Commentary June edition: welcome from Dr Mumtaz Patel

Dr Mumtaz Patel, RCP president, prefaces this edition of Commentary and shares her reflections on the pieces.

Welcome to the June edition of *Commentary*. This includes my interview, featuring my journey to becoming RCP president. Thank you to Bethan, our wonderful editor who captured my story so well. Lots of pictures of my family, friends and colleagues from my early career to now. I hope you all enjoying reading it.

Dr John Dean, our clinical vice president has done a great interview with Anna Parry, the AACE's managing director, on modern ambulance care. They discuss the relationship between in-hospital physicians and the ambulance service – and how both roles need to evolve to create more integrated, community-based care.

Another interview is with Dr Chris van Tulleken who held a fantastic session at the RCP last November on the commercial determinants of health. This was followed by the hugely popular Christmas lecture. Chris has managed to get some of the children who attended the Christmas lecture to contribute to an upcoming article in the RCP's *Future Healthcare Journal*. These will be our youngest contributors to the journal! It is great to support our next generation at such a young age and they are so impressive. Our future leaders to come, no doubt!

We also have an update on the NHSE postgraduate training review work. Our RCP NextGen group have been instrumental in shaping our response to the NHSE Postgraduate Medical Training Review and we present some of the early findings from the NextGen survey. Thank you to all those who contributed to this.

Other updates include our RCP outpatient strategy, sustainability work and the RCP report card, and an overview of the Global Health Diploma recently developed and launched with the Médecins Sans Frontières. Continuing the global theme, I had the great pleasure of attending the first RCP fellowship ceremony in India earlier this year. This was done in partnership with MGM Healthcare in Chennai, our RCP international adviser, Dr Georgi Abraham and wider RCP fellows who were instrumental in organising and delivering such a successful event.

Lastly, we have shared our Turner-Warwick alumni experiences which are a great read. Some of the prior winners were my resident doctors and I am super proud of all of their achievements. 'The sky is the limit' for everyone, as one of the winners very rightly said.

hank you to our wonderful *Commentary* team and all the staff for putting together such a fantastic edition. Enjoy the read!

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

Back to the future of healthcare: welcome from Professor Anton Emmanuel

Professor Anton Emmanuel, Commentary editor-in-chief, shares his thoughts on articles published in this June edition.

The 10-Year Health Plan has been a long-anticipated imagining of what the NHS ought to be aspiring for as it approaches its 90th year. It is intended to cover the entirety of health (if not social) care. Efficient use of resource is prioritised and the utilisation of outpatient services is at the heart of that consideration. Working with the Patients Association, the RCP has produced a report to envisage what future outpatient clinic services should aspire for. At the heart of this is the challenge of integrating primary and secondary care as envisaged by some regions and integrated care systems. The summary of the report shared in this edition of Commentary highlights the familiar prevailing challenges– how to permit patient choice, how to use expert resources efficiently and how to bridge data gaps.

On a related theme, there is a parallel article about the future vision of the ambulance services. Anna Parry of the Association of Ambulance Chief Executives discusses with Dr John Dean, our clinical vice president, about the integration of ambulance and hospital services in order to optimise community-based care. Central to this is the recognition of the complexity and expertise of staff in the ambulance sector, organised as 14 organisations across the United Kingdom. Building on that knowledge of professional skills moves into creating accountability frameworks and efficient patient pathways – and the challenges of this are covered in this excellent dialogue.

Another future-facing article in this edition addresses future training of physicians. The piece draws on the next generation survey of doctors, which demonstrated the loss of morale engendered by resident doctors feeling that service delivery was prioritised over training or personal wellbeing. The unsustainability of a model which fails to nurture talent has been highlighted in the RCP response to the NHSE's review of medical training. The complementary priorities of addressing health inequalities and optimising workforce retention need to be at the core of any viable and meaningful reform.

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

Meet your new PRCP: Dr Mumtaz Patel

In April, Dr Mumtaz Patel was elected as the 123rd president of the RCP (PRCP). A consultant nephrologist in Manchester, her most recent RCP role is senior censor and vice president for education and training – during which time she was acting as president since June 2024. Other RCP roles include global vice president, regional adviser and college tutor.

Mumtaz speaks to *Commentary* about what inspired her to become a doctor, her vision for the presidency and the challenges and opportunities that she has faced in her career.

What made you want to become a doctor?

It's always been something that I wanted to do. My grandfather was a medical officer in India and a doctor through the World War II. He would tell us stories and I used to think, 'Oh, gosh, this sounds really exciting … you can support people at their time of need.'

If anything, my dad did not want me to be a doctor because my grandfather used to travel and move jobs a lot and was not very present at home due to the long hours that he worked. None of my grandfather's children became doctors; I was the first to pursue it. Getting into medical school just reaffirmed my love of wanting to help, support and make a difference to people.

Who has been the biggest influence and inspiration in your career?

My mum was probably my biggest inspiration to go further with education and medicine – given that was my passion.

My mum was from India, from very humble beginnings, not very affluent. She had to stop education at 14. Despite her being very clever, she didn't have the opportunity as she had to work to support the family. So, for my siblings and I, it was always instilled that education is a great privilege, education is power and education will be your path to independence.

Then, further on in my career, I had different people encouraging me along the way … I've been really lucky with lots of lovely supportive mentors invested in my journey. A lot of people encouraged me to become a hospital doctor. My initial thoughts were to become a GP … but when I started my training, I really enjoyed the hospital setting. Renal medicine was like a family, because you get to know your patient over decades and follow their journey across their lifespan. Even now, becoming PRCP, people from my medical student journey – both patients and colleagues – have reached out, which is wonderful.

How has medicine changed in the time that you have been practising?

I think medicine – expectations from patients, your role as a doctor within the profession – has changed dramatically from early in my career in the late 1990s and early 2000s.

The wider team has changed, with lots of multidisciplinary working, which I'm a big fan of. We, as a team and a department, all work together. There are new approaches and different methods of teaching and training which didn't exist before; we only had 1–2 days of communication teaching in my fourth year – and that was it.

A lot of changes are for the better, but we need to keep pace with how we teach, how we train and how we support so that the next generation will be future-proofed for the demands they face.

How did you first become involved with the RCP?

My first involvement was with the MRCP(UK) exams. They take up a big chunk of your life! Once I got my membership in 2000, I started getting involved with the college, because I wanted to help people sitting the exams. I struggled with them, like a lot of other people. I started doing MRCP teaching in my hospitals, in Preston and Manchester.

I became a resident doctor college representative in 2001; and I really enjoyed the advocacy bit. Soon after becoming a consultant, I became a college tutor – supporting resident doctors going through internal medicine training, exams, and help with their rotas and rotations. I became a regional adviser in 2014 for nearly 8 years. My first national role was in 2016 with the Federation of the Royal Colleges of Physicians of the UK, as clinical lead for quality management, which I thoroughly enjoyed. I enjoyed working with key stakeholders nationally and influencing policy.

Education and training was a big theme in my career – and giving something back, which I found very rewarding. If you've gone through challenges and

hardship, it's nice to share what works and how to make it better for subsequent cohorts at both an individual and system level – to improve things for our next generation of doctors.

Many of your roles at the RCP have focused on supporting inclusion and widening access to medicine as a career; what inspired this work?

