



شہجار ‘Shehjar’

(Shade, a place of comfort & peace)

The British Kashmiri Medical Association

NEWSLETTER 2026

3rd Edition

September 26’



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Editorial

Dr Safina Amin

Sitting 4,000 miles away from home, it is easy to think about just how big the world really is. Yet, somehow, the further away you travel, the smaller it seems to become. Sometimes, it is the simplest things that remind you of home, mountains on the horizon, green valleys stretching into the distance, or the mist settling over the hills. For a moment, Kashmir doesn't feel quite so far away. But perhaps the strongest connection to home is through the people themselves. For Kashmiris, no matter how far you travel, there always seems to be someone who makes you feel a little closer to home.

While preparing for PLAB 2, I met Dr. Mantasha Imtiyaz through Facebook. Coincidentally, our PLAB 2 exam dates were just a day apart. We bonded so well that we ended up travelling together and staying in the same accommodation for our exams in Manchester. I feel lucky to have made a friend for life. Dr. Mantasha was also the one who introduced me to BKMA and told me about the support and opportunities the organisation provided to doctors making their way to the UK. I looked up BKMA, joined the group and, as luck would have it, there were openings for executive members at the time. I applied and was selected.

A few months later, I arrived in the UK and started my clinical attachment, where I was posted in the Acute Medical Unit. My supervisor there was Dr. Mohamed Shamooun. On my very first day in the ward, as soon as I heard him speak, I remember thinking to myself, "He sounds Kashmiri!" and sure enough, I was right. As my supervisor, he was kind enough to share his journey from GMC Srinagar to the UK and give me an insight into his experience of working as a doctor in the NHS. Hearing about his journey and the path he had taken to build his career in the UK was both encouraging and reassuring, particularly at a time when I was finding my own way into the NHS. It still amazes me that thousands of miles away from Kashmir, in a small town in the north-east of England, you can unexpectedly come across someone from the same community. It may seem like a small thing, but moments like these remind you that home is never quite as far away as it seems.

Over time, I have also been struck by the amount of work, enthusiasm and commitment that exists within BKMA. Whether it is fundraising, supporting projects in Kashmir, helping someone find a clinical attachment, sharing advice before a job interview, or simply being there when someone needs guidance, there always seems to be someone willing to help. It is not always the big projects that stand out. Often, it is these small, everyday acts of support that show the real strength of the community.

Of course, it is not always easy. Most of us are trying to do all of this alongside busy clinical jobs, full-time on-call rotas, exams, families and everything else that comes with life. Finding the time can be difficult, but somehow, we keep going. People step up, help each other out and keep things moving. That, for me, is one of the things that makes BKMA special. This year's newsletter is a reflection of some of that work. It brings together our achievements and contributions over the past year, along with articles from specialists sharing their experience and perspectives, clinical stories from our members, and a look at what lies ahead for BKMA.

Putting this issue together has been a busy process, but it has also been a rewarding one. More than anything, it has been a reminder of what can happen when a group of people come together with a shared sense of community and a willingness to contribute.

I hope you enjoy reading this issue as much as we have enjoyed putting it together.

President's Message

Dr Tafazul Hussain

Dear BKMA Family,

A huge thank you for your continued support. BKMA is growing stronger, our membership is rising, and our new website, <https://bkma.uk/> has given us a fresh new look—because even organisations deserve a makeover!

I am especially delighted to see our second-generation medics becoming more involved in BKMA. You will hear some excellent presentations from them at the conference. They are the future of our organisation, and it is wonderful to see them bringing fresh ideas, enthusiasm and energy.

We have transferred most of the funds raised to the Hope and Health Cardiac Hospital. The dialysis funds have faced a few regulatory hurdles, but we are working hard to find a legal solution so they can support much-needed charitable dialysis services in Kashmir.

I am delighted to welcome you to our Fourth Annual Conference on 19 September at the Marriott Hotel, Leicester. We have wonderful speakers, a fantastic programme and, of course, our gala dinner afterwards—so there will be plenty of learning, laughter, food and darbar!

I look forward to seeing you all. Inshallah, I will share more about our achievements and future plans at the AGM, with the date to follow soon.



Thank you for being part of the BKMA family. Together, we are doing something truly special—and enjoying ourselves along the way!

Warm wishes,

Dr Tafazul Hussain

President, BKMA

Our Year at A Glance

Dr. Shaheen Shora

British Kashmiri Medical Organisation (BKMA) has achieved significant milestones in the last one year in medical education, shared learning, charitable healthcare initiatives and raising awareness regarding patient safety and drug addiction in Kashmir. BKMA organised and successfully delivered a series of event in the last year.

SAZ-E-KASHMIR

2ND BKMA FUNDRAISER EVENT WAS HELD AT THE MARLOWS IN BUCKINGHAMSHIRE ON 18 TH OCT 2025

Guest of Honour Prof Ghulam Jeelani Mufti, OBE, world renowned haemato-oncologist spoke about his remarkable journey from Kashmir giving details of 'Jabri schools' (forced government primary schools which were established in the 1930s to promote basic literacy) – 'Jabri' meaning forced or compulsive in local parlance to becoming the world-renowned professional sharing his valuable experiences of the fascinating advances in hemato-oncology.

Guest speaker Prof Magdi Yaqoob, internationally recognised expert in nephrology and transplant medicine with over 350 peer reviewed publications gave a passionate talk about his mission to help people live better and healthier lives reducing morbidity and mortality due to kidney disease and cardiovascular diseases.



The evening social event brought the spirit of Kashmir alive with the melodious singing by Rashid Jhangeer, very well renowned artist from Kashmir. The audience found him very engaging and captivating with active participation from guests taking part in singing traditional Kashmiri songs.

The evening ended with the traditional Kashmiri dancing called 'Rauff' leaving wonderful memories to cherish for long, of a very well organised and beautiful evening.

3RD ANNUAL CONFERENCE AND SOCIAL EVENT IN LEEDS

ON 26 TH APRIL 2025

British Kashmiri Medical Association held its 3rd Annual conference at Mercure Parkway hotel in Leeds on the 26th of April 2025. The theme of the conference was 'Medical Ethics and Patient Safety' – 70 delegates attended the conference in person and delegates from Jammu & Kashmir joined us online. Dr Shaheen Shora, General secretary and Dr Eram Durrani, Social Secretary hosted the conference. Miss Sakina Itoo, Honourable Cabinet Minister for Education, Health & Medical Education and Social welfare in Jammu Kashmir, India was planned to inaugurate the conference but due to network issues, Mr Nasir Aslam Wani (Sogami), Advisor to Honorable Chief Minister, Jammu Kashmir, stepped in and inaugurated our conference. Mr Nasir welcomed the collaborative working initiative between health care professionals in UK and Jammu and Kashmir to improve standards of safety and quality of health care in Jammu and Kashmir. We are grateful to Mr Nasir Wani. Our guest speaker Prof Nusrat Husain spoke about 'Intergenerational trauma and building resilience' and Mr Tawqeer Rashid, spoke about the 'Impact of MDT & Patient Education in cutting Diabetic Foot Amputations'



We had a very constructive panel discussion on 'Safety in Healthcare Saves Lives' which was chaired and moderated by Mr Gulzar Mufti and co-moderated by Mr Arshad Bhat. Our panelists from Kashmir – Prof Mohammad Ashraf Ganie, Prof (Dr) Rukhsana Najeeb and Dr Jehangir Bakshi shared their valuable insights working in Kashmir and the panelists from UK – Dr Afifa Qazi, Miss Sameena Muzaffar and Dr Yasir Rashid shared the protocols followed in UK along with their vast experience. Dr A R Mahroo, retired Consultant Anaesthetist was given a Lifetime achievement award for his exemplary work as part of the British Kashmiri Medical Fraternity towards delivering excellent patient care, teaching and improving standards of care here in UK and back home in Kashmir. BKMA recognised the outstanding contributions of its members at regional and national levels in UK and Dr Nazir Bhat, ENT consultant, Dr Sarfaraz Shora, Consultant Psychiatrist & Deputy Medical Director & Director of Medical Education and Dr Shah Faisal Tarfarosh, Consultant Psychiatrist were felicitated and given awards of recognition for their excellent work in various fields of medical training and patient care.

Awards were given for poster presentations at the conference. Dr Kamran HassanDar won the first prize for "Driving Advice Audit—A Quality Improvement Initiative to Enhance Patient Safety and Adherence to DVLA and GMC Guidelines" and Dr Hameem Fayaz won the second prize for 'Patient Safety Awareness Audit amongst healthcare professionals in Jammu and Kashmir'. 2nd edition of BKMA newsletter was released by Dr Nazir Shameem, GP and senior BKMA member. BKMA thanked Dr Roshan Ara Khuroo as lead editor of the newsletter and everyone who contributed to making this edition a diverse and interesting one.

Our President Dr Tafazul Hussain thanked the outgoing executive members Dr Mehdi Hassan, Dr Roshan Ara Khuroo, Dr Qazi Manaam, Dr Salim Punjabi and Dr Aadil Zargar. Dr Mudasar Firdosi, outgoing Vice President received a special memento for his valuable contributions over the last 3 years in office and he thanked everyone for the support he received over the last 5 and a half years since his time first in the interim office as interim Vice President and the last 3 years in his role as Vice President of BKMA.

