

Commentary



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Royal College of Physicians

December edition: welcome from Professor Mumtaz Patel

Welcome to the December edition of *Commentary*, the RCP's membership magazine. This edition includes some great interviews with Dr Alex Crowe, who discusses the breadth of the RCP education programmes, and Dr Rebecca Farrington, who talks about her experience working with asylum seekers.

There is a great piece by the incoming ECSACOP president, Dr Chris Pasi, who I had the pleasure to meet recently in Kenya when I visited the ECSACOP annual scientific conference and exams. On the international theme, have a look at the article by an RCP examiner doing a quality review of exams in Dhaka, Bangladesh, which is fascinating.

We have published some guidance around corridor care – which sadly has become an unacceptable situation all year round, as demonstrated by our snapshot surveys this year. Although we would never want to normalise corridor care, the guidance gives some helpful advice and support for clinicians to protect patients and staff. Dr Zuzanna Sawicka, RCP clinical director for patient safety, discusses this guidance in this edition.

Commentary also includes a piece covering the party conferences, which the RCP team and I attended this autumn. There is also a piece celebrating the winners of the virtual poster competition and an interview with our upcoming 2026 Turner-Warwick lecturers.

The piece on healthcare and homelessness from a geriatrician and a GP is very thought-provoking. In Manchester, where I am based, this is a sad reality for many, and it is great to hear about the work being done by colleagues.

I was delighted with the post-AGM constitutional voting reform results where our RCP fellows voted to extend the right to collegiate members. This is in line with my election manifesto to modernise the RCP and make it fit for the future. It is fantastic to give our resident doctors and our new consultants a voice in the direction of the college.

In October, we had the Harveian Oration, which was delivered eloquently by Professor John Feehaly, a fellow consultant nephrologist, who celebrated pioneers and progress made in renal medicine over the last 75 years.

We celebrated SAS week in October too, and I hosted the first 'Meet the president' conversation exclusively for SAS doctors across all colleges and specialties – which was one of the first of its kind. It was very well received and was a really good discussion.

In November, we celebrated Med+ and launched

the new *Voice of physicians* report. Med+ was a huge success and it was wonderful to meet so many colleagues and hear some amazing talks. I always enjoy the poster judging and it is one of my favourite bits of the conferences. A huge thank you to all those who submitted and presented their brilliant work and congratulations to all the winners too.

The McLachlan report was also published in November, which was the external, independent review of the MRCP(UK) Part 2 written examination error. We welcomed the report and its recommendations and will continue working with our colleagues in the Federation of the Royal Colleges of Physicians of the UK in implementing these recommendations.

Thank you for your continued support.

This feature was produced for the December 2025 edition of *Commentary* magazine. You can read a [web-based version](#), which includes images.

Interview: supporting refugees' mental health

What does it mean to work with some of the most vulnerable patient groups in the UK?

Dr Rebecca Farrington, a GP with a special interest in asylum seeker mental health, works with the Greater Manchester Mental Health NHS Foundation Trust. She shares the unique challenges that she encounters in this role and how physicians can provide patient-centred care to refugees and asylum seekers.

How did you get interested in this area of medicine?

Kind of by accident. I worked with Médecins Sans Frontières for a few years in the 1990s, so I became aware of what horrible, nasty places refugee camps are and why people might want to escape from these situations.

I'm interested in other cultures and how health beliefs impact health-seeking behaviour, and how to be patient centred with groups that aren't like me. I've become quite interested in cultural humility in medical education.

I think that how we treat the most vulnerable people in our society – the people that we offer sanctuary to – says a lot about our society. If we can get healthcare right for them, we get it right for a bigger population..

Can you tell me about your day-to-day work with asylum seekers?

My role has evolved over the years. I've worked overseas, but the current iteration of that is in Salford, Manchester.