It stems from my own journey … my parents were immigrants from India in the 1960s and I was brought up in a very working-class background. When I used to say that I wanted to do medicine, it was frowned upon a bit. At the careers fair, I went to the medicine stall … they said: 'Oh no ... People from your school don't do medicine. They don't even go onto university, so you will be lucky if you get into medical school'.

It was really challenging to feel that I could achieve it. My parents would always say, just keep going – it doesn't matter what people say, you can do it and just prove it to them by getting the grades.

Despite being predicted all grade As at A-level, I didn't get a place at medical school. They used to ask what your parents did and many of the extracurricular activities you were asked about, we could not afford … I took a year out and applied again with all grade As. I then got offers and started medical school.

I didn't want other people to go through that. I've been involved with a lot of widening access and inclusion programmes, like the one at Edge Hill University.

It's not just about access to a career in medicine; you can leave people to fail if you don't support them through their journeys. That's where inclusion and belonging comes in; through medical school, into postgraduate training. As a woman, people questioned: 'You'll want to have a family, why do you want to do renal medicine? That's a hard career path. Why do you want to get a PhD? You don't need to do that.'

It's all these barriers that I encountered, which I don't want others to face. You can change things at an individual level … but we need change at a system level, so that people are not going through these barriers. The RCP has a role here.

How can we ensure that the RCP becomes an organisation that represents modern medicine?

We pride ourselves with being over 500 years old and one of the largest medical colleges. We respect the history, but moving with the times is really important too, particularly for our current and next generation of doctors.

If you can't see the relevance of what the RCP is doing, and why, then our core purpose is lost. The modernisation of our organisational structures, our strategic approach and how we're viewed by others is really important.

Our resident doctors ask me, 'What does the RCP offer?'. There's loads that we are doing, and can do more of, that is relevant to and representative of our membership throughout their career stages. We should look at our current and future generations – doctors at the early start to the end of their careers – and see it as a continuum.

The true, unique thing that we have the potential to do is support people right through their career journey, through educating, influencing and improving. We advocate for our membership at a national and international level to fight for things that matter most to them, to influence and change policy in order to improve things for our membership and ultimately improve patient care. For me, that's the value the RCP offers. And there's so much more potential.

You are still working as a consultant nephrologist, a mum and now PRCP – in what ways can we support the growing number of women in medicine and leadership?

I'm very proud to be a mum of two and continuing as a nephrologist; keeping your hand in the day-to-day work and doing senior leadership roles is important.

Balance is really important and that sometimes is difficult. I had my children as a consultant, because as a resident doctor, I thought it would be really hard. But the work–life balance aspect shouldn't be a barrier. From a systemic perspective, we should be supporting women and people with different needs to not have these challenges affecting their future career.

When I started as a consultant, I was 27 weeks pregnant and my mum, sadly, was going through treatment for a glioblastoma. I took a career break at that critical time – just after starting a consultant job. But life happens. Thankfully I had a good support mechanism, and my trust – where I had been a resident doctor and PhD research fellow – was fantastic, which enabled me to progress.

Individual capability is not an issue. It is how we enable organisations to support individuals. Children, caring responsibilities, broader life, different protected characteristics; none of these should be a barrier. It is about making sure that the system can adapt, providing flexibility, different work options or career breaks as I had. I have always pushed for an inclusive supportive working environment for everyone.

I'm a big advocate for women in medicine and leadership – supporting the RCP Emerging Women Leaders programme and the Global Women Leaders programme – which we started in my global role and I am very proud of.

What would success at the end of your presidency look like to you?

Success would be making sure that our membership is happy with what we do and bringing people along on that journey.

The start is developing the new RCP strategy, a new approach … that we are relevant in modernising our approaches and the foundation is laid for the organisational structures to flourish over time. It's not just about producing a document; you want to see that that change and impact at all levels – for our membership, the staff, and for the wider influencing work that we do ultimately to improve patient care.

At the moment, it's such a turbulent time for medicine as a whole – and for our role as a doctor and professional in the wider healthcare system. I see a lot of challenges as opportunities. There's much more that we can do; working to be more harmonious in how we approach things, that greater collaboration.

Over the years, I've worn a lot of different hats; as a hospital clinician supporting my teams and patients, and then with national organisations – whether it's the RCP, NHS England or universities. We should all work together – that's really important. If we have a unified voice, we can do so much more, which will be beneficial and supportive for our membership, and ultimately our patients as well.

How can the RCP rebuild trust after a tumultuous time? What strategy does the RCP need?

That's a really important question …. In my mind honesty, integrity, being open and transparent; that approach is absolutely essential for the RCP. That's what I've been trying to do since I started acting as president. But that's always been my approach; to be very open in how we operate.

It is also about listening. There was a disconnect between what our membership was saying and what was being heard by the senior leadership team. Actively listening is really important, and demonstrating that by actions. I am keen to hear the voices of as many physicians as possible.

A lot is changing around how we operate and function as a college, how we do day-to-day business and breaking down artificial barriers of old. We're here for our membership, we're here for our patients; that needs to be front and centre.

With the strategy, it is the same approach. Any big strategy shouldn't be written behind closed doors. It should include all relevant stakeholders. Whenever I've done strategy development, the first thing was consultation; a listening exercise with our teams, our staff, our wider stakeholders and, most importantly, with our membership – regional advisers, RCP Council, different specialties etc. Then I would try to create themes from what we're hearing – something that's tangible, deliverable, sustainable and will have measurable, demonstrable impact over time.

It's about bringing people with us to help shape the RCP's future. We all want to improve things for current and future generations, but also patient care and systems. The RCP is a big player. The potential of what we can do is huge. It's about making people part of that journey, so that we can provide positive change together.

If you weren't a doctor, what would you like to do?

I don't know – I've always wanted to be a doctor! I don't think there's any other career that gives as much reward and satisfaction. If I hadn't become a doctor, I'd probably have gone into some kind of educational role – I love the idea of supporting, influencing, being part of somebody's journey and making a difference. But as a doctor, you can do all that! You can do wider things too such as research like I did, quality improvement, service innovation, and regional and national leadership roles to influence and drive meaningful change, you can do lots of other things. It's still the career for me. .

This interview was produced for the June 2025 edition of *Commentary* magazine and published on 1 June 2025. You can read a web-based version, which includes images.

Interview: Chris van Tulleken

Dr Chris van Tulleken is the guest editor of the June issue of *Future Healthcare Journal (FHJ)*, which will focus on commercial determinants and conflicts of interest in public health and policy. This issue of FHJ is due to publish at the end of June 2025.

***Commentary* speaks to Chris about his career and his interest in the commercial determinants of health, such as ultra-processed food and tobacco..**

Many readers might recognise you from TV, but could you share your medical background – particularly in virology and infectious diseases?

I trained at Oxford and then in tropical medicine at the London School of Hygiene and Tropical Medicine. Then, as a young registrar, I did a lot of work in 'complex humanitarian emergencies' in the Central African Republic, Pakistan and Myanmar. These are beyond just medical situations – they have political context or violence. Those were where I started to see the impact of the food industry on human health.

I was a Medical Research Council clinical research training fellow and did a PhD at UCL in molecular virology. During that, I simultaneously built a children's broadcasting career with the BBC.

