Nepalese Doctors' Association (UK)

Established 1985

NDA Journal/Souvenir

28th Annual Conference

26th – 28th July 2013
Quality Hotel, Hagley Road
Birmingham, UK

Many Nepalese doctors have been coming to the United Kingdom for their postgraduate studies for many years. Some of them have settled in various parts of Britain. In 1984 they held a series of meeting at various venues with the aim of bringing these doctors and families together, and Nepalese Doctors' Association NDA (UK) was established in 1985. The first Annual General Meeting was held in 1986 at Durham University under the chairmanship of Dr. Prem B Hamal. The association has since then grown and the tradition of an annual meeting every summer has continued. This annual event is not only a chance to share medical knowledge in the scientific session and discuss the progress of the organisation, but is also a great social event to catch up with old friends and meet new ones. The association is a non-political, non-racial and non-profit making voluntary organisation open to all Nepalese doctors presently residing in UK.

Executive Committee Members 2011-2013

Mr. Bharat Shrestha	Chairman
Dr Arun Jna	Vice Chairman
Mr. Badri Man Shrestha	General Secretary
Dr. Siri Gautam	Treasurer
Dr. Dhiraj Tripathi	Joint Secretary
Dr. Ramesh Khoju	Member
Dr. Beena Subba	Member
Dr. Robin Serchan	Member
Dr. Phauda Thebe	Member (immediate past chairman)

Local Organising Committee for this AGM 2013

Dr Dhiraj Tripathi	Chairperson
Dr Rajani Tripathi	Member
Dr BP & Mrs N Tripathi	Members
Mr Niraj Tripathi	Member
Dr B & Mrs A Sharma	Members
Dr SM and Mrs B Joshi	Members
Dr MP and Mrs K Acharaya	Members
Dr CB and Mrs R Pradhan	Members
Drs Milan and Rojeena Piya	Members

Editorial Policy

NDA Journal is published annually from the material provided by doctors, their family members and friends in the UK and abroad. Both medical and non medical articles are welcome. Medical articles should be original, properly referenced e.g. Vancouver style. Interesting case histories and abstracts of articles published in other journals are also accepted. Non-medical articles should be interesting, informative, impartial, non-political and if possible linked to Nepal and Nepalese cultural heritage**.**

Material for publication should be typed clearly in double space and submitted preferably electronically as a word attachment well in time for publication. The editorial board reserves the right to reject any article they deem inappropriate, or submitted after the deadline.

Articles, both medical and non-medical should be brief and concise, and should preferably not exceed 1500 words (although exceptions will be made at the editorial board's discretion).

Abstracts should be submitted as a word document not exceeding 400 words (although exceptions will be made at the editorial board's discretion). A format of Introduction, Methods, Results and Conclusions should be followed.

Short stories, poems, travel experiences, recipes, anecdotes, etc are included in the journal. Views, particularly in relation to medical, dental and social aspects of life are most welcome. Relevant health news, news and achievements in academic and social life of NDA (UK) members and their families are given ample space. There is also space for readers' feedback in the form of letters to the editor.

Editor and Layout:
Dr Dhiraj Tripathi

Editorial Assistance:
Mr Badri Man Shrestha

Website: http://www.ndauk.org.uk

Web Design: Dr Ramesh K Khoju

Yahoo Groups: NDA (UK) is on Yahoo groups. You must be a paid member to join the group.

Facebook: NDA (UK) is on our favourite social networking site.

Feedback: Please send your feedback to d.tripathi@bham.ac.uk.

Members' contact details: We would kindly request all members to inform the NDA of any changes to their contact details, especially emails to ndauk@doctor.com.

Opinions and views expressed in the published articles in the journal are not necessarily the views of the Nepalese Doctors' Association (UK).

Editorial

I am delighted to welcome members and guests to NDA (UK) Journal 2013. There is a great variety of articles to interest all.

NDA (UK) has been particularly active in charity this year, thanks to the wonderful efforts of **Dr Beena Subba** and others for organising the charity dinner in London. Please read her article on page 7. A record sum of over £20K was raised this year to help the ambulance service in Tapeljung.

Dr Jha continues to take an active role in dementia training during his recent visit to Nepal, and even met with politicians to make his case. Please read about his journey on page 19.

A special thanks to **Hind Vaidya** for the lovely poems and sharing some Greek recipes with us. I am sure the results will be worth the effort.

Dr Ramesh Khoju writes a helpful article enhanced recovery after surgery with some helpful advice. Staying on a surgical theme, **Dr Aryal's** provides an overview of postgraduate surgical training in UK. This has been subject to much change in recent years.

Our youngest writer, **Cara Pathy** (aged 13 at time of writing) writes an excellent review on the history of the changes in healthcare between 1750-1900. Please make time to read this fascinating article.

Dr Sharma and **Dr Gurung** provide some light hearted articles.

There are 4 interesting **abstracts** which demonstrate the hard work of Nepalese doctors in the UK with regard to research and audit.

Many thanks to **Mr Badri Man Shrestha** for editorial assistance. As this is my last year as editor of NDA (UK) journal, I would like extend my gratitude to NDA (UK) for giving me this opportunity.

With kind regards

Dr Dhiraj Tripathi MD FRCP
NDA (UK) Joint Secretary

Contents

Welcome Message from Dr Dhiraj Tripathi
Chairman, Local Organising Committee

Dear Members and Friends

Welcome to the 28th NDA (UK) AGM in Quality Hotel, Hagley Road, Birmingham. A special thanks to those that have made the effort to join us from a long distance (as far as Northern Ireland!), and to those that have come to the AGM for the first time.

There is a full programme as detailed on the back page of this journal, with highlights being the AGM and elections, scientific session and some excellent complementary facilities of the hotel. We are particularly fortunate to have all the main meals prepared by Sukhdev, one of the finest caterers in Birmingham. I would like to thank Dr Badri Man Shrestha for co-ordinating the evening entertainments, with the music supplied by Nepali DJ Sapan Rai. There really is something for every taste.

Birmingham is in the heart of England. The venue for the AGM is a pleasant walk from the city centre and a very short journey by bus or car. It is in one of the most desirable locations in the city, being near Edgbaston Cricket Stadium, The Botanical Gardens and University of Birmingham with its Barber Institute of Fine Arts. In the city there are excellent shopping opportunities including The Bullring and The Mailbox (designer shopping and many fine restaurants and cafés). Birmingham is the home of chocolate and Cadbury's World is not too far from the venue. Some of you may venture to Brindley Place and take a trip on the canal system. Brindley Place is also well known for its nightlife. Birmingham has some of the finest Indian restaurants in the U.K and is famous for its Balti dishes.

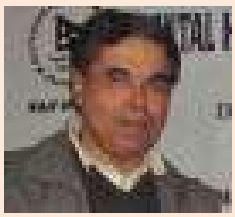
Finally, I would like to thank all members of the organising and executive committee for all their efforts this year. We all hope that you will have a wonderful, relaxing and highly enjoyable weekend.

With kind regards

Dr Dhiraj Tripathi, MD FRCP
Consultant Hepatologist

NDA Executive Committee 2011 -2013

Mr Bharat Shrestha
Chairman



Dr Arun Jha
Vice Chairman

Mr Badri M Shrestha
General Secretary

Dr Siri Gautam
Treasurer

Dr Dhiraj Tripathi
Joint Secretary

Dr Ramesh Khoju
Member

Dr Beena Subba
Member

Dr Robin Serchan
Member

Dr Phauda Thebe
Member (Immediate Past Chairman)

Chairman's Message

Dear Colleagues

It has been a great pleasure and privilege to be chairman of NDA UK for the last 2 years. During this period, I have had enthusiastic support and co -operation from the hard- working executive committee and other NDA members to organise great activities and achieve many goals.

Many thanks to Dr. Dhiraj Tripathi who successfully organised a charity dinner on 28th of April 2012 in Birmingham; money raised during this event went to Mental Health First Aid (MHFA) in Nepal. I thank Dr. Arun Jha and his team who implemented his knowledge and skills to train mental health workers in Nepal.

Dr. Beena Subba and her team very successfully hosted a charity dinner in support of Ambulance Service for Eastern Nepal (Taplejung) at North Middlesex Hospital, London in 20th April 2013. Councillor Kate Anolue, Mayor of Enfield, was Chief Guest at the event. This charity dinner was unique in its own right and splendidly organised to raise large amount of money, beyond our expectations, for which we are very thankful to Dr. Subba and her team. On behalf of NDA, I also handed a cheque for £500.00 to Sickle Cell Charity, run by the Mayor of Enfield. In addition, the NDA gave £250.00 to the Guest of Honour, Mr. Charles Walker, MP for Broxbourne, for his charity Children's Scheme.

The NDA has also been pleased to support two doctors from Nepal; Dr Rajani Hada and Dr Kalpana Shrestha for 'Transplant in Nepal' during Sept –Oct 2012. Thanks are also due to Dr Sanjeeb Nepali and his team for organising 'Smile Across Nepal' in Dental Implant Work Shop in March 2013.

I also take this opportunity to thank our life members Dr Shambhu Acharya, Dr Bhawani Lekhak, Dr Purna Joshi and Dr Ramesh Khoju who actively participated in 14 SANCON and Silver Jubilee Celebration of the Society of Anaesthesiologist of Nepal (SAN) in April 2013. Recently, Dr Arun Jha was in Nepali media and gave elaborate interviews regarding Dementia in Nepal, for which I congratulate him.

I would also like to thank Prof Satyan Rajbhandari for his excellent work in various important fields. I personally wish him every success for his charity 'HexN (UK)' for the excellent work for the people of Nepal.

Apart from educational activities, I am very delighted that our members also achieved successes in the field of sports. Dr Anup Pradhan has taken part in Birmingham Marathon and Dr Mohan Thapa completed 10 km Preston Marathon in September 2012 and raised money for Health Exchange Nepal. Congratulations also to Sabrina Shrestha who is a 5th year medical student in Prague for successfully completing Prague Half Marathon on 6th April 2013 and Full Marathon on 12th May 2013.

We are also grateful to Dr Khoju for keeping the website updated and making it more attractive and to Dr Robin Sherchan for his continuous effort to track new junior doctors from Nepal.

Thanks are also due to the very hardworking General Secretary, Dr Badri M Shrestha, who is the 'back bone' of our Association. I would also like to thank Dr Siri Gautam, our present Treasurer, for her excellent job and also would like to thank her and her team, who very successfully organized 2012 AGM in Newcastle.

Special thanks to Dr Dhiraj Tripathi and the local organising committee for this year's AGM in Birmingham. I would also like to congratulate him for his hard work for NDA UK Journal.