My patients are mainly referred from GPs, but also from within the mental health trust and community organisations. I'll see one or two new patients most days. We're very lucky that the first appointment with them is an hour long, usually with an interpreter (which means that everything takes a bit longer). For a GP, that length of appointment is a fantastic amount of time, compared to 10–15 minutes.

Then I see patients for 30-minute follow-ups; the equivalent of 15 minutes, with an interpreter. I'll check in with these patients; were the recommendations that I made to their GP enacted? Did the recommendations work?

A lot of the focus is on how my patients feel about their immigration status; the wait to know whether they'll be safe is the most stressful thing that they encounter. It's hard to focus on other things when you're unsure about the physical safety in your life. Trying to talk about

long-term health is challenging when my patients aren't sure where their next meal is coming from, or whether they're going to get deported in an immigration raid tomorrow. I find that there's a lot of trauma-related distress, depression, anxiety and PTSD – but a lot is distress around safety, and not having support through a distressing situation.

The other thing that I do regularly is advocacy. I write letters for patients, some of which will make a difference. Some of them won't, but it will make the patient feel that I'm on their side and taking them seriously, which is a really important therapeutic tool.

I'm not there to judge their immigration claim; that's not my role. I am there to listen, to hear the impact of my patient's story as they perceive it and advocate on their behalf. My role is to let the Home Office know that the patient has symptoms that are consistent with their diagnosis; worries, fears and difficulties related to their circumstances.

How do you approach your first consultation with a new patient?

New patient assessments with asylum seekers or refugees take a bit longer than usual. Obviously, there are sensitive things to discuss – but also setting the scene for the patient; explaining the service, who I am, what will happen to their information (they're always very worried about confidentiality), and explaining about how we work with interpreters.

I have to think about what experiences the patient may have had and how to sensitively approach topics – not just launching in, as that can be quite re-traumatising. These initial appointments have to be a gentle introduction, building trust and rapport. It's person-centred, trauma-informed care; really thinking about how somebody might react to you as a stranger, as a person in authority – and their possible interactions with medical professionals in the past.

Many of my patients might not have routinely seen a doctor, or seen one only in an emergency – or they might have had much better access to medical services than we have in the UK! It's important to not take anything for granted about what my patient's expectations are.

I think about the environment where we are working. It's an office building – not very friendly or welcoming. I try to make the room a little bit more comfortable. Privacy and not being interrupted are really, really important.

Working through an interpreter is challenging. I'm lucky that I've managed to retain face-to-face interpreters most of the time, because so much communication is non-verbal. Visual things are really important; you see somebody looking away, breaking eye contact or becoming upset. The interpreter and I can manage that much better face to face.

What are some of the challenges that physicians might encounter when treating asylum seekers?

The level of poverty that many asylum seekers experience is important to consider; often they'll be told by doctors that their child needs over-the-counter medicine, but that can be a whole day's money. The GP surgery might write a letter advocating for housing or a health-related accommodation, but charge £60. It becomes out of reach.

For hospital doctors, there are slightly different challenges. My hospital colleagues worry about communication – getting hold of interpreters in the first place, having to rely on the telephone, what to do in an emergency when you haven't got somebody speaking a patient's language. Those things are challenging.

So is discharge planning, particularly for people who are homeless, with no recourse to public funds. Where do you send them? If you're sending somebody home from an operation, are you discharging them to a park bench? Is that morally and ethically right in the sixth richest country in the world by nominal GDP?

Confidentiality is challenging across the board. Sustainable safeguarding for people is hard, particularly for those who've exhausted their appeals. You might get action in the short term, but in the long term, that tends to drop off. Home Office safeguarding teams and housing provider safeguarding teams are available to hospital or community clinicians – and they can be quite useful.

Charging for care is messy. There's a very long government document on who's chargeable and who isn't; it's really challenging to wade through. Essentially, all people seeking asylum are entitled to primary care and care for infectious diseases. But there are lots of areas that aren't available – maternity care, caesarean section delivery and termination of pregnancy are all chargeable. There is a real gender bias and inequality.