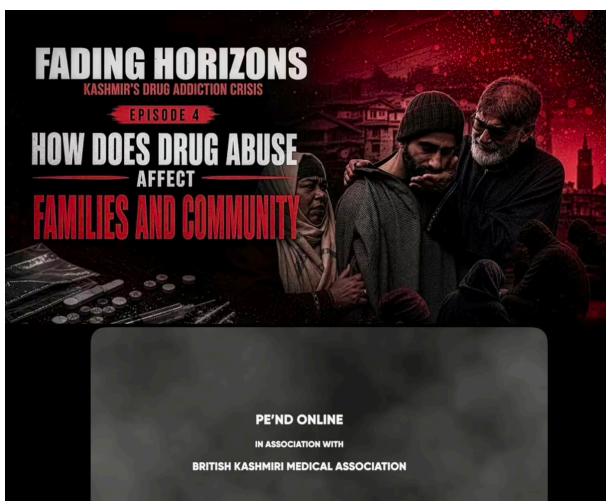
Dr Tafazul extended a warm welcome to new executive members Dr Burhan ul Islam Malik as Treasurer and Mr Arshad Bhat in his new role as Vice President, Dr Eram Durrani as social secretary and Dr Shaheen Shora as General Secretary.

We would like to thank Dr Mehdi Hassan for leading the IT support for the conference and our sponsors 'Lifeline Protect'. Finally, a special thanks and gratitude to Dr Eram Durrani, our social secretary for organising a successful conference & all BKMA members and delegates for their active engagement and support.

We had organised a social event and dinner for families of members and all British Kashmiris. Ajaz Rah, well known singer from Kashmir performed at the social event and received great appreciation. All guests enjoyed the social event.

FADING HORIZONS A 6-PART VIDEO SERIES ON DRUG ADDICTION & SUBSTANCE MISUSE

This project in collaboration with Pend online, Educational Research centre is available to access on social media platforms - Youtube, Instagram and Facebook. The Fading Horizons Drug Addiction series is a six-part video series that delves into the hidden reality of addiction. It was aimed to raise awareness regarding Substance Misuse in particular in Kashmir and it explores how people fall into addiction, what keeps them trapped and the difficult path towards recovery and hope. It brings forth the perspectives and struggles of drug addiction, including trauma, cravings, denial and silent battles that drug addicts face and the detrimental impact on mental and physical health, relationships, employment, finances, families and the whole society.



The series is designed to foster healing and uphold dignity of those affected by the substance misuse disorders and drug addiction. It is presented by Pend Online and has had a very positive response from viewers.

BKMA convey their gratitude to Touseef Mir for the series concept, Dr Aadil Shah, Substance Misuse specialist and Dr Shaheen Shora, Consultant Psychiatrist as series consultants. BKMA wants to express their gratitude to the professionals and editorial team and all artists on the ground in Kashmir for making this informative series.

Dr Shaheen Aslam Shora
General Secretary, BKMA



Fundraising Update

Mr. Burhan Malik

We held a very successful fundraising event in Marlow on 18 October 2025, with more than 200 people in attendance. It was truly heartening to see the community come together in support of such an important cause.

Thanks to your generosity, we raised almost £80,000 on the day, of which £70,000 has already been received.

To date, we have successfully transferred £35,000 to Children's Hospital, Hope and Health. Combined with previous donations of approximately £100,000, this means that nearly £135,000 has been provided to support their wonderful work. We are also due to transfer £21,000 to Al Imdad Dialysis Unit and £14,000 to Al Fatima Dialysis Unit, pending legal clearance (FCRA). Many donors have kindly set up monthly direct debits, while others are continuing to fulfill their pledges over the coming months.

We would like to kindly remind anyone with an outstanding pledge to transfer the remaining balance at their earliest convenience. The fundraising campaign will remain open on our website until March 2027 and will also include our Ramadan Appeal. Together, let us strive to exceed our target of £100,000. We are also delighted to report that we have successfully claimed almost £11,000 in Gift Aid on donations received.

Membership fees continue to be the backbone of BKMA's income. We kindly ask all members to check their payment arrangements and ensure that their membership subscriptions are still being debited.

Active participation in conferences, fundraising activities, and BKMA events is another valuable way of supporting and engaging with the organisation.



Once again, a heartfelt thank you to the entire BKMA community, especially our donors, for your generosity, trust, and continued support. It is only through our collective efforts that we are able to make a meaningful difference.

With regards,

Burhan

Treasurer/Trustee, BKMA

Safety of Healthcare in Kashmir

- Are we doing things right?

Dr. Yasir Rashid

In the last decade, Kashmir has witnessed a monumental advance in the delivery of healthcare, with the introduction of new technologies, the growth of government medical institutions, the creation of super-specialty departments, the expansion of the private sector with corporate investment, and much more. The work accomplished by medical teams across the Union Territory is truly extraordinary. To put this into perspective, according to the Directorate of Health Services Kashmir, approximately 30,000 surgical procedures are carried out every month. In addition, tertiary centres such as the Sher-I-Kashmir Institute of Medical Sciences and GMC-associated hospitals are providing high-volume specialist services. A considerable amount of work is also being carried out within the expanding private sector, which has seen significant growth in recent years. It is encouraging to see that we are on a path of progress in terms of healthcare provision and ensuring that the common citizen can feel more secure when it comes to matters related to health. However, as healthcare professionals, we need to apply appropriate scientific methods to evaluate these services, making them robust, fit for purpose and, most importantly, safe for our patients, who have the right to question every intervention offered to them.

Patient safety has been high on the agenda for the BKMA, and for this reason, last year's BKMA conference was themed around this topic. Senior health executives from Kashmir, including the Director of Health Services, Director SKIMS and Principal GMC Anantnag, were among the panelists, with an introductory message from the Minister for Health and Medical Education, J&K. It was decided that, as a pilot project, we would try to implement WHO checklists within SKIMS and then roll them out to other institutions across the Union Territory. Although teams were formed by BKMA and SKIMS to collaborate on and implement the project, progress has been slow so far. Why has patient safety become more relevant than ever before?

Patient harm is directly related to unsafe care. Adverse events during hospital admission affect nearly one in ten patients, and about 50% of these are preventable.¹ Avoidable risks, adverse events and errors are major challenges to patient safety.

The provision of safe care is essential for maintaining trust between patients and healthcare providers. For healthcare institutions and medical professionals, patient safety is not just a legal or ethical obligation—it is a moral commitment to ensuring that every patient receives a standard of care that prioritizes their well-being.

The WHO recognized the importance of patient safety at the 72nd World Health Assembly in 2019 by adopting resolution WHA72.6 on global action on patient safety and mandating the development of a global patient safety action plan. This global ac-

tion plan was adopted by the 74th World Health Assembly in 2021, with a vision of “a world in which no one is harmed in health care, and every patient receives safe and respectful care, every time, everywhere”.

To support the WHO Global Patient Safety Action Plan 2021–2030, the WHO also published the Patient Safety Rights Charter in 2023,³ with the following objectives:

1. Affirm patient safety as a core patient right, for everyone, everywhere.
2. Identify the key patient safety rights that health and care workers and healthcare leaders are to uphold when planning, designing and delivering safe health services.
3. Promote a culture of safety, equity, transparency and accountability within health systems.
4. Empower patients to actively participate in their own care as partners and to assert their right to safe care.
5. Support the development and implementation of policies, procedures and best practices that strengthen patient safety.
6. Recognize patient safety as an integral component of the right to health.

HEALTHCARE IN KASHMIR – AT A CROSSROADS?

Our healthcare systems are expanding at a phenomenal rate, but are we keeping up with the policies and strategies required to regulate stakeholders and ensuring that the rights of citizens are upheld?

Major medical incidents are regularly reported in the local press, with aggrieved families struggling to understand the reasons for complications. Sometimes, these events end up in ugly incidents involving the targeting of medical professionals and damage to healthcare institutions and property. Although I am not aware of any local study or survey that would tell us about people's trust in healthcare institutions and healthcare professionals, I do not think we would score highly in these domains.

As we have more specialists in our com-

munity, we are also witnessing the introduction of newer therapies, advanced surgical techniques, and specialized diagnostic and therapeutic procedures within premier institutions and the private sector without any approval or regulation. This is another grey area that needs serious attention. Is there a system for approving these services? Do we have medical bodies or experts who would regulate the provision of such services? Without a proper regulatory framework, we are risking patient safety, furthering loss of trust in healthcare, and building upon a fear of engaging with modern treatments.

Local governing bodies, premier institutions and senior clinicians should take this up as a priority because time is critical to prevent further patient harm. Even though local politicians regularly

visit healthcare institutions, demonstrating their interest in improving services, the delay to prioritize patient safety measures is critical as it is risking further patient harm. It is high time that they support the idea of patient safety and allocate funds for this purpose.

Another major factor that can influence outcomes and help improve patient safety is the local press, including social media. Although most incidents come to light because of the great work done by journalists, opinionated reporting can sometimes lead to incorrect conclusions among the general public.

LOOKING FORWARD AND PLANNING AHEAD

In order to provide modern and up-to-date medical services, we need to adopt urgent regulatory measures that evaluate every aspect of healthcare provision. The common endpoint should be the delivery of safe medical care to our patients. Safe healthcare will lead to increased levels of trust between healthcare professionals and patients, not only increasing their willingness to undergo procedures and treatments but also improving adherence to medical advice.

It is therefore important to develop a roadmap for achieving the ultimate goal of safe medical care. Although this requires consensus between the authorities, institutions, senior clinicians, politicians and, most importantly, patients, the following are some of my suggestions:

1. A simple starting point would be to look at the WHO Global Patient Safety Action Plan 2021–2030, as it is a comprehensive guide for developing patient safety systems.

2. Premier tertiary care institutions should take the lead in developing local guidelines to regulate patient safety measures. These guidelines can then be recommended to the Department of Health for implementation across secondary and primary care.

3. Development of a mandatory incident-reporting system for every healthcare institution licensed to operate in the Union Territory.

4. Establishment of a regulatory body for every specialty, responsible for approving the surgeries, treatments and other diagnostic and therapeutic procedures that can be performed in any facility within the Union Territory.