How did that broadcasting, public-facing side of your career develop?

The answer is a set of accidents, chances and good fortune. Xand, my identical twin, and I auditioned to present a show about children for the BBC called *Operation Ouch*. And 14 years later, we're still presenting it. We literally applied to present a kids' show because we thought it would be fun to do together. This led to doing more for broadcasting for adults.

We're all doing [these different types of communication] to some extent. Whether you're mainly a clinical consultant doing the odd radio interview or writing the occasional piece, versus spending a quarter of your time [communicating] like me – we all end up doing a bit of it. Particularly as an infection and tropical diseases specialist, my patients are often unable to advocate for themselves. They're often from low-income settings and very marginalised. It's important to advocate for our patients, and I do a lot of that with my colleagues at UCLH.

I've tried to make my broadcasting, research, advocacy and my clinical work all focus on the same thing: these big structural problems – largely that we don't regulate corporations very effectively.

I'm still unsure about how to describe myself when speaking to policymakers, governments and intergovernmental organisations. I want to be regarded as a serious academic, who does good research and generates new knowledge, you know? But I'm also very proud of being a kids' TV presenter.

In the RCP journal *FHJ* and in *Commentary*, a lot of doctors are going to know me as they have kids who watch *Operation Ouch*. I'm keen to say that, when I'm talking about food policy, this isn't just my opinion. I'm working with institutions like RCP, WHO, UNICEF and the *BMJ* to try and ask for very well-evidenced changes in the food system.

How did you become interested in ultra-processed foods, and how has this area developed over the last few years?

[It started with] my experiences in low-income countries, watching the food industry displace traditional ways of feeding – particularly for children. Plus, very early on in my broadcasting career, I realised that we were giving people good advice that they were unable to follow. That switched my research into studying 'the social and commercial determinants of health'; how the structure of our society affects human health and especially how we might regulate corporations more effectively.

Globally, we've seen a massive amount of progress. We've seen the World Health Organization release a large report on commercial determinants of health last year. It shows that, in northern Europe, fossil fuels, food, alcohol, tobacco and gambling contribute to a large proportion of early deaths.

We've seen a growing understanding that the food industry and the tobacco industry aren't just similar – they were the same industry for a long time. The biggest tobacco companies were also the biggest food companies. There is an understanding now that many ultra-processed food products have more in common with tobacco products than with fruits and vegetables.

In the UK, we are way behind. We don't have any effective warning labels on our most harmful food, we have very little effective regulation of harmful food with regard to public health. I work with WHO and UNICEF globally, where we're seeing lots of progress. But in the UK things are very static.

Could you tell me about what inspired the upcoming edition of *FHJ* that is focused on the commercial determinants of health?

We had a tripartite meeting at the RCP last year, between the BMJ, the RCP and WHO. This issue of FHJ comes out of that meeting, which was called Dangerous Liaisons. It was a brilliant meeting, with incredible experts who said; 'We see the government partnering with industry, and this helps industry evades regulation.'

The aim was to draw attention to conflicts of interest between industries that affect human health and those who should regulate them. The tobacco industry pioneered this idea about paying doctors and scientists to mislead, or just lie, and massively delay effective regulation. For a long time, we thought that tobacco was a weird industry. But what's clear now is that the model of corrupting science, biasing policymakers and buying influence is used by fossil fuels, pharmaceuticals, gambling, tobacco, infant formula, the food industry, tech etc. [The meeting] was about bringing together experts, from different disciplines, under the RCP / *BMJ* banner to say that this is a real problem.

The backing of the RCP on that is incredibly important. It's arguably the biggest public health problem in the UK.

It's very hard to get funding [for research on the commercial determinants of health] because, by definition, we can't get funding from industry to study this problem. If you don't do this work extremely carefully, you're very vulnerable to critique because many people make a huge amount of money from these industries.

In this issue of *FHJ*, we've got contributors who have been lobbyists, we've got young people affected by marketing. We've got people running not-for-profit pharmaceutical companies, reflecting on how not having a financial incentive changes what they do.

Then we've got academics who study pharmaceuticals, gambling, tobacco, alcohol and food. All showing the subtle and different ways in which industry co-opts those who might regulate them – both the formal government regulators.

Are there any particular highlights in this issue of *FHJ*?

All the pieces are excellent; they're unusually readable, this is very accessible to the public as it's showing the ways in which industry manipulates us all. And the journal is open access, so everyone can read it.

These are, often quite young, researchers who are exposing really bad behaviour by the biggest companies on Earth and trying to do something about it. Every article is a David and Goliath story; someone trying to tackle enormous corporate power that massively damages public health.

The young people's voice is incredibly important to have in there and it's unusual. We don't often get peer-reviewed academic publications from kids at high school. That's been really exciting.

The piece about not-for-profit pharma shows that there are other ways of doing business, creating innovation and products, and serving communities that aren't just about making profits and generating investor value.

Then Lord James Bethell, who was a lobbyist for many years, has written the most powerful insider piece of how it works. We have the insider voice saying that the academic analysis is right and we have to do something. It has, in a way, much more power than a bunch of public health academics, who've been saying all this for decades.

What reaction and response are you hoping for from this issue of FHJ?

For many years, I've tried to take academic research and turn it into responsible broadcasting that isn't campaigning. We use science to make the argument. We then use those television programmes to generate more evidence and more press coverage. We've been quite successful at turning evidence into programmes, and using that to create more evidence. In a way, this issue is a continuation of that.

Getting the *imprimatur* of the RCP is what changed the tide on smoking. The RCP was a crucial institution in bringing [accountability to the tobacco industry]. To be doing this work on commercial determinants with the RCP – even among a lot of gloom and lack of progress in the UK – it starts to feel as though this is something tangible.

The very clear ask from this issue of *FHJ* is that government regulators must deconflict. You cannot have people advising the Food Standards Agency and advising the Department for Environment, Food and Rural Affairs who are in-house at, or paid by, big food companies.

As you will see in *FHJ*, the extent to which policies are written by the industries that policymakers are intending to regulate is astounding. Industry is in the room when we're writing policy that affects public health around food: they're writing the policy. We did achieve a degree of control with tobacco, so we need to use that template for all of the other industries and get industry money out of the room.

I think everyone who works in these areas understands that we will be doing this work for many, many years – probably until we die. My colleagues in South and Central America have been threatened, there's been violence. This work has to be done in partnership with WHO, the RCP, the *BMJ*; we're trying to bring many people into the room, so that it's not just lone actors taking risks.

How can physicians think about the commercial determinants of health when they are speaking with patients?

When you're in a consultation with a patient who can't lose weight, who's spending money on gambling machines, who's drinking too much alcohol or smoking

too much, it is not because they are a weak-willed person who's lazy or morally inadequate.

It is because the consumer-facing marketing budget of any one of these corporations runs into billions of pounds every year. Our patients' health is perhaps mainly determined by commercial incentives.

There's that very simple clinical reframing. I spend a lot of time saying to patients: 'It is not your fault'. It really isn't. Many *Commentary* readers will themselves be struggling with alcohol, tobacco and food – it's not our fault either. There's a personal element where you can be a little easier on people, understanding that it's a structural problem.

What can physicians take away from this edition of FHJ in their research or their own behaviours?

