to a 3-judge bench at the High Court. The Appeal Court in October 2007 ruled in favour of BAPIO that the Guideline issued by the Department of Health was illegal. The government then appealed directly to the House of Lords. On the 28th of February 2008, a 5-judge bench at the House of Lords upheld BAPIO's hard fought challenge against the government's attempt to retrospectively introduce regulations to restrict non-EU doctors already in the UK from applying for training posts in the NHS.

Dr Mehta welcomed the Judgement with the comment, "The House of Lords has vindicated our position that the government had acted in haste and prematurely without thinking through the damaging consequences for thousands of international medical graduates that its retrospectively applied unfair regulations were likely to impose".

The decision saved the careers of an estimated 15,000 doctors who would have otherwise been thrown out

of Britain. The majority of them are now in consultant positions in various NHS hospitals providing excellent service.

The team that led the protest, the petitioning process and the legal action all deserve our sincere appreciation. We are grateful to Dr Ramesh Mehta, Dr Satheesh Mathew, Dr Sajayan, Dr Joydeep Grover, Dr R Chaudhary, Mr Buddhdev Pandya and many others who worked in the background and took an active part in the process.

Judicial Review: CSA results

The CSA is a crucial element of the final exam process for GP training in the UK. The RCGP annual report showed that BME UK graduates were four times more likely to fail the CSA than white UK graduates. International graduates were discovered to be 16 times more likely to fail than white UK candidates. BME international graduates were also more likely to fail the test than white international graduates.

Following many discussions with the relevant institutions, in April 2014 BAPIO decided to launch a legal action against the RCGP, which conducts the exam, and the GMC, which is accountable for ensuring a fair process.

The legal battle to seek fairness and equality was not successful; however, the concluding remarks of the Honourable Judge vindicated our position. While he did not agree with our claim that the CSA is unlawful, he did agree with our concern about the results of the examination, stating, “if not a legal victory then [this is] a moral success for BAPIO". The judge also noted: “[An] endless amount of research has been commissioned to date with no solutions or action points; it has taken a court case to effect action”.

He further added that the “RCGP should now take action, including by selecting more representative examiners and role-players for the assessment” and that "If it does not act and its failure to act is the subject of a further challenge in the future, it may well be that it will be held to have breached its duty".

Although we were extremely disappointed with the verdict our campaign team felt vindicated, with the judge stating that “the claim had been brought in good faith and in the public interest”. He concluded by commenting, “The bringing of this claim is likely, in the end, to bring something of benefit to the medical profession”.

Since then, there has been a most welcoming ripple effect that has facilitated a number of meetings with the RCGP and the GMC to seek redress and find solutions. The Executive Committee of BAPIO is grateful to the hundreds of doctors who supported the BAPIO campaign.

Discrimination still Thriving in the NHS

In the 2008 Annual Report of the Chief Medical Officer, Sir Liam Donaldson, the rampant discrimination against ethnic minority doctors and its adverse impacts was acknowledged for the first time.

Welcoming the report, BAPIO President Dr Ramesh Mehta said, “Our members appreciate the acknowledgement in the report that historically ethnic minority doctors have suffered discrimination and many doctors experienced systemic prejudice, overt racism and harassment which impeded their career progression”. Dr Raman Lakshman, the BAPIO Vice-Chair, commented that “The report contains some laudable recommendations which now require joint efforts for effective implementation”.

The disproportionate number of ethnic minority doctors being referred to the GMC continues to be a major concern. In 2008 a BAPIO team visited the GMC to observe and learn on-site the process of dealing with a complaint. It was observed that the problem was at the time of screening the complaint and that a disproportionate number of ethnic minority doctors were referred to the Fitness to Practise committee. The GMC agreed to look into this.

Several research papers had revealed that BME doctors were not getting the appropriate recognition in excellence awards. The President led the discussions with the Advisory Committee on Clinical Excellence Awards and initiated a process that has led to some improvement in the transparency of decision making.

We had meetings with the Medical Defence Societies, as we noticed that BME doctors were not getting appropriate support. Weak excuses such as the cultural background and communication issues were not accepted. Eventually we had to launch our own support system (Medical Defence Shield).

We have been involved in extensive negotiations with the Immigration Advisory Service and other service providers to secure special deals for our members regarding immigration challenges.

For example, BAPIO received a complaint from a doctor returning from India, who was accused of fraud through using NHS resources by immigration officers. BAPIO took up the issue with the authorities, and the Head of the UK Borders’ Agency has since issued a sincere apology.

House of Commons Select Committee:

BAPIO has been involved in several consultations and appearances at the House of Commons Select Committee meetings. In December 1997, BAPIO gave written evidence to the Select Committee in Westminster. Dr Mehta gave evidence to the Select Committee on Heath regarding unfair changes in immigration rules for trainee doctors by the Home Office.

We acknowledge the contributions of Dr Joydeep Grover, Dr Asha Reddy, Dr Vinay Shanthi, Dr Ashok Beckaya, Mr Buddhdev Pandya and Dr Raman Lakshman for researching the evidence and preparing consultation documents.

General Medical Council

In 2006, the BAPIO team began useful meetings with Prof. Graham Catto, the GMC President, and Mr Paul

Philip, the GMC Fitness to Practice Director, to discuss why there were more complaints and disciplinary procedures against EMDs. Of course, the GMC moves slowly! However, over the years BAPIO has maintained steady pressure on the GMC to ensure fair practices. There have been several successes, including the separation of the GMC's disciplinary and adjudication parts. The GMC has also recognised the differential attainments of BME doctors as a serious issue, and has been collaborating with us in finding a solution.

BMA

The BMA supported BAPIO's challenge to the RCGP and GMC regarding the pass rates in the CSA exam both financially and morally. This was a turning point in BAPIO's relationship with the BMA. BAPIO now has regular dialogue with the BMA. Although BAPIO does not compromise its principles of equality and fairness, it is happy to use the BMA's influence to find solutions for BME doctors' issues.

London Deanery

By now BAPIO had established a stronger working relationship with the London Deanery and its Director, Prof. Elisabeth Paice. It was the era of the importance of the ARCP and RITA processes to identify the progress of trainees and where they were stalling, to prescribe action to improve the progress where necessary.

Prof. Paice concluded that "rather than focusing on the management of poor performance, we should concentrate on providing a supportive working and learning environment for all trainees, recognising everyone has the potential to be a doctor in difficulty at some time in their career, and that most of us can be helped through our tough times".

On the 3rd of July 2008, BAPIO brought together all concerned bodies in an essential first step to get everyone talking about this very important area. Dr Raman Lakshman, Vice Chair of BAPIO and policy lead noted, "We hold a brief that there are no problem doctors, only doctors with problems. And problems can almost always be solved".

Royal Colleges

BAPIO has developed collaborations with many Royal Colleges as well as the Academy of Royal Medical Colleges to raise issues pertinent to equality and inclusion. There are regular ongoing discussions with the RCGP, RCP and RCPCH.

Care Quality Commision

BAPIO has raised the issue of single-handed and inner-city GPs, who are mostly BME doctors, being harassed by CQC inspections. Following several meetings with CQC Chair Prof. Steve Field, we have been assured that support rather punishment will be the CQC's policy.

Health Education England

BAPIO has been having discussions at the highest level with Health Education England regarding issues, training, assessment and the Medical Training Initiative. Prof. Simon Gregory and Prof. Ged Byrne have been particularly supportive in finding solutions for GP trainees and overseas recruitment.

NHS Employers

We have had meeting with Mr Danny Mortimer, the CEO of NHS Employers, to raise issues like the harassment of whistleblowers. We are holding ongoing discussions to improve the situation.

Department of Health

We keep in touch with the Department of Health at various levels. We have had meetings with the Secretary of State for Health and other senior offices to raise issues pertaining to our members. We can communicate at the highest level.

Collaboration with NHS Trusts

We have been actively soliciting collaboration and partnership with various NHS Trusts. The first MOU was signed in 2015 with Morecambe Bay University Hospital Trust to support them with the Workforce Race Equality Standards and with disciplinary matters concerning doctors. We thank the CEO Jackie Daniel and the Director of Human Resources David Wilkinson for their support. There are ongoing discussions with other Trusts.

Dr Mehta summed this up with a note: "We are committed to the NHS and patient safety. We will also actively promote the principle of Equality and Diversity". ■

BAPIO

A Journey of Two Decades

FOUR PILLARS:
Education and Training

Dr Amit Gupta -Vice Chair

BAPIO is committed to the principle of providing high quality patient care through the National Health Service. We also actively promote the principles of diversity and equality. Education and Skills Development is critical for Continuous Professional Development, and thus it is one of our central pillars that guide our work.

Over the years we have conducted a large number of courses, seminars, workshops and conferences to support professional development as well as career progression; the latter especially for trainees and SAS doctors.

In view of the increasing demand and importance, BAPIO launched a new initiative for Education and Training in pursuance of its central theme of promoting professional excellence and leadership. The 'BAPIO Training Academy' was formally launched on the 1st of November 2015 by Mr Simon Stevens, CEO of the NHS.

The core purpose of the academy is to:

- Contribute to enhancing the practical leadership skills & capabilities of medical graduates
- Promote and assist in the development of professional excellence in patient care
- Provide forums to share experience of common heritage to add value to patient care
- Promote diversity and equality

The BAPIO Training Academy (BTA) board of directors appointed a strategic team of experts to plan and develop the initiative further. This included Dr Amit Gupta (BTA Director), Dr Vivek Chhabra, Prof. V Gautam, Dr M Hemadri, Dr Rashmin Tamhne, Dr Ankur Khandelwal, Dr Abrar Hussain, Dr Milind Karale, Prof. Murali Raj, Dr Rajeev Gupta, Dr Vinod Singaravelu, Mr Enoch Stuart and Dr Ramesh Mehta. Policy and administration is overseen by Mr Buddhdev Pandya MBE.

International Fellowship Programme

In view of the national shortage of medical staff in Emergency Medicine (EM), the BTA initiated an International Fellowship Programme in EM in collaboration with the Academic College of Emergency Experts (ACEE), New Delhi, India, to support training and induction.

The programme is conceived under the Medical Training Initiative (MTI) scheme, but ensures the appropriate selection and induction in India, and the allocation of a paid trainer and mentor. This is to ensure that these doctors get appropriate training before they return to India.

The BAPIO network in various regions of the country provides socialising opportunities for newcomers and their families during the settlement phase.

Education & Training Courses

The BTA have plans to start several courses including those for exam preparation. Courses will be held nationally and in India.

We have embarked upon a collaborative approach. We have developed a partnership with the Doctors Academy

SUCCESS STORY: A total of 18 candidates at Basildon and 10 at Loughborough from all grades and levels including trainees, SASG and consultants and from specialties including EM, Anesthesia, Surgery and one from Psychiatry gave strongly positive feedback

through running some specific and generic courses, for which we greatly appreciate Mr Enoch Stuart's support and guidance.