This year we made a historical amendment to our constitution and finally agreed to accept non-medical professionals as members for our Association with some exception.

Lastly, on behalf of my wife Dr Rekha Shrestha and myself, I would once again like to express our sincere thanks for your support and trust giving me the opportunity to serve as your Chairman.

I wish and assure my successors will do the best to further strengthen and raising the profile of the Association.

Yours sincerely

Mr Bharat R. Shrestha
Chairman, NDA (UK)

Annual Report by General Secretary: General Secretary's remarks

Charles R. Swindoll had very aptly said "I cannot even imagine where I would be today were it not for that handful of friends who have given me a heart full of joy. Let's face it; friends make life a lot more fun." I pay full tribute to the Nepalese Doctors Association (UK) and we all do, for the incredible achievement of bringing all Nepalese doctors and their families together under one roof and providing the opportunity to share their feelings and reinforce friendship, in this beautiful city of Birmingham.

I would like to express my heartfelt thanks to Dr Siri Gautam and local organising committee members for hosting the 27th AGM in Newcastle last year, which was a great success and memorable. Since then, Dr Dhiraj Tripathi supported by the whole Tripathi family, hosted a charity dinner in Birmingham in support of the Mental Health First Aid Programme in Nepal and Dr Bina Subba hosted similar charity dinner in London to establish an ambulance services in Taplejung, Nepal. Both were extremely successful in achieving their targets and deserve appreciation and thanks. Dr Robin Sherchan has been instrumental in motivating newly qualified Nepalese doctors to join the NDA and hope the numbers to increase further in the forthcoming future.

The executive committee has made amendments in the existing NDA Constitution to incorporate non-medical family members in the executive committee, which will be discussed in the AGM for final ratification. This year NDA had supported training of two nephrologist doctors from Nepal to assist the transplantation programme.

This is my fourth year as the general secretary of the association, which I enjoyed very much, although tremendous amount of constrain was imposed by the NHS commitments. I wish to thank our chairman Dr Bharat Shrestha, vice-chairman Dr Arun Jha, joint secretary Dr Dhiraj Tripathi and treasurer Dr Siri Gautam and all members of the executive committee and the association for their relentless efforts to keep the association in good shape. Dr Ramesh Khoju, who has been the key person in maintaining the NDA website, which is our great strength and the prime means of communication, deserves special thanks.

I do express my sincere thanks to Dr Dhiraj Tripathi, Dr Rajani Tripathi and local organising committee members for organising the AGM with great enthusiasm, despite their full-time job-related commitments.

I wish you and family members rejoice every moment in this weekend event.

Mr Badri Man Shrestha MS, MPhil, MD, FRCS (Eng, Edin and Gen), FICS,
General Secretary NDA(UK)

The announcements below have been volunteered by the individuals concerned or their families/friends. Congratulations to all!!

Miss Diya Lohani Tripathi (left) born summer 2012 (proud parents Dhiraj & Rajani, proud grandparents Bharat and Nirmala Tripathi, Dhana Nani Lohani, uncle Niraj, aunts Roshani and Deepa).

Dr and Mrs Shakya on becoming proud grandparents for a third time.

Miss Sabrina Shrestha (right and below), a 5th year medical student in Prague Charles University successfully completed the Prague International Marathon, May 2013 sponsored by Volkswagen. Her timing for full Marathon (42 km) was 4h 22 mins and 37 sec. She raised £ 151 and has donated this to Rapti Samaj UK through NDA(UK). Rapti Samaj UK is a charitable, voluntary organisation based in UK mainly for the welfare (education and healthcare) of ex-Gurkha family here and also poor families in Nepal. Proud parents Dr Bharat and Rekha Shrestha and sister Shivani.

Dr Jason Adhikaree (below), a research SpR in Oncology at City Hospital, Nottingham on completing the London Virgin Marathon. Proud parents Dr Shambu and Mrs Anne Adhikaree.

Mr Santosh Bhandari was awarded FRCS in May 2013 and MD in June 2013. He has also been offered surgical training in Leicester.

Dr Shivani Shrestha on engagement to Morgan Baynham and on completing her GP training.

Dr Donna Shrestha on passing her MBBCh examinations and starting as a Foundation doctor in East Anglia Deanery. Proud parents Mr Badri Man Shrestha and Mrs Sita Shrestha.

Dr Milan Piya (right and below) on becoming Chairman of the Young Diabetologists and Endocrinologists' Forum (YDEF) which is the organisation of trainees in diabetes and endocrinology in the UK. YDEF represents around 500 trainees in the country and runs 14 courses/events each year as well as have a website that gets around 2 million hits a year. YEDF is also the trainee wing of Diabetes UK, the national patient charity for people with diabetes. The website is http://www.youngdiabetologists.org.

Milan recently organised a YDEF skydive to raise diabetes awareness and raise money for Diabetes UK. He raised about £1100 and as a group over £5.5k.

Ambulance Service in Taplejung, Nepal

Kamana Subba,[1] Beena Subba[2]
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INTRODUCTION

The Nepalese Doctors' Association is a professional organisation of doctors of Nepalese origin in the UK established in 1985.[1] Since its inception, NDA (UK) has been actively supporting Nepalese communities through charity[2] and also from every possible[3] way, such as, last year it helped in conducting a Mental Health First Aid training programme in Nepal[4] and has also supported various organisations for different medical conferences and projects over the years.[3]

In this year too, the tradition has remained same. The hard work of Dr. Beena Subba, Consultant Gynecologist, executive member of NDA (UK) has led to another successful Charity Dinner Program for Ambulance service in Taplejung, Nepal, with the help of the event organiser Ms. Bidhya Limbu, the lead of the project management Dr. Kamana Subba and Dr. Numa Thebe. Almost 250 guests had participated in the event; along with fund raising program, there were cultural show, khukuri auction and raffle too.[5]

AMBULANCE SERVICES IN NEPAL

As per the study done in Patan Hospital by Gongal et al, carried out on 1964 patients, during a period of one month in Sept 2006, a very less number of people called for ambulance for emergency services. Only about 10% patients actually used ambulance to reach hospital, resembling only 13.5% of triage category I (acute danger for life) patients. The remaining casualties and sick people used other means of transport like taxi (53.6%), bus (13.5%), private vehicle (11.4%), motorbike (5.4%) and so on. There were 31 service providers with 49 ambulances, and 720 patients per day attend Emergency Departments in the surveyed area.[6]

As far as the capital city is concerned, there are currently 45 ambulance services in the Kathmandu valley, out of which 23 are owned by hospitals, while remaining 22 are chiefly owned by non-governmental organisations and community based organisations. Researchers have found that 17 ambulances out of total 45 are small vehicles that fail to meet the normal standard for ambulance services.[7] There has not been any authentic data as how many ambulance services are currently available in different places of Nepal.

AMBULANCE SERVICES IN TAPLEJUNG

Taplejung is one of the most beautiful regions in eastern Nepal with spectacular landscape, Himalayan peak of heights above 7000 meters and a wide range of flora and fauna. It occupies an area ranging from 670 m to 8586 m (Mt. Kanchanjunga, the world's third largest peak) above sea level. Alpine grassland, rocky outcrops, dense temperate to subtropical forests, and river valleys make up the region. One of the major attraction that lies in this area is the Pathibhara Devi temple. This secret region attracts tourists seeking spiritual fulfilment and blessings from the powerful Pathibhara Devi. Hindus as well as the Buddhists reach the temple for celebrations during special occasions. The trek to Pathibhara Devi (3794 m) combined with the natural and cultural experiences of the region make the visit a unique exhilarating experience.[8]

Taplejung lies in an altitude of 1441 metres (4730 feet), covers an area of 3,646 km² and has a population of ~200,000. Majority of the population consist of Limbus followed by Sherpas. The inhabitants of the Taplejung depend on its District Hospital for their health care. However, the district hospital is struggling to deal with an increasing number of patients each and every day.[9]

As reported by ekantipur, an e-magazine of Kantipur Publication, Taplejung District hospital is struggling to deal with increasing number of patients. The health personnel are forced to treat patients on the floor and veranda of the building due to shortage of adequate number of beds. The hospital authorities have stated that around 25 patients from 50 VDCs in the district and the neighbouring districts, Panchthar and Terhathum visit the 15-bedded hospital on a daily basis. A health worker have also reported that patients, mostly referred from rural health posts, visit the hospital, walking on foot. Health workers at the hospital claim that the government's failure to add beds since its establishment has added to the problem. Majority of patients are referred to the higher center as the hospital is not well equipped with required infrastructures. Due to increasing number of referrals from the hospital, there is a need of fully functioning ambulance service for transport of critically ill patients to the higher centers.[10]

The old tradition of carrying sick people using dokos (a carrier made up of bamboo) is also disappearing due to shrinking number of male youngsters in villages. It is also noticeable that because of rapid rural-urban and international migration, many villages are left with a large gray and young population. These vulnerable groups of people can no more depend on irregular public transport and virtually non-existent emergency facilities, but require more frequent health support with timely follow-ups.

SELECTION OF TAPLEJUNG

During her regular visit to Nepal, Dr. Beena Subba also visited Taplejung district. She saw a huge burden of disease among poor villagers and was deeply touched by a poor health system of that place, especially when she noticed that many people were struggling to reach their nearest local health centers after a day walk. She decided to help these locales by providing ambulance service in that place. She put forward her proposal for a charity program to the NDA (UK) so as to donate an ambulance in Taplejung district, particularly in Sinam village.

The Sinam was selected as the prime location to be the base of the ambulance service because this is a secure area along with Armed Police Force base camp. Health workers are already posted in health centres who are proficient to work as paramedics, so, no extra cost is required to train them. The volunteers from Sinam High School and College along with cooperative village committee will be the available manpower/working force.

Once, an ambulance service is based in Sinam, it can help sick people from nearby villages, such as, Ambegudin, Chaksebotey, Khebang, Limbudin, Mehele, Pedang, Sablakhu, Sikaichha, Telok, Thummidin, Tharpu, Yamphudin and many more. Patients will be charged a small fee for a sustainable long-term functioning of the service. The fuel costs, driver's salary and maintenance are supposed to be managed by the local organising committee with the guidance of the Board of Trustees.

MANAGEMENT OF AMBULANCE SERVICE

There will be a governing board which will be called a Board of Trustees. It will provide policy, guardianship and be responsible for the financial transactions along with number of patients who use the service. There will be a half-yearly review of the ambulance services followed by an annual review which will be made publicly available.