Many clinicians will advise or work within industry. That's important and great, but the difficulty comes with conflicted individuals. [We all] need to ask advisory boards and guideline committees for drugs, devices or food policy to be conflict free.

There's a lot of important research conducted by the pharmaceutical industry, involving scientists and physicians. Pharma is incredibly well regulated, in some respects, when it comes to research outcomes. That's the kind of model, the regulatory systems that we should be looking at much more carefully with food, gambling and alcohol.

You can't mitigate conflict. You don't get to decide if you're conflicted. If you are paid by an institution whose primary interest is making money, and your primary interest is meant to be caring for patients or improving patient care – you can't serve those two at the same time.

If you are a physician or scientist, you should absolutely be able to advise industry and you should be paid for your time. We need good, effective corporations. You should not then sit on a guideline committee that creates regulatory policy for that industry. We need to severely limit the ability that those corporations have to mark their own homework and to regulate themselves.

It's all very possible. Other countries have done this, with no hit to the economy. None of this is incompatible. This is not an anti-growth, anti-economic agenda. Everything we're proposing is fully compatible with robust vigorous economic growth and innovation.

I get offered a lot of money by the food industry and I turn it down – because I influence food policy as a broadcaster about food. I think all the institutions that affect health policycharities, royal colleges, government regulators, influencers, doctors, academics must deconflict from the industries that harm health.

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

Modern ambulance care – physicians and emergency services working together

In 2025, the Association of Ambulance Chief Executives (AACE) published their vision for the UK NHS ambulance sector, seeking to create a more integrated system of urgent and emergency care.

Dr John Dean (JD), RCP clinical vice president, spoke to AACE's managing director, Anna Parry (AP), about the relationship between in-hospital physicians and the ambulance service – and how both roles need to evolve to create more integrated, community-based care.

What is the existing relationship between ambulance services and in-hospital physicians?

JD: Traditionally, physicians' major interaction with ambulances are in an urgent or emergency care setting; in the accident and emergency (A&E) department rather than the wider hospital.

Over the past few years, we've seen more direct interaction between acute medical services and ambulance services – predominantly at the point of receiving patients. More recently, there have been links in same-day emergency care but traditionally, it's been quite a distant relationship.

AP: I'd echo that – it's the emergency department (ED) interface with ambulance conveyance and handover.

AACE is a membership organisation representing all UK NHS ambulance services. We've often been working against the perception that that the ambulance service only comprises drivers; staff in the ambulance service are clinicians. We're keen to build on that, with ambulance service clinicians working more closely with hospital physicians to ensure the right approach for individual patients.

What are the limitations in the current system?

AP: Working with clinicians within the ambulance service, chief executives and other senior leaders, I have seen things being 'them and us' rather than working together. We are much stronger and better together.

The context of current pressure and system demands can exacerbate this feeling. The introduction of the 45-minute maximum handover from NHS England's planning guidance is an example.

Handover delays have been an issue for many years. We've been charting the risk and have studied the harm that occurs for people waiting in the back of and ambulance and waiting in the community.

Where the new guidance is working is in places where ambulance and ED clinicians are talking and collaborating. This takes time, culture, leadership and leaving behind any isolationist approach. Seeing each other's point of view and having dialogue is key; that hasn't always happened historically.

It's really encouraging to hear examples where that that is happening. The starting point is quite a simple one; that mindset shift is key.

JD: You're absolutely right. The starting point is understanding each other's worlds and the common issue that we're trying to address – and then absolutely keeping the patient's needs at the centre, not the organisation's or the individual professions' needs.

AP: The ambulance service is small, but its impact can be massive. If we make a suboptimal decision, the impact is massive. If collectively we can ensure those decisions are the right decisions from the outset, then everybody stands to benefit.

How does the relationship between physicians and the ambulance service need to evolve?

AP: There is work to be done on enhancing relationships between different types of clinician. Together, we make sure that the patient gets the right care in the right place, straight away. That would be more efficient, timely and better for everybody.

JD: How we can talk more, clinician to clinician – taking the trusted assessment of the clinician who is with the patient? Then enable them to access the person who can help make the best decision for that patient.

AP: AACE advocates for paramedics to be recognised as trusted assessors, which isn't currently the case. The fundamental components in our AACE vision are navigating people to the right care and working with partners in a multidisciplinary way, managing triage behind the scenes.

In ambulance service control rooms, we have

multidisciplinary teams – doctors, nurses, palliative care and mental health clinicians – to make sure that we can make more intelligent, more effective decisions. Care coordination hubs can link with multidisciplinary teams, use that expertise and ensure that we're getting more right first time.

JD: It strikes me that these care hubs act as the first line of clinicians – but there might need to be a second line behind that. If you've got a patient with uncontrolled diabetes, the [ambulance] team might need to access a diabetes specialist for advice. Could we create the opportunity for ambulance services addressing acute presentations to link directly to a specialist team who already know a patient?

AP: Absolutely. Ambulance teams bring care to the patient and can facilitate bringing expertise to the patient.

JD: So, [physicians could see] ambulance services as clinical professionals and expert navigators for the patient, incorporating clinical assessment to enable the best navigation. Physicians see emergency physicians working with ambulance services less [than] the wider medical team, but there are examples of that happening. I'm sure people would see the potential benefits.

AP: Having the right people ending up with the right patients in the right place – that's in everybody's best interest.

JD: One thing that's impeded this – and is something that health professionals need to work on collectively – is trusted assessment and shared accountability for patients. There's been caution about taking somebody else's assessment, rather than their own face-to-face assessment of the patient. We need to create a culture where that is better understood and better delivered.

AP: I completely agree, and I appreciate that it's difficult to implement that on a national basis. But it is about seeing things from each other's perspective and getting back to what is best for the patient. It will require a mindset shift, a different way of working, which needs to be built on better understanding each other's position.

The paramedic profession is amazing. We want to move into a space where paramedics work alongside other allied health professionals and specialist experts.

How does the relationship between physicians and the ambulance service need to evolve?

JD: As professional organisations, we've got a role to be clear that we've moved from individual accountability to shared accountability. We can be clear who has a primary role for that patient in each setting. If we've outlined [ways of working] clearly, as professional standards, then it's much easier for clinicians to work and feel protected.

AP: That feeling of being protected and not going out on a limb, without organisational support, is really important.

JD: A better understanding, early in people's careers, of the knowledge, skills, and capabilities of paramedics is needed. Training [is important], how we enable physicians at an early stage of their careers to understand all members of the professional workforce.

Many physicians are educators; therefore, they might ask about their opportunity to be involved in the training of paramedics because that's one of the ways we build confidence.

AP: We want to ensure that educational institutes use the College of Paramedics curriculum, which seeks to have specialists informing undergraduate courses and training within ambulance services. We are also keen on rotational working, so that paramedics get experience of working directly in other environments. We struggle getting placements within acute settings, but it's absolutely key.

JD: We've got constraints to training, but creating that opportunity is vital. At an early stage of a physician's career, experiencing how paramedics work would be really important to unlocking understanding.

AP: Generally, in the urgent care space, we don't handle booking next-day appointments. We could be more nuanced and intelligent about care coordination; linking in with clinicians in hospital to ensure that that somebody can get a response in a timely way but without aspiring to get there in minutes or hours. Management of expectations is key because ambulance callouts see – in some instances – a false urgency when having a next-day appointment is appropriate.