The other effective collaboration has been with the All India Institute of Medical Sciences, the premier medical establishment in India. As a first, the BTA hosted a master class titled AIIMS Advanced Ultrasound in Trauma and Life Support at two centres in the UK in May 2016. With popular demand, the course is being repeated in Basildon and Bristol.

There is ongoing discussion with some UK universities, including Leicester University, for collaboration in different aspects. This also includes a student exchange programme.

The BTA is in discussion with the National Board of Examination in India for collaborative work in the UK and India. There are also ongoing discussions with several Indian universities of Health Sciences for collaboration in Medical Education.

Appraisal Services

The BTA plans to start appraisal services for doctors in the UK and the Indian subcontinent. There is a pool of high quality and experienced appraisers amongst our members. With them we hope to form a panel of appraisers.

Website: www.bapiotrainingacademy.com

FOUR PILLARS:

MDS Professional Support Without Compromise

Medical Defence Shield

BAPIO has been helping its members faced with professional, regulatory and employment related difficulties since its inception. Over a period, it became very difficult to provide consistent and professional advice on an ad hoc structure.

It was obvious from the experience of most the doctors in difficulty that the many of the traditional service providers were not sensitive to the needs of the international medical graduates. It just did not lack merely the cultural sensitivity despite have a very large membership originating from abroad, but often their commitment to protect the interest was amiss. This became obvious at the time of the Judicial Review where the mainstream organisations refused to help our core members despite them being fully paid up and in good standing.

At this juncture BAPIO executive Committee initiated a working group to explore and to plan for a project of its own that would provide access to professional advice and representation support that would be sensitive to the needs of the doctors desperately needing help.

Under the leadership of the President Dr Ramesh Mehta and Vice-President Dr Satheesh Mathew the team which included Dr Sajayan Nair, Dr Joydeep Grover, Dr Anand Deshpande and supported by Mr Buddhdev Pandya several consultations exercised were held.

The challenge for the team was to take a holistic view of the problem and provide a comprehensive response that could be best tailored support for ensuring the best professional outcome for an individual.

Our first task was to consolidate many aspects of advice and representation support for which the members had to go to different agencies the employment contract related issues and the disciplinary process. To prevent, 'pillar to post' approach, the model of services was developed to include both aspects.

The team negotiated with one of the internationally renounced insurance brokers and a Manchester based law firm to provide much needed kick start support for the initiative. This also helped to enhance our capacity to provide indemnity cover for those involved in private practice and after extensive ground work Medical Defence Shield (MDS) was formally launched on the 1st of March 2010.

Initially led by Dr Rajendra Chaudhary, and assisted by Dr Paul Lambden, Dr Vinita Manjure and Dr Nanda Kumar, in 2014 MDS appointed its first CEO, Prof Rajan Madhok, former Medical Director from Manchester to lead who was assisted by Mr Buddhdev Pandya MBE as Deputy CEO.

THE MDS TEAM

Since 2015, after Prof Madhok's retirement, MDS has been headed by Dr Joydeep Grover, a NHS Consultant, in capacity as Medical Director. In the last year there has been a sea change, the website was updated, the office was moved to Bedford and a full-fledged in-house legal team was set up to reduce reliance on external providers.

MDS remains a not-for-profit initiative which makes it a highly competitive and cost effective programme. The members of the scheme are able to access advice from an experienced team of doctors with legal background, specialist legal advisors and senior caseworkers. It is BAPIOs' pride as the MDS team has been able to turn around the outcomes in many cases that were considered by others hopeless. Direct and early intervention by the professional team of MDS had made a huge difference in the way the employers were processing complaints, particularly from the international medical graduates.

Over a period of more than 6 years, MDS has a proven track record of successful provision of a unique and comprehensive service and a milestone for BAPIO in pursuance of one of its goad to support doctors in difficulties. It is a role model approach which moves from protest to projects to make a real difference in the careers of many of our colleagues. ■

MDS

MEDICAL DEFENCE SHIELD

INVITATION FROM MEDICAL DIRECTOR

It gives me great pleasure to introduce Medical Defence Shield, a unique service providing Comprehensive Professional Support for doctors based in the UK.

Since its inception in 2010, MDS has steadily grown in strength, with a wealth of experience in supporting doctors. The uniqueness of MDS has two aspects – we provide comprehensive cover for both employment and professional defence under one subscription and we remain a not for profit organisation.

The last year in particular has seen significant reorganisation and as Medical Director, it has been my privilege to shape this change. We identified 'Professional Support without Compromise' as our ethos and with this vision in mind, we meticulously reviewed and renewed all processes and services, including our advice line, MDS website and quality control of the advice we provide our members.

In the last year alone, MDS has resolved over 250 cases, ranging in complexity from training, ARCP, rota & salary issues on the one hand and to unfair dismissals, whistleblowing and Employment Tribunal Appeals on the other. We have defended our members before the GMC, in trust internal disciplinary proceedings and MHPS investigations. We have ACAS trained mediators in our team who have helped in obtaining local resolutions and mediation.

It is heartening to note that our membership has increased by leaps and bounds, up by over 35% in the last calendar year. Almost all new members have joined us on recommendations and I would like to thank each one of you who recommended a friend or colleague to join MDS.

In the current regulatory climate, it is wise to have experienced and personalised support and to have the ability to access it with one phone call for advice and support which is unique to MDS.

I invite you to visit our website at www.mdsuk.org or call our friendly membership team on 030 030 32 442 for any further information.

I look forward to welcoming you to MDS on behalf of our team.

Dr Joydeep Grover
Medical Director MDS

FOUR PILLARS
International Heath care and Charity

Dr Anand Deshpande

The British Association of Physicians of Indian Origin is built on the membership of those who have originated from the Indian sub-continent. It takes as given that they have an affinity to the sub-continent and a keenness to do some charitable work to support the healthcare there.

A significant amount of BAPIO's charitable work is carried out through the Global Association of Physicians of Indian Origin (GAPIO). BAPIO is a co-founder of this global organisation.

Global Association of Physicians of Indian Origin

GAPIO stands to empower physicians of Indian origin to achieve the highest professional standards, to encourage affordable good quality healthcare, to contribute to local and regional community development, and thereby to help to reduce health inequalities and alleviate suffering globally.

Several BAPIO members have actively participated in the activities of GAPIO and we are fortunate that the President of BAPIO is now the designated President to lead the organisation for the next 3 years. He takes over in January 2017.

Swaasthindia.gov.in, a major collaborative effort between GAPIO, BAPIO, AAPI and the Government of India's Ministry of Health is designed to connect and make it easier for physicians of Indian origin residing abroad to find out about opportunities to support various healthcare

requirements in India, ranging from helping at health fairs and eye camps to screening, etc. In addition, state governments will be posting their requirements for healthcare professionals, and overseas physicians of Indian origin will be able to apply for them online. This is the first website of its kind that will act as a true matchmaker between the healthcare experts of Indian origin living abroad and the requirements in India. It was launched in 2015 and is being used by an increasing number of Indian states to post their requirements.


Dr Anand Despande
Vice Chair - BAPIO

Skills Development Council of India

BAPIO has collaborated with the Skills Council of India in the form of a memorandum of understanding to support skills development for healthcare workers. One of the projects being organised by Dr Sathish Rao, a paediatrician at Birmingham Children's Hospital, is to train Indian therapists in looking after children with autistic spectrum disorders.

National Board of Examination (NBE), India

BAPIO works in close collaboration with the National Board of Examination, which is responsible for postgraduate examinations there. Our collaboration consists of a skills exchange between the educators in the two countries. It also involves the induction of doctors planning to work in the UK. We are grateful to Dr Abhijat Sheth, the Chairman, and Prof. Bipin Batra, CEO of the NBE, for the alliance.

All India Institute of Medical Sciences (AIIMS), Delhi

This is a partnership in the making. As the first project BAPIO hosted the AIIMS Advanced Ultrasound master classes in Trauma and Life-support Services in May at Leicester and Basildon. It was a great success and the

second course is being hosted in November. We thank Prof. Sanjeev Bhoi and Dr Sagar Galwankar for leading this course in the UK.
We also look forward to welcoming the Director of AIIMS, Dr Mahesh Misra, during the BAPIO Annual Conference.

Government of India (GOI)

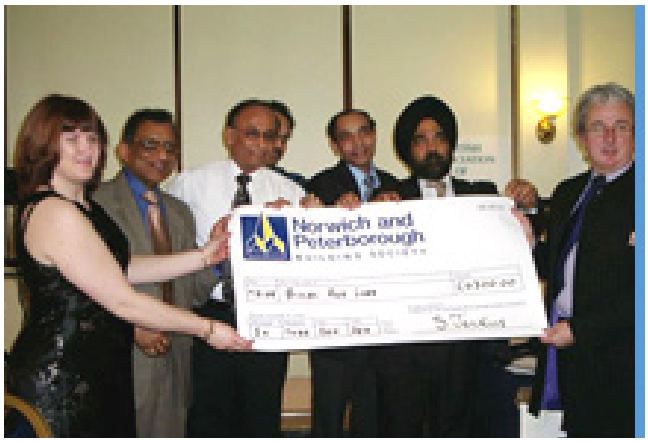
In 2008, the Indian government's then Minister for Health came specially to attend our Conference to celebrate the 60th anniversary of the NHS and the 10th anniversary of BAPIO. Our team assisted the GOI in obtaining evidence for their campaign for smoking secession. We have close links with the GOI through the Indian High Commission in London.

BAPIO International Fellowship Programme

The BAPIO Training Academy (BTA) has opened a new opportunity for IMGs from abroad to be part of its fellowship programme. The programme as a part of the Medical Training Initiative (MTI) offers a two-year appointment in various specialities in NHS hospitals. The BTA ensures proper induction before coming to the UK, and then supervised training and mentoring in the UK. The trained doctors then return to their mother country to provide better quality health service.

BAPIO Charity

BAPIO members are always actively involved in collecting funds for natural disasters in the Indian sub-continent. Some significant charitable work has been done for the Kutch Earthquake in India, the Pakistan Flood disaster, the Nepal Earthquake, and many others.



Sustainability in Healthcare
– *the case for innovation*

Dr Indranil Chakravorty

We are poised on a precipice in more ways than we may be able to contemplate. Health is one of the fundamental rights of humanity, enshrined in World Health Organisation's ethos for the free world. The vision for 'Health for All' is far from being achieved anywhere in the world. One may argue that vast swathes of the world may even have regressed to poor healthcare as a direct result of human activities. The basic premise that health is integral to human development is a two-way relationship. A healthy population drives productivity and the economy is dependent on an effective healthcare delivery system. Does healthcare delivery have to be universal and should we strive for excellence? This is where the opinions differ across the different populations across the world. The debate over 'Obamacare' in the USA has split the country along multiple lines and after two stints in office, there is little evidence to show that a consensus is emerging. Yet in post-war United Kingdom, Labour party could establish a universal access and free at the point of care, health system which has survived many economic and political challenges for 60 years.