NDA CHARITY PROGRAM 2013

The NDA (UK) assessed the gravity of situation and felt the need to help the people of Taplejung. Hence, to materialize this concept NDA (UK) organized a charity dinner program to support the cause and assigned Dr. Beena Subba to co-ordinate the charity event with cultural program.

North Middlesex Hospital immensely supported this program by sponsoring Hospital canteen for the program. The program started at 6:30 PM with registration followed by wine reception with starters consisting of delicious Shel rotis and curries that was made by Mrs. Geeta Limbu, worth £250. Dr. Beena Subba, the chairman of the organising committee of NDA UK welcomed everyone with her welcome speech. Mr. Lex Limbu, a non-resident Nepali blogger, introduced all the guests for the need for ambulance service in Taplejung, Nepal. Guest of Honour, Mr. Charles Walker, member of parliament for Broxbourne, gave a short speech. This was followed a formal talk by chief guest, councillor Kate Anoloue, mayor of Enfield, where she expressed her opinion emphasising the need of more charitable works to support those in need. Dr. Bharat Shrestha, President of NDA UK, also shared his thoughts for the cause. He also handed a cheque of £500 to the Sickle cell charity run by the mayor of Enfield, and another cheque of £250 to the Children's scheme, a charity run by the MP for Broxbourne.

Meanwhile, Dr. Prem Hamal, the first president of NDA UK, presented certificates of honour to both the chief guests.

After this, all the guests had a buffet dinner sponsored by Mr. Bijay Thebe (worth £3000) and catered by Mr. Khem Raj Maden. Mrs. Tika Gurung had personally prepared a vegetarian dish for the dinner. All the guests enjoyed the food along with ongoing cultural program organised by Mr. Narendra Idingo, the cultural director of the show. Total 13 dancers, eight from Wales, performed 7 cultural and fusion dances. Mr. Laxmi Bantawa, an ex-Gurkha Major, and Mrs. Nirupa Thebe Bantawa raised £140 for charity by auctioning a special khukuri. Likewise, Mrs. Bimala Thebe Pandhak also raised £50 by auctioning another khukuri. Both Mrs Nirupa and Mrs Bimala are from Sinam, Taplejung Nepal. Dr. Rekha Shrestha, consultant O&G at Derriford hospital Plymouth gave away the raffle prizes which entertained guests with further excitement.

As a part of a function, Dr. Robin Sherchan, registrar at Queens Medical Centre in Nottingham, introduced new Nepalese doctors and current medical students to the mass of audience. Meanwhile, Dr. Chuda Karki, Consultant \Psychiatrist, congratulated young doctors handing each newcomer a certificate. Finally, Dr. Badri Man Shrestha, general secretary of NDA UK, expressed vote of thanks to everyone.

Maximum 200 invitees were expected to participate on the day of the event with target of raising about £12,000, which is the approximate cost of an ambulance. To everyone's surprise, by the end of the day, the team had entertained over 250 guests and the total amount achieved was around £13,500. The program was successfully organized with the help of many volunteers, sponsors and support from NDA UK executive members.

STORY OF SUCCESS

Interplay of multiple factors led the event to achieve above and beyond what was thought possible! A strong leadership played a major role in smooth functioning of the program where young volunteers actively participated with high enthusiasm throughout the evening. The feelings of ownership and a strong teamwork boosted the atmosphere with positive outcomes. A role model for various Nepalese communities, such as, Mr. Bijay Thebe, highly mobilised Nepalese mass to move forward to contribute in every way possible. This flourished the concept of a strong community for the community. Selection of some popular figures, like Mr. Rohit Thebe and Lex Limbu, as key speakers, facilitated the success of program by grabbing more mass attention because of their charismatic personalities. Frequent drills were conducted with volunteers for effortless functioning of the program. The success of this program proved that the young people can contribute more than what we can expect from them, provided that right people are allocated in the right place.

FUTURE CONTRIBUTIONS

The NDA (UK) will keep working for supporting and initiating health services in rural and needy areas of Nepal. Although providing even a single ambulance for emergency medical care is itself a daunting task, we can still aim to contribute more for emergency services, such as, vital medical equipment for emergency care, standard training for paramedics and other medical staffs. Moreover, other fields of services beside emergency medicine can also be targeted as per the priority of need.

ACKNOWLEDGEMENT

We thank North Middlesex hospital, London for providing venue for the program and the volunteers for their active participations. We also thank all sponsors and philanthropists for their valuable contributions.

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Sponsors for NDA(UK) Charity Dinner			
Name	**Surname**		**Contribution in**
Bijay & Beena	Thebe	North Middlesex Hosp	Food and drinks
Bimala & Bhawani	Thebe Pandhak		Khukuri auction, worth £50
Dharma Raj	Rai	North Middlesex Hosp	Photography & sound system operator
Frances	Kipping	North Middlesex Hosp	Environmental Services
Geeta	Limbu		Starters (Sel rotis & curries), worth £250
Ian	Abernathy	North Middlesex Hosp	Poster printing
Laxmi & Nirupa	Bantawa		Khukuri auction, worth £130
Maxine	Malpass	North Middlesex Hosp	Audio visual, Communications
Michael	Harris	North Middlesex Hosp	Restaurant premise
Narendra	Idigno	Wales Group	Cultural program
Stanley	Okolo	North Middlesex Hosp	Hospital premise
Tika	Gurung		Veg dish (oyster mushroom with soyabean sauce), worth £50

Figure 1: Group session for the charity dinner

Figure 2: The chief guests.

Figure 3: Executive members of NDA (UK)

Figure 4: Khukuri dance being performed by young dancers from Wales

Figure 5: The mass of spectators enjoying the cultural show

Figure 6: Limbu Chyabrung dance being performed by young dancers from Wales

Enhanced Recovery after Surgery: a multi-modal approach to improve peri-operative outcome in colorectal surgery and a role of anaesthetist

Dr Ramesh K Khoju-Shrestha FRCA, FFICM
Consultant Anaesthetist, Bronglais General Hospital
Aberystwyth, UK

Background

Traditionally, patients undergoing major open colorectal surgery take prolonged rehabilitation during the postoperative period, as a result of significant morbidity. Complication rates of more than 15-40 % (1) have been reported after this type of surgery. A key factor for postoperative recovery in these patients is the return of bowel function, which is influenced by several postoperative factors. They are preoperative fasting and bowel preparation, anaesthetic and analgesics technique, magnitude and complication of surgery, fluid overload, and also by the patients' co-morbidities.

Stress response during surgery is common to all surgical patients which induces widespread changes in hormonal, metabolic, haematological, and immunological system in the body and activates sympathetic nervous system. Professor Henrik Kehlet, a gastro-intestinal surgeon from Denmark postulated that by providing stress free surgery and anaesthesia, one could speed up patient's post-operative recovery times and reduce their morbidity and mortality (2).He proposed multi-modal approach towards peri-operative care to improve the outcome (3). His model comprised of better patient information, minimally invasive surgical techniques, increased use of regional anaesthetic techniques, effective pain relief, early enteral nutrition and early mobilisation as a way of modifying the stress response and minimising the impact of surgery on the patient.

Since then, there have been a lot of studies and recommendations which looked at multi-modal surgical approach towards peri-operative care (4, 5). Based on the principles outlined by Kehlet, the "Enhanced Recovery after Surgery (ERAS) Programme" or "fast track" surgery pathways have been developed. In the UK, the Institute of Innovation and Improvement has collaborated with a number of other national organisations to create the Enhanced Recovery Partnership Programme in 2010. Many of these techniques can be adapted to optimise perioperative care in a wide variety of health care setting. It was originally developed to use in major colorectal surgery. Now it has also been expanded to include in major orthopedics, urology and gynaecological surgery too.

The studies showed that the implementation of four or more elements of the ERAS pathway leads to a reduction of hospital stay by more than 2 days and almost 50% reduction in complications rates patients undergoing open colorectal surgery (4).

Key Elements of ERAS

The aim of the Enhanced Recovery programme is: to ensure that patients are prepared physiologically and psychologically in optimal way and to provide perioperative care that reduces the stress of surgery and improves the recovery.

Essential components of the ERAS are:

- Preoperative preparation (preparing patient for best possible condition for surgery)
- Intraoperative management (best possible management during surgery)
- Postoperative management and follow up (patient experiences the best postoperative rehabilitation)

Preoperative preparation

Preoperative optimisation*:* Following decision to make for surgery patient should be optimally prepared for surgery. Patient's general practitioner or family physician may be an ideal position to optimise chronic conditions, like anaemia, diabetes and hypertension. Patients are then, seen in preoperative assessment clinics, either by specially trained nurse or anaesthetist. It will ensure that necessary preoperative investigations are performed in plenty of time, help to reduce patient's anxiety, allow times for planning altered potential problem. And it also prepares patients to stop alcohol intake or smoking cessation.

Pre-admission information and counseling: Good preoperative information to the patient and counseling will help the patient to get a clear understanding of expected perioperative course, leading to reduce anxiety, improve patient experience and stress response to surgery (4).

Nutrition**:** Preoperative nutritional supplementation is associated with a reduction in infectious complications and anastomotic leaks. Enteral supplementation (including vitamins and minerals) for 10-14 days preoperatively is suggested in severely malnourished patients.

Preoperative carbohydrate load and fasting*:* Carbohydrate rich clear oral fluid is given to the patient the night before and 2-3 hours before the start of surgery which will help to reduce preoperative anxiety, thirst and hunger (6). In diabetic patients carbohydrate treatment can be given along with the hypoglycemic drugs. Fasting time should be kept to a minimum. Clear fluid should be allowed up to 2 hours and solid up to 6 hours prior to induction of anaesthesia (7)

Preoperative bowel preparation*:* In colorectal surgery, bowel preparation can cause significant dehydration and may produce electrolyte disturbances (8). It is distressing for the patient and is associated with prolonged ileus after colonic surgery. It should not be used routinely, but may still may be necessary in selected patients, for example those requiring intra-operative colonoscopy.

Pre-anaesthetic medication: Preoperative education can reduce patient anxiety without the need for anxiolytic medication. Long acting sedative premedication should be avoided within 12 hour of surgery, as it can affect immediate postoperative recovery by impairing mobility and oral intake (9).

Prophylaxis against thromboembolism*:* The incidence of asymptomatic deep vein thrombosis (DVT) in colorectal surgical patients without thromboprophylaxis is about 30%, with fatal pulmonary embolus occurring in 1% f the patients. Patients with malignant disease, previous pelvic surgery, taking steroids preoperatively, multiple co-morbidities and hypercoagulable states are at high risk (10). So, all colorectal patients should wear well fitting compression

stockings, have intermittent pneumatic compression, and receive pharmacological prophylaxis with low molecular weight heparin (LMWH).