5. Every healthcare provider should have a patient complaint management policy.

6. Collaboration with national and international bodies to achieve the above goals.

7. Last but not least, we have a galaxy of great clinicians who are held in high regard not only locally but also internationally, both within our medical fraternity and the wider society. I believe that they can influence the direction of healthcare towards safer care by using their good offices at multiple levels.

Dr. Yasir Rashid

FRCA

Consultant Anaesthetist

Oxford University Hospitals NHS Foundation Trust



Navigating The Shift

Dr Mudasir Firdosi



UNDERSTANDING UK MEDICAL TRAINING POLICY CHANGES AND STRATEGIC PATHWAYS FOR INTERNATIONAL MEDICAL GRADUATES

UK postgraduate medical training has changed substantially over the past year, and international medical graduates (IMGs) - including many members of our British Kashmiri medical community - need to understand what's shifted before they plan their next move.

Here I set out what the Medical Training (Prioritisation) Act actually changes, what it leaves untouched, and the routes that still work for IMGs building a career in the NHS.

1. The Policy Context: Why Training Rules Have Shifted

Over the past decade, the number of International Medical Graduates joining the General Medical Council (GMC) register rose rapidly, driven by the removal of the Resident Labour Market Test in 2020 and expanding global recruitment. While this provided crucial staffing to acute NHS services, the growth in applicant numbers far outpaced the expansion of national speciality training posts.

By 2024–2025, competition ratios for early-stage speciality posts (ST1/CT1) in fields such as psychiatry, internal medicine, surgery, radiology, and general practice reached some of the highest levels recorded in recent recruitment cycles. In response to pressure from domestic medical graduates and professional bodies, Parliament enacted the Medical Training (Prioritisation) Act 2026.

The government's own case is straightforward: UK taxpayers fund medical school places at roughly £4bn a year. Speciality applications have risen from around 12,000 in 2019 to nearly 40,000 by 2026, leaving growing numbers of UK graduates without a training post despite that investment. Ministers argue prioritisation is needed to protect that pipeline and keep medicine an attractive career for people trained in the UK.

Critics, including BAPIO and the legal team representing the QMUL Malta claimants (see Section 2C), have questioned the Act on ethical and humanitarian grounds, arguing that IMGs already in the UK, who face growing difficulty securing training posts and jobs, should either have been exempted or given a delayed commencement so that only those choosing to come to the UK after the rules changed would be affected.

The primary objective of the legislation is to have a structured hierarchy in postgraduate training recruitment, giving priority to doctors who completed their primary medical qualification or foundational training within the UK healthcare system, while defining a clear transition framework for IMGs already serving in NHS trusts

2. Key Changes to Speciality Training Allocation

The new regulatory model changes how applicants are shortlisted and appointed to national training numbers (NTNs):

A. Foundation Programme Tiering

Graduates from UK and Irish medical schools now get priority placement in the UK Foundation Programme, along with holders of recognised qualifying degrees from a handful of EEA/EFTA nations (Norway, Iceland, Switzerland, Liechtenstein). For overseas graduates without one of these qualifying degrees, direct entry has become considerably harder - getting into Foundation Year 1 (FY1) or FY2 through national matching is now close to a rarity.

B. Speciality Training (ST1 / CT1 / Higher Training)

Speciality recruitment now works on a tiered model. UK/Irish medical graduates, doctors who completed UK Foundation or Core training, and doctors with verified 'Significant NHS Experience' sit in the primary priority pool and are assessed and offered posts first. Everyone else is only shortlisted if capacity remains once that pool has been

worked through.

C. The 'Significant NHS Experience' Pathway

Recognising the contribution of overseas doctors working across NHS trusts, the framework establishes that IMGs who build a designated period of verified NHS clinical service gain access to the prioritised applicant pool.

Exactly how long that period needs to be is still being worked out in secondary regulations, with the government aiming to settle it ahead of the autumn 2026 application round for 2027 training posts. The numbers on the table range from 2-3 years - the Academy of Medical Royal Colleges' position, with the RCP specifically backing 3 - up to 5 years, which the BMA's resident doctors committee has now formally adopted as its position.

In the meantime, IMGs who hold British or Irish citizenship, Indefinite Leave to Remain, or EU Settled Status skip the NHS-experience test altogether: the legislation places them in a priority category on status alone, regardless of where they trained. That route is confirmed for 2026 recruitment as a temporary stand-in while 'Significant NHS Experience' is defined properly - whether it survives unchanged once the experience-based rules land for 2027 hasn't been confirmed yet.

Several professional bodies have proposed differing thresholds, but the final definition remains subject to secondary legislation and consultation.

The British Association of Physicians of Indian Origin (BAPIO) has called it discriminatory, creating a two-tier system, and has threatened legal action if a 5-year threshold is imposed by the Department of Health.

There’s also a legal challenge running in parallel: independent of BAPIO, a Judicial Review claim has already been filed by British medical students studying at UK overseas campuses (e.g., QMUL Malta) challenging the compatibility of the Medical Training (Prioritisation) Act with human rights protections against indirect discrimination.

3. What Has Not Changed

Just as important is what the Act leaves alone: GMC Registration & PLAB: The mechanisms for professional registration—including the Professional and Linguistic Assessments Board (PLAB) pathway, GMC primary medical qualification verification, and English language requirements (IELTS/OET)—remain fully operational. Locally Employed / Service Posts: Direct NHS trust employment—such as Trust Grade, Clinical Fellow, and Locum Appointment for Service (LAS) roles—is completely exempt from statutory training prioritisation. Trusts continue to recruit internationally qualified doctors directly based on merit, experience, and clinical capability.

4. Strategic Career Pathways for IMGs in the NHS

While direct entry from abroad into national training schemes has narrowed, clear alternative avenues exist for professional advancement.

Strategy 1: The Service-to-Training Transition
(Pathway 1 in the table 1 below)

The standard progression route for overseas doctors involves securing an initial NHS service role (e.g., Trust Grade or Clinical Fellow post). During that time, the priority is getting your Certificate of Readiness to Enter Speciality Training (CREST) signed off by an NHS consultant, while building a portfolio through clinical audits, Quality Improvement Projects (QIPs), undergraduate teaching, and workplace-based assessments (WPBAs). Once your service time reaches the ‘Significant NHS Experience’ benchmark, your application moves into the prioritised recruitment tier for speciality posts.

Strategy 2: The Portfolio Pathway, formerly CESR
(Pathway 2 in the table 1 below)

National speciality training (CCT) is not the sole route to becoming an NHS Consultant. The Portfolio Pathway lets doctors in non-training roles build up a portfolio - clinical, academic, administrative - that maps onto the CCT curriculum. Upon GMC approval, doctors are placed directly onto the GMC Specialist Register with full consultant eligibility.

Strategy 3: The Modernised SAS & Specialist Grade
(Pathway 3 in the table 1 below)

The Speciality, Specialist, and Associate Specialist (SAS) career structure offers high professional stability. SAS roles are permanent, come with protected time for teaching and study, offer decent pay progression, and increasingly build in structured clinical leadership opportunities - and, unlike training posts, they don’t require you to rotate around the region.

Table 1

Pathway	Core Requirements	Long-Term Outcome
1. Service-to-Training Route	Start in LED/Fellow post -> Obtain CREST -> Reach NHS experience threshold	Access to Priority Pool for Speciality Training (CCT)
2. Portfolio Pathway (CESR)	Non-training clinical role → Map competencies to CCT curriculum → GMC submission	Direct entry to GMC Specialist Register / Consultant status
3. Modernised SAS Track	Direct trust employment in Specialist / Associate Specialist posts	Permanent senior hospital posts, usually offered to experienced doctors in respective speciality

5. How BKMA Can Support Our Community

In my view, BKMA has a real role to play here for Kashmiri medical professionals, international graduates, and students navigating these changes. We're not starting from scratch: the "New To UK" resource page and the Trainee Wing (formerly the Students Wing) already give us infrastructure to build on. Working with other similar organisations, I think BKMA should focus on a few things:

Clinical Mentorship & Induction:

Connecting new IMGs with senior NHS consultants and SAS specialists for clinical guidance and workplace orientation

Portfolio & CREST Workshops:

Delivering focused webinars on building competitive portfolios, completing clinical audits, and navigating CREST sign-offs.

Peer Advocacy & Community:

Providing a collaborative forum where doctors share experiences, address career queries, and foster professional growth.

Keeping "New To UK" Current:

Updating the existing New To UK page with this article and future developments on the Act, so it remains the first point of reference for members navigating these changes. I've had enough messages from worried members over the past few months to know this needs to be someone's clear job, not an occasional update.

Her Last Icecream

Dr Ibrahim Masoodi

Down the memory track , years back

Mrs Radha (name changed) was a 28-year-old woman who was admitted to our hospital with recurrent vomiting and jaundice of one day's duration. There was no history of a viral prodrome, fever or intake of any offending medication. She was conscious and oriented, with mild icterus. Her systemic examination was otherwise unremarkable.

An ultrasound scan of the abdomen did not reveal any obstruction in the biliary system. All the routine investigations were sent and she was started on supportive treatment.

CONCLUSION

None of this is straightforward, and I don't think anyone should pretend otherwise. Direct national training matches from overseas have narrowed, but NHS hospitals still need skilled doctors - that demand isn't going away.

IMGs who start in direct NHS employment, build clinical competence, and use either the training priority pathway or the Portfolio Pathway can still build genuinely good careers here - I've seen colleagues do exactly this.

If you're weighing up whether to move to the UK and sit PLAB, look hard at all the options first, because the landscape has shifted since many of us made that decision ourselves. I think BKMA needs to step up and guide members through what is now a considerably more complex path.