How do physicians working with the ambulance service fit into the future of out-of-hospital care?

JD: There is now good evidence that hospital at home can be safe, effective and efficient. The constraints are often workforce-related, sometimes cultural or financial. Increasingly, physicians are working in community-based settings and have been for many years. Community care is well developed in some medical specialties, but there are a lot at the developmental stage.

Supporting urgent community response and providing care in people's homes – particularly around pain in older people, palliative care and respiratory care – are big examples. We're only going to see that grow.

AP: The ambulance service is pivotal and can make a real difference. It isn't about us doing it all. Instead, we seek to coordinate care at a regional level, then work

with localised, neighbourhood teams to pass information down.

JD: If the ambulance service has a patient with atrial fibrillation and we're able to have a clinical conversation, then many patients (unless they're haemodynamically compromised) wouldn't need to come to hospital immediately. We have all seen patients like that, who are in hospital because we currently aren't able to enact the right clinical dialogue. We can't transfer our knowledge to the expert in the patient's home.

We're still at early-stage development in the broader thinking about how we can be much more connected with technology. Physicians don't have to be in the same place as the patient – we can do much more with remote advice to other professionals, who might be in that patient's home.

AP: That has made such a profound difference. It can be much better to care for a patient remotely in their home , rather than pulling them into the hospital.

JD: There is the sharing of expertise and knowledge that ambulance services and paramedics have – and bringing that to physician leaders, to really explore what the opportunities are.

What might be the limitations that we face in community-based care?

JD: The aim is providing the most appropriate care, for that patient, in the best environment. There is a secondary benefit of reducing pressure in hospital – but it is important that the reason for community care is not crowding in hospitals, but that it's the right thing to do for the patient.

AP: We know how difficult things are in EDs right now; any move to reduce hospital bed numbers needs to be undertaken carefully, rather than just taking beds out. If we can get to a position whereby care can be provided in the community in a reliable, sustainable, funded way – that's preferable. But we certainly wouldn't advocate taking out provision, unless other provision is available.

We have to ensure that we're mindful of health inequalities. We see certain cohorts within the population being more regular users of emergency services. It is important to understand inequalities to ensure that those individuals get the most appropriate care. AACE does a lot of work around health inequalities and we should share that, so we can ensure that patient groups are getting appropriate care – and we can understand our service users better. We need to spend time looking at the data, so we can seek to do better for areas of the population whose needs we're not currently meeting in the best way.

As soon as you get the wrong patient in hospital, it starts an unhelpful chain of events. Long, extended hospital stays are usually not in the patient's best interest, unless they need to be there.

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

Reforming outpatient care: what the RCP recommends

In April 2025, the RCP and the Patients Association jointly published 'Prescription for outpatients: reimagining planned specialist care', a landmark report setting out a 10-year vision to transform outpatient services across the NHS.

Describing the current system as 'not fit for purpose,' the report responds directly to the challenges highlighted by Lord Ara Darzi in his 2024 independent review of the NHS in England.

RCP clinical lead for outpatients and consultant rheumatologist Dr Theresa Barnes describes the current model as 'archaic, disjointed and ultimately ineffective for both patients and staff,' noting that 'outpatient care has remained largely unchanged for decades, despite advances in technology.'

> *'Outpatient care is more than appointments. We need to define the purpose of each interaction – what we want to achieve, and how best to do it, whether through virtual clinics or asynchronous communication with patients.'*

However, she also pointed to systemic barriers: 'currently, commissioning and job planning still count appointments – not outcomes. We need to incentivise new models of care that deliver results, even if the work is done differently.'

With over 40 recommendations for clinicians, patients, policymakers, and healthcare providers, the report outlines a comprehensive roadmap for change. It calls for a fundamental shift – from siloed teams to integrated models of care, and from complex, hard-to-navigate systems to simplified, accessible and personalised care pathways delivered closer to home.

In the report, the government is urged to put outpatient reform at the heart of its 10-year health plan. This vision for reform has the potential to transform the way services are delivered by:

- ensuring timely care from the right professional in the right setting
- empowering patients through personalised care and shared decision-making
- improving communication between clinicians and with patients
- using innovative models to make the most of every interaction
- harnessing data and technology to reduce health inequalities and target care where it's most needed.

The report attracted immediate media attention, with coverage in The Telegraph, Independent and Mail Online – highlighting strong public interest in reforming this essential aspect of NHS care.

Developing the report

Work on the report began in 2023 with a series of summits held by the RCP, the Patients Association, and NHS England to explore current challenges and future opportunities in outpatient care. More than 250 individuals and 110 organisations contributed to this process, sharing their insights and experiences.

In 2024, the RCP convened a writing group led by Dr Theresa Barnes to develop the report. The group – comprising Dr Fiona McKevitt, Dr Tanya Bleiker, Dr Anne Kinderlerer and Sarah Tilsed – set out to capture the realities of outpatient care from patient, clinician, and system perspectives – and craft a new vision for services that meet the needs of today's population.

Dr Fiona McKevitt, consultant neurologist at Sheffield Teaching Hospitals and outpatients clinical lead for NHS England, emphasises the critical role of communication in safe, effective care, explaining that:

> *'Good care depends on smooth information transfer between professionals. It improves outcomes, reduces errors, and minimises treatment delays.'*

Hospital-to-community shift: RCP workshop

In April 2025, the RCP hosted a major workshop bringing together physicians, patients, primary care leaders, and government representatives to explore the role of outpatient reform in the shift from hospital-based to community care. Topics included hospital-at-home models, advanced illness management, and the evolving role of physicians in neighbourhood care.

Workshop participants – including patients and resident doctors – discussed how to implement innovative care models, the new skills clinicians will need, and how best to support patients in the community.

'Patients should see the right person first time, for early diagnosis and the best outcomes. Every encounter should count. Too often, appointments offer little benefit. We need to rethink how we add value to patient care,' says

Dr Tanya Bleiker, dermatology consultant at University Hospitals of Derby and Burton, who spoke virtually at the workshop about the importance of value-based care.

Sarah Tilsed, head of partnerships and involvement at the Patients Association emphasised the need for person-centred care:

'Patients must feel empowered to take an active role in managing their health. Personalised care, shared decisions, and self-management support can ease pressure on services and improve health outcomes.'

And what about the urgent need for better data integration? Dr Anne Kinderlerer, RCP digital health clinical lead and chair of unplanned care at Kingston Hospital agrees:

> *'Clinicians managing chronic disease need longitudinal data across systems. Interoperable records and better coding can unlock the potential for AI to identify risk and direct care to those who need it most.'*

Feedback from this workshop will inform future RCP policy and advocacy.

Looking ahead

The RCP and Patients Association hope this report will catalyse long-overdue reform in outpatient services – ensuring that care is timely, effective, personalised, and delivered where patients need it most. As momentum builds, the voices of patients and clinicians must remain central to shaping what comes next.

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

Innovative spaces for medical excellence

Located within The Spine building, Spaces at The Spine is the award-winning event venue of the RCP in Liverpool. It offers a range of flexible event spaces over three floors, all designed to support learning, collaboration and wellbeing.