Is the NHS now faced with its greatest challenge ever and why do most frontline staff believe that the right-of-centre political thinking sweeping across the European Union is creating the atmosphere for changing the basic ethos of healthcare delivery for all into a dichotomous situation of excellence versus deprivation. Healthcare cannot be divorced from the state of the nation's political and economic realities. The collapse of the economic stability of UK and major nations in the world in 2008, placed huge burdens on national resources. Combine this with a constant state of imminent external threat to political stability from the activities of hostile parties both physical and via cyber space creates a protectionist ethos. When populations are put on the defensive then every threat takes on an aura much larger than at any other time. The political rhetoric about external threats, from violent acts of terrorism to being flooded with swathes of immigrants, is now dominating the public mind. Where is the space to reflect on healthcare delivery? In such times, when parliament debates renewing nuclear deterrent at the same time as healthcare reform, where do you think the emotional intelligence of the 'unsuspecting public' will dwell? There is bound to be a fundamental divide in the thinking of people entrusted with delivering 'excellent healthcare to all' i.e. the political masters versus the institutions implementing this at the frontline. Such apparent incompatibility of purpose is manifest in feelings of disempowerment and breakdown of trust between the professionals with their political masters. The junior doctor industrial action over changes to contracts and working conditions is an example of such mistrust. The professional bodies including arms-length-bodies find themselves caught in the middle. Is there a way forward?

Dr Indranil Chakravorty
Consultant Physician

The elephant in the room rears its head in the form of Sustainability Transformation Programmes or STPs. STPs are designed to rationalise healthcare delivery, adjust resources along health priorities and create the restructuring necessary to achieve the lofty goals set out in the Five year forward view. Any change is unsettling to the public and changes proposed in such mammoth scale as in the draft STPs is bound to cause upheaval. Yet the nettle must be grasped and the current direction of travel where health expenditure keeps rising out of proportion to the shrinking public purse cannot continue to its own inevitable ruin. The major shift in policy is to direct resources away from expensive post-hoc funding of specialist hospitals to primary care and to improving public health. For the last 60 years, NHS has spent majority of its budget on after care with little done to encourage healthy living. The major schism is in this area. Most think tanks believe that governments have a responsibility to resourcing schemes which invest in programmes to improve public health and then to social care for those who are unable to look after themselves. The relatively stronger populace in the middle of this triumvirate will need to tighten their belts and come up with alternative ways to fund and run their services. This is essentially where health policy is heading and it is inevitable.

So how does the NHS now resolve the fundamental challenge to how it has been funded versus the incremental expectations placed upon it by the public. Remember that the public are mostly unaware of the shift in policy. Can thinking outside the box provide answers? There is always a way forward out of the most humungous of challenges. The answer lies in innovation.

Unlike scientific and technological innovation which is traditionally expected to provide de novo solutions, we need answers from systems innovations and delivery models which can help deliver the basic health and social goals. Integrating health and social care under one roof is a step in the right direction. We are poised to see how this model delivers outcomes in Manchester and Essex. We are witnessing the utilisation of advances and democratisation of digital communication technology to run tele-consultations, tele-monitoring and virtual wards. NHS 111 has taken over the task of a national triaging system which, once intelligent and adaptable computerised algorithms in current development, come on line; will have the potential to reduce unnecessary visits to out-of-hours care.

The same level of innovation and investment is needed in primary and social care delivery. Integrating these systems will allow breaking down of the inherent barriers faced by frontline staff. Networks of council run services such as leisure centres, community pharmacies, community or parish networks and schools provide the frontiers which remain under-utilised in improving the health of the nation. The Manchester care model needs to be expanded to include all local government initiatives and budgets need to be linked so there are no artificial barriers to the flow of resources tuned to the needs of the public.

Bare foot healthcare staff with focussed training such as nursing and physician associates, health care workers will need to work seamlessly with other more specialised care providers to provide a continuum of care. NHS needs now, more than ever before, to develop and deliver an IT infrastructure fit for the present century and integrated via cloud interfaces and without artificial boundaries. Yes, the challenges from data security will escalate but no industry is immune from such challenges. Every digital device in every individual hand provides a robust end-to-end encryption of data transfers. This is the gateway for health care systems to reach every individual citizen with a personalised care plan. This is the future. We need to embrace it with open minds.■

"Leadership is inherent in each one of us"

NW BAPIO Leadership Group
Dr JS Bamrah, National Chairman, BAPIO

In the wake of the BAPIO Annual Conference 2014, members in the North West felt there was a real need to bring together a group of doctors to develop and support each other and further their leadership potential. It was just an idea, a construct – there was no formal constitution or terms of reference to it. And as such, no governance was required.

The first meeting of the group took place on 20th December 2014, a month after the Annual Conference, and since then there have been regular monthly meetings except for the month of August. Key to the success of the group was that it would be informal, the meetings would occur at the same venue, and the timing would be fixed. Hot food and beverages were not essential, but after a long day at the office they appeared to be a good way to help people relax and not rush in halfway through the meeting.

There were a variety of topics which we discussed, and presentations were made by outside speakers on whistleblowing; the career of one of the notables Kailash Chand; the merits or otherwise of CQC; the Patient Safety Summit; the Faculty of Medical Leadership and Management; the Francis Report; the junior doctors' contract; the workings of ACAS by Mr Suresh Rao, Mr Shyam Kumar, and Mr CR Selvasekar; while we held a workshop organised by Mr Shyam Kumar and Mr CR Selvasekar on the Freedom to Speak Up, which was held at Christie Hospital on 3rd July 2015 jointly with the Clinical Leaders Network, and was not only very well attended by a variety of people, but gained the support of the Medical Director and the CEO of Christie, with high profile speakers such as Sir Anthony Hooper. There was a talk from Girendra Sidera on the Information Dissemination research project, supported by his Trust librarian, and insight into getting grants from the HEE, among others. As something of a novelty, we had something different too.

A Ghazal night was held on 15th May 2015, where we were graced by the enchanting Radhika Chopra of Delhi. There was a head-to-head contest between me and Kailash Chand on the motion that 'BREXIT is Bad for Health', with Kailash supporting the motion and me opposing it. You can guess who won! At the time of writing, the latest meeting was held on 21st October 2016, led by Dr Vimal Sinha. Another pivotal meeting was when we met with a number of ex-GP trainees, causalities of the discriminatory MRCGP CSA exam system which BAPIO has been challenging for some time. At that meeting we also had our first formal elections for the newly formed North West division of BAPIO, where Mr CR Selvasekar was elected as Chairman, Dr Parveen Sharma as Honorary Secretary, and Dr Jaspal Dua took the lead on communications for the division.

And so the latest division of BAPIO was born, with a gestation of 22 months, and the prelude being a reflective, supportive and peer-led monthly meeting bringing together like-minded people in what can best be described as personal development.

I reflected on what might have played out during these last two years, and what our many members and attendees might have gained. Leadership, as I perceived it, was all of the characteristics below, but in different proportions for each one of them.

- Expert Power: Attained by the individual due to his/her own talents such as skills, knowledge, abilities, or previous experience. A leader with these attributes may be a very valuable and important team player in the department
- Charisma Power: A person who has charisma will have a positive influence on workers, and create the opportunity for interpersonal

influence

- Referent Power: A power that is gained by association. A person who has power by association is often referred to as an assistant or deputy

- Information Power: A person who has possession of important information at an important time when such information is needed for organisational functioning. Someone who has this information knowledge has genuine power, such as a trainee

In that context, leadership in general is about:

- A process of social influence, in which one person can enlist the aid and support of others in the accomplishment of a complete task
- Ultimately creating a way for people to contribute to something extraordinary happening

In its Tomorrow's Doctors (2009) publication, the General Medical Council states: "It is not enough for a clinician to act as a practitioner in their own discipline. They must act as partners to their colleagues, accepting shared accountability for the service provided to their patients. They are also expected to offer leadership and to work with others to change systems when it is necessary for the benefit of patients." You cannot escape it. Leadership is a prerequisite for any role that doctors will get into, from junior doctors, SAS doctors and GPs to consultants.

The Academy of Medical Royal Colleges sets out a competency framework which is depicted below. The key attributes are that doctors are expected to deliver services by setting the direction, managing and improving them, working in multidisciplinary teams and displaying behaviours that will facilitate all these processes.

Fig 1. Medical Leadership Competency Framework (AoMRC)

For good leaders to succeed, a mixture of attributes helps, with the key amongst these being:

- Intelligence
- Adjustment
- Extraversion
- Conscientiousness
- Openness to experience

It is really about taking the 'I' out, and ensuring that wherever possible the togetherness is acknowledged and celebrated. This is what has been embodied through the North West BAPIO Leadership forum.

Finally, I leave you with this thought: 'Leadership counts for something but it cannot succeed without the spirit, élan and morale of those led' (Sir John Monash, 1927).

HERMES:

Healthworkers' Early Resolution
Mediation & Engagement Services

By Dr Suresh Rao

Forty percent of NHS doctors are overseas graduates, but few reach the top of their career ladder. They also form the largest group of clinicians to be excluded from their teams, and for disproportionate periods of time. They are usually under informal processes for various disciplinary proceedings, formal MHPS investigations, referrals to the NCAS or the GMC.

Sir Robert Francis has highlighted how the failure to act upon concerns raised by whistleblowers can be lethal to the organisation, unearthing cases of bullying, harassment, discrimination and the blaming of staff. Some of these cases highlight the phenomenon of merely labelling individual members of the team as 'difficult' that blur the boundaries between inter-personal issues and institutional, cultural or systemic causes, giving rise to conflict arising in the workplace, overwhelming the resilience of the organisation. Retraining adds to the spiralling costs, draining energy and destroying team spirit still further. If stress at work can kill performance, lack of support for clinicians can result in poorer outcomes for patients, creating more victims among frontline staff. Complaints against doctors from employers have been

on the rise. Risk of suicide has been noted among vulnerable doctors awaiting GMC investigation. All the evidence suggests that currently BME doctors appear to suffer the most. This does not bode well for the NHS if we are depending upon overseas medical students to train and practise as doctors and solve our manpower crisis. Sir Anthony Hooper has recommended reforms to the way the GMC handles referrals from Trusts for investigation. It is too early to know how effective the reforms will be, including the new Freedom to Speak Up Guardians, considering those Trusts that desperately need them the most have failed to appoint any.