Dr Mudasir Firdosi,
FRCPsych

Although her bilirubin and liver enzymes were only mildly elevated, her INR was four times the upper limit of normal. When we looked carefully at her liver function and coagulation profile, it was obvious that her liver function was deteriorating. She was therefore managed as a case of fulminant hepatic failure in the intensive care unit.

What had caused her jaundice and such a markedly prolonged INR remained a mystery. Later that evening, at around 8 pm, the resident doctor on duty received an urgent call from the central laboratory.

"Doc! The INR of Mrs Radha has prolonged further. It is now

18 times normal,” the laboratory technician informed him.

A repeat blood test confirmed the severely deranged coagulation profile.

She was still conscious, but such a high INR placed her at considerable risk of spontaneous internal bleeding and death. The resident doctor therefore called the head of the department.

“Dr Ibrahim, are you at home? Let us see Mrs Radha together,” Prof Prasad(name changed), the head of the department, said at around 9 pm.

I immediately changed my clothes and headed towards the hospital, which was within walking distance from my home.

Prof Prasad had already examined Mrs Radha earlier that day, but the alarming deterioration in her INR had made this astute clinician restless. He drove from his home, nearly 10 kilometres away, to review her again.

We met beside her bed in the ICU and began discussing the possible causes of this unusual clinical picture. Yet, despite going through the possibilities, we could not find an explanation.

With his characteristic infectious smile, Prof Prasad approached Mrs Radha. He gently placed his hand on her forehead. “My dear daughter, has your vomiting settled?”

“Yes, doctor. I feel better now.” “Did you take any medication before coming to the hospital? We are still not getting any clue about what is happening to you.” “No, doctor,” Mrs Radha replied.

“Doc, do you perform kidney transplants in this hospital?” she suddenly asked. “Yes, we do,” Prof Prasad replied.

“But why are you asking? You do not need a kidney transplant.” “Doc, I had an ice cream yesterday.”

“Yes, yes. Tell me more. We are here to help you,” Prof Prasad said affectionately. “What happened then? Everyone eats ice cream. There is no need to worry.”

“Doc, do you perform kidney transplantation in this hospital?” she asked again.

“Yes, my daughter, we routinely perform kidney transplants here. Your kidneys are alright and you do not need a renal transplant. Tell me what happened. Please go on. We are here to help you.”

She remained silent for a few moments.

“I want to donate my kidney to clear the hospital dues because we are poor.”

Her voice began to break. “I don’t want anyone to be in trouble.” Tears began rolling down her anxious face.

“Doc, please don’t tell my family. She paused and then continued.

“I have been silently suffering because my father could not afford a handsome dowry for my in-laws. Since my marriage, they have been teasing me and making my life miserable in one way or another.”

It will not be out of place to mention that dowry-related violence remains a serious social and public-health problem in India. Thousands of cases of dowry-related deaths are reported every year, while many more women experience harassment, intimidation and domestic violence that may never reach the authorities.

Behind these statistics are individual women whose suffering can remain hidden from healthcare professionals, families and society.

Coming back to the patient. “Doc, yesterday, when I purchased an ice cream from the market, I mixed a bottle of blackish-coloured rat poison with it. I consumed the whole of it.”

She continued to weep bitterly. It was difficult to stop the fountain of tears from her eyes

“I know I am dying. Let me go peacefully from this world. I request you not to tell my family.”

Our jaws dropped in shock. Both of us were speechless. The mystery behind the severely prolonged INR had been solved in a matter of minutes.

Her innocent face carried the look of someone who had already accepted that her story was coming to an end.

The possibility of severe bleeding, progressive liver failure and death was now very real. Depending on the type of rodenticide and the severity of poisoning, urgent specialist treatment and, in severe cases, assessment for liver transplantation may be required.

But who would donate a liver? With such a severely deranged coagulation profile, who would be willing to undertake an hours-long, high-risk operation?

And, added to this, there was bitter poverty.

It seemed as though we were being asked to ask for the moon. It was heartbreaking to listen to her painful story.

We immediately went to the counselling room and called her parents and husband.

It was extremely difficult to break the sad news to them.

Despite all our efforts, days later she breathed her last. That ice cream proved to be her last ice cream.

This tragic encounter has remained etched in my memory, not merely because of the unusual presentation of severe coagulopathy, but because of the human story hidden behind the laboratory report.

Her INR had provided us with a clue, but it was empathy that revealed the diagnosis.

As doctors, we often focus on blood tests, scans, endoscopies and other investigations. Yet sometimes the most important diagnostic test is simply to sit beside the patient, hold their hand, listen patiently and ask, "Tell me what happened."

Patients may not always reveal the truth during a hurried consultation. They may be frightened, ashamed, threatened or worried about the consequences of telling us what is really happening. A compassionate and non-judgemental approach can create the safety they need to speak.

We must also remain alert to the warning signs of suicidal behaviour. A person at risk may become withdrawn, lose interest in usual activities, experience changes in sleep or appetite, express hopelessness or worthlessness, or show a sud-

den change in behaviour. Such signs should never be ignored. As healthcare professionals, we have a responsibility not only to treat disease but also to recognise suffering. We must speak openly against dowry-related abuse and domestic violence and advocate for marriages based on dignity, equality and mutual respect rather than financial demands.

Most importantly, when someone appears to be struggling, we should ask, listen and act. Sometimes, behind an abnormal blood test lies a story that only compassion can uncover.

Dr Ibrahim Masoodi

Consultant Gastroenterologist

Cardiff and Vale University Health Board, Cardiff UK

Development of Neonatology Services

Dr. Nisar A Mir

DEVELOPMENT OF NEONATOLOGY SERVICES AT SHERI-KASHMIR OF INSTITUTE OF MEDICAL SCIENCES, SRINAGAR, KASHMIR

Introduction

In the developing countries, with rural based population and inadequate resources, the progress in the state-run and private reproductive healthcare has been mainly focused on larger cities.

In Northern India, AIIMS New Delhi and PGI Chandigarh established the level 2-3 newborn services by 1970s followed by their development into advanced, level three medical Neonatal Intensive Care Units.

However, prior to 1983, there were no neonatal health-care services in (J&K) Jammu & Kashmir. During my paediatric training in the UK, at various children's and the linked maternity hospitals (1973-1978), I gained good experience in the care of sick children and newborn infants from resuscitation to assisted ventilation.

It was the time that I became aware of the reality as to how far we were behind in our neonatal care practices in J&K. I undertook advanced training (1978-80) in Neonatal-Perinatal Medicine at the prestigious 800-bed, Hospital For Sick Children and Women's Hospital, Toronto. It had the largest NICU in the world at that time with 18 intensive care and 22 level-2 care cots in the NICU.

I worked, as a Senior Clinical and Research Fellow, under Professor Paul Swyer, who was one of the first neonatologists in North America to initiate assisted ventilation in sick neonates. As I progressed in my knowledge and skills, I was becoming increasingly clearer in my dream of returning to Kashmir to establish the neonatal care units(s), in Srinagar. At the Medical College (GMC) and SMHS Hospital Srinagar, I was inspired by our teachers, who had trained overseas and had returned to the valley and set up the speciality departments at GMC; they served as role models for us, in their dedication to the clinical services and undergraduate and postgraduate teaching. During my regular visits to Srinagar GMC, I received great encouragement to pursue this dream (of developing Neonatal



-atal Care Services in Kashmir), from my teachers, notably Late Professor S N Ahmad Shah (Principal GMC Srinagar), Late Professor A M Jan, late Professor Daljit Singh and late Professor Purn Raina. What was soul-lifting was their belief in my commitment to achieving my goal, despite all odds against it at that time.

Setting up Neonatology in Benghazi Libya (1980-84)

While SKIMS was deciding about its plans for Neonatology Department, I was invited by Professor Dr Murad Lenghi (Dean University of Garyounis Benghazi), to develop advanced neonatal care Services in Benghazi; it had no facilities for neonatal intensive care at the Children's and the Maternity Hospitals (with over 18000 deliveries pa)³. We moved to Benghazi in 1980 and found it very challenging to start a new service which required considerable resources and structural changes at the two hospital sites, procurement of equipment and specialised disposables followed by recruitment and training of the nursing staff and paediatric residents as well as appointment of the senior staff. It was a gigantic task which took nearly three years in completion and implementation of newborn care services with 4-bed neonatal intensive care unit at the Children's Hospital and a large 18-bed level-2 Special Care baby unit, at the Maternity Hospital.

Neonatology at SKIMS Srinagar

Benghazi served as my training ground for learning the art and A-Z of starting and running neonatology services in a rapidly developing country. These lessons would become my guidebook for starting the same process all over again at SKIMS in Kashmir.

As SKIMS was establishing its adult-oriented healthcare ground in the valley, there were no plans for establishing any paediatric specialty (other than paediatric surgery) at SKIMS. However, Late Dr Mufi had joined and was setting up the Paediatric Surgical unit; he was keen to have the pre- and post-operative care services for the surgical neonates.

I had been regularly in touch with late Professor A M Jan who was the vice-chairman of the Governing Body SKIMS. He arranged for us to meet the late CM, Jinab S M Abdullah (Chair Governing Body SKIMS) and we discussed the need, logistics and the requirements of the project for the development of advanced neonatal care at SKIMS. While I was still in Benghazi, the SKIMS Medical Director, late Professor B K Anand, informed me, on telephone, about the SKIMS Governing Body's decision to create the Neonatology Department and my appointment as Associate Professor with commencement of my post in 1983/4.