Intraoperative management

***Anaesthetic protocol*:** The anaesthetist is responsible for three key elements in affecting outcome after surgery: stress reactions to the surgery, fluid therapy and analgesia. A regional anaesthesia used in addition to general anaesthesia (if possible short acting agents) during surgery can minimise the need for postoperative intravenous opiates which allows rapid awakening from anaesthesia. It will facilitate early enteral intake and mobilization on the day of surgery. A regional anaesthesia can also reduce the stress response.

Analgesia: Good pain management is essential for rapid recovery from surgery (11). Intra and postoperative analgesia should focus on multi modal technique, aiming to minimise side effects of the different classes of drugs, particularly opioids. In open surgery, the use of epidural analgesia has proven to be superior to opioid based alternatives. In laparoscopic surgery, spinal anesthesia or patient controlled analgesia may equally effective. There is also increasing interests in alternative methods of regional analgesia which cause less motor and sympathetic block. For example, rectus sheath block, transverse abdominis plane (TAP) block or continuous wound infiltration.

Fluid management: During surgery, fluid delivery should be targeted against physiological measures and mean arterial pressure maintained using vasopressors once normovolaemia has been established, to avoid salt and water overload. Intraoperative minimal invasive monitoring of cardiac output is being increasingly used to target fluid therapy. The oesophageal Doppler monitor (ODM) has been validated as a method to guide the administration of fluids during colorectal surgery (12). Tailoring fluid therapy to the individual patient needs is a key aspect of enhanced recovery.

Maintenance of normothermia: Intraoperative hypothermia increases the risk of post-operative complications (13). Intraoperative maintenance of normothermia with a suitable warming device and warmed intravenous fluids should be used routinely to keep body temperature > 36° C.

Glucose control: Insulin resistance due to stress response is the cause of hyperglycaemia. It is an independent risk factor for postoperative complication (14). Normoglycaemia should be maintained in diabetic patients and hyperglycaemia should be detected and treated in non-diabetic patients.

Prevention of postoperative nausea and vomiting (PONV): the incidence of PONV is 25-35% of all surgical patients and it can lead to patient dissatisfaction and delayed discharge from hospital. Major colorectal surgery is associated with a high prevalence of PONV, reaching 70%. Prophylactic antiemetics during surgery can reduce incidence of PONV by ≤ 40%. A multimodal approach to PONV prophylaxis should be adopted in all patients with ≥ 2 risk factors (4)

Surgical technique: Use of laparoscopic or minimally invasive approach, minimum length of incisions in open procedure, selective use of surgical drains and avoidance of routine use of nasogastric tubes (4) should be adopted to enhance recovery.

Postoperative management

Postoperative analgesia: Multimodal analgesia combining regional analgesia or local anaesthetic techniques and avoiding parental opioids and their side effects are main aim of postoperative pain management. It will give good pain relief; allow early mobilization, early return of gut function and feeding, and prevent complications (4).Intravenous Paracetamol is a vital part of multimodal analgesia. Non-steroidal anti-inflammatory drugs can be used in selected patients. For break through pain, titration to minimum dose of opioids may be used.

Drains, nasogastric and urinary catheters: There is no significance difference in the incidence of anastomotic complications, wound infection or re-interventions in colorectal surgery with or without abdominal drain (15). Routine use of drains is not recommended. It may impair mobilisation of the patient.

Routine use of nasogastric use can delay the return of bowel function, and possibly increase nausea and hospital stay. It may be necessary to insert a nasogastric tube intraoperatively to evacuate air from stomach, for example in laparoscopic surgery. When it is used, it should be removed before the patient wakes up from anaesthesia (16).

Prolonged urinary catheterisation can delay early mobilisation and cause urinary tract infection. It is recommended while epidural analgesia is in progress, but it does not need to stay for the full duration and removal may be considered before the epidural is stopped (4).

Early oral hydration and nutrition: Oral nutrition can speed up early return of gut function and reduce complications, like ileus. Patients should be encouraged to take normal food as soon as possible after surgery, along with oral nutritional supplements 2-3 times a day (4).

Early mobilisation: Prolonged immobolisation can increase the risk of pneumonia, insulin resistance and muscle weakness (4). Measures should be taken to facilitate mobilisation and patients should be nursed in an environment that encourages independence.

Follow up: Patients should be made aware of how to access and service following discharge. For prompt and safe readmission there must be a clear pathway. Patient's general practitioner or family physician must be kept informed about the enhanced recovery programme.

Conclusion

Evidence has shown that enhanced recovery after colorectal surgery produces improvement in patient care and outcome, including fewer complications and shorter length of hospital stay. ERAS programme can be successfully implemented, by involving multidisciplinary team (surgeon, anesthetists, nurse, dietician, and physiotherapist). Anaesthetist can play an important role in implementation of some elements of ERAS to reduce stress response after surgery. For example, proper pre-operative assessment of

the patient avoidance of long acting agents or opioids, use of regional or local anaesthetic techniques, (including opioid sparing multimodal analgesic techniques postoperatively), keeping normothermia, multimodal approach of prophylactic antiemetics etc.

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Your shoulder

Sometimes
I want you here
With me, mother
So that
I can have your shoulder
When I am feeling low
There were times
I like to come to you
And stay with you there
But
I myself is a mother
Of three lovely children
And I am blessed with
Wonderful grandsons!
I wish to see them
Growing and flourishing
If you are here, mother
How nice it would be
To share these joys with you
I don't know
How far is my journey?
And what's around the corner
Sometimes
I have acted like a child
In front of my own children
That was so wrong
That's why, mother
I wish
If you are here with me
I could have your shoulder
When I am feeling low

Hind Vaidya

Postgraduate Surgical Training in the United Kingdom

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Abstract
Surgical training in the United Kingdom has evolved over the last 500 years. The Four Royal Colleges have played central role in delivery of training. The training has been shaped on the current form after several reforms over last 30 years including Sir John Tooke's report in 2008. General Medical Council, Specialty Advisory Committee, Post graduate Deaneries, Hospital Trust, Trainer and Trainee all have an important role in maintaining standards of training and improve quality. In the future the Universities may have increasing role in complementing the surgical training in the United Kingdom.

History

The UK surgical training has evolved over the last 500 years. In the olden days the General Surgeon managed and knew all aspects of surgery from head to toe. With medical advances and specialization surgeon knew more in depth on a particular branch of surgery and more sub specialities developed. There have been several reforms since 1980s which have shaped up the current surgical training.

The four Surgical Royal Colleges of London, Edinburgh, Glasgow and Ireland have traditionally been responsible for surgical training. In the 1980s The Joint Committee on Higher Surgical Training (JCST) and its subcommittee Specialist Advisory Committee (SAC) was established by these four Royal Colleges.

The Calman Report [1] published in 1993, to bring the UK training in line with European Union specialist training, abolished the the old Senior Registrar grade and introduced new Specialist Registrars (SpR). The "old style" FRCS came to be replaced by the "new style" MRCS. The "new style" Intercollegiate FRCS (FRCS Exit) was introduced. Trainees took this around completion of the Higher Surgical Training with award of Certificate of Completion of Specialist Training (CCST).

While there was more structured training in the SpR grade, there was stagnation of training in the Senior House Officer (SHO) grade as a result of this reform. The Unfinished Business report [2] of 2002 sought to address this issue. The four UK Departments of Health introduced Modernizing Medical Careers (MMC) in 2003[3] in response to this report and one of the provisions was that all postgraduate medical training should be guided by clear curricula. The Royal Colleges established the Intercollegiate Surgical Curriculum Project (ISCP) which produced formal curricula. Around the same time Post Graduate Medical Training and Education Board (PMTEB) was introduced by the government to assess quality of training and award of certificate of completion of training (CCT).

Although MMC was led by clear curricula it had several problems. The trainees who had not got to the specialist registrar post before 1 August 2007 were required to apply for posts under the new curriculum; there were technical problems in the application process and many trained doctors would have to leave the country to find jobs elsewhere due to lack of enough training slots[3].

In response to these criticisms, Sir John Tooke's report in 2008 "Aspiring to Excellence" encompassed surgical training and provided recommendations in structure and provision of surgical training[4]. The role of PMETB was taken over by GMC.

Entry to higher surgical training

One year of house officer posts with 6 months placement in medicine and surgery has been replaced by 2 year foundation year one and year two posts form 2005. Following this they apply for core surgical training (CT) posts at national level and on successful entry complete 2 year rotation at different sub specialties. On passing the MRCS exams; completing the Advanced Trauma Life Support (ATLS) and Basic Surgical Skills course; completion of work based assessments and satisfactory Annual Review of Competency Progression (ARCP) assessments to satisfy competency based progression they can apply for the Higher Surgical Training to one of the following 10 surgical specialties[5].

Cardiothoracic surgery
General Surgery
Neurosurgery
Oral and Maxillofacial surgery
Otolaryngology
Paediatric Surgery
Plastic Surgery
Trauma and Orthopaedic Surgery
Urology
Vascular Surgery

After competitive selection process if selected they enter as Specialty Trainee year 3 (ST3) trainee in that specialty.

Duration of Higher Surgical Training, CCT

In General Surgery, Specialty Training goes to ST8 level totaling 6 years in higher surgical training. The general surgeon on completion of the training should be able to manage unselected acute surgical admissions. The new curriculum being published in August 2013 has been based on this and is very detailed. The general surgeon generally has a subspecialty interest. These include Breast, Transplant, upper GI, Lower GI. Based on the trainees subspecialty interest, duration of placements during the 6 year training rotation are very clearly defined including the number of operative procedures they are supposed to perform[6].

They undergo ARCP each year to review their performance during the last year and development plan for the next year. They have to submit evidence of satisfactory progression including set number of work based assessments, log book summary, Procedure Based Assessment (PBAs) and trainee assessment forms (trainer report). They take FRCS exit examinations in General Surgery and their subspecialty

interest towards the later half of their training and are awarded FRCS (Gen Surg). The JCST recommends the trainee for award of certificate of completion of Training (CCT) on satisfactory completion of ARCP and examinations. CCT is awarded by the GMC. Possession of a CCT allows entry onto the Specialist Register, and the individual may apply for Consultant posts or Staff Grade/Associate Specialist Doctor positions for service. Some opt for a further period of sub-specialist 'Fellowship' training prior to or while awaiting appointment to a substantive position[5]. Summary of training pathway is shown in figure 1.

Traditionally trainees went off to do research after SHO appointments and applied for higher surgical training positions. The trainees now mostly perform research when they heave entered the training programme taking some time off. Many academic training programmes tend to have research integrated to their training[5].