NEED FOR CHANGE

The modern NHS can ill afford to ignore the financial burden imposed by the unprofessional behaviour of many employers in generating multiple victims from poor patient care. Failing to manage potential conflicts within clinical teams appropriately without resorting to bullying and harassment is essential to avoid high rates of turnover and greater dependence on locums.

In the current climate of fear and uncertainty within the unstable workforce, it is a challenge to create an environment for improving clinical standards that encourages innovative service development through calculated risk-taking. Understanding the psycho-dynamics of the interactions between the victims and the prevailing system in the organisation and learning from mistakes as they arise is the key to making any improvements.

BAPIO has been at the forefront of raising awareness about these issues. We have been working across the board with NHS England, Health Education England and regulators at many levels to improve the situation for all clinicians.

A NEW SERVICE

In Greek mythology, Hermes was an Olympian who successfully argued on behalf of humans for the need to 'find a resting place for weary men', on the basis that humans were always prone to err, and anyway were mere mortals compared with the powerful Gods.

HERMES is a task force of senior clinicians from diverse leadership roles in the NHS that have been trained by ACAS in conducting investigations and mediation. The aim is to prevent conflicts arising in the first place. Nipping problems in the bud and supporting the teams through coaching and mentoring will build resilience.

HERMES services will soon be accessible to employers, staff and managers at all levels in Trusts via the BAPIO phone line. A separate website portal with online

information about the services is being developed to provide independent advice and remediation by the network of clinicians. Memoranda of Agreement are being sought by interested Trusts to provide the service as recommended by NHS Improvement, the GMC, and other regulatory organisations.

SUMMARY OF INTERVENTION ELEMENTS

- Supporting employers, responsible officers, non-executives, FTSUG and deaneries to ensure staff are not divorced from their clinical teams whilst investigations are on-going
- Enhancing clinical performance and patient safety through reducing stress, conflict and overload at work
- Coaching and mentoring for a Calchasian approach to enhancing Communities of Professional Practice
- Identifying tell-tale signs of failing to practise the art of encouraging constructive dissent
- Minimising risk of group attack by managing denial and naivety in team members and leadership
- Conducting a Root Cause Analysis of failing team performance in a fair and open manner
- Developing a monitoring schedule with feedback for dealing with emerging team performance issues
- Creating a balanced revival plan in an appropriate manner, with specific performance rectification where possible
- Providing training in Subconscious Bias, Motivation of Teams, and developing Positive Behaviours
- Advising on re-employment and alternative career pathways where this is not possible

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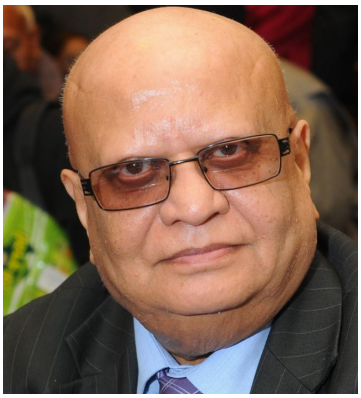
Dr Suresh Rao

Dr Rao is consultant orthopaedic surgeon for last 25 years. Currently he is with North Cumbria University Hospitals NHS Trust andvisiting Professor to the University of Cumbria. He is also the Chair of the 'Cumbrian Consultants Association' (CCA), Chair of the Medical Staff Committee and LNC Member for the Trust. Was Past President of West Cumbria Medical Society & Past President of British Indian Orthopaedic Society. Dr Rao is the lead for th Interventon inititive of BAPIO.

THE NHS CRISIS - shortage of skilled staff



Most health unions blame poor workforce planning, but officials say the NHS has more staff than ever before. The austerity measures were expected by all, and the fact remains that public services such as the NHS are also seeking to bring about efficiency savings of £22 billion over the next few years. The impact of the Brexit vote is bound to compound the challenges!

Buddhdev Pandya MBE
Director of Policy and Promotion

The debate about any possible impact of the decision to leave The European Union (EU) in June '16 is the talk of the town today. Generally, it is understood that health is not an area of significant EU competence; its role is limited to supporting member states in their health endeavours. Often too much introspection is futile since very little is known or understood by the public about the process of negotiating the terms of the withdrawal. It is fair to say that the challenges for the NHS are not new and most are reflected in the level of resources made available and the way the reforms are implemented to accommodate the public private partnership (PPP). The nature and the pace at which these changes move when the economy seems to be turning the corner from the global economic meltdown, requires a major realignment. So, departure from the EU cannot be viewed in isolation from the other influences.

The shortage of doctors in the NHS has been recognised for quite some time. Many sources cite a significant shortage of primary care physicians and social care workers. Some suggest that by 2020, the UK's National Health Service (NHS) would face a shortage of around 16,000 primary care physicians. The nurses' shortage would be near 100,000 by 2022. Since the 1930s, successive governments have recruited doctors, nurses and other health workers from overseas to work in UK health services with the first mass recruitment of nurses from Africa and Caribbean in the 1950s and doctors from the Indian subcontinent in the 1960s. In February, this year, a BBC report highlighted that more than two-thirds of trusts and health boards in the UK are actively trying to recruit from abroad as they struggle to cope with a shortage of qualified staff. Some organisations have been proactive in seeking suitable recruits from countries including India via the Medical Training Initiative. Following BREXIT, the May Government will have an opportunity to set rules that would bring in stringent restrictions for granting work visas to allow in only highly trained medical graduates from the EU and beyond. It is not fair to dismiss the potential impact of the decision to leave the open borders policy of the EU without recognising that there are some serious consequences for our health and social care sector.

Most health unions appropriate the blame for shortages on workforce planning, but officials claim that the NHS has more staff than ever before. Information obtained under the Freedom of Information Act, showed that on 1 December 2015, the NHS in England, Wales and Northern Ireland had more than 23,443 nursing vacancies - equivalent to 9% of the workforce. For doctors, the number of vacancies went from 2,907 to 4,669 - an increase of roughly 60%. There were 1,265 vacancies for registered nurses in emergency departments - about 11% of the total. For consultants in emergency medicine there were 243 vacancies - again 11% of the total; paediatric consultants with 221 vacancies - about 7% of the total.

The aspirations to fill the gaps from the EU nations seemed to have not materialised. This is also now compounded with Indian healthcare sector expanding at a much faster pace. High calibre professionals may be more inclined to enter its more lucrative private healthcare sector where generous perks may be offered. Previously, it was the case of 'brain drain' from India and that is now slowing down considerably. I would not be surprised if many Indian companies would bid for contracts for providing services to the NHS patients by sending their skilled experts under a cooperation package in the future as is manifest in the technological and digital sector.

The nature of the public and political mood is such that all governments in the past and even in the foreseeable future will be required to show their robustness in controlling the 'migrants' to win votes. But most have managed to import the resources required by the public and private enterprises. NHS under severe austerity measures is going through a sea change driven through the Sustainability and Transformation Projects (STP). The planned service reorganisation is expected to deliver huge savings and are reliant upon transition

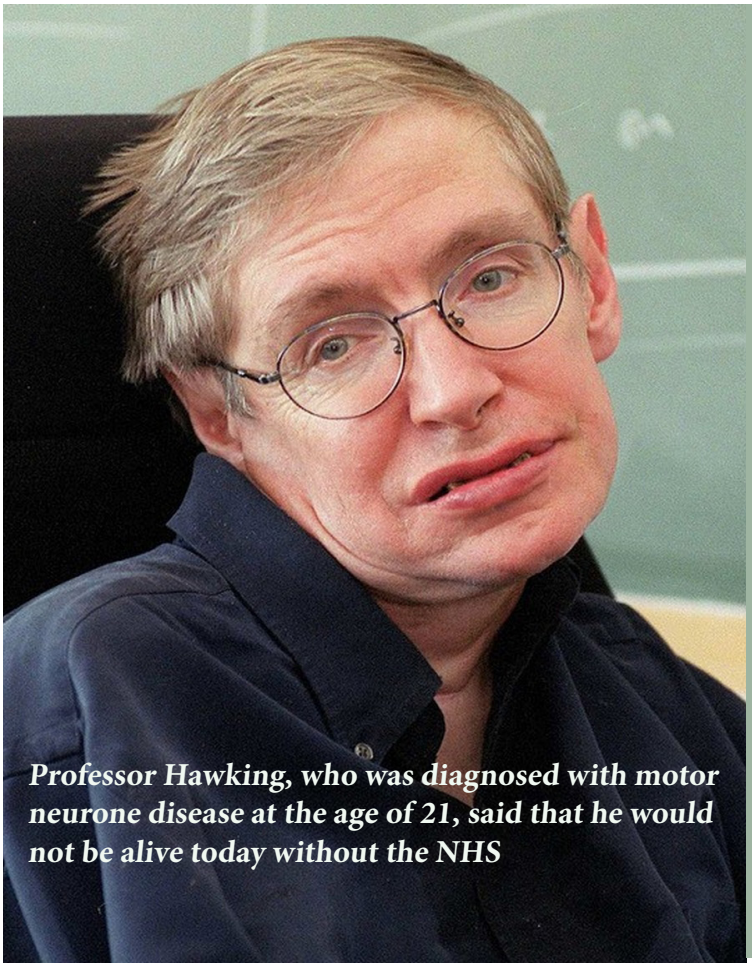
of care away from hospital-based episodic care models to primary and public health models. It is now going through a process of creating integrated care solutions that is closely linked to the entire spectrum of care providers, and is also necessary to improve the efficiency of care provision. This is where the private sector is playing an important role and is often a catalyst for innovation and changes in the management approach.

The pharmaceutical sector should find new ways of accessing the UK market and companies seeking to conduct multi-country clinical trials will need to apply individually to each country. The country may also experience significant reduction of funding streams for medical research.

If Britain is to reduce the heath care budget, the biggest impact on workforce is expected to be in social care provision. If it cannot find money to recruit, or is unable to find a more efficient way to fill those vacancies, not only the hospitals but many areas of chronically ill and elderly patients would bear the brunt. Currently primary and long term care account for around 22% of the total health budget. The Economic Intelligence Unit predicts that by 2020, the UK NHS will spend £135 less per head, if the UK leaves the EU. With rising healthcare costs, this may result in lower quality of care.

It is very easy for the political opposition to make lofty suggestions, but the fact is that their policies should show the core shift from the state provided services or draw a redline beyond which the private sector partnership does not thrive at the expense of the public service. The opposition seem to have no realistic answers that can match, what is needed to cope with both the economic recovery in a new competitive market and the fallout from the Brexit decision. I must end by saying that the British NHS is living monument of public health service that is managed under a democratic system. And I quote, the words used in the heartfelt tribute to the health service by Professor Stephen Hawking; “The NHS "must be preserved from commercial interests who want to privatise it". He described the NHS as "Britain's finest public service". ■

Buddhdev Pandya MBE has been asociated with BAPIO since its formation. He holds the postion of Director of Policy and Prosmotion. He was Deputy CEO of Medical Defence Shiled. He also has addtional responisbility of Dirctor of Policy and Administration of BAPIO Training Academy.