Soon after I joined at SKIMS, we had a series of meetings with Professor A M Jan, Professor BK Anand and Late Professor Girija Dhar, Head Obstetrics-Gynaecology Lal Ded Maternity Hospital (LDMH), Srinagar. While I was asked to: (a) develop the Neonatal ICU (on the 7th floor of SKIMS, which was still in the process of being built); I was also asked to (b) review, from a neonatal perspective, the care facilities at LDMH and (c) develop a pathway between the SKIMS NICU with the care of the sick neonates born at LDMH. I was invited by Professor Dhar to visit LDMH and we submitted a report to the Chief Minister, suggesting the establishment of level 1 & 2 neonatal units at Lal Dad Maternity Hospital (given the physical and the geographical limitations of LDMH at that time). Since both the Children's Hospital and LDMH came under the jurisdiction of the Health Ministry, my role was in the advisory capacity only, however I was happy to participate in their teaching and educational activities and my focus of work remained at the SKIMS.

In Benghazi, I had gained enough experience and know-how to start it afresh in Srinagar in 1983/4. Move to Kashmir and identifying priorities in establishing the NICU Services at SKIMS was much harder task and involved personal, family, economical and professional sacrifices.

SKIMS was an independent institution with wider support from the state for funding and development as well as recruitment of the required staff. However, there were stringent limitations in the approval of the resources for each department in piece meals and the administrative bureaucracy, that was a normal practice in the system. It was nearly over 18m-2 year period before we received the equipment and significant parts of required materials. The structural changes to the 7th floor area needed multiple revisions to transform the empty space of the ward into the Neonatal Intensive Care Unit. It took nearly 9-15 months to get the required work, involving structural, electric, ventilation, central oxygen supply and the suction systems, installed. It became my regular routine to take a 'ward round' with the project engineer, of the empty ward 7 spaces, to check the progress of the work, which required frequent alterations.

Dr Masoodul Hassan, my colleague at GMC, was bestowed on us as assistant professor and was my advisor and guide in helping me walk the tight rope of administrative roles at the institute and outside. Dr A M Nadroo and Dr Shahzada Javed joined as my colleagues and we became a family and spent endless hours, after the clinical work, in various administrative chores, choosing and ordering the equipment and related items that were required in the NICU.

NICU SKIMS Srinagar Year 1984-9

By the end of my tenure at SKIMS, our team consisted of 4 neonatology consultants with 2-4 neonatal senior residents and 4-6 residents. One of the challenges was convincing the medical, nursing and the technical staff, that we were the surrogate parents of the tiny babies, whose parents had put trust in us for neonatal care, from keeping them warm and clean, besides feeding and offering the required medical care which was needed 24/7. I have such admiration for our team of doctors, nurses and technicians who could see through these needs and sacrificed their precious hours of off-duty time to be available beyond their normal working schedule.

We worked very hard to develop a robust teaching and training programme for the trainee residents and the newly appointed nurses. We appointed four newly qualified science graduates as trainee technologists (three for the NICU and one for the neonatal laboratory) and a dietician. We were given a core of the best nurses, from the hospital pool, who have had some training/experience in paediatric care. However, the neonatal care was new to them.

We evolved a daily teaching and training session for our NICU nurses and the technical staff and sent few of them to New Delhi and Chandigarh NICUs for brief visits and courses on neonatal care. The Neonatal level 3 ICU Intensive care unit, after completion, had 4 cots for assisted ventilation with invasive and non-invasive monitoring including umbilical venous and arterial haemodynamics monitoring, exchange transfusion and total parenteral nutrition and 8-12 level 2 neonatal cots for medical and surgical, non-ventilated or post-ventilated babies as oxygen therapy, phototherapy, IV or blood transfusions.

The trans fontanel intracranial pressure monitoring and cerebral blood flow monitoring in neonates was introduced, first time in India, which helped us in offering advanced modalities and treatment in infants with birth asphyxia, intracranial haemorrhage and meningitis. We also introduced oxygen concentration devices in the unit (given the regular breakdown of oxygen cylinder delivery to the hospital), used for first time on children in India. The department had its own on-site portable x-ray machine, and the cranial ultrasound examinations were conducted by the radiologist-neonatologist teams.

Neonatal laboratory (on site in the unit) with the arterial blood gas machine and venous/arterial blood analysis gave us, round the clock, access to hematology and biochemical parameters. The hospital pathology and radiology and the blood bank departments offered great support. We established a network of cooperation with various national and international institutions and were able to seek help for review of our data as well as send our difficult pathology samples for analysis. The needle biopsy sample analysis, at the overseas centres, for histology, microbiology and cytogenetics on postmortem samples, were of great benefit for the diagnostic confirmation and counselling the bereaved families.

A small high-risk pregnancy and delivery unit was also developed by SKIMS at an old dispensary site close by, with

facilities for limited number of deliveries. Our team was actively involved in providing neonatal care, including routine examinations of all newborn infants, ranging from prescribing and delivery of immunizations to babies born at this site. The sick babies, born here, were transferred by the neonatal team in controlled conditions, in transport incubators with facilities for oxygen, IV infusion, as required, to the NICU. Our team established the norm of attendance by a trained neonatal staff member at the delivery of high-risk pregnancies. On surgical operating theatre model, we introduced a system of total inpatient care by the neonatal staff with no entry for visitors and attendants; this was a new concept in the state. Only after scrubbing, the parents were allowed to go in the NICU behind the glass screen partitions for brief visits at selected times. The mothers were encouraged to send expressed breast milk daily till the baby was free from cardio-respiratory intervention and intensive care.

We developed an outpatient service for the neonatal follow up of babies discharged home after admission and for new non-emergency sick babies. There were separate facilities of neonatal care for those babies treated at other hospitals or at home.

With a strong academic and research background, I was able to lead the department in practice-outcome audit and clinical research. As a team, we hosted various national and international educational events and participated at regional, national and international scientific educational events with presentation of our original research work from SKIMS. Appendix (1)

Outcome

Our data indicated a steady decline in neonatal mortality and morbidity, which was higher among babies transferred from other hospitals, with low birth weight and in infants with birth asphyxia, sepsis and life-threatening congenital anomalies⁴⁻⁵.

Conclusion

Neonatal Intensive care has high mortality and morbidity, given the background of very sick and tiny babies with complicated diseases who are struggling for life from birth. However, it is a great satisfaction to see that both sick, premature and low birth weight babies have now a clear chance of survival at SKIMS6. It was also very gratifying to see that the department being rewarded with national and international recognition for training senior residents to take over as consultant roles in and outside the country.

I am personally indebted to the medical, nursing, technical and secretarial colleagues in the department who spent so much of their time and effort in the cause of SKIMS on the path of development of Neonatology in Kashmir. I have tried to use term 'we' rather than 'I' throughout this write up, because I do believe it was the teamwork that sailed us through.

I would like to express my deep gratitude to Dr Masood, Dr Nadroo and Dr Javed for being the foundation of the institution that is Neonatology in Kashmir today.

Finally, I would like to thank Valerie, my wife, without whose sacrifices and support, my dream of having the neonatal care service in Kashmir would not have materialized. She has also been the proof-reader/editor and co-author of my academic manuscripts and texts.

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Early Detection of Oral Cancer: The Dentist's Role.

Dr. Eram Durrani

Introduction

Oral cancer remains a significant challenge, with prognosis strongly influenced by the stage at diagnosis. Early lesions may be small, painless and clinically subtle, while advanced disease can cause considerable morbidity affecting speech, swallowing, appearance and quality of life.

Dentists are uniquely placed to support early detection through routine examination of the oral cavity. Regular dental attendance provides repeated opportunities to identify suspicious mucosal changes and oral potentially malignant disorders (OPMDs) before disease progresses.

Risk Factors

Oral squamous cell carcinoma accounts for the majority of oral malignancies. Important risk factors include:

- Tobacco use, including smoked and smokeless tobacco
- Alcohol, particularly when combined with tobacco
- Areca/betel nut use
- Previous OPMDs or epithelial dysplasia
- Previous head and neck malignancy

Human papillomavirus (HPV) is particularly relevant to a proportion of oropharyngeal cancers, although its role should be distinguished from conventional oral cavity squamous cell carcinoma.

Importantly, oral cancer can occur without traditional risk fac-

The key message is simple:

if we do not look systematically, we may not see the lesion that matters.

The Systematic Oral Examination

Soft-tissue examination should be a deliberate part of every dental assessment. Extra-orally, assess the face, lips and cervical lymph nodes. Intra-orally, systematically examine the labial and buccal mucosa, gingivae, tongue, floor of mouth, palate and visible oropharyngeal tissues.

Particular attention should be paid to the lateral and ventral tongue and floor of mouth. Visual examination should be combined with palpation where appropriate. Induration, fixation or an underlying mass may be more concerning than surface appearance alone. Record the lesion's site, size, colour, surface characteristics and consistency. Clinical photographs are valuable for documenting and monitoring change.

Red Flags

Suspicious features include:

- Persistent unexplained ulceration
- Red or mixed red-and-white patches
- Persistent, particularly non-homogeneous, white lesions
- Induration or fixation
- Unexplained oral or lip lumps
- Unexplained tooth mobility
- Persistent cervical lymphadenopathy
- Altered sensation
- Progressive changes in an existing lesion
- Pain should not be considered reassuring — early oral cancer may be completely painless.

Oral Potentially Malignant Disorders

OPMDs include leukoplakia, erythroplakia, erythroleukoplakia and oral submucous fibrosis. Leukoplakia is particularly important in dental practice. A recent systematic review and meta-analysis involving 55 studies and 41,231 patients reported an overall malignant transformation proportion of 6.64%.

Risk was significantly greater with non-homogeneous lesions, larger lesions, epithelial dysplasia and lateral tongue involvement. Leukoplakia affecting the lateral tongue showed a malignant transformation proportion of approximately 12.7%. Clinical appearance alone cannot reliably determine the presence of dysplasia; histopathological assessment remains essential for suspicious lesions.