Read on to discover the potential of Floor Eleven

As the RCP continues to educate, improve and influence for better health and care, Floor Eleven strengthens our ability to support the medical profession. Whether it's for advancing clinical knowledge, shaping policy, or nurturing future leaders, Floor Eleven offers a space that reflects the core values and ambitions of the RCP – both now and for the evolving landscape of healthcare and commercial events in the years to come.

Spaces at The Spine

Since its opening in 2021, the venue has captured attention for being WELL Certified at the Platinum level, the only building in the city to hold this prestigious title. Its wellbeing-focused design and architectural elements make it an inspiring environment for conferences, meetings and educational events, actively enhancing the physical and mental wellness of its visitors.

Available to RCP members and fellows for a range of event types, Spaces at The Spine not only reflects the organisation's commitment to innovation and sustainability, but also serves as a hub for healthcare professionals from across the UK and beyond.

Among the venue's many distinctive features, Floor Eleven stands out as a dynamic and multifunctional space. Purpose-built to support the evolving needs of medical education, professional development and clinical excellence, the floor is home to the RCP's medical assessment centre. It offers state-of-the-art medical facilities alongside a wellbeing-centred design, providing healthcare professionals of the future with a bespoke environment to replicate real-life clinical scenarios and practise essential skills.

Elevating learning and fostering collaboration

The clinical and technical capabilities of Floor Eleven firmly establish it as one of the leading medical simulation suites in Liverpool and the wider north-west region. Combining panoramic views across the city with interior design that balances form with function, the floor offers an inspiring area for a variety of medical, clinical and academic activities.

The floor plan includes two identical clinical assessment suites, each containing two circuits of 14 individual rooms in each half, created to simulate real-life medical environments. Designed with adaptability in mind, Floor Eleven can support a wide range of exams and educational programmes, from accredited multi-professional skills training and workshops to the PACES, OSCE and MRCP(UK) examinations that are pivotal in professional medical development.

At the core of Floor Eleven is an intelligently designed audiovisual and IT system that significantly enhances both functionality and the user experience of examiners and trainees alike. Each space is equipped with technology that allows real-time monitoring from a remote location, with audiovisual systems seamlessly integrated into a control panel. Additionally, digital signage panels throughout the facility can be fully branded, serving as a dynamic platform for communication and wayfinding.

Wellbeing-focused workspaces

The wellbeing of visitors is at the forefront of Spaces at The Spine. Whether attendees are participating in an intense training session or attending a day-long conference, the Platinum WELL Standard architectural features integrated within the venue's design are proven to enhance concentration levels, reduce stress and contribute positively to boosting overall health and a sense of wellbeing.

Natural daylight floods Floor Eleven, creating a bright and energising atmosphere. Thoughtful and subtle design features, including natural colour palette and textures, create a calming connection to nature. Furthermore, the ambient temperature and lighting systems are carefully regulated throughout the day to maintain an optimal environment for all users and visitors.

Floor Eleven is part of one of the UK's healthiest workspaces, providing access to wellness facilities, including quiet areas for reflection, as well as ergonomic furnishings that prioritise physical comfort.

A space that sparks creativity and innovation

Beyond its core educational and professional functions, Floor Eleven has an unexpected side; its capability to become a filming location for production companies. Featuring a flexible and contemporary layout that feels both adaptable and practical, it has already proven to be a popular choice for a wide array of projects – spanning from health education films to impactful promotional content.

The floor is also part of a wider full-service approach to event delivery. From exceptional in-house catering and audiovisual support to expert event coordination, the Spaces at The Spine team can work closely with members, fellows and external companies to plan and execute events with precision and care.

The floor is also part of a wider full-service approach to event delivery. From exceptional in-house catering and audiovisual support to expert event coordination, the Spaces at The Spine team can work closely with members, fellows and external companies to plan and execute events with precision and care.

A space that sparks creativity and innovation

Enquire with the team at Spaces at The Spine to find out more about Floor Eleven and how we can assist you.

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

RCP calls for reform of medical training

The RCP has submitted a detailed response to the NHS England (NHSE) medical training review, warning that the postgraduate medical training system urgently needs to change to meet the needs of our next generation of physicians.

Drawing on our next generation survey of over 1,000 doctors, the RCP has painted a picture of a system where service delivery takes priority over education, doctors struggle to plan their lives and careers, and the training experience fails to reflect modern patient care.

Burnout and disillusionment

At the heart of our response is a warning about resident doctor morale. Only 44% of respondents to the next generation survey said that they were satisfied with their clinical training, and over two-thirds have considered leaving the NHS to work abroad.

'They feel trapped on a treadmill. Rotating through a variety of short-term posts, managing intense workloads, and chasing senior doctor sign-offs – it's not sustainable,' said Dr Anthony Martinelli, RCP Resident Doctor Committee (RDC) co-chair.

Competition for internal medicine (IMT) and specialty (HST) training posts is also fuelling stress. Respondents to our next generation survey called for greater transparency, broader assessments and better consideration of geography and personal circumstances. Alongside the promised expansion of medical school places, we have called on the NHS to fund and deliver a major expansion in postgraduate training posts for the medical specialties.

A mismatch with patient demand

In particular, areas with higher health inequalities and/or a high proportion of older people living with frailty or chronic conditions should be funded for more training posts. The current distribution of training posts does not reflect population health needs. Underserved regions – often with older or more deprived populations – struggle to attract or retain resident doctors despite high patient demand. We have proposed using local data on health inequalities, consultant vacancies, and service plans to inform post allocation, and called for decentralised, college-accredited, 'stay local' training models that allow doctors to remain in one place for longer.

Redefining generalism

Many residents also find general internal medicine (GIM) training unrewarding and overly focused on the acute take – which, after all, represents just one part of generalist care.

'A modern definition of generalism must include outpatient, community, and team-based care,' says Dr John Dean, RCP clinical vice president.

Training should prepare doctors to lead multidisciplinary teams, manage complex conditions over time, and deliver care in community settings – reflecting how most consultants now practise.

Training environments under strain

Service pressure is eroding training quality. Inconsistent access to outpatient clinics and procedural skills, rota gaps, and limited supervision are common concerns.

We have recommended clearer national standards, protected educator time in job plans, and investment in core infrastructure – such as functioning IT, rest spaces, and workstations – to improve the learning environment.

Call for flexibility

A recurring theme is the need for more flexible training structures.

The RCP has proposed modular, competency-based progression, structured return-to-training programmes, and recognition of experience gained outside formal training posts.

RCP RDC co-chair, Dr Catherine Rowan aid: 'Nearly half of respondents to our next generation survey told us that they want to work less than full time in future, but many report stigma and logistical barriers. The training system needs to better recognise individual competency and merit and put less emphasis on rigid, time-based progression.'

Tackling inequalities

Our response highlights continued disparities for international medical graduates (IMGs) and doctors from minority ethnic backgrounds, including lower progression rates and higher burnout risk. It urges stronger induction for IMGs, mandatory anti-discrimination training for supervisors and disaggregated data on outcomes by ethnicity, disability and IMG status.

Preparing for the future

Training must also evolve to prepare doctors for the digital and community-based care models of the future. We have called for more training placements outside hospitals, a stronger focus on population health to align with the promised government shift to a prevention first approach, and better integration of digital health, AI and remote care into curricula.