We do see erroneous charging happen. I've certainly had patients who've been wrongly sent bills that they can't pay – and then they get intimidating debt collector phone calls and letters. It has put people off seeking care.

People worry about being charged for a professional interpreter as well, which is a real deterrent to seeking care. They'll offer to bring along family members, link

workers or volunteers, who may be inappropriate as interpreters.

How does the stigma around asylum seeking impact health and social care?

There's a lot more stigma around being an asylum seeker in the UK than there was, even 4 or 5 years ago. People are very reluctant to disclose their status as asylum seekers, so often clinicians treating them won't know – and it is quite difficult to find that out.

Within society, the general opinion of who might constitute the asylum-seeking population is not always correct. There are not always sympathy and empathy in the general population – and of course, healthcare workers are part of that population, with a variety of political and societal beliefs around immigration.

There's a lot of mislabelling of people. That impacts how healthcare professionals treat, see and communicate with patients – and it impacts on the likelihood of somebody accessing care in the first place.

I see people having procedures done without informed consent, because there's an assumption that the patient has understood the interpreter without it being checked. I see people making unusual decisions about care due to fear of how people will treat them.

Stigma also impacts on patients' ability to complain or give feedback. I have encouraged people to complain [about inappropriate treatment they've received when seeking care] and they absolutely won't, as they don't want to cause a fuss or trouble or bother – or to raise their head above the parapet and draw attention.

There's a lot of misinformation in the media around why people come to the UK – it lumps asylum seekers together as one big group. Everybody gets lumped together under one label of 'illegal immigrants'. It's not helpful.

I really struggle with calling people illegal; I think acts and behaviours are illegal, not people. Often people are seeking, or on the journey to, legality.

How might physicians encounter asylum seekers in their practice?

Physicians will encounter asylum seekers in the same way that they encounter every other patient. It's a human body; things go wrong.

You might not know straight away. If you have a patient who's very reluctant to talk about where they're from or why they're seeking treatment, spending that extra time talking to them could be really important in building trust and continuity. There's a lot of mislabelling of people. Asylum seekers have exactly the same medical complaints that everybody else does – but often neglected.

Somebody who has had a 2-year journey across Europe

without access to their medication is not going to have well-controlled asthma. Somebody with diabetes may not have had any choice over their diet or access to drugs for prolonged periods. People who've been living outside for long periods of time will have skin conditions, hygiene-related problems, burns and respiratory problems from cooking on smoky, open fires. This is often a young, sexually active population, so there are often people with vulnerable or high-risk pregnancies – sometimes a consequence of sexual assault in their home country or precarious sexual relationships in host countries.

Asylum seekers are not vectors of infectious disease. Sometimes that's what people are interested in, but I don't see huge amounts of infectious disease.

How might physicians encounter asylum seekers in their practice?

Don't make assumptions about who they are, why they're here and what they might want or feel. Spend some time. Develop that rapport. Get that trust. Be explicit about who you are, why you're there, what information you need, why you need it and what you're going to do with it.

Proper interpretation saves time in the long run. Do it right. It's the right thing to do, and medicolegally, it will protect you as a clinician. Your communication with your patient is patient safety.

One of the things that patients tell me is that they hate telling their story over and over again. It's so re-traumatising. Remember that often people who are traumatised and have had violence perpetrated against them may have difficulty with shared decision making. They might be worried whether their response or decision is going to make that violence worse. Your patients also might be coming from cultures where doctors don't always give them choices, so you'll need extra time and information around shared decision making.

Think about the wider determinants of health. Somebody is not going to feel better while living in a horrible, cold, mouldy house, with flatmates banging on the walls all night, and no access to nutritional food.

If you're in a leadership position, make sure that your team is being fair and not discriminating; that everybody understands that they're not there to make judgement on somebody's immigration status.

There are some pockets of really good practice. Some teams do amazing work with outreach, and lots of people do the best that they can. But it's not well resourced and it's often contingent on goodwill; often healthcare workers go over and above what they're employed to do, because they can see the need.