Training roles of different institutions

GMC is responsible for award of CCT and approval of curriculum. The Joint Committee on Surgical Training (JCST) is an advisory body to the four surgical Royal Colleges of the UK and Ireland for all matters related to surgical training, and works closely with the Surgical Specialty Associations in Great Britain and Ireland. It is the parent body for the Intercollegiate Surgical Curriculum Programme (ISCP), the ten SACs one for each of the surgical specialties and the Intercollegiate Core Surgical Training Committee (CSTC). Schools of surgery exist within each postgraduate deanery. The school of surgery oversees all aspects of training in the SAC-defined surgical specialties. Its core function is to coordinate the educational, organisational and quality management activities of core and specialty surgical training programmes. The school of surgery draws together the representatives and resources of the deaneries, colleges, Hospital Trusts and other local providers of training and stakeholders in postgraduate medical education[7].

Quality assurance of surgical training

The training programme and rotating appointment placement leading to CCT should be of high standard to which public have confidence in being treated for their surgical illness.

GMC quality framework consists of policies, standards, systems and processes directed to ensuring maintenance and enhancement of the quality of specialty training leading to CCT. The five principles of proportionality, accountability, consistency, transparency and targeting are observed for better regulation.

Postgraduate deaneries are responsible for maintaining standard by making sure local education providers are meeting the standards set by the GMC in delivering training through annual reporting and continuous monitoring. Royal colleges through SAC have role of delivery and review of curriculum, assessments and examinations.

Local education providers (NHS Trusts/Boards) are responsible for quality control and ensure that the education and training delivered are up to local, national and professional standards. There should be adequate opportunities in theatre, clinic and on the ward, and requires time for the trainer to supervise the trainee appropriately.

The quality framework consists of 5 elements (standard, shared evidence, surveys, visits to deaneries and response to concerns). Standards are set by GMC and form the back bone for other elements. GMC approves the training posts and curriculum which meet the standards. Generic standards include 9 domains (including patient safety, recruitment/selection of trainee, management of education and training, assessment/feedback) to enable them to develop as good doctor set in 'the duties of doctor registered with the GMC'. The standards based on above generic standards are judged by surgical specialists providing authoritative judgement. The trainee and trainer feedback at the end of each placement is taken seriously and if there is any concern this may trigger SAC visit. There are standards developed for the trainers to be eligible to train[8].

International perspective

Each year approximately 1000 medical graduates enter the general surgical training scheme in the United States. Other surgical training residency programmes include Neurological Surgery, Obstretics and Gynaecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology: Head and Neck Surgery, Plastic Surgery and Urology. In General Surgery after satisfactory completion through year 1 to 5 they take board certified written and oral examinations. On successful completion, 70% of the general surgical residents enter subspecialty fellowships which may last few years before they enter as independent practitioner as attending[9].

University based surgical qualifications

There have been some University degrees mostly in the form of online learning either at the level of basic surgical training such as Edinburgh Surgical Science Qualification (ESSQ) and ChM delivered by Royal College of Surgeons Of Edinburgh (RCSEd) and University of Edinburgh[10]. More advanced subspecialty degrees to prepare the candidate for year one consultant level have also been developed. These include University of East Anglia Mastership(MS) course in Oncoplastic Breast (OB), Coloproctology (CP) and Regional Anaesthesia (RA) [11].

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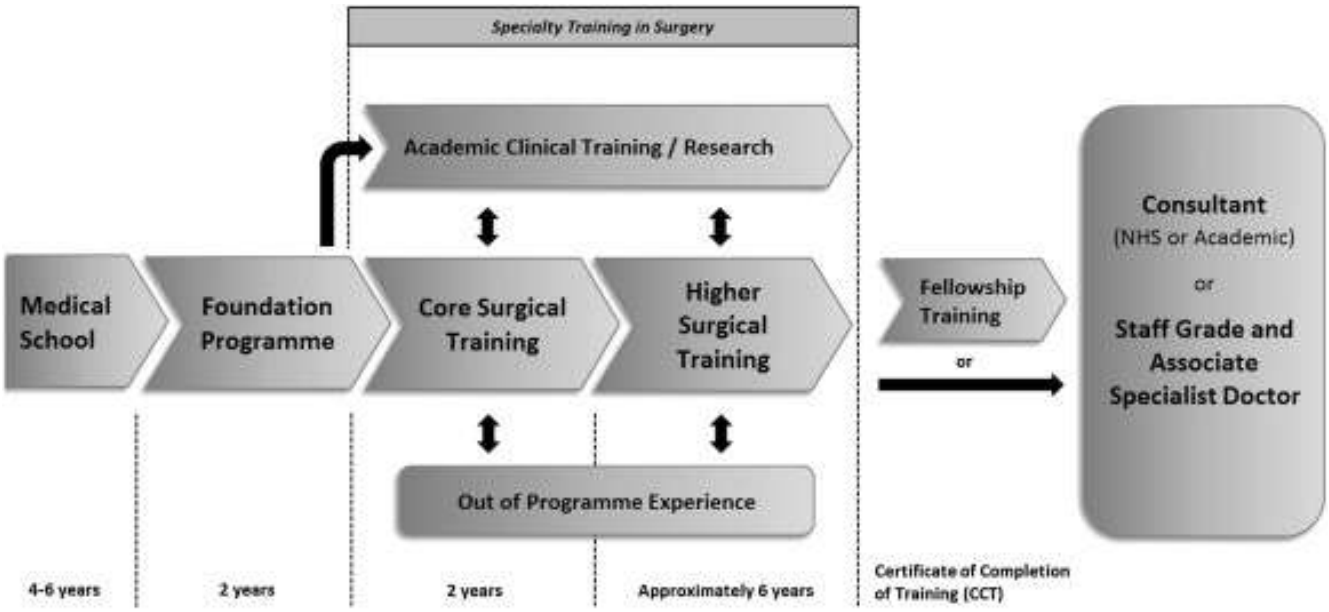
Figure 1: Summary of training pathway



Greek style recipes

Hind Vaidya

Stuffed tomatoes (Greek Style)

Whenever tomatoes are used in Greek recipes, a sprinkle of sugar is added to neutralise the acidity. It also adds to the taste

Ingredients

(i)
6 large ripe tomatoes
1 onion, chopped
A packet (250g) of fresh or frozen spinach, chopped
4 big potatoes, peeled and cut into wedges
8 tbs olive oil
1/2cup of water

(ii)
1/2 cup basmati rice
½ cup currents
½ cup pin nuts
2 tbs tomato paste
1 tsp sugar
Salt
Freshly ground black pepper

(iii)
½ cup grated cheddar cheese
1 cup crumbled feta cheese
1/2cup mixed fresh herbs of your choice (parsley, mint, dill, coriander)
A few of unpeeled garlic cloves

Procedure

Step 1

Slice tops from tomatoes and set aside. Scoop out pulp leaving the cavities without damaging the skin. Blend the tomato pulp and mix with sugar, tomato puree. Set aside.

Step 2

Arrange tomatoes in an oven proof shallow dish (6×30cm. Put potato wedges around & in between the tomatoes to support them upright. Put the garlic cloves in between.

Step 3

Heat a frying pan and put in half the oil. Fry onions until transparent, put in nuts and currents, rice. Stir and fry for 2-3 minutes. Then add half the blended tomato and simmer for 5 minutes or until the liquid is absorbed. Add in feta , cheese, herbs, salt and pepper. Mix well. Start stuffing the tomatoes and peppers with the mixture allowing some space on the top. Then replace the tops.

Step 4

Pour the left over blended tomatoes over the potatoes. Add half cup of water in the dish. Sprinkle the salt and black pepper. Spoon the saved oil all over. Bake in preheated oven at 190°C for 1hr or until done. Serve hot or cold.

Serves 6-8

Note: You can make variations in the stuffing using mince meat or tofu instead of feta and cheese. Use grated courgette and carrot instead of spinach. Use large peppers instead of tomatoes. Traditionally in Greece, green peppers

are used for stuffing, but, you can also use different coloured peppers. This dish can be prepared days ahead and served cold.

Greek Yogurt and Feta Pie

This recipe is given by my daughter to me. Change of time! It does not have to be passed on always from mother to daughter.

Ingredients

(i)
100ml (8tbs) of olive oil
3 eggs

(ii)
400g of Greek Yogurt
300g of Feta cheese crumbled
200g of cheddar cheese
150g of self rising flour

(iii)
Freshly ground black pepper
1tbs of finely chopped fresh dill

Procedure

Pre-heat the oven to 170°C. Beat the eggs and olive oil in the mixing bowl. Then add all the ingredients (ii), stir and mix. Sprinkle freshly ground black pepper and fresh dill. Mix the content well.

Brush olive oil inside an oven proof dish (27cm diameter, 6cm high). Bake for 40-45mins until the pie has a golden colour. Let the pie cool for at least 25min before cutting.

Serves 4-6

Wherever you are

My baby
I love you so much
I understand that
You decided to walk
Another way
You two were so perfect
I have always admired
Following your sweet heart
You went away
I know that
You had a wonderful time
In so many ways
Blessed with wonderful boys
You have got priceless joys
They are the lights
In your journey
As you are in my life
I know that
You will take care of them
Love and support in every way
My baby
You are a part of me
Sometimes,
I can't help
I may be sad
I may be upset
But
Your individuality
I do respect
Whatever happened to you
In past and present
That matters to me
My baby
Whatever you are
Wherever you are
Remember me
I never stop loving you
26/11/2012

Hind Vaidya

Why did Disease, Medicine and Healthcare change so much in Britain between 1750 - 1900?

by Cara Lakshmi Pathy, Aged 13

During the Industrial Revolution, Medicine and Healthcare made incredible advances. As a result of this, some diseases have since been completely eradicated, and the many which have not are now much better understood.

Industrialization changed medicine and healthcare in numerous ways. Communications such as railways and the telegraph were developed, so new ideas were exchanged between doctors and scientists across the world more rapidly. Wars in France and the Crimea paved the way for safer surgical procedures and more attentive nursing. Improved technology and large factories could produce more advanced medical implements, including stronger microscope lenses and finer needles for syringes.

The main body of this assessment is in the format of a detailed timeline. It is divided into three major sections - Disease, Medicine and Healthcare. Key events in medicine and healthcare are listed in chronological order, describing and explaining what happened, and how it has affected our lives, up to the present day. I also have written a paragraph about the Miasma Theory and the Germ Theory of Disease, the two ways in which illness was understood in the Industrial Revolution.