Professor Hawking, who was diagnosed with motor neurone disease at the age of 21, said that he would not be alive today without the NHS

THE GREATEST ENEMY OF KNOWLEGE IS NOT IGNORANCE, IT IS THE ILLUSSION OF KNOWLEDGE

Professor Stephen Hawking

Mentoring Doctors

Dr Rajeev Gupta
Consultant Paediatrician,
Chief Mentor BAPIO,
Vrgin Group Mentor for Start Ups
Executive and Corporate Coach

Mentoring is a process to support and encourage people to manage their own learning so that they can maximise their potential, develop their skills, improve their performance and become the person they want to be.

In the medical world, mentoring is used to provide support, direction and an objective view on how a doctor can develop and progress in the desired direction. Although sometimes given a negative connotation, mentoring is a powerful personal development and empowerment tool. Good mentors need the special skills of facilitative thinking and a questioning technique. Incongruous mentoring skills can damage the self-confidence and future performance of doctors.

A skilled mentor asks questions and challenges, while at the same time providing guidance, support and encouragement. Mentors push the mentee to explore new ideas, new ways of doing things and new ways of managing challenges in their personal and professional life.

Mentoring opens opportunities for a person to look more closely at him/herself, explore issues and opportunities and confidently manage their way through challenges to success. Mentoring enables people to become more self-aware, taking responsibility for life and steering themselves in the direction of choice, rather than leaving it to chance.

Although traditional mentorship was thought to be a more experienced or more knowledgeable person guiding a less experienced or less knowledgeable person, in the current world, and in the medical world in particular, the emphasis is on skills rather than age or seniority.

One of the important qualities of a mentor is catalysing the thinking of the doctor effectively, and thus burgeoning the ability and performance. Knowing the right moment to punch, while actively listening the rest of the time is crucial.

The Leadership authors Jim Kouzes and Barry Z Posner advise mentors to look for 'teachable moments' in order to 'expand or realise the potentialities of the people in the team or organisations they lead', while they emphasise that personal credibility is as essential to quality mentoring as skill.

Mentoring can be formal or informal. Although there is a place for formal mentoring to provide maximum benefit, informal mentoring is quite valuable for senior people who don't want to gain a full mentoring or coaching training or qualification.

There are several types of mentorship in the medical world. I would like to highlight a few important ones here.

Situational mentoring: Sometimes things don't go right, and so the senior doctors can help and guide the juniors on how they can do the task better next time. It's a process of learning, and the learning can be situation specific or the principle can be generalised.

Supervisory mentoring: It is good to use the coaching/mentoring style for clinical or educational supervision. This not only reduces the trainee–supervisor gap, but also enhances the relationship, confidence and bi-directional flow of conversation to set realistic goals and the assessment of progress.

Career mentoring: Senior doctors are quite often asked to offer career advice, which has been effective for many years; however, the younger generation is using a coaching/mentoring style where it is more a guided facilitation of thinking rather than mere advice. This is much more useful and effective as the doctor has the facility to use the knowledge and guidance of the senior person while taking into account his/her personal circumstances, thus making more effective decisions.

The Day after independence!

Dr Parag Singhal
Consultant Endocrinologist
Hon Secretary - BAPIO

Britain woke up to a new era following the BREXIT referendum with political bloodbath and a nation divided. The result of the referendum over Europe has exposed deep divisions in British society.

The first to be hit was the political landscape of the country. The most prominent departure was of The Prime Minister the Rt Hon David Cameron MP who, quite rightly decided to step down in October 2016. Then, came the turn of the Opposition - Labour party leadership faced a revolt of sorts from its own members of parliament.

The size and nature of the perceived impact on the economy is yet to be felt beyond the initial shocks in the shares markets and the fall in the value of the British Pound Sterling against prominent world currencies. The political divide has engulfed the British political parties in a fog of uncertainty over the terms of the negotiations for the departure.

The Conservative party manged to make a smooth transfer of power to a new administration that has both pro and anti- Brexit supporters in the Cabinet. The new interim Prime Minister the Rt Hon Teresa May is determined to deliver 'Brexit' and remains under pressure from Parliament to provide a blue print for the new equation.
It is more complex than a process of simple negotiations. There is some way to go before we would see the real colour of the proposals that balances the Brexit budget that can absorb those promises made during the campaign. In other words, it is too early to know how and when the most feared new 'austerity' measures will be settled. And, will it be enough to keep the British economy on the path of recovery? The gap period may even spring up a giveaway budget with lots of handouts for the benefit since the next general election is not too far!

The temptation for the government may be more towards producing the economic changes for the main purpose of justifying redefining new relationships and how Britain can still maintain a working relationship with the EU.
Most political pundits fear that referendum has given a boost to the right-wing mind-set. Over the past few years, we are witnessing the right leaning elements raising their profile on many fronts. The 'issue' of immigration has always been at the centre of their argument with the typical sound bites; 'the foreigners are taking our jobs and benefits'. It has been the traditional cry for explicit strategy that spreads a perceived fear of loss of own cultural or national identity! Instead of embracing diversity and the presence of the migrants, a climate of intolerance is emerging, "enough is enough we must reclaim our country". A mood that is emerging in many EU countries and has now trumped all liberalism across the pond.

The review of the 'immigration policy' is most likely to have two main considerations. One is to deal with refugees and illegal migrants entering in to the United Kingdom. The other will involve students, skilled professionals and unskilled labour to fill the gap in the job market. The Home Secretary Rt Hon Amber Rudd MP said the government was mulling a two-tier visa system for students, linking factors such as the ability to study afterwards and the to the academic potential of the university. The Home Office said, "We have made it clear the country wants to be open to the brightest and the best students," adding that Britain gave more student visas to Indians than it did to Chinese and U.S. combined. "Yes we need to balance it against concerns of the British public against immigration."

Mentoring Doctors contined from page 24

High achievers' mentoring: This is a highly specialised area that definitely needs a full set of coaching skills to maximise the talent of the person. With innovation, changing leadership and entrepreneurship evolving into the NHS, there is an increasing role for this type of mentorship, and the results are astounding. If one innovation or change management project or entrepreneurship model comes to fruition, several hundred thousand pounds can be saved or generated – a big winner.

Benefits of mentoring:

- Clarity of goal and sense of purpose
- Better self-awareness and sense of where things commonly go wrong for the mentee
- Better performance due to accountability
- Improved self-confidence
- Improved skills and knowledge
- Better visualisation of the direction of life
- Safe place to discuss or evaluate reasons for successes and failures
- Possible ideas from experienced senior colleagues

Mentoring can thus be life changing, and many of those who receive effective mentoring cannot imagine where they would have been without it.

BAPIO is the biggest organisation of international doctors, and knowing that a majority of international doctors in the UK don't realise their full potential due to subtle inhibitions, invisible and visible barriers, an enhanced mentoring scheme would benefit them immensely. In addition, it will prevent a good proportion of doctors from getting into difficulty. ■

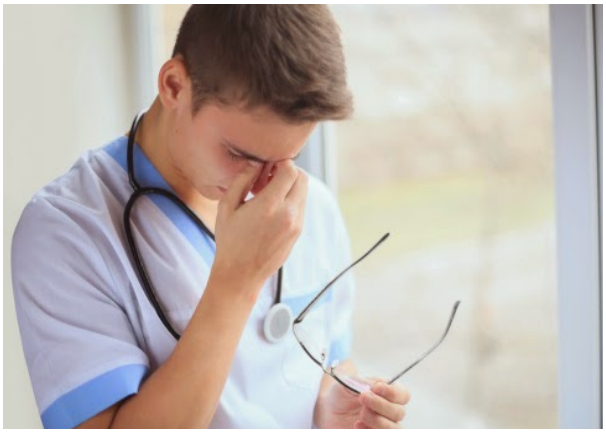
BREXIT contined from page 25

The austerity measures considered before Brexit would need to be revised to include the new allocations for the NHS. Particularly, there was a promise of creating many home-grown doctors to fill the shortage. The concerns of the Junior Doctors are compounded by two major factors. One would, on hind sight say that the negotiations of the new contract could have been handled better to ensure a course of action that followed, was prudent and creditable.

Finally, it is the economic blue print that will matter most. Meanwhile areas to watch out would be;

- The level of integration of the private sector within the NHS and growth of the private service providers.
- The immigration rule changes for recruiting doctors from overseas.
- The austerity measures are most likely to manifest 'cut backs' in the name of efficiency drives.
- How far the departure from the EU will impact upon the research and training opportunities?
- What would be the impact on the 'race equality' issues? Brexit arguments have opposed the progressive human or equality directives that have come out of EU! ■

First Minister of Wales The Rt Hon Mr Carwyn Jones at
the BAPIO Annual conference 2013 held at the Cardiff City Hall.



The Junior Doctor Maelstrom

Dr Reena Aggarwal, MRCOG MSc BPharm
Specialist Registrar in Obstetrics and Gynaecology

In July 2016, junior doctors in England's National Health Service (NHS) voted 58% to 42% to reject the final contract offer from the UK government. This rejection followed 3 years of negotiation and the first all-out strike for English doctors in 40 years. The government refused to re-enter negotiations after this final vote, and proceeded with the imposition of the contract in October 2016. We now have an impasse where many junior doctors are angry and frustrated that the negotiations did not fulfil their concerns, yet the government has the more pressing concerns of Brexit and immigration to address, and is unwilling to revisit the junior doctor saga. How did we end up in this situation?

The quest of the junior contract redesign commenced in 2013 to modernise the terms and conditions, ensure fair remuneration and to enshrine training contractually. In July 2015, in the wake of a newly elected majority Conservative government, the Secretary of State, Jeremy Hunt, outlined his vision of the NHS for the next 25 years, declaring that we needed to remove a 'Monday to Friday 9–5 culture' and bring back a 'sense of vocation' to medicine. Indeed, he put the BMA on notice that he would impose a contract on junior doctors in August 2016 unless they agreed to terms in six weeks, and urged them to 'get real'. These jibes at our lack of commitment and the misuse of weekend mortality statistics galvanised 54,000 junior doctors to become politicised and engage in a year-long vocal and visible battle with the government.