'This is about the kind of doctors we want to train – and the kind of care we want to deliver,' Dr Martinelli concludes. 'Without action, we risk losing a generation of doctors and compromising care for the patients who need them most.'

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

How green is the RCP?

In 2024, the RCP endorsed a set of organisational sustainability commitments. Commentary takes a look at the progress made so far to embed sustainability into the RCP's activities.

In 2016, the RCP was a founding member of the UK Health Alliance on Climate Change (UKHACC), an organisation that brings together the health community to campaign on climate change and sustainability. UKHACC has published 11 commitments – covering a range of areas including campaigning, educating and operational activities – to help member organisations mitigate and adapt to climate change.

The RCP signed up to these commitments in 2024 and has undertaken an audit to determine the progress that has been made against each category. In May 2025, we published our first report card, summarising the work that we have done so far – and setting out the future work that we need to do.

'We have been advocating for action on climate change for several years but our commitment extends beyond advocacy. We recognise that the climate crisis is the biggest threat to human health and we are dedicated to minimising the environmental impacts of our operations. That is why the RCP signed up to the UKHACC commitments – a set of guiding principles to help health organisations take steps to mitigate and adapt to climate change,' say RCP interim chief executives, Tom Baker and Catherine Powell.

Policy and campaigning work

Throughout recent years, the RCP has consistently declared that the climate emergency is a health emergency, as set out in our 2024 general election manifesto.

Campaigning for the government and NHS to mitigate the impact of climate change has been a priority for the RCP. This has involved being a founding member of UKHACC, co-hosting an event at COP26 in Glasgow in 2021, making healthcare sustainability and climate change a policy priority in 2023 and contributing to policy reports led by UKHACC. An advisory group on sustainability and climate was established in 2023 to steer this work, which is led by the RCP's special advisers on sustainability and climate change.

Encouraging our members to build their understanding of the links between health and climate change is a core aspect of the RCP's work in this space. In 2024, we published the Green physician toolkit – the first-of-its-kind for the physician community – which suggested actions that physicians can take to practise greener medicine and adapt to climate change. UKHACC has even published this as a case study on its website. Podcasts and videos about the health impacts of climate change have been produced to leverage modern ways of communicating with physicians. Sustainability has also been a key feature of our conferences, with a net zero workshop taking place at Medicine 2025 to support our members to consider adopting sustainable healthcare in the workplace.

Our buildings and practices

As well as encouraging sustainable healthcare practices, the RCP has made significant strides in improving the environmental impact of our organisation.

In 2021, we ended all investments in fossil fuels – 2 years ahead of our initial deadline, and we signed the fossil fuel non-proliferation treaty in 2022. Our new staff travel policy, implemented in 2025, discourages domestic air travel and asks claimants to consider the impact of travel on the planet.

RCP catering, provided by Company of Cooks, features a selection of plant-based options and we have been taking steps to improve our supply chains – prioritising local produce and working with companies like Waste Knot to help reduce food waste.

In both our London and Liverpool home, we have been reducing sources of plastic and other types of waste. In Liverpool, all food packaging is compostable – and in London, we have a compost area with five worm bins to process kitchen waste. The recycling rate in London has recently received a gold rating from the waste supplier; 0% of waste is sent to landfill, with an 8% recycling rate. With this we have saved over 30 tonnes of CO_2.

One of our highlights of 2024 was The Spine becoming WELL Certified™ at the Platinum level. The building was built with sustainability in mind and is the only venue in Liverpool to be awarded this certification.

Our next steps

The RCP at Regent's Park, London presents one of our main challenges. With recent upgrading and retrofitting – including making the building 99% LED compliant – the building now uses 100% renewable energy. As a Grade I listed site, built in the 1960s, it is not possible to achieve net zero in this building. Alignment with the RCP's sustainability goals is a key priority for future estates planning.

The Green physician toolkit will continue to be promoted to our members, and we will explore an update of this resource to ensure that its contents remain useful and relevant. There are plans to create more educational resources and embed sustainable healthcare into our current programmes, such as the Chief Registrar Programme. As a supporting partner of a newly established 5-year research hub that will help deliver a more sustainable NHS, we will continue to support its delivery.

The report card published in May 2025 was just our first; we will be publishing another later in 2025 and then provide an annual update from 2026 onwards The RCP will continue to progress our work in this area, to make our organisation and healthcare delivery more sustainable.

Dr Bryony Alderman, the RCP sustainability fellow, stated:

> 'Healthcare sustainability, and the complex interplay between climate change and health can feel like an overwhelming and insurmountable problem, so part of my role is to find ways to support physicians to build their knowledge and feel empowered to make positive changes in clinical practice. The RCP has already published the excellent Green physician toolkit, but I have also been helping to deliver inspiring podcasts on topics such as sustainable quality improvement and sustainable diabetes care, and developing pre-made teaching materials to help spread the word!
>
> Within the education directorate, we are working to embed teaching on healthcare sustainability within a range of new and updated workshops and courses, including the Chief Registrar Programme, as well as looking at how we can reduce the environmental impact of the courses we deliver.'

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

Turner-Warwick lecturer scheme: the alumni experience

Five resident doctors share their experiences of being Turner-Warwick lecturers – including the opportunities that this prestigious award gave them, how it improved their confidence and why resident doctors should apply for the 2025–2026 scheme.

The scheme

The RCP's Turner-Warwick scheme is a fantastic opportunity for early-career doctors – one that not only emphasises the value that resident doctors bring to healthcare, but also builds confidence, a sense of pride and public speaking skills.

The scheme gives RCP resident doctors the chance to give a lecture at one of the RCP Update in medicine conferences, attended by a diverse medical audience. Winners also receive free RCP membership for a year, the opportunity to publish a digital presentation on RCP Player and several other prizes – including a profile in Commentary magazine. The RCP works with our lecturers to help foster public speaking skills and their professional profile.

Named after the RCP's first female president, Dame Margaret Turner-Warwick, the scheme has been running since 2019. However, it is still evolving in order to bring the most value and support to our resident doctors. The application window for 2025–2026 is now open, closing on 2 July; it offers three resident doctors the chance to become the Turner-Warwick lecturers on clinical research, advances in medical education or quality improvement for 2025–2026.

New opportunities

There is a huge breadth of topics that Turner-Warwick lecturers have presented on – and the scheme can offer unique and exciting opportunities.

In 2023, Dr John McDermott delivered a presentation on implementing pharmacogenetics the NHS. The scheme gave him the opportunity to present his work to a multidisciplinary audience and receive feedback from opinion leaders in multiple specialties. Since giving his lecture, he has been appointed as an NIHR academic clinical lecturer, expanding on the work that he presented on as a Turner-Warwick lecturer.

He returned to speak at the Update in medicine Liverpool in June 2025 to provide an update on his work: 'Being asked to be a Turner-Warwick lecturer acts as a demonstration that your research is of high calibre and respected by your wider medical colleagues. This award undoubtedly strengthened my CV and contributed to my success in applying for personal fellowships.'