Disease

The creation of the Germ Theory of Disease – 1890

- What happened: Before the Industrial Revolution, disease was understood by the Miasma Theory, which stated that disease was caused by "bad air" (miasma). However, there were many sceptics of this theory, who tried to find scientific reasons to disprove it.
- Although the Germ Theory of Disease was put together by Louis Pasteur (France) and Robert Koch (Germany), many basic contributions to it were made by British doctors, such as Edward Jenner, John Snow and Joseph Lister. In 1796, Edward Jenner invented vaccination - introducing weakened bacteria to the body to make a person immune to a certain disease. John Snow hypothesised and proved that cholera was caused by contaminated water, and not by "bad air". Joseph Lister created anaesthetic to treat wounds in 1865.
- How it has affected our lives: Without the Germ Theory of Disease, there would be no vaccinations, antiseptics, antibiotics, sterilization or even soap. Medicine and disease would be viewed differently (and incorrectly) and many more people would die as a result of poor hygiene, as they did before the Theory was developed. Due to the theory, hygiene is important to the public and well understood, and recovery rates from injuries and resultant surgery are much higher.

Medicine

Invention of the vaccination – 1796

- What happened: Edward Jenner saw that milkmaids rarely caught smallpox, which was a serious and often fatal disease. His theory was that after catching cowpox (a similar disease to smallpox, but less virulent), the milkmaids were protected from catching smallpox. To test his hypothesis, he carried out an experiment on six-year-old James Phipps. First, he collected some pus from a cowpox sore, and placed it in an incision he had made in James' skin. The boy became ill, but recovered, as Jenner had planned. Next, he repeated the process, this time with pus from a smallpox sore. This was very risky, because if Phipps died, then Jenner would have a death on his hands, and would be no closer to proving his theory. However, the smallpox had no effect on James. Jenner named his development Vaccination, after the Latin *vacca*, meaning cow.
- How it has affected our lives: Smallpox is now completely eradicated from Britain and the rest of the world. Furthermore, without Jenner's intuition, vaccination would not have been invented, and inspired other doctors and scientists such as Louis Pasteur (who developed vaccines for anthrax and rabies). These days vaccination is widely accepted, preventing diseases such as polio, rubella and tetanus, which could otherwise be fatal if contracted.

First successful blood transfusion – 1829

- What happened: In 1818, an obstetrician named James Blundell thought blood transfusion could be a way to handle severe haemorrhage. Many of his patients had died in childbirth, due to loss of blood, so he wanted to prevent this from happening. He first conducted his experiments on animals, and saw that if blood was transfused quickly, the procedure would be effective. In 1829, Blundell successfully transfused four ounces of blood into a patient, using blood extracted from her husband.
- How it has affected our lives: Since 1829, many lives have been saved with blood transfusion; not just during childbirth but after near-fatal accidents or even grievous bodily harm. Dr Blundell developed many instruments used for blood transfusion, the majority of which are still used today. A notable change is that, because of understanding about blood typing, people can now donate blood at blood banks, rather than patients receiving blood from families. A more negative result is that some patients have contracted HIV and AIDS after receiving contaminated blood.

Discovery of the cause of cholera – 1854

- What happened: Dr John Snow was believed that the Miasma Theory, which definitively stated that diseases were caused by inhaling "bad air", was incorrect. At this time there was no Germ Theory of Disease, so these views were considered controversial. In a London cholera outbreak in 1854, Snow traced the illness back to a water pump on Broad Street. The pump had actually been built near a cesspit, and bacteria were leaking into the public water supply. He used statistics as evidence of a link between the cleanness of the water and the number of cholera cases. Then, he used a map to show how instances of cholera were centred on the pump. He revealed that Southwark and Vauxhall Waterworks Company was distributing polluted water to homes, further increasing the risk of disease.
- How it has affected our lives: We now understand the

enormous importance of drinking clean water. Dr. Snow's work can also be viewed as the start of Epidemiology, the study of how public actions affect public health. His investigation was a major breakthrough which eventually contributed to the forming of The Germ Theory of Disease.

Healthcare

Discovery of the anaesthetic properties of nitrous oxide – 1800

- What happened: Humphrey Davy was an English chemist, who discovered that nitrous oxide could be used to numb pain during surgery in 1800. He had already been experimenting with the possible therapeutic properties of several gases - he also inhaled four quarts of pure hydrogen, nearly suffocating himself. Davy later persuaded his friends to take nitrous oxide, to see its effect on them. They discovered it made them feel euphoric, and nitrous oxide became known as laughing gas. However, Davy also saw its potential as pain relief during minor surgery.
- How it has affected our lives: It was nearly half a century before this particular innovation was accepted by the medical profession. However, it eventually lead to further experimentation with anaesthetics, such as ether and chloroform (which was used to anaesthetise Queen Victoria during childbirth). Nitrous oxide is still used in anaesthetics today, especially in dentistry.

Use of Carbolic Acid as Antiseptic – 1865

- What happened: Joseph Lister experimented with applying carbolic acid (phenol) to open wounds to prevent gangrene, after reading papers by microbiologist Louis Pasteur. Lister's idea was that gangrene was caused by microbes on the skin, and weak carbolic acid could kill them. He tested his theory on an eleven-year-old at Glasgow Infirmary with a compound fracture, by applying a dressing soaked in phenol. After four days, there was no sign of infection, and in six weeks, the boy's bones had actually fused back together.
- How it has affected our lives: After Lister's huge advance, death rates due to gangrene dramatically decreased, as surgeons began using phenol as an antiseptic, as well as washing their hands with carbolic soap. This discovery lead to experimentation with antiseptics. Today, common antiseptics include ethanol, iodine, boric acid and even raw honey. Antiseptics such as Dettol (chloroxylenol) are even available to the general public, as opposed to only doctors and nurses.

The primary factor that changed medicine and healthcare in the Industrial revolution was that the abolition of the Miasma Theory and its succession by the Germ Theory of Disease. This transformed medical thinking, correcting it and opening doors to new ideas. Treatment vastly progressed with new understanding, and medical care improved.

Another reason is that other major industrial developments had an impact on medicine. The invention of the telegraph ensured better communication, as did the invention of railways. Factories could mass-produce complex medical equipment that could have only been imagined beforehand.

The Industrial Revolution of Medicine and Healthcare was achieved by innovation and clear thinking by the best doctors and scientists of the time. However, it could not have happened without the other incredible progress that was happening all around. The story of medicine is far from over, but it indisputably would not be what it is today without the events between 1750 - 1900.

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Why does psychiatry specialty fascinate me a lot?

Freedom is a power to determine action without restraint. Imagine a situation of a slave under slavery. People do not realize the value of things until they lose it. In modern world, the greatest punishment you can get for a crime is imprisonment. I am embarking on this issue because I see people who have psychiatric conditions to be trapped inside their own body. Let me clarify this statement by presenting in this way....mind is a centre of our body and it is like a window to analysis and see the world. So what happens if this window is closed.....you are trapped in a room called body with lost of liberty and independence.

Hope is a desire and dream to achieve utopia and nirvana. Buddhism elucidates that hope to achieve enlightenment. Humans aspire to achieve it, to relieve their feel good hormone endorphin. However we can not differentiate a thin line between reality and human ability to achieve it. Mind is the most powerful entity in the whole world. The balance is inevitable. So what happens if the arrangement is shattered.....you are a car with no brakes to stop it.

Time is a dimension in which events can be ordered from the past through present into future. Immortality is not the definitions for our HUMAN .We are born with time capsule to expire just like the drug that runs out after its date is over. God has given equal time from hours, minutes to seconds. If time is polluted with certain unforgotten milestones, then it strikes and leaves its scar marks. So what happens if equilibrium is not gained.....you are lost in a limbo, with no clear indication either to ride in circle of life or leave it with social stigma.

SO, why psychiatric specialty fascinates me a lot? I aspire to live in a room with window to see, feel and experience. To have a car with proper brakes to teach people to drive a car called life. In a nutshell, psychiatry is a subject that studies human minds which even time may collapse to explore its mystery.

Dr Deoman (Dipen) Gurung

My Dementia Training Trip to Nepal

Dr Arun Jha
Vice President, NDAUK

An Invitation

On 18th December 2012, I received the following invitation from the organising secretary of the Psychiatric Association of Nepal (PAN):

> Dear Dr. Jha
> Namaste
> We are grateful to Psychiatrists Association of Nepal (PAN) for entrusting us with the responsibility of hosting the 5th National Conference of PAN in Pokhara. The theme for the conference is "Challenges in geriatric psychiatry".
>
> **Venue:** Waterfront Resort, Lakeside Road, Pokhara, Nepal
> **Date:** 12-13th April 2013 (30-31 Chaitra 2069)
>
> It's my pleasure to invite you as an Expert in Geriatric Psychiatry for workshop/symposia/guest lecture as you choose. Sir, in case you could not manage time we are still expecting help from you to suggest expert(s) who can organize workshop/Symposia/Guest Lecture. It will be very useful to all of us here in Nepal to hear from experts in the field. Particularly our MD residents will benefit the most.
> Hoping for a positive response.
> With Regards
> Sincerely,
> **Dr. Nirmal Lamichhane**, Organizing Secretary
> **Conference Secretariat**

You can imagine how pleased I was to be invited by my Nepalese colleagues for their national conference as one of the keynote speakers. I have been trying to promote dementia awareness and training in Nepal for last few years. NDAUK has been supporting me whole-heartedly for this cause. NDA had organised a charity dinner at Birmingham in April 2012 to raise fund in support of the Alzheimer's and related Dementia Society (ARDS) Nepal, which was successfully launched in July 2012 (inaugurated by the honourable Vice President of Nepal).

The above invitation provided me a perfect opportunity to provide dementia training to Nepalese doctors and nurses. In this report I would like to outline some of my achievements and contributions towards the cause of dementia care in Nepal.

Dementia First Aid Training in Dhading

We have written a 'Dementia First Aid' book in Nepali that was published by the ARDS-Nepal with the money raised at NDA Birmingham charity dinner. I wanted to test out the usefulness of the 'Dementia First Aid Training' for general public. By coincidence, the Rotary Club of Orange Daybreak (RCOD) NSW Australia had asked the Mental Health First Aid (MHFA) Nepal to run a MHFA course in Dhading. I used that offer to promote the dementia first aid programme. Mr. Prabhat Kiran Pradhan of MHFA Nepal and I went to Dhading for a two-day course where he taught mental health and I talked about dementia first aid.

Dhading is one of the seventy-five districts of Nepal with a population of 338,658. About 90 km west of Kathmandu, Dhading is surrounded by 'Ganesh' mountain range on one side and Trishuli River on the other.