There are a lot of people in healthcare, our colleagues, who are displaced or who've left their countries for various reasons. It's great to support them as well.

Remember: most of the people that I meet want to contribute, want to work, want to get better, have an education, a family and have an ordinary life. The people who are seeking asylum can be the most interesting people you will ever meet. They've had to be incredibly resilient – they've had to live through, survive and sometimes even thrive after, unimaginable experiences.

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Tackling temporary care environments

Delivering care in temporary environments – such as corridors, gyms and converted offices – is a year-round challenge which increasing numbers of physicians are forced to experience. These spaces often lack essential equipment, access to necessary medications, or even privacy to consult or examine patients.

Throughout 2025, the RCP has shone a light on the extreme pressures being faced by physicians in NHS hospitals. Two snapshot surveys of our members have highlighted the extent of this issue with a recent survey finding that three in five (59%) of doctors reporting they had provided care in temporary settings over the summer.

The RCP is clear that corridor care is unsafe and unacceptable. Throughout this year, the RCP has continued to call on the NHS, Health and Social Care Northern Ireland, and governments across the nations of the UK to:

- > **protect** patients and staff by supporting them when care is delivered in temporary care environments
- > **prevent** this practice by implementing systems and processes to improve patient flow and discharge
- > **pledge** long term investment in social care and public health initiatives to tackle avoidable admissions and improve health
- > **publish** data all year round on how many patients are being treated in temporary care environments.

Until corridor care is eliminated, staff need support to protect patients and safeguard their wellbeing in these environments. As a result, the RCP has updated its clinical guidance to help safeguard patients and support physicians that are being forced to work in temporary care environments.

Commentary speaks to Dr Zuzanna Sawicka, RCP clinical director for patient safety and clinical standards, about temporary care environments.

The RCP's new guidance recognises that corridor care is now a reality for many clinicians and patients, all year round. How have we reached this point?

There are reports that we increase the patient numbers as the age of our population and frailty increases; that more patients are presenting at hospital. But [the issue is] actually the number of patients who don't need to be

in the hospital – often stuck in the system due to lack of social care or other complications.

There is a real burden on secondary care when patients or relatives cannot access primary care efficiently or effectively. Somebody once told me, 'the lights in the hospital are always on' – we don't close the doors [at weekends or at night], like general practice.

For many years, we've seen trolley waits in our emergency departments (ED), but we're seeing the further emergence of corridor care on the wards. The problem arises when we get extra beds, but no increased medical or nursing resources. Time for people to be seen becomes precious; people are having to wait for assessments.

Another reason for an increase in corridor care is that we're seeing a rise in social care demand. Many people during the COVID pandemic supported their relatives at home, but now – in a [difficult] financial climate where people need to work – they are less able to cope with the demands of looking after relatives. People can't easily offer support on a daily basis, so we're seeing this rise in the need for social care; particularly as we continue to advocate to maintain people's independence, in their own homes, for as long as possible

What has been your experience of delivering care in temporary environments?

As both an acute and a community geriatrician, I have seen corridor care both in emergency care and on wards. In EDs, I've seen people being lined along corridors with lack of dignity, lack of facilities, agitated – particularly over the winter periods. Something that is really close to mine and RCP clinical vice president RCP clinical vice president Dr Hilary Williams' hearts is that some people are dying in ED corridors.

I've also had the opportunity to see corridor care in wards; extra beds being put into places designed for fewer. To enable that, the curtains there for dignity might only slightly cover patients or you have to pull a [screen] across – but it's never the same privacy.

It's really difficult to deliver information. The available spaces where we would normally have private and important conversations – such as end-of-life or diagnostic discussions – have been lost. We can't necessarily speak to a patient or relative away from a busy world.

We've seen the use of patient lounges and other spaces; only yesterday I had to use our relatives' room,

which doubles as a staff room, to speak to two relatives. I had to move staff into another area to break bad news and have sensitive conversations somewhere other than a corridor.