Junior doctors were suddenly thrust headlong into a political quagmire, where their very existence was questioned vociferously by the media, the government and even the public. But they united over this rhetoric and attacked every erroneous statistic, every misrepresented fact, every vitriolic commentary and every attempt to make this into a dispute purely about pay. The 'increased mortality at weekends effect' sound bite used by politicians and journalists was headline grabbing and a powerful spin. The only consistently proven factor shown to affect death rates at weekends versus weekdays is how sick a patient is at the time of admission (more numbers of sicker patients are admitted over the weekends than on weekdays). Yet, the seven-day promise remains undefined, uncosted and unmodeled, with Department of Health representatives accused of 'flying blind' with these plans (https://www.youtube.com/watch?v=LnH-Pc6MicM).

To counter the rhetoric, junior doctors used every weapon in our armoury: social media to create a public movement, lobbying Members of Parliament, numerous articles penned by junior doctors in local and national newspapers, media appearances, national demonstrations, local activities and industrial action. The BMA showed their strength not only as a professional organisation, but also as a trade union that was willing to go toe-to-toe with the government to represent and secure their members' interests. This secured a negotiated contract between the BMA and the government that crucially would not

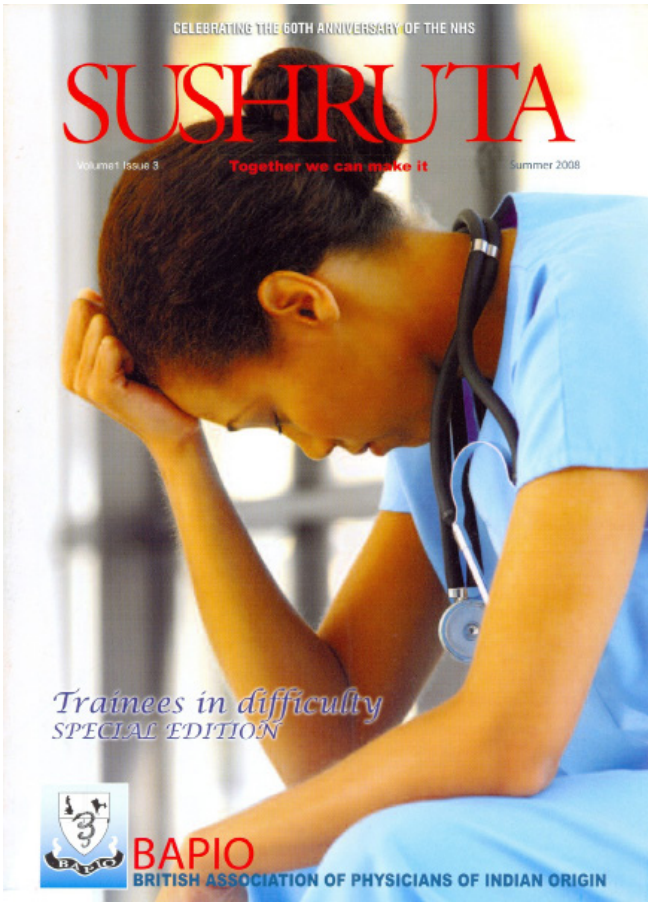
Dr Reena Aggarwal

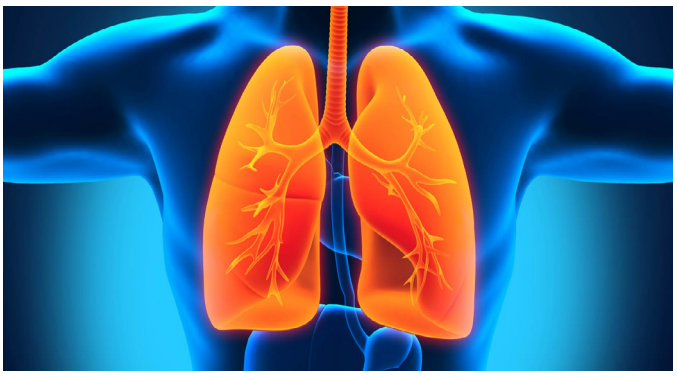
be imposed in August 2016, as the government had threatened in July 2015.

The final terms and conditions were published in May 2016, with 105 concessions gained from the government. The third iteration of the contract did provide accountability, transparency and contractual levers to protect junior doctors in the workplace from excessive hours, prevent increased weekend rostering without adequate resources and ensure that junior doctors' voices would be integral to the safety mechanisms within a hospital. Yet, two main issues were left unaddressed for junior doctors: fairness and safety. In terms of fairness, in line with its commitment to remove a time-based automatic pay progression system since 2011 for public service contracts, these were lost in the junior contract. This has been a loss for those in less-than-full-time (LTFT) training, since automatic pay progression had created positive discrimination for those in LTFT compared to fulltime (FT) training, as those that take longer to train pick up more pay increments by virtue of being in the system for longer. But, the new contract treats men, women, FT and LTFT equally, paying everyone the same per hour of work done. So, is the contract fair? Yes. Did it unduly disadvantage those that are in LTFT compared to FT? Sadly, yes. Equality has been preserved, but equity potentially sacrificed. Personally, I would have rather that equity had not been a casualty in promoting equality in this contract, but this was not within the remit of negotiation.

In relation to safety, the local role of the 'guardian of safe working' who will act as a 'champion of safe working hours' has come under much scrutiny. This role was to be jointly appointed by junior doctors, advised by an elected junior doctor forum, must not have a role within the management structure of the employer organisation and must report at least quarterly to the board on exception reports from junior doctors, which could include excessive working hours, rota gaps and training infringements. Most juniors and seniors agreed in principle that this would be an excellent system, but there were fears that it would be toothless; while it could highlight individuals who submit too many exception reports, making them vulnerable in direct opposition to the intended aspiration of transparency and accountability at the board level. The fear of recriminations for training and for being the individual that places your head above the parapet at a local level was still very much evident amongst doctors that have been vocal on social media. There is much to be done to address this mismatch.

Despite the contract being rejected by the majority of junior doctors that voted, it was still imposed from October 2016. Morale remains low and is insidiously chipping away at doctors. Perceived pay cuts, increased antisocial working and feeling undervalued may result in a 'brain drain' from England, especially with the result of the referendum on Europe. This dispute became a vehicle for junior doctors to voice their concerns about ever dwindling resources, persistent hierarchical structures, a chronic workforce crisis and the toxic handling of this issue from the very start by the government. At the protests and on the picket lines, junior doctors wanted to talk about issues facing front-line workers including staff shortages, nursing ratios, service cuts, the potential privatisation of the health service, and the '7 day NHS'. Despite this, the contract has been introduced since October 2016 with a staggered timeline for all grades and specialties. Many juniors feel despondent and disillusioned at this situation, whilst others are assertively engaging with the contract – ensuring training and hours' violations are logged as part of the exception reporting. It remains to be seen whether NHS leaders can come together to listen to the voices of junior doctors and address these concerns together in order to future-proof the workforce to deliver world class healthcare. ■





Improving your Lung Health in COPD through Singing

by Dr A N Banik

Introduction:

During the 2011–12 period nine community singing groups were set up in Kent, backed by Canterbury University and the Sydney De Haan foundation. Research on the many positive outcomes of singing on health was published in 2013 and demonstrated that singing not only helps breathlessness in COPD, but has a significant impact on enhancing quality of life. Similar work has since been conducted showing the benefits of singing in depression, dementia and Parkinson's disease.

Breathlessness and COPD:

- Over 1 million people in the UK have a diagnosis of COPD, which is a chronic lung condition usually caused by smoking over many years. COPD damages the lung airways and structure, making the lungs weaker and less efficient, while also weakening the muscles and bones throughout the body. The lungs in COPD are over inflated with air – like a full balloon all the time – which makes it very difficult to breathe in or out without considerable extra effort. This over-inflation is even worse when the speed of breathing increases during exertion. This breathlessness on light exertion often puts off COPD patients from exerting themselves and makes them more sedentary, which in turn can make their lungs and body weaker, and also more susceptible to infection, isolation and depression.

Benefits of Singing:

- Positive feelings
  People say singing is uplifting and joyful. They feel positive during the singing session – and the positive mood continues afterwards. Singing can help if you feel depressed, stressed or anxious.

- **Confidence-building**
  People living with long-term lung disease say groupsinging makes them think of themselves as choir members, rather than patients. Singing and being part of a group gives you confidence and a sense of achievement. It can motivate you to try other activities.

- **Feeling part of a group**
  Regular group singing can make you feel less isolated and is a way of feeling part of a group. You can make new friends. They will understand your challenges because they face them too. It's also a chance for you to share your own experiences and help others.

- **New skills**
  Joining a singing group is a way of learning new skills and maybe reviving existing ones. Learning new songs can help to improve your ability to focus and concentrate, and also to stimulate your memory.

- **Breathing better**
  One of the major benefits of singing, as per the recent research, is reduced feelings of being short of breath. People living with COPD who joined a singing group said singing regularly reduced their feelings of being short of breath and helped them to manage their symptoms better. Singing has been shown to train the diaphragm and respiratory muscles to work in tandem, and also allows the lungs to deflate better through prolonged expiration techniques.

By strengthening the muscles you use when you breathe, you learn to breathe more slowly and deeply. Singing can:

- Help you to feel more in control of your breathing
- Increase the strength of your voice
- Improve your posture
- Increase your lung capacity
- Boost your body's response to infection

- Reduce your use of medication when you have a flare-up

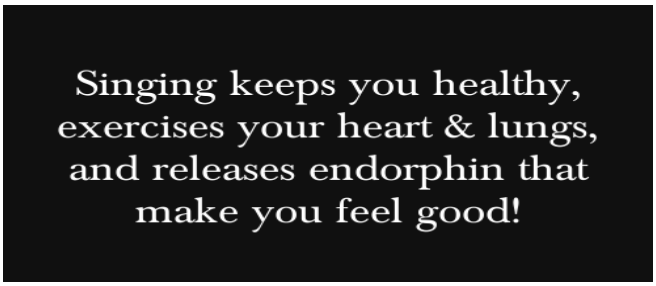
Comments from the group:

- "I find this group very beneficial. It is very healing and affects me deeply. As my breathing improved, so also [did the] clarity of my mind and general well-being."
- "When you sing, you cannot be sad for long. It really lifts your spirits. Being in a choir means you are in a team – you all help each other which gives tremendous satisfaction."

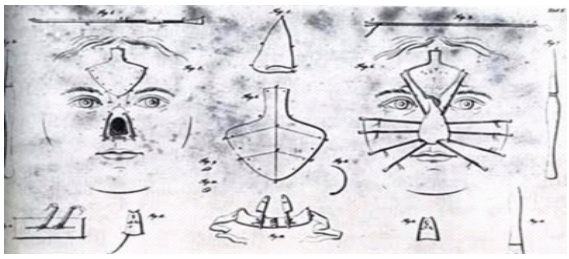
Singing has also been found to help when you are feeling weak and so moving around less. Rhythmic movements such as clapping or stepping, which is part of the group activity, will increase your awareness of your core strength and also help to improve your mobility.