Proliferative Verrucous Leukoplakia

Proliferative verrucous leukoplakia (PVL) is a progressive, often

multifocal disorder with particularly high malignant potential. Systematic review evidence suggests malignant transformation occurs in approximately 44% of cases. Suspected PVL therefore warrants specialist assessment and long-term surveillance.

When Should We Refer?

Dentists should be familiar with local suspected-cancer pathways. NICE NG12 recommends considering suspected cancer pathway referral for:

- Unexplained oral ulceration lasting more than three weeks
- A lump on the lip or within the oral cavity consistent with oral cancer
- A red or red-and-white patch consistent with erythroplakia or erythroleukoplakia
- The three-week threshold should not delay referral of a lesion that already appears highly suspicious. Clinical judgement remains essential.

The Emerging Role of AI

Artificial intelligence and image-based systems may increasingly assist clinicians in recognising suspicious mucosal changes and triaging lesions. However, AI remains an adjunct rather than a replacement for clinical examination. A photograph cannot adequately assess induration, fixation or cervical lymphadenopathy, and definitive diagnosis continues to rely on appropriate specialist assessment and histopathology.

The Dentist's Responsibility

Early detection does not require sophisticated technology. It starts with consistently examining the soft tissues and acting appropriately when something is abnormal.

Five principles can guide everyday practice:

- **Look every time.**
- **Palpate when appropriate.**
- **Recognise the red flags.**
- **Document and safety-net.**
- **Refer early when concerned.**

Conclusion

Early detection remains one of the most important opportunities to improve outcomes in oral cancer.

The dentist's role is not to diagnose every lesion definitively in primary care, but to recognise abnormality, identify increased risk and ensure timely specialist referral.

Ultimately, early diagnosis begins with one simple clinical habit:

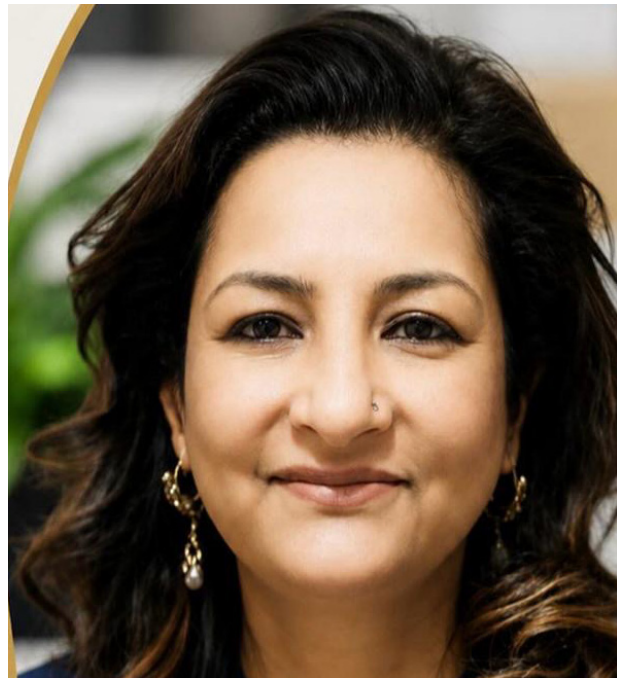
If you don't look, you won't see it.

Dr. Eram Durrani

BDS | MFDS RCPSG | MJDF RCS Eng

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Cosmetic & Implant Dentist



State-of-art screening of Diabetic Retinopathy in the United Kingdom

Dr Riyaz Ahmad

Introduction

The revolution in technology has made the imaging and analysis of retinal changes so accessible that appropriately trained non-medical personnel can effectively screen for Diabetic Retinopathy, reducing the burden on Hospital Eye clinics. Diabetic Retinopathy is a leading cause of visual impairment and blindness among working age adults. Early detection through regular screening can prevent visual loss and blindness. The NHS Diabetic Eye Screening Programme is one of the most successful and well established examples of eye screening in the UK.

How is screening carried out? Non-medical staff, including healthcare assistants, technicians, medical photographers and optometry support staff, are trained to use digital fundus camera. Tabletop cameras are commonly used in community screening clinics, making screening more accessible to patients. They can capture and store high-resolution retinal images within seconds. Essentially, a digital fundus camera combines the functions as a low-power microscope, flash and

digital camera. Visual acuity is assessed and short acting mydriatic drops instilled. Non-mydriatic cameras can obtain good quality images without dilating the pupils. The retinal images are then graded by appropriately trained screeners/ graders. Patients requiring further management are referred to the Hospital Eye Services. Optical Coherence Tomography (OCT) provides high resolution, cross sectional images of the retina within seconds, and is increasingly incorporated in diabetic eye screening pathways in England, particularly for assessing diabetic macular disease.

Who is screened? Everyone with diabetes aged 12 years and over is eligible for diabetic eye screening. Women with gestational diabetes are not routinely screened, unless they have pre-existing diabetes.

Frequency of screening: Screening is generally carried out annually. For people whose previous two screening episodes have shown no diabetic retinopathy, screening may be extended to every two years, depending on the individual risk.

Over the past decade, the number of International Medical Graduates joining the Grading and management: The NHS Diabetic Eye Screening Programme in England, uses the RxMx grading system to classify diabetic retinopathy and macular disease.

This is summarised as follows:

R0: No diabetic retinopathy

R1: Background retinopathy – e.g. microaneurysms and or small haemorrhages

R2L: Pre-proliferative retinopathy, lower risk – monitored in digital surveillance

R2H: Pre-proliferative retinopathy, higher risk – referred to Hospital Eye Services

R3A: Active proliferative retinopathy – requires ophthalmic assessment

R3S: Stable treated proliferative retinopathy

M0: No diabetic maculopathy

M1: Referable diabetic maculopathy

U (ungradable) category is used when the retinal images cannot be adequately assessed, for example because of lens opacity, small pupils or poor image quality.



Patients with sight threatening retinopathy or macular disease are referred to the Hospital Eye Services for further assessment and appropriate management. Overall, this world-class screening programme demonstrates how modern imaging technology, combined with appropriately trained non-medical personnel and specialist clinical oversight, can provide large scale screening for a major preventable cause of sight loss.

By **Dr Riyaz Ahmad**

D.O. MRCOphth. PhD

The Marvels of Ultrasound: The Silent Hero Behind IVF

Dr. Suraya Shabnam

For a couple going through infertility treatment, an IVF journey is not just about medicines, injections and procedures. It is an emotional journey filled with hope, expectations and many questions.

In this journey, there is one technology that quietly guides doctors at almost every important step— ultrasonography, commonly called USG or ultrasound. Today, particularly transvaginal ultrasound (TVS), has become an integral part of IVF treatment. It allows us to see the

ovaries and uterus in real time and helps us decide what needs to be done next

It all starts with a scan

Before starting an IVF cycle, a baseline ultrasound is usually done. It gives the doctor a good idea about the condition of the uterus and ovaries. We can look for ovarian cysts or other abnormalities and also count the small follicles in the ovaries, known as the antral follicle count (AFC). This gives us an idea of how the ovaries may

respond to the medicines used during IVF. In simple words, the first scan helps us understand where we are starting from.

Watching the follicles grow

Once the IVF medicines are started, ultrasound becomes a regular part of the treatment. The patient comes for scans at intervals, and we carefully monitor how the follicles are growing. We look at their number, size and overall development. Every woman responds differently to stimulation. Some develop a few follicles, while others may develop many. The ultrasound findings help the doctor adjust the medicines according to the individual response. This is one of the biggest advantages of modern IVF — treatment can be tailored to the

woman rather than following a fixed approach for everyone.

Getting the timing right

In IVF, timing is extremely important. At a particular stage, the patient is given a trigger injection, which helps the eggs complete their final maturation. Ultrasound plays an important role in deciding when the time is right for this trigger. The decision is not based on follicle size alone. The overall picture, and sometimes hormone levels, are also taken into consideration.

Once the trigger is given, egg retrieval is planned at the appropriate time. A well-timed process gives the best possible opportunity to retrieve mature eggs.

Looking at the baby's future home

While we are watching the ovaries, ultrasound also gives us information about the endometrium — the inner lining of the uterus. This is the place where the embryo will eventually implant. We can assess the thickness and appearance of the lining. However, it is important to understand that pregnancy does not depend on endometrial thickness alone. Embryo quality, age, uterine factors and several other aspects also play a role.

When ultrasound guides the egg retrieval

One of the most impressive uses of ultrasound in IVF is during egg retrieval or oocyte pickup. The procedure is performed using a transvaginal ultrasound probe. The doctor can see the ovaries and follicles on the screen and guide a fine needle towards them. The fluid from the follicles is then collected and sent to the embryology laboratory, where the eggs are identified. For a patient, it may look like a simple procedure. But behind it is a combination of medical skill, ultrasound guidance and laboratory expertise working together.

Helping during embryo transfer

Ultrasound can also assist during embryo transfer, another important moment in the IVF journey. It helps the doctor understand the position of the uterus and guide the catheter into the uterine cavity in a controlled manner. For the couple, this can be an emotional moment — after days or weeks of treatment, the embryo is finally being placed inside the uterus with the hope that it will implant and develop into a healthy pregnancy.

Keeping an eye on safety

IVF medicines stimulate the ovaries to produce multiple folli-

cles. Sometimes, the ovaries may respond more than expected. Regular ultrasound monitoring helps the IVF team identify an excessive ovarian response and assess the risk of complications such as ovarian hyperstimulation syndrome (OHSS). If the response is higher than expected, the treatment plan can be modified and appropriate precautions can be taken.