I was at a clinical service for over 5 years, and I used to pride myself that there were no extra patients on the corridors. People did, however, wait longer in ED. The problem is that the longer it takes to see a senior decision maker, the higher the likelihood of much poorer outcomes.

What are some of the key risks and problems that arise from delivering care in temporary environments for staff and patients? Have you seen any of these in action?

The first and foremost risk has to be patient experience; their dignity or ability to access appropriate facilities like toilets. And as I mentioned, there is obviously the compromising of conversations. When I've seen beds being left on the corridor – just due to pressures yesterday, people were in the actual corridor for a couple of hours at a time – you can't easily have staff or a relative sit with that person, because you're then blocking the corridors.

I've known of situations where there's been a lack of access to equipment, like oxygen and suction. I've also sadly heard of somebody dying in their sleep on a corridor. It's really sad to think that things like that may have happened in other places which aren't appropriate.

For patients, there are simple things – access to a plug point, a TV or other people to speak to – which, as physicians, we don't necessarily recognise. The work that we've done with our Patient and Carer Network (PCN) really shows that we don't always think what the patient may need in these hospital environments.

None of us want to work like this. While it has become the 'new norm', it does upset us. There is a lot of dissatisfaction and increased burnout currently. We know that corridor care is increasing complaints [from patients]. But unfortunately, our hospitals are full to bursting.

What is some of the main advice for physicians who find themselves working in temporary care environments?

Safe and dignified care, and clear communication. I would urge physicians to document what is happening. Make it clear in patient notes that someone is being cared for in a temporary escalation space.

We are part of a team. This doesn't just affect us as medics – it affects the nurses, the advanced health professionals, and relatives and patients. There has to be clear communication that this isn't how we wish to care for somebody, that we're trying to do our roles in a very

difficult situation.

Physicians also have an advocacy role and a leadership role – considering who goes into a temporary escalation space. We have a role in identifying which patient is most able to be in these spaces. We have to think about alternative pathways; that is only achievable through efficiency and collaboration. We not only need to ensure safe discharge, but increase the use of things like virtual wards, hospital at home programmes, early supportive discharge and discussions with relatives about discharge.

We also have a role in advocating from a patient safety point of view and making sure that incidents are properly reported, so that we can really understand the burdens and patient safety issues that are attributable to these temporary escalation spaces.

How can physicians best support patients who may end up being treated in these environments?

One of the big things is to advocate for our patients. The PCN has made good suggestions about how patients may feel, and how we can best support them. These include making sure that patients are not forgotten and are kept honestly informed about their situation, and how it might change. The PCN also emphasised to ensure that patients are receiving adequate treatment and not getting worse. Most of all, keep patients safe, respect and maintain their privacy and dignity – and enable contact with family and carers, keeping them informed.

I think those are really valuable points to think about when we are managing patients in those areas. When we are maintaining patient flow with structured, evidence-based assessments, the better we can care for people and understand who can appropriately be cared for in temporary environments. Then we can perhaps prevent patients at the end of life from dying on those corridors, and work together to get a beneficial solution for all.

What can managers and healthcare providers do to support their staff?

Burnout compounds these problems. There is a great deal of importance in solidarity – and the visibility of senior staff members and healthcare providers.

Acknowledge key successes when temporary escalation spaces get closed, but acknowledging the hardship is also really important.

I'd advocate for the power of a cup of tea or an offer of support to colleagues – it may mean the difference between managing to keep them hydrated or going to lunch on time.

There is work that can be done on enabling discharges, supporting further development of the virtual wards, supportive discharges or hospital at home programmes.

A home-first approach will take time to build, but start by thinking about whether people must stay in hospital. What are the possibilities? For example, we keep some older people in hospital for constipation that can be managed easily by district nurses or virtual wards. The longer somebody is in hospital, the less mobile and used to their normal environment they become. Some support will be about changing the culture of an organisation and driving for improvements at the front door.