My journey from Kathmandu to Dhading was adventurous as well as scary at times. There was an unexpected Nepal 'BUND' on the day of our travel, Sunday, 7th April 2013, which meant we could not leave Kathmandu before 6 pm. The journey included one and half-hour travel on a muddy

road by jeep and we reached Dhading 'Maidi' village just before midnight. Our stay in a tent at a campsite without electricity and running water was equally adventurous! Participants were 27 local school teachers on day one, and 32 primary health workers on the 2nd day.

Pokhara PAN Conference

Coming to Pokhara from Dhading was like coming from Nepal to England, especially the plane journey and stay at a four-star hotel compared to the tent! I will thing twice before going to Dhading again!

As the Vice President of NDA UK I was offered a seat at the dais along with the chief guest and the representatives of Nepal Medical Association and Indian Psychiatric Society at

the opening ceremony of the PAN conference, where I was able to fly the NDA Flag.

I was given two slots at the conference – first was the keynote speech on 'challenges of setting up memory clinics in Nepal' and the second was to run a three-hour 'Dementia diagnosis and management' workshop. One of my consultant colleagues from Hertfordshire, Dr. Hazel wood (right in the photo below) had especially gone to Pokhara to run the workshop. That was well attended not only by the trainee psychiatrists but also by senior psychiatrists.

Pokhara to Kathmandu

After two days at the Pokhra Lakeside I was pleased to return Kathmandu. But as they say 'there are many slips between the cup and the lips', all flights from Pokhara to Kathmandu were cancelled on 14th April due to an unusual bad weather. We had to travel by road on a private 'micro bus'. It took us 7 hours and by the time we reached Kathmandu, it was dark without electricity in the capital. It reminded me of Dhading again!

However, my 3-day stay in Kathmandu was packed with various activities. I had a series of meetings with the ARDS executive committee members mainly to draft a 'National Dementia Plan', which was to be delivered to the Ministry of Health on my final day. On day one, I went to Om Nursing campus to give a talk on dementia to the BSc nursing students. On day two, I was invited by the Image Channel TV for an interview about Alzheimer's disease.

Although it was rather cumbersome to talk about dementia in Nepali, I thoroughly enjoyed the experience. My talk is available at YouTube and its link is available at our website www.ndauk.org.

Lobbying with the Health Minister

On the last day of my Nepal visit, I did a very important piece of work. ARDS colleagues had fixed an appointment with the honourable Health Minister, Mr. Vidyadhar Mallik, to hand over a copy of the 'Nepal Dementia Plan'.

I was included in the delegation to explain to the minister the importance of dementia care in Nepal and its inclusion in the national health plan. I felt privileged to impress upon the minister why dementia is becoming a growing public health issue. The minister listened to us carefully, offered a cup of tea, and assured us that necessary action would be taken. We gave him a copy of the plan, a summary of which is given below for the attention of NDA colleagues:

Nepal Dementia Care Plan

Objective 1: Advocacy and Awareness-raising measures

There is a very low level of public and non-specialist professional understanding of dementia in Nepal. People generally believe that dementia is part of ageing for which nothing can be done. The result is that people with dementia do not know that they suffer from a type of 'disease' for which treatment and care are available.

Objective 2: Human Resource Development (HRD) for dementia care

Dementia training to all health care professionals at every level. Dementia should be included in the curriculum of all health related training programmes. All psychiatrists should be offered further training in old age psychiatry including dementia to provide memory service

Objective 3: Establishment of Regional and Zonal Memory Services

Ideally, building health and social system is required to provide a range of care and services for person with dementia and their caregivers. For Low and Middle-income countries (LMIC), WHO's Mental Health Gap Action Programme (mhGAP) has explicitly acknowledged the need for building health systems. In Nepal where the number of dementia specialist psychiatrists is very low, health system can be built by 'task-sharing' whereby teaching hospital psychiatrists can train, support and supervise non-specialist doctors, nurses and health assistants who deliver care at primary care level.

Objective 4: Access to affordable medication for dementia

Govt of Nepal should subsidise dementia medication so that it is affordable and accessible to all that need it

Objective 5: Dementia care in the community

Telecare and Day care services are crucial for keeping people with dementia in their own homes without feeling isolated and cut off from the rest of the society.

Day care services are friendly, welcoming, comfortable and safe meeting place for people with dementia and their carers.

Objective 6: Inpatient care for people with dementia

The Government should provide inpatient service at tertiary & teaching hospitals as well as at regional and zonal hospitals for the care of people with dementia. Each hospital should appoint/nominate a dementia liaison nurse to provide dementia care to senior citizens admitted with medical and surgical problems. Offer cognitive assessment to older people admitted with confusion. Identify the needs of older people with dementia. Raise dementia awareness amongst hospital doctors and nurses

Objective 7: Establish a National Dementia research and training Centre

There has been no epidemiological survey of Dementia done in Nepal, nor any clinical trial about what works well for people of dementia and their caregivers.

Government of Nepal should establish a 'National Dementia Research and Training centre.

Concluding Remarks

It is always a pleasure for me to visit Nepal especially to see my mother and family members, but this visit was special because of dementia First Aid training in Dhading, Dementia Training workshop at Pokhara PAN conference, TV interview, and drafting and handing over of the Nepal Dementia Care Plan to the Health Minister on behalf of ARDS Nepal. I would like to thank NDAUK for supporting and encouraging me to work in the field of mental health and dementia care in Nepal. I hope to continue receiving more support in the future.

My grandfather's horse

Dr Bhaskar Sharma (Ghimireigh)

After over half a century of being together Asha and I are still having arguments, probably more so than ever since my retirement. Once I was discussing these little bickering with my good friend Subarna when he said "Bhaskar it is quite normal to have these arguments you know", and adding rather philosophically, "there is no lawn without any weed. Is there?"And that was that. I had to shut up. But then fortunately this kind of arguments is exception rather than a rule.

One day while we were going through one of these moments, we started discussing about being in routine or break these routine now and again. My point was that I would like to keep myself within the limitations of my routine activities such as timely yoga, meditation, going for a walk and even the same time table for meals and bedtime and so on. Asha does not feel happy to restrict life within a time frame. She wants change. Her philosophy is quite simple in that it is the animals who like no disturbance to the pattern of their chores. Human beings are different. They need change to make their life more enjoyable. Unless you make changes and adjustment you are unable to make progress. In other words, change means progress in life. Well she makes sense. I *had to swallow my pride* and shut up.

Our argument got me thinking the following day. I went back to my memory lane. I wondered where I would be now, had I not decided to move on and carried on living in my village minding my grandfather's rice mill. I would have probably spent all my life buying and selling rice, corn, pulses and mustard. I would have been 5'2" all around. I would perhaps have succumbed with Diabetes, high blood pressure and high cholesterol with all that purified ghee on a massive pile of rice. I would have been dead long ago like my contemporary cousins. At the best scenario I would have been extortionated by the Maoist guerrillas. Scared of them I would have bought a little house in Kathmandu like most people from all over the country and lost my wealth in their hands.

Looking at the bright side though (like my dear friend Bharat and of course my better half, who always think positive) I would have been a very happy person, weighing something like 20 stones, being the head of the family with several children and grandchildren. I would not have to move at all. My sons, grandsons and their wives together with half a dozen servants would be pampering me till my last breath. What a wonderful life it would have been!!!

That then reminds me of my grand father. He was a remarkable man. Orphaned by his father as a child he was brought up by his widowed mother and as an adult he was supposedly the sole bread earner of the household. He was supposed to get married at his early teens so that she would be his mother's wage free servant. He was supposed to tend his land and raise cattle and family. Yes indeed he bowed to his mother's wish, got married when he was sixteen.

As soon as he got married he sensed that he has added responsibility. Up until now he had his mother, a small piece of land and a couple of cows with a yolk of ox. Now he had extra mouth to feed and soon there would be more and more and more. Something has to be done to escape this wheel of "destiny". He would not accept this very form of life and so he did escape!

He ran away from his home without anyone's knowledge. For five years he disappeared. For five years his wife thought she lost him although his mother did not lose hope, that one day he will appear back like a rising sun.

What he did was beyond anyone's comprehension. Over a hundred years ago when there were no roads, no transports, no habitation and when the whole belt was a part of "char kose Jhadi" (massive belt of wild forest) with ferocious wild animals roaming around all the time he went to a far away district popular for its Sanskrit College (pathsala), risking his life in search of knowledge. There he post graduated in Sanskrit literature and grammar. And when he did return he was a wise, learned man, a true Pundit. He was, in true sense an enlightened being.

Physically not too robust he had a glowing face and a very strong personality. His words were his command. He was highly respected for his immense practicality, knowledge, entrepreneurship and of course his ever growing wealth. He used to say "a prickly thorn needs no sharpening", meaning if you are good you will be good. You don't need any help from anyone. This, perhaps he wanted to reflect his own life. He used to have a huge, white Tibetan horse named "Bhote".No body, but nobody was allowed to ride it. There was a minder called "Chyangba" solely responsible for its well being. My grandfather occasionally rode to go inspect his lands and cattle, see the peasants and listen to their grievances. Sometimes travelling far and wide giving discourses, Bhote was indispensible. It looked as though those two were complementary to each other.

It so happened that one day my uncle fell ill with high fever. It lasted several days getting worse day by day. They gave up the hope. My grandfather was not too keen on modern "English" medication but even he appeared concerned. Some of the well wishers whispered as to whether the "English" medication will be of any avail. Someone should fetch a doctor. A doctor (they would not speak loud lest he heard them and rebuked)! Apparently he heard their whisper. He gave in. It was decided. But then who would bell the cat. It was not easy to find a doctor that too in the Pundit's household!

There *would* be no doctor in the whole district, no dispensaries; just a rudimentary hospital in the district headquarters which was almost impassable. So someone should ride fast and try to get a doctor from across the border in India which would be more practical. There were some Bengali doctors who knew my granddad well by his reputation. They would be obliged to come albeit reluctantly.

It so happened that I was there, fresh back home after my SLC (GCSE) from Darjeeling. I knew the place across the border and I knew the doctor in question relatively well because I had to take a trip from that market town several times during my schooling in Darjeeling. He looked at me and said, "Gairhe" (rhino) will go. Take Bhote. H is quite fast". He used to call me "Gairhe" out of affection.

Although I was delighted with the prospect that I would be the only person apart from himself to ride the Bhote I did not want to show my eagerness. Mildly I protested, "but I have never rode him. Will he allow"? "Don't be a fool. If you can't tame an animal how can you tame your whole life?"And to the horse minder, "Oye Chyangba go and get the Bhote ready. My grandson will take him today."And that was it.