More than just a scan

For many patients, ultrasound may simply mean lying down for a few minutes while the doctor performs a scan. But in IVF, it means much more. It helps us see what is happening, understand how the patient is responding and decide what should be done next. From the first assessment of the ovaries to follicular monitoring, trigger planning, egg retrieval and embryo transfer, ultrasound remains an important companion throughout the IVF journey.

The eyes of IVF

Modern IVF is a combination of medicine, science, technology and, of course, the human touch. Ultrasound brings many of these together. It allows the doctor to look inside the body without surgery and make decisions based on what is happening in real time. For this reason, ultrasound can truly be called “the eyes of IVF.” For a couple hoping to have a child, every follicle, every carefully timed injection and every step of the treatment carries immense importance. And behind many of these carefully planned steps is a technology that we often take for granted—the humble ultrasound machine.

By **Suraya Shabnam** (London Women Clinic)

MBBS, PG diploma in Obgyn ultrasound,

Professional diploma in Obstetrics & Gynaecology RCPI.

ARDMS in Obgyn



Member Achievements

Dr Eram Durrani Recognised as an Iconic Woman Leader in Dentistry

The award recognises Dr Durrani's contribution to dentistry, leadership and professional development. The summit brought together leaders and professionals from a range of fields, providing a platform for networking, sharing experiences and exchanging ideas on leadership and professional impact. Speaking about the recognition, Dr Durrani described the experience as both an honour and a humbling moment. She noted that one of the most valuable aspects of the event was the opportunity to interact with leaders from around the world, exchange perspectives and learn from individuals working to create a positive impact within their professions and communities.

As part of the programme, Dr Durrani also had the opportunity to meet the Lord Mayor of Oxford, the former Lord Mayor, Members of Parliament and other distinguished leaders attending the summit. The recognition adds to Dr Durrani's professional achievements in dentistry and reflects her ongoing involvement in leadership and community initiatives alongside her clinical and professional work.

Dr Ishaq Pala Wins National Award for Leadership in Medical Education

Dr Ishaq Pala has been honoured with the College Tutor/Department Education Lead of the Year award at the Medical Education Leaders Awards, recognising his outstanding contribution to inclusive medical training and professional development within the NHS. Dr Pala has gained national recognition for his work as International Medical Graduate (IMG) and Differential Attainment Lead, where he has championed initiatives designed to support doctors arriving in the UK from overseas. Through his leadership, he has helped establish new standards for inclusion, mentorship, and professional development, setting what many colleagues describe as a national benchmark for supporting international doctors in the healthcare system. One of his most impactful initiatives has been assisting new NHS starters with essential resources and financial support during the early stages of their careers. The programme has helped many international doctors

Eram Durrani, Social Secretary of BKMA, has been recognised as an Iconic Woman Leader in Dentistry at the Women Leaders Forum UK 2026 and World Leaders Summit, held at Oxford University.



settle into the NHS with greater confidence and stability. Dr Pala also developed an IMG support framework that has been recognised nationally and featured as an exemplar by NHS England for its role in addressing differential attainment and improving training outcomes. Award organisers praised him as “an outstanding leader who has transformed the IMG experience.” His vision, compassion, and practical initiatives continue to strengthen support systems for doctors across the NHS.

Professor Owase Jeelani Awarded MBE for Services to Neurosurgery and Global Child Health

Professor Jeelani is internationally respected for his pioneering work in paediatric neurosurgery, craniofacial reconstructive surgery, and the highly complex separation of craniopagus twins—children born joined at the skull. Since joining Great Ormond Street Hospital in 2000, he has played a transformative role in advancing specialist neurosurgical care for children. From 2012 to 2018, he served as Head of the Department of Neurosurgery, helping expand it into one of the largest paediatric neurosurgery services in the world.

Beyond the UK, Professor Jeelani is widely recognised for his expertise in separating craniopagus twins. Through the charity he founded, Gemini Untwined, he collaborates with international medical teams to provide life-saving surgery and training across the globe. The British Kashmiri Medical Association has expressed immense pride in Professor Jeelani's achievement, praising his dedication, leadership, and commitment to improving children's health worldwide. Members of the association highlighted his recognition as a source of inspiration for British Kashmiri healthcare professionals and young doctors aspiring to make a global impact. His MBE celebrates a career defined by innovation, compassion, and an unwavering commitment to saving young lives.



Professor Owase Jeelani, a world-renowned paediatric neurosurgeon at Great Ormond Street Hospital, has been awarded a Member of the Order of the British Empire (MBE) in recognition of his outstanding services to neurosurgery and global child health.



Dr. Shaheen Shora Honoured as Mental Health Professional of the Year at British Muslim Health Awards 2025

Dr. Shaheen Shora Honoured as Mental Health Professional of the Year at British Muslim Health Awards 2025

Dr. Shaheen Shora, a Kashmir-born consultant psychiatrist and Clinical Director at Hertfordshire Partnership University NHS Foundation Trust (HPFT) in the United Kingdom, has been named Mental Health Professional of the Year at the British Muslim Health Awards 2025.

The award recognises her exceptional leadership, compassion, and dedication to improving equitable access to mental healthcare. Dr. Shora currently serves as a senior leader within HPFT, where she has played a key role in advancing patient-centred care and strengthening mental health services across diverse communities. Colleagues and patients alike have praised her for combining clinical expertise with empathy, ensuring that vulnerable individuals receive culturally sensitive and inclusive support. Originally from Kashmir, Dr. Shora has built a distinguished career in the UK's National Health Service, advocating for better awareness and support for mental health issues, particularly among underserved populations. Her work emphasises breaking stigma, improving community outreach, and promoting equality within healthcare systems. The British Muslim Health Awards celebrate the achievements of healthcare professionals who make significant contributions to medicine and public health. Dr. Shora's recognition highlights not only her professional excellence but also her commitment to compassion-driven care and leadership in modern mental health practice. Her achievement stands as an inspiration for aspiring healthcare professionals and a reminder of the vital role mental health specialists play in building healthier, more inclusive communities.

Snippets from 2025 Fundraising Event



Snippets from 3rd Annual Conference & Social Event 2025



Partnerships & Collaborations

Mr. Arshad Bhat

Partnership and collaboration remain at the heart of BKMA's work. Over the past year, we have continued to build meaningful relationships with healthcare institutions, professional organisations and voluntary groups in Kashmir, the UK and internationally. These partnerships enable us to share expertise, support professional development and contribute to improvements in healthcare delivery. Our aim is not simply to provide short-term assistance, but to help create sustainable opportunities for learning, service development and better patient outcomes.

Strengthening Healthcare Through Collaboration

Our collaboration with SKIMS and other healthcare institutions in Kashmir has continued to develop across several areas. By working alongside local colleagues and institutions, BKMA is able to understand local priorities and support initiatives that are relevant, practical and capable of making a lasting difference.

Following last year's discussions on the WHO Surgical Safety Checklist, BKMA worked with the Directorate of Health Services and SKIMS to support wider awareness and implementation of patient-safety principles. The checklist is a simple but important tool that encourages effective communication and teamwork before, during and after surgery. An awareness session at GMC Anantnag was particularly well received, with excellent participation from local colleagues and strong interest in strengthening surgical safety practices.

BKMA also initiated a UK Medical Student Elective Programme in collaboration with SKIMS and its affiliated medical college. Two UK medical students were selected through a formal process, reflecting the enthusiasm for developing educational links between the UK and Kashmir. Although the programme could not proceed this year because of additional governmental requirements, we remain committed to developing this initiative in the future. Such exchanges can provide valuable learning opportunities while also encouraging a deeper understanding of healthcare systems, clinical practice and the needs of local communities.

Our collaboration with Lal Ded Hospital resulted in the successful delivery of the internationally recognised Winchester OASI Course in Kashmir. The one-day programme attracted 117 delegates and combined educational lectures with practical, hands-on training. The strong attendance and positive response demonstrated the value of direct UK-Kashmir knowledge exchange and highlighted the importance of continuing to provide high-quality professional education locally.

Palliative Care – Building for the Future

One of our longer-term collaborations has been the development of a Pallia-

-nals who can return to Kashmir and help develop a sustainable service locally. Palliative care is an essential part of healthcare, supporting patients with serious or life-limiting illnesses while also providing guidance and support to their families.

Two SKIMS nurses were selected for training and BKMA committed approximately £22,000 towards the project. Unfortunately, Government NOC requirements and subsequent changes affecting the UK training provider have delayed the programme. These challenges have been disappointing, but they have not changed our commitment to the initiative.

BKMA is now exploring alternative UK-based centres that can provide meaningful face-to-face clinical exposure and appropriate training. The funds remain ring-fenced, and we will continue to work with our partners to identify a suitable way forward.

Supporting Children's Cardiac Care

BKMA continues its collaboration with the Hope and Health Foundation and Voluntary Medical Society Kashmir on the development of the Children's Heart Surgery Hospital in Bemina, Srinagar. This is an important project that has the potential to improve access to specialist cardiac care for children and families in Kashmir.

BKMA has transferred £135,000 from donated funds towards this important project. Work on the hospital is progressing, with the service expected to become operational next year. We recognise the trust placed in BKMA by its donors and supporters and will continue to keep our members informed about the progress of the project and the utilisation of donated funds.

Expanding International Partnerships

Our partnerships are not limited to the UK and Kashmir. BKMA has also begun working with KASHMER in USA, a like-minded organisation with Kashmir Healthcare as their primary focus with whom we hope to collaborate on projects of shared interest. Potential areas include initiatives addressing drug addiction and rehabilitation, an issue that continues to affect individuals, families and communities.

BKMA has also supported educational initiatives in this area, with drug de-addiction webinars being delivered in collaboration with local specialists and organisations working in Kashmir. These sessions aim to increase awareness, encourage open discussion and promote a better understanding of prevention, treatment and recovery.