Dr Michael Drozd was also appointed as an NIHR clinical lecturer and continues to investigate infection risk and inflammation in people; he gave his lecture 'Anti-inflammatory therapy in atherosclerosis: balancing cardiovascular and infection death' at the 2024 Update in medicine in Newcastle. He described being selected as a lecturer as 'a tremendous honour [which] created an invaluable opportunity to present my research'.

Similarly, Dr Roopa Chopra was offered a GIM clinical lead role in her trust. She believes thay these opportunities were related to her Turner-Warwick lecture on 'Enhanced support programme to improve transitioning of IMGs to the NHS' and publishing an RCP blog in August 2024. She said: 'I reckon that boost in confidence and my improved leadership skills were the result of winning this scheme.'

Dr Daniel Pan gave his lecture 'Can we make better tests to quantify host infectiousness?' at the Update in medicine in Loughborough in October 2024. He has found the Turner-Warwick lecturer scheme to be a 'great opportunity for the findings of my work to be disseminated to a broader expert audience'. It has opened doors, 'allowing me to catch the attention of experts across the world, for the purpose of collaboration and exchange'.

The Turner-Warwick lecture was 'overwhelmingly a positive experience', according to Dr Charlie Finlow, a palliative medicine resident.

She found that the scheme had impacted the environment within her trust and opened up region-wide conversations and quality improvement work, including a pilot project in in the area she gave her lecture on: 'Caring for the deteriorating patient: Implementing an evidence-based complex intervention to improve end-of-life decision-making'.

Roopa said: '[The Turner-Warwick scheme] has helped me understand my strengths and also weaknesses as a leader. This has made me realise my potential and that the sky is the limit.'

Confidence

Our Turner-Warwick lecturers have also emphasised how the scheme helped them to improve their confidence in presenting and going forward with their research.

John stated: 'Speaking in front of such a diverse audience is a rare opportunity, and meant I had to ensure my work was framed in a broadly applicable way. I have taken this forwards, and now feel confident in speaking about my research to colleagues from across the medical profession.'

Charlie stated that the scheme helped with improving confidence and skills in presenting in front of an audience of all medical backgrounds. 'The scheme has given me the confidence to apply for other schemes.'

Balancing the award with his final year of his PhD, Daniel found that planning and delivering the lecture helped him to develop his thesis ideas, gain early feedback and responses, and prepare confidently for his viva voce examination to discuss his research. He said that 'everyone at the RCP who is part of this scheme is incredibly helpful and a huge asset to the organisation … [I] highly recommend application to the scheme.'

Michael shared a similar perspective: 'Presenting complex research findings about plasma protein biomarkers to a diverse audience significantly enhanced my confidence both as a researcher and science communicator … The scheme represents a fantastic opportunity for medical [resident doctors] to showcase important research and gain recognition for their work. I'm very grateful for this experience and would highly recommend it to others.'

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.

Improving global health: the RCP's newest educational

The Diploma in Global Health (DGH) is the newest addition to the RCP's established set of qualifications. It is awarded in collaboration with the international humanitarian organisation Medicins Sans Frontieres (MSF) who have, since 1971, been treating people who may be caught in complex crises, natural disasters and chronic healthcare emergencies.

We developed this diploma as we believe that the RCP, as an internationally renowned clinical organisation, should have a clear focus on offering opportunities for doctors to demonstrate innovative and evidence-based healthcare.

With over 26% of our members, and 30% of our fellows, based outside of the UK, we hope that the DGH will bring an international focus to our suite of examinations. The RCP wants to allow doctors working in areas of low resource and humanitarian settings to demonstrate their specialist knowledge – under the banner of two prestigious organisations committed to improvements in healthcare across the globe.

The first iteration of the exam is set to take place in July 2025, with over 300 candidates taking the exam from more than 70 countries across the world; showcasing the truly international reach of the DGH exam.

It will assess a candidate's clinical knowledge from a huge variety of areas that includes child health, clinical infectious diseases, global public health, humanitarian medicine, mental health, non-communicable disease and women's health.

Dr Chiara Morrison, medical lead, Global Health and Humanitarian Medicine (MSF) and DGH senior examiner said:

> 'MSF UK and the Global Health and Humanitarian Medicine team are incredibly proud to have developed this unique qualification, in collaboration with the RCP. Together we have worked hard to create an affordable, accessible and relevant qualification for doctors working in global health. We hope that those gaining the DGH find that it not only adds value to their career but that the knowledge gained ultimately improves the care of patients around the world.'

Tom Baker, RCP interim chief executive:

> 'The RCP is delighted to establish this new qualification that aims to enhance patient care and improve the organisation of health services in resource-limited and humanitarian settings. The DGH exam is a testament to the collaborative efforts of MSF UK and the RCP, designed to provide an affordable and accessible qualification that equips doctors with essential knowledge to enhance patient care globally.'

Developing a new diploma

Following the closing of the Diploma in Tropical Medicine in 2023, we were keen to collaborate with a global healthcare partner to develop a new examination that focused on health services in resource-limited and humanitarian settings – in a simplified and more accessible manner than before. MSF was a natural partner for this diploma's development.

Developing the exam was a lengthy and complex process, but with the support of the team from MSF we have produced a fit-for-purpose and up-to-date knowledge-based assessment. It is delivered in a single best answer format that meets the needs of the workforce. A team of specialist doctors and clinical experts from MSF have been working with the RCP since 2024 to establish the processes and plans for the exam, including syllabus generation and question production.

The RCP Assessment Unit has built collaborative relationships with clinical volunteers in 18 countries through our open recruitment. These governance groups oversee question selection, clinical review and examination results sign-off. The exam is managed by the RCP Assessment Unit, in line with our existing governance frameworks with oversight from the RCP educating board, senior clinical examiners and of course our standards / development and psychometrics / analysis teams who specialise in content development, results processing and quality assurance.

Open to all doctors

It is not mandatory for doctors working in global health to have the diploma – however, it is offered to enhance a doctor's personal development and allow them to demonstrate their unique clinical skillset in this hugely important field of medicine. The aim is to enhance the careers of doctors and wherever possible, to improve outcomes for patient care in all areas of medicine across the world.

While the new DGH examination is based on the

MSF Global Health and Humanitarian Medicine course curriculum, it also recognises the expertise of doctors who may choose to study independently. They can undertake the examination when they feel prepared to do so. As a standalone examination the DGH does not have any taught modules.

It is recommended that those taking the exam have at least 3 years post-qualification experience with experience working in global-health and/or humanitarian intervention settings. However, this does not prevent doctors from applying for and taking the exam if they wish to grow their experience and knowledge in this important field.

The DGH is awarded upon successfully passing a 200-question knowledge-based assessment taken over two question papers. We use our online examination delivery platform, which allows candidates to take the exam anywhere in the world with a working internet connection.

Each paper is 3 hours long with a 60-minute break in-between and wherever possible we aim to allow candidates to sit the exam at an appropriate time in their own country should that not be the UK or similar time-zones. While this requires operational flexibility from the Assessment Unit, we recognise the international importance of this examination and feel it is an essential accommodation that supports an internationally diverse cohort of candidates.

Should anyone be interested in either taking the exam or supporting its development more information can be found on the RCP website or by emailing the team on dgh@rcp.ac.uk.

This feature was produced for the June 2025 edition of *Commentary* magazine and published on 18 June 2025. You can read a web-based version, which includes images.