It was a marvellous animal. It ran smoothly and effortlessly as if it is flying in air. I have heard people saying that if you wish to judge a horse for its smooth ride you should hold a cup full of water when you are on its back and make it run fast. If there is no spillage of water then that is the sign of a fine animal. Bhote was like it most of the time. But then it had a very strange habit. It used to stop suddenly in the middle of canter now and again for no apparent reason without and would not move whatsoever for nearly a minute. It would then start its usual steps without any command! I was flabbergasted to see this behaviour. Is it some kind of psychological barrier? Is it tired? If it was tired how on earth it started again.I was at total loss.

I was given my answer after about six weeks. My grandfather had to go to a discourse and he wanted me to accompany him. He had a great desire to see my talent flourish in Sanskrit rather than in western education but as he could see I was already in the wrong tract. He must have felt that all is not lost yet. So I accompanied him on foot whilst he rode his Bhote in a very slow pace not to tire me. What I saw and observed was phenomenal. I saw that when a person, a man or a woman came nearer the horse it stood automatically so that the approaching person bowed their head in my grandfather's feet. So long the person was near it would stand still but as soon as they move it would start moving again. So that was what it was doing all the time when I rode it although I do not think it knew that I was not its master! I had never have thought and considered the sequence of events had I not accompanied my grandfather that day. Good Lord! It knew all its life that people around his master have to pay respect to him!!

xx xx xx xx
xx xx

It was a flash back which probably lasted for about five minutes. I was not completely out of my past but then I was half way through to my present as if I am recovering from my deep sleep but not fully awake though, like a Trans.

I said "Yes I can see what you are saying. I must not be like my grandfather's horse. Can I?"
"What are you talking about?"
"Nothing".
"Well if you don't want to talk to me that is OK with me"
I hope I have not triggered up yet another argument!!!

Birmingham 15/03/2013

Treasurer's report – Dr Siri Gautam

Accounts

NDA AGM and Current Account 2012

AGM In £22593.50

AGM out £21938.50

Ambassador and Guests £385

Cancellation fee:£1903.32

AGM drug rep pull out £1049.18

Deficit: £3337.50 -ve

Left in current account: £4900-£3337.50=1562.50

Other expenses:

Audit of accounts £450 west waters

Journal £249.50

=£863

Refund delegate=£360

Account Current £503 July 2012

1. Oncological outcomes of osteosarcomas in the upper distal extremity

A. Pradhan, R. J. Grimer, A. Abudu, R.M. Tillman, S.R. Carter and L. Jeys
Royal Orthopaedic Hospital Oncology Service, Birmingham, B31 2AP, UK

Background: Osteosarcomas are rare malignant tumours seen in the upper distal extremity. Few studies have assessed the outcomes of osteosarcomas in this location and there is debate on the best way of management. This study looks at the oncological outcomes of patients with osteosarcomas in the upper distal extremity managed at a regional tumour centre in the United Kingdom.
Methods: The centre database was used to identify all patients with osteosarcomas in the elbow or distally between 1985 to 2012. Patient, tumour, treatment and outcome data was collected from the database and medical records.
Results: 30 patients were included in this study. There were 14 males and 16 females with a mean age of 36.4 years (9 to 90). 18 osteosarcomas were located in the forearm (60%), 9 in the elbow (30%) and 3 (10%) in the hand. The two most common sub-diagnoses were parosteal (28%) and osteoblastic osteosarcomas (16%). Local excision was carried out in 15 patients (51.7%), 4 patients underwent endoprosthetic replacement (13.8%) and amputation in 9 (31%).
The overall risk of local recurrence was 14.4% in this series with risk increased by older age, grade and type of tumour. The overall survival rate at five years was 67% and was related to the grade, type of the tumour, type of surgery and patient age.
Conclusion: This series has shown that patients with osteosarcomas of the upper distal extremities have favorable outcomes with current treatment methods. It highlights that tumour characteristics and patient age impact both on local control and overall survival.

2. The management of patients with septic arthritis in the University Hospital North Staffordshire

A Pradhan[1], T Jones[1], K Banavathi[2], N C Neal[1]
Trauma & Orthopaedics[1] and Microbiology Department[2]

Aims: This audit was undertaken to establish whether management of patients with septic arthritis in the University Hospital North Staffordshire was in line with best clinical evidence.
Methods: This retrospective audit assessed patients admitted in the UHNS over a twelve-month period. Patients with suspected septic arthritis were identified from the trust trauma database and medical notes of relevant patients were assessed in order to decide whether the appropriate investigations had been carried out. Current management was audited against the BSR & BHPR, BOA, RCGP and BSAC guidelines for management of the hot swollen joint.
Results: 16 patients (11 males, 6 females) with septic arthritis were identified during the 12 month period. The mean (range) age of the patient group was 48.4 years (8 months – 82 years). The knee was the site of infection in over 38% of patients. The average length of symptoms was 7 days. 93.8% (15/16) patients had synovial fluid aspirated before antibiotic administration. None of our patient group had delay in aspiration due to warfarin. All patients had synovial fluid culture and sensitivity sent, while 62.5% (10/16) patients had blood cultures sent on admission. With respect to other blood tests, all patients had a white cell count done, 93.8% (15/16) patients had a CRP and ESR done. 87.5% (14/16) patients had washout of their joints with no one having delay in surgery. Microbiology advise was taken in 87.5% (14/16) patients.
Conclusions: The results of this audit are encouraging showing evidence that the UHNS trust is following guidelines in a high percentage of patients. 93.8% of patients had synovial fluid aspirated prior to antibiotics, while all patients had synovial fluid culture and sensitivity sent. Awareness needs to be made for patients to have blood cultures sent and to discuss all patients with septic arthritis with the microbiology department to ensure appropriate antibiotics can be given.

3. Situs Inversus: A case report

Dr Sudarshan Gurung,
Foundation House Officer, West Midlands

Situs Inversus (SI) is a rare genetic condition, autosomal recessive or X-linked, with a prevalence of 1 in 10000. However, phenotypically their medical condition is unimpaired and can live a normal healthy life. Dextrocardia is seen in 3 out of 5 Situs Inversus but cause no clinical problem,there is 5-10%of congenital heart disease in SI mostly Transposition of Great Vessels and some have primary cilliary dyskinesia.Situs inversus leads to confusion with clinical findings as the organs are placed in an opposite fashion e.g. left sided pain in a patient with appendicitis.

A case study of 82 years lady presenting with fainting attacks and anaemia had an accidental finding of Situs Inversus- dextrocardia on CT scan with no symptoms in the past. The cause of her symptoms was diagnosed to be Hepatic flexure Ascending Colon Carcinoma. After successful treatment with laparoscopic hemicolectomy she was discharged on 3rd post- operative day without any complications.

Thus, Situs Inversus may create confusion in clinical diagnosis and complicate organ transplant as geometric problems arise to place an organ in a cavity with a mirror image.However, the medical condition of an individual with Situs inversus is often stable and the affected people mostly live a normal healthy life.

4. Temporal Logic–Based Fuzzy Decision Support System for Rheumatic Fever and Rheumatic Heart Diseases in Nepal

Sanjib Raj Pandey[1], Dr Jixin Ma[2], Professor Choi-Hong Lai[3]
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Abstract:
Decision Support Systems (DSSs) have been used in many fields as a tool to support decision making at different levels in an organisation. However, use of DSSs in medical diagnosis is always hampered by levels of uncertainty in that observed symptoms cannot be precisely described. It is this inability to describe observed symptoms precisely that necessitates our approach to develop a DSS for diagnosing Rheumatic Fever (RF) and Rheumatic Heart Disease (RHD) using Fuzzy and Temporal logic. Developing a decision support system for RF/RHD is complex due to the level of vagueness, complexity and uncertainty management involved, especially when the same symptoms can indicate multiple diseases. In this paper we describe how fuzzy logic could be applied to the development of a DSS that could be used for diagnosing arthritis pain (diagnosis of arthritis pain for rheumatic fever patient only), in four different stages namely Fairly Mild, Mild, Moderate and Severe. Our diagnostic tool allows doctors to log in symptoms describing arthritis pain using numerical values that are estimates of the severity of the pain a patient feels. These values are used as input parameters to the fuzzy logic tool box, which invokes rules in the knowledge to determine a value of severity for the arthritis pain. This fuzzy logic uses rules in the knowledge-based to determine whether the symptoms logged describe arthritis as being fairly mild, mild, moderate or severe. Our approach employs a knowledge base that was built using WHO guidelines for diagnosing RF, Nepal country guidelines and a Matlab fuzzy tool box as components to the system.

Keywords: Rheumatic Fever, Arthritis Pain, Temporal Logic, Fuzzy Logic, Fuzzy Rules, Knowledge-Based, Fuzzy Inference, Defuziffication.

Nepalese Doctors' Association (UK) 28th Annual General Meeting
July 26-28, 2013, Quality Hotel, Birmingham

Programme

FRIDAY 26th July 2013

15.00 – 17:00	**Check in and registration in hotel reception. Welcome refreshments (hot and cold beverage, samosa, sweet snacks etc) in hotel lounge area.**
19.30 - 21.00	**Buffet Dinner (Cobden Suite). Cold meal for late comers (by prior arrangement only)**
20.00 onwards	**Evening entertainment and cultural programme (Cobden Suite)**
Private bar closes 12.00	

SATURDAY 27th July 2013

07.00 -09.00	**Breakfast (Cobden Suite)**
09.30- 12:15 (Coffee at 11:00 – 11:15)	**AGM and Scientific Session in Cobden Suite (full programme tbc)**
10.00 – 12.00	**Alterative programme (Gymn/Swim/Sauna) also Spa (prior arrangement and extra cost). Ladies programme: Mendhi and Fashion Show (Oak Room/Acorn Suite). Children's Magic Show (10:00-10:45 in Acorn suite**
12.30- 14.00	**Buffet lunch (Cobden Suite)**
14:00 – 18:00	**Free time to explore Birmingham**

Evening Programme

18.30 - 19.30	**Drinks reception (Hotel Lounge)**
19.30 - 21.30	**Gala Dinner in Cobden Suite (catering by Sukhdev)**
18.30 – 21.30	**Children's Dinner in Oak Room with baby sitting.**
22:00	**Disco/ Entertainment (Cobden Suite)**
Private bar closes 12.00	

SUNDAY 28th July 2013

07.00 – 09.00	**Breakfast (Cobden Suite)**
10.00 - 11.30	**Family forum/Charity talks (full programme tbc) – Cobden Suite.**
12.00	**Checkout**
12.30	**Buffet lunch (Quality Hotel gardens weather permitting or Cobden Suite)**
16.30 onwards	**Bon Voyage**