Looking Ahead

These partnerships demonstrate what can be achieved when organisations work together with a shared purpose. BKMA will continue to focus on collaboration rather than duplication, bringing together expertise, resources and experience from different parts of the world.

Our ambition is to develop partnerships that are not only meaningful today, but that create sustainable improvements in healthcare, education and patient outcomes for years to come.

Mr Arshad Bhat

Vice-President BKMA
Consultant Urologist,
Wye Valley NHS Trust



Looking Ahead: Vision for the future

Dr. Saba Bashir

The British Kashmiri Medical Association (BKMA) has evolved from a relatively new professional organisation into an increasingly established association, bringing together healthcare professionals in the UK and connecting them with colleagues, institutions and communities in Jammu and Kashmir. As BKMA looks to the future, its vision is centred on building stronger professional relationships, expanding education and training, supporting sustainable healthcare development and continuing its humanitarian contribution.

Education and professional development will remain at the heart of BKMA's future plans. Through conferences, teaching programmes, professional networking and knowledge exchange, the association has already created opportunities for healthcare professionals to learn from one another. Looking ahead, BKMA aims to strengthen these activities and develop more structured opportunities for doctors, nurses and allied healthcare

professionals at different stages of their careers. Greater collaboration with colleagues and institutions in Jammu and Kashmir could provide opportunities for specialist teaching, mentoring, clinical education and leadership development, benefiting professionals on both sides.

A particularly important area for future development is nursing and palliative care. BKMA has sought to establish training opportunities for nursing colleagues from SKIMS, with the aim of developing specialist knowledge that can ultimately contribute to sustainable palliative care services in Kashmir. Although practical and regulatory challenges have delayed the programme, the commitment to developing this

area remains strong. Such initiatives reflect BKMA's wider ambition to move beyond short-term interventions and invest in people, skills and local capacity.

BKMA also intends to continue supporting healthcare projects that can make a direct difference to patients and communities. Its charitable objectives include supporting medical education, providing equipment and supplies, and assisting people affected by illness, disasters and hardship. Previous fundraising has contributed to areas such as paediatric cardiac care and dialysis services, demonstrating how the commitment and generosity of BKMA members can be translated into tangible healthcare benefits. Future projects can build on this experience while placing an increasing emphasis on sustainable service development and measurable outcomes.

Developing stronger partnerships will be central to this approach. BKMA is well positioned to act as a bridge between UK-based clinicians, hospitals, universities, charities and healthcare professionals in Jammu and Kashmir. Through these relationships, there is potential to develop regular professional exchanges, specialist training, mentoring, research collaborations, quality-improvement initiatives and the sharing of best practice. Over time, this could allow BKMA to develop from supporting individual projects towards establishing longer-term programmes with clear objectives and lasting impact.

The association also recognises the importance of investing in the next generation. Young doctors, nurses, allied healthcare professionals and medical students should have opportunities to engage with BKMA, develop professional networks and contribute to its future direction. As part of this commitment, BKMA is currently developing a UK Medical Student Elective Programme, which aims to provide students with valuable clinical and educational experiences while strengthening links between healthcare professionals in the UK and Kashmir. The programme is currently in progress, and BKMA remains committed to developing it further as an important part of its future educational and professional development activities.

Research, innovation and digital healthcare will provide further opportunities for collaboration. Stronger links between UK academics, researchers and clinicians and their counterparts in Kashmir could support joint research, academic mentorship and knowledge-sharing. Developments in telemedicine, digital education and artificial intelligence may also make it increasingly possible to share specialist knowledge and educational resources across geographical boundaries.

As BKMA continues to grow, strong governance, organisational development and effective communication will become increasingly important. Clear structures, transparent financial management, appropriate oversight and meaningful engagement with members will help ensure that the organisation develops sustainably. A stronger digital presence can also help BKMA communicate its activities, promote educational opportunities, highlight fundraising and volunteering initiatives, and demonstrate the impact of its work to members, partners and supporters.

Ultimately, the future of BKMA is about creating a lasting and meaningful bridge between the United Kingdom and Jammu and Kashmir.

Its greatest strength lies in the expertise, goodwill and commitment of its members and the wider Kashmiri healthcare diaspora. By bringing this expertise together with the needs of healthcare professionals and communities in Kashmir, BKMA has an opportunity to develop partnerships that endure, programmes that strengthen local capacity and initiatives that deliver meaningful improvements in healthcare

The years ahead therefore represent an important opportunity for BKMA to build on its achievements with ambition, unity and a clear sense of purpose. Its future success should not be measured simply by the number of events organised or projects supported, but by the professionals it inspires, the knowledge it shares, the partnerships it creates and the lasting difference it makes to patients, healthcare services and communities in Jammu and Kashmir. In doing so, BKMA can build a strong and sustainable legacy for future generations of healthcare professionals.



Tributes

Dr Sasha Bhat, beloved wife of Dr Sarfaraz Aslam Shora, Deputy Chief Medical Officer and Director of Medical Education at Bradford District Care NHS Foundation Trust; beloved daughter of the respected senior GP, Dr Hafizullah Bhat; and dearest sister-in-law of Dr Shaheen Shora, General Secretary of BKMA, returned peacefully to her Creator at her home, surrounded by her close family and loved ones, on 19 June 2026 (4 Muharram 1448 AH), after courageously facing a period of illness.

A distinguished public health and mental health leader, accomplished academic, and passionate advocate for justice and equality, Dr Sasha Bhat dedicated her life to improving the wellbeing of others. Her outstanding contributions to public service, mental health, and community development were recognised through numerous honours, including the National Public Sector Heroes Award in 2015, recognition at the Race Equality Awards, and an Outstanding Achievement Award for co-founding The Elysium Project, which helped improve the confidence, wellbeing and opportunities of young women.

Dr Sasha was also actively involved in BKMA's health initiatives and generously contributed to webinars and other programmes focused on mental health and wellbeing. She was immensely proud of her Kashmiri roots and her heritage from Shahr-i-Khaas, Srinagar, carrying Kashmir close to her heart throughout her life. Her deep connection to her heritage was reflected in many aspects of her life and work in the United Kingdom.

A scholar of exceptional calibre and an avid reader, Dr Sasha amassed a personal collection of more than 12,000 books and lovingly transformed her attic into the renowned Waterwood Library in Wakefield, Yorkshire. She possessed a deep appreciation for art, antiques, history and culture, reflecting her remarkable intellect, curiosity and lifelong love of learning.

Known for her compassion and unwavering commitment to fairness, Dr Sasha championed justice, equality and inclusion for all. She mentored and inspired many talented young people to fulfil their potential and played an active role in community initiatives, including Speakers Corner and Roshni Ghar, helping to create more inclusive spaces for ethnic minority communities, particularly women.

Despite her many achievements, Dr Sasha lived her life with great humility. Throughout her illness, her Tawakkul remained steadfast, reflecting her deep faith, strength and trust in her Creator.

A devoted animal lover, she adored her six cats, who brought her immense happiness and companionship. Dr Sasha's intellect, kindness, generosity and dedication touched countless lives. Her legacy will live on through the communities she strengthened, the people she mentored, and the many lives she transformed through her service, advocacy and friendship.



In recognition of her outstanding and selfless contribution to improving mental health and the wellbeing of others, Dr Sasha Bhat was awarded an Honorary Degree of Doctor of Health by the University of Bradford in 2026.

The family has been overwhelmed by the love, kindness and tributes received from people from all walks of life in honour of Dr Sasha. Her remarkable contribution to the NHS and to the many communities she served has been recognised and celebrated by colleagues, friends and community members alike.

Throughout her career, Dr Sasha brought positive energy, integrity and compassion to every role she undertook. In Bradford, she served as Deputy Director of Integration & Transformation and Mental Health Priority Director, as well as Programme Director for Healthy Minds & Integrated Neighbourhood Health & Care. She continued to fulfil her professional responsibilities with dedication until just four weeks before her passing.

The links below provide a selection of the many heartfelt tributes celebrating Dr Sasha Bhat's outstanding work within the NHS and the wider communities she served.

Dr Sasha will forever remain in our memories. Her legacy of compassion, integrity, courage, humility and steadfastness in making a positive difference to the lives of others will live on.

Dr Sasha Bhat

MSc in Systemic Practice awarded with Merit – University of Leeds

MA Critical Approaches to Mental Health, Spirituality & Diversity award with Distinction

PG Cert Policy & Participation awarded with Distinction – University of Central Lancashire

MSc Clinical & Public Health Aspects of Addiction – King's College London; Institute of Psychiatry
Special Clinical Psychology, BSc Hons – University of Hull

<https://www.bradford.ac.uk/news/archive/2026/university-honours-mental-health-champion-sasha-bhat-following-her-death.php>

BKMA Elected Office Bearers and Trustees 2026**Non-executive Trustees:**

Dr Nazir Ahmad Kuchhai

Mr Gulzar Mufti

Mrs Sadaf Butt

Mr Nazir Bhat

Dr Yasmin Naqushbandi

Executive Trustees:

Dr Tafazul Hussain – President

Mr Arshad Bhat – Vice President

Dr Shaheen Shora – General Secretary

Burhan Malik – Treasurer

Dr Eram Durrani - Social Secretary, Supporting Dental Health

Executive members:

Dr Saba Bashir - Executive Member For Education & Health Initiatives

Dr Yasir Rashid - Executive Member For Education & Health Initiatives

Dr Kamran Dar - Executive Member Supporting New Members

Dr Yawar Yaseen - Executive Member Supporting New Members

Dr Safina Amin - Executive Member Supporting Social Media

Dr. Rukhi Mackay – Executive member supporting student wing