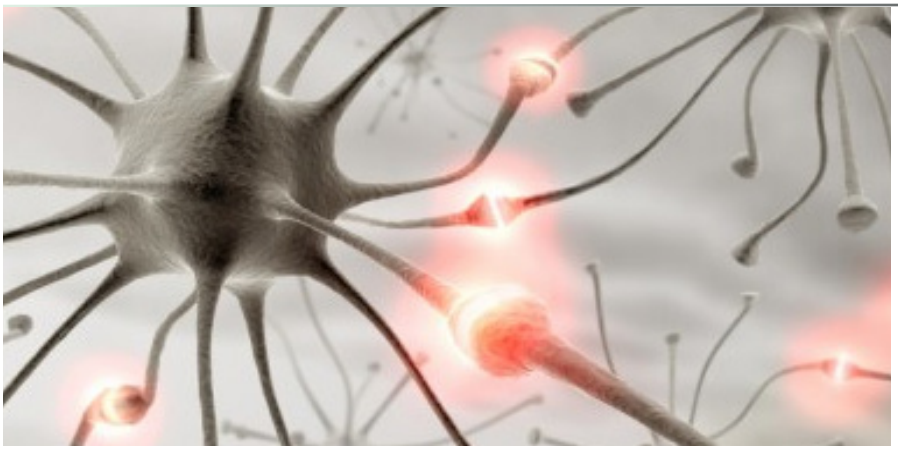
Conclusion:

There is lots of evidence that singing is good for you, for your lungs and especially good for psychological health. So, throughout the UK today we now have singing groups that are often linked to the British Lung Foundation (BLF), where you can sing popular songs for an hour a week. You can bring a friend or relative along with you to the singing groups, and they will be most welcome to join in.
Singing is a great way to take control of your breathing, make new friends and have fun.



Sushruta, one of the earliest surgeons of the recorded history (600 B.C.) is believed to be the first individual to describe plastic surgery. In 600 B.C. Sushruta's compendium, known as 'Sushruta Samhita' is one of the oldest treatise dealing with surgery in the world indicates that he was probably the first surgeon to perform plastic surgical operations. Sushruta believed that knowledge of both surgery and medicine are essential to constitute a good doctor who otherwise "is like a bird with only one wing." In fact, Sushruta emphasized in his text that unless one possesses enough knowledge of relevant sister branches of learning, one cannot attain proficiency in one's own subject of study. BAPIO has named this publication in honour of the 'father of surgery'; a pride of India .





The Pathfinders

– medical education in colonial India in the 19th century

Dr Soumit Dasgupta
Consultant Neurotologist, Liverpool and Sheffield & Hon. Lecturer, University of Manchester

European colonial ventures in the Indian subcontinent started from the 15th century, followed by expansion and empire building. The English, the French, the Portuguese, the Danish and the Dutch began their journeys as traders, but all were eager to acquire pieces of land after the demise of a centralised government in the region, that is, the Mughals. By the 19th century, the English, the French and the Portuguese had prevailed. And with their political settlements rose the need for looking after the health of their own and of the native population they depended on to continue their empires. They felt the necessity of disseminating western medical education in their empires. Since the public dissection of a human cadaver by Vesalius in 1543 and the flowering of the Renaissance, followed by the Baroque and the Romantic period, medical science has evolved at an astonishing pace in Europe with regards to the systematic study of the human body and its diseased state.

The very first European medical school was founded in 1823 by the French in present day Pondicherry: L'Ecole de Medecin, which imparted medical education for their personnel only while natives were not allowed. The first so called 'native medical school' was set up in the recently emerging metropolis of Calcutta, the then capital of British India. This was established in 1794 and originally run by European physicians, before then soon being manned by untrained native apprentices with disastrous results. It was felt that a system of formal medical education needed to be instituted among the natives, and thus The School for Native Doctors was born on 21st June, 1822, which is the earliest known medical educational institute in colonial history imparting medical education in vernacular. This institution was a deserving precursor of what was about to come.

In 1827, a medical school for medical education in Arabic and Farsi was founded in the Calcutta Madrasah, and in 1826 a medical school to teach medicine in Sanskrit was established in the Sanskrit College. It is to be noted that these vernacular medical schools were training in traditional medicine which was also influenced by translated European treatise on human anatomy and physiology. This subsequently paved the way for formal medical schools in colonial India to impart western medical education to the locally trained population and to cater for the vastly expanding empire.

Calcutta Medical College:

Calcutta Medical College was founded on 28th January, 1835, as The Calcutta Medical College. The first classes were taken on 1st June, 1835, with 49 new entrants from the local Indian and Anglo Indian community, as well as a handful of Europeans. Four of these students along with their anatomy professor Madhusudan Gupta made history when they dissected a human cadaver imported from Edinburgh for the first time in India on 18th January, 1836, ushering in a new era of liberalism and shattering the shackles of age-old superstition and traditions. The college expanded at an astonishing pace in the 19th century with the expansion of its estates, medical students taught and services incorporating diverse medical disciplines from Materia Medica and midwifery to pathology and medical jurisprudence. In 1885 one western traveller, Montague Massey, dubbed the Calcutta Medical College as being on par with London and Edinburgh, and better than medical schools in the USA and Europe.

The Royal Colleges in England granted recognition to the college in 1842, and in 1857 it became affiliated to the University of Calcutta. The luminaries gracing the Calcutta Medical College in the 19th century were Hugh Falconer (proposer of the theory of evolution before Darwin); Nathaniel Wallich (eminent botanist who introduced the ubiquitous rhododendron to our households); Kenneth McLeod (the father of antisepsis and sterility in the empire);

Calcutta Medical College

Kadambini Ganguly (the very first Indian woman graduate in 1883); and Mahendralal Sarkar (the founder of homeopathy in India); to name but a few.

Madras Medical College:

The Madras Medical College was founded on 2nd February, 1835, in a small and improvised medical school started by the superintendent of the government hospital, Dr D Mortimer. Initially, natives were not allowed in the school, but this changed from 1842 when the door was thrown open for the local population to train in western medicine.

The Madras Medical School was accorded the status of a college in 1850 and became known as the Madras Medical College, a name it retains to this day. Like the Calcutta Medical College, the Madras Medical College was quick to adopt and modify the medical teaching and training prevalent in the world, and pioneered the segregation of medical disciplines as early as the late 19th century. The University of Madras granted affiliation to the college in 1857. Luminaries from the Madras Medical College in the 19th century include Sir Charles Donovan, the co-discoverer of the organism responsible for causing Kala azar, and Mary Ann Dalcombe Scharlieb, the very first woman graduate in colonial India in 1878.

Madras Medical College

Grant Medical College:

Grant Medical College was founded on 1st November 1845 in Bombay, and enrolled 9 students from the local Asian and Eurasian populace. Before its inception, Sir Robert Grant, the then Governor General in Bombay, worked tirelessly to establish a medical college in the city and initially started a society for the peer exchange of medical ideas.

Grant Medical College

One of the very few colleges in the world, Grant Medical College had a dedicated chair for midwifery as early as 1849. Like Calcutta Medical College, Grant Medical College saw a significant expansion in services in the 19th century with dedicated buildings for ophthalmology, obstetrics and ENT. The college gained recognition from the University of Bombay in 1857. Luminaries from the college in the 19th century include Sir Waldemar Haffkine, the eminent Russian microbiologist who discovered the vaccine for plague; and Robert Koch, the German bacteriologist who rediscovered the cholera organism in Bombay.

Other colleges:

Hyderabad Medical School, also known as Osmania Medical College in 1846; the Lahore Medical College in 1860; the Ceylon Medical College in 1870; and the Byramjee Jeejebhoy Medical School in Poona in 1871 were all established as part of the great colonial drive to cover as much of the subcontinent as possible in order to impart dedicated and systematic medical training in the empire. These institutions are continuing as centres of excellence in present day India, Pakistan and Sri Lanka and proudly fly the colours of their glorious traditions.

All pictures used by copyleft and fair use policy. The pictures are photos of the institutions taken in the 19th century

Anandi Joshi, India's First Lady Doctor at A Time When No Girl Was Educated in India

Born in 1865 in an extremely orthodox Brahmin family in Maharashtra, a 9-year-old girl got married to a widower who was almost thrice her age. Sounds like a normal "old Indian saga"? Not really! The girl later became the first Indian woman to qualify as a doctor. Even though she died at a very young age of 21, she opened the gates for many young women in India who wanted to do much more than devoting their entire life to household chores. Yes, we are talking about Anandi Gopal Joshi, India's first lady to qualify as a doctor from the USA in 1886.

Despite poor health, Anandi agreed and started studying medicine in Women's Medical College of Pennsylvania (now known as Drexel University College of Medicine) at the age of 19 and got her M.D. degree in 1886. On her graduation, Queen Victoria sent her a congratulatory message. She completed her thesis on obstetric practices among the ancient Hindus.

Her health worsened when she returned to India in 1886. She received a grand welcome and the princely state of Kolhapur appointed her as the physician-in-charge of the female ward of the local Albert Edward Hospital. Anandi died a few days after it. She passed away on 26th February 1887, a month before turning 22. Her ashes were sent to Mrs. Carpenter, her host in America who placed them in her family cemetery near New York.

आनंदी गोपाळ जोशी.
Anandibai Joshee

Women in Medicine

and the Impact on Sustainability in the NHS

Dr BN Ertansel & S Vig
Consultant Vascular Surgeon
Croydon University Hospital, London
svig@doctors.org.uk

The phrase 'women in medicine' has held many different landscapes over the years. With the proportion of women entering into medical degree programmes recorded to be 55–65% [1] at some UK medical institutions, it is inevitable that the hierarchical picture will continue to adjust in order to represent the growing female presence. However, this has not necessarily been the case and the question one has to ask oneself is why and what effect will this have on the dynamics of the health service?

The prejudice against women in medicine has been historically noted, starting from the struggles that Elizabeth Blackwell (the first woman to receive a medical degree in the United States, as well as the first woman on the UK Medical Register) came across in her plight to receive medical education. While we have come a long way from the 18th century, and thus today's female clinicians may not be turned away from the hospital wards, the ratio of women in clinical academic positions lags behind that of men, with only 28% currently holding posts. In UK higher institutions, less than one in five professorial appointments are women [2]. One may wonder why.

Obvious factors include cultural, structural, organisational and personal barriers to women entering leadership roles. The latter is pivotal in this context, with childcare responsibilities and often inflexible working hours quoted as the greatest barriers [3], which seem to be disproportionately higher for women than men.

In this time of unprecedented pressures on the health service, sustaining good medical practice with an optimum workforce should be at the forefront of the agenda. Gender re-balancing in higher positions may improve financial and operational performance, a concept the business world has started to take advantage of. Additionally, it is often quoted that women tend to take the initiative and be more collaborative in problem solving [4]. Consistently, the strong qualities that women display include empathy, compassion and integrity, which are all associated with an open organisational culture. This is particularly pertinent in recent years with the release of Sir Robert Francis' report, addressing the severe failings of Mid-Staffordshire Hospital NHS Foundation Trust and detailing how culture change can prevent the recurrence of poor care by creating an open and transparent healthcare system [5].

Women are not necessarily better than men in senior leadership positions, but both genders can possess complementary skills and in order to create a diverse perspective and broad dialogue, we need to create an environment where both men and women are equally valued and represented. Additionally, as Lord Davies quoted in his business report 'Women on Boards', by under-representing women in senior roles, we fail to attract and retain the widest possible range of talent [6]. This concept is also applicable to the clinical environment. More women are entering traditionally male-dominated medical specialties such as surgery. In 2014, the Royal College of Surgeons reported that 30% of surgical trainees were women, but only 10% filled consultant posts [7]. Such under-representation matters, because female doctors are known to be strong in building relationships, collaboration and teamwork with junior trainees and the multidisciplinary teams.

The gender distribution is slowly evolving, and over recent years there have been many targeted programmes for women such as the King's Fund; and the Athena Swan Charter, established to encourage, promote and recognise commitment to advancing the careers of women in science, technology, engineering, maths and medicine (STEMM) [8]. Ultimately, by providing better development and educational opportunities, it is anticipated that this will propel women into leadership roles.

Other factors that may be pivotal in supporting women to reach higher positions include more parenting-friendly working arrangements, and encouragement and mentorship from successful female role models [9]. The importance of such mentorship can be seen at the modern SUNY Upstate Medical University, USA (previously known as the Geneva Medical College), from where Elizabeth Blackwell graduated all those years ago. There, current surgical residency programmes across all subspecialties are gender-balanced.

The influence female leaders have on the preservation and nurturing of the NHS are to be determined. Initiatives for gender equality at the higher levels of management will ultimately impact on how junior female trainees project their ability to achieve similar heights, without prejudice or hurdles. A gender-balanced leadership team will ultimately foster a robust team at the top of NHS organisations, filtering through the organisational hierarchy. The healthcare system is moving at an exceptional pace with scientific and technological advancements; therefore, it is paramount that the workforce reflects the values fit for a modern world. We can hope that sustainability and reform will ensure the delivery of a continuously improving, high quality, safe and compassionate healthcare system in the hands of both men and women.

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Dr Satwinder S Basra was awareded 'GP of The Year' by the BME Health and Social Care Network at an event held at the University of Lonodn. Dr Basra is former Hon Secreatry of BAPIO.

NHS Hub Richmond House London for Award Ceremony conferring Gold Award to Dr Rajeev Gupta for galvanising the workforce for healthy eating and physical activity thus improving the outcomes through unique workforce health programme.

Buddhdev Pandya MBE was presented an award for ' Lifetime Service' by the BME Health and Social Care Network.


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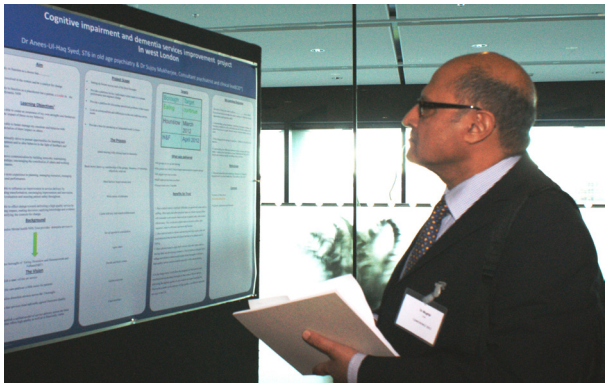


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2nd Medical Brigade is a unit of the British Army formed under Force Troops Command as part of the Army 2020 reorganisation that predominantly provides deployed hospital care via 13 Field Hospitals. It also provides pre-hospital emergency care via 335 Medical Evacuation Regiment.

The Centre Cross

The centre cross within the LOGO is representational of the Red Cross, under which all elements of the Army Medical Services operate in accordance with the Geneva Convention.

Each arm of the Cross is representational of the 4 Corps that make up the Army Medical Services which are:

Royal Army Medical Corps (RAMC)
Queen Alexandra's Royal Army Nursing Corps (QARANC)
Royal Army Dental Corps (RADC)
Royal Army Veterinary Corps (RAVC)
The Rod and the Serpent

The centre of the LOGO depicts the Rod of Aesculapius who lived in ancient Greece in the year 1256BC. Aesculapius was known in ancient Greece as the father of medicine and was raised to God status according to Greek mythology.
The serpent was revered by the ancient Greeks as having healing powers and combined with the Rod of Aesculapius has been recognised as the international symbol of medicine and healing since 1200BC

2nd Medical Brigade

Headquarters 2nd Medical Brigade, located in York commands 3 Regular Field Hospitals, 10 Regional Reserve Field Hospitals, a Reserve Hospital Support Regiment, a Reserve Specialist Medical Evacuation Regiment and the Reserve Operational Headquarters Support Group; the Brigade's footprint is visible in each of the Devolved Administrations as well as in London and the seven largest cities in the UK.

Our principal role is to deliver Deployed Hospital Care (DHC) Force Elements (FEs) for current and contingent operations. Provision of DHC directly contributes to the capability and morale of our Fighting Power by ensuring that the physical health of those deployed is sustained. The Brigade has delivered significant hospital capability to recent operations in Iraq and Afghanistan, and these deployments have often been Joint, multi-national and part-Reservist in composition. We are particularly proud that our cohort of 1,850 Reserve officers and soldiers which have completed nearly 3,000 individual Medical Reservists deployments since 2003.

2nd Medical Brigade continues to develop and deliver its Contingent capability, the Vanguard Field Hospital (VFH).

This is a hospital retained at 5 days' Notice To Move, and is task-organised with the support of transport, engineer, communications, medical resupply, operational hygiene and mortuary affairs specialists from across FTC. The VFH is capable of delivery by Air or Sea, and at two scales of effort flexible enough to meet a wide range of operational scenarios. This capability was the core upon which Defence was able to respond rapidly to the DfID request to support the outbreak of the Ebola epidemic in Sierra Leone.

2nd Medical Brigade is also involved in the development of specialist ground in-transit care capabilities for critically ill patients (335 Medical Evacuation Regiment); supplying niche surgical, clinical & nursing teams (i.e. Neurosurgical teams) for the augmentation of DHC requirements (306 Hospital Support Regiment); the generation of Headquarters medical support staff elements to reinforce key deployable formations such as HQ ARRC and the Reaction & Adaptive Force Divisional HQs (AMS Operational Headquarters Support Group); and the recruiting and training of the Army Medical Services Reserve DHC component. 2nd Medical Brigade is delighted to have been given the opportunity to attend this conference.

British Association of Physcians of Indian Origin

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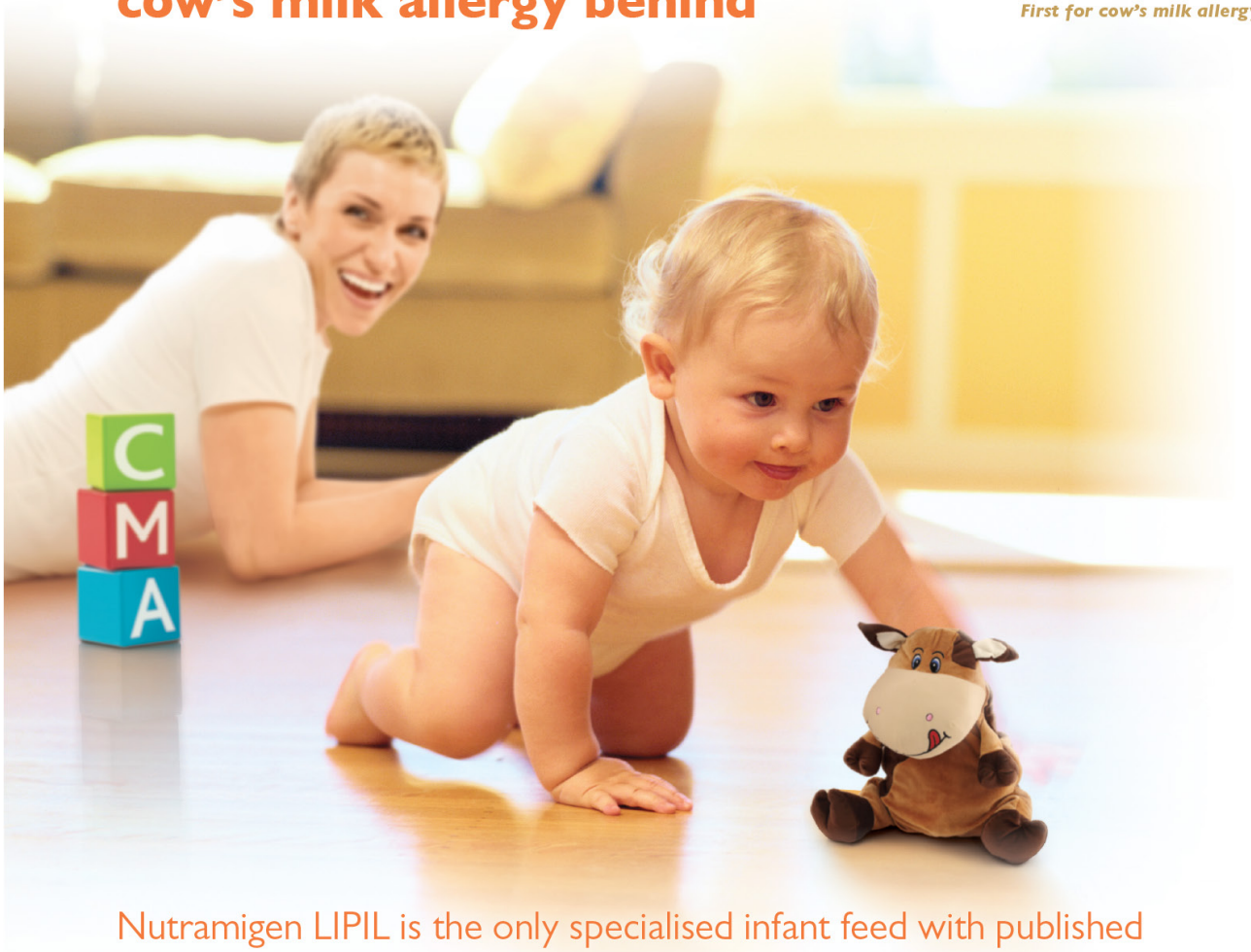

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