What steps need to be taken to tackle this at a national level? What is the RCP doing to minimise the use and impact of temporary care environments across the NHS?

The government is determined that corridor care will end. They're clear that it is unacceptable and undignified.

We know that the shift from hospital to community needs to be in place. We can see the development of neighbourhood working and hospital at home programmes, but we can't neglect the need for specialists to be reaching out into the community.

Last year, half a million patients received more appropriate care in the community, so there is a real need for national messaging about the appropriateness of hospital admission and vaccinations.

We also need the strengthening of social care services to enable people to reach out before reaching crisis; often the people that don't need to reside in hospitals have reached a crisis, essentially because they haven't had access to carers or simple equipment that may have made a difference.

From an RCP point of view, we are continuing to advocate. We're continuing to work on emergency and urgent care, looking at how to support that home-first

approach, but we're also looking at what we can do to support our physicians within temporary working environments. How can we advocate for our members and fellows? How can we advocate for the patients we serve and make sure that the patient voice is heard alongside the voice of physicians?

We continue to highlight the definition of temporary escalation spaces, not just classifying it as 'corridor care'. This isn't just about corridors, this is also about day rooms, bathrooms and other spaces that have been converted. We're also encouraging the building of medical workforce models and doctor-patient ratios that will further support the work being done.

We will also continue the work that the RCP does around prevention – advocating for vaccinations and what people can do to prevent themselves being admitted to hospital.

At the RCP, we firmly believe that there needs to be an end to corridor care. That is not going to be achievable unless all three shifts – community, prevention, digital – are delivered. The implementation of those shifts will hopefully enable us to make a real impact in reducing temporary care environments.

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'Systems are simply not built with complex needs in mind': a spotlight on health inequalities and homelessness

'Systems are simply not built with complex needs in mind': a spotlight on health inequalities and homelessness

Homelessness remains one of the starkest drivers of health inequality. People without stable housing often struggle to access services, fall through gaps in care and experience worse health outcomes than the general population.

Pippa explains: 'Homeless people are sick, vulnerable and in need of help. They are heavily dependent on GP practices and homeless health clinics for their multiple, complex health needs, as there is poor support from hospitals, drug and alcohol services, and mental health services.'

Homelessness and healthcare

The consequences of a fragmented and often inaccessible system are stark. Amin often sees the effects of poverty and social exclusion on a person's health and access to care, particularly people who are homeless or seeking refuge:

'We see individuals whose physical and mental health have been deteriorating long before they ever make it through our doors, often because the systems designed to help them are either inaccessible or simply not built with their complex needs in mind.'

'Being homeless exposes individuals to harsh environmental conditions, violence and isolation, all of which directly affect health outcomes. At the same time, ill health (particularly mental illness or substance dependence) can lead to losing one's job, relationships and housing.'

The impact of stigma

Among the homeless patients that Amin's surgery supports, many have untreated chronic conditions and experience harms from high levels of substance misuse, deteriorating mental health and trauma. Chronic conditions such as diabetes that require regular medical intervention can easily become unmanageable and result in emergency hospital admissions.

One patient who had been sleeping rough for years

was struggling with unmanaged diabetes and severe foot ulcers. They had been avoiding primary care services due to past negative experiences and mistrust, which eventually led to hospital admission and possible amputation.

'Many individuals in this situation face stigma and find it difficult to form meaningful connections with services. They need a greater degree of empathy and compassion. If they're treated as just a number, they tend to disengage from services,' says Amin.

Contact and discharges

But it's not only stigma that prevents people experiencing homelessness from accessing healthcare. The unstable nature of being homeless can make it difficult to attend appointments on time or at all. Not having a physical address or digital device makes it impossible to receive appointment letters or reminders. Amin explains that people miss out on care due to frequently arriving late or not attending GP appointments, which often leads to them being discharged.

Since 2018, there has been a legal duty to refer anyone from hospital who is homeless (or at risk of homelessness in the next 56 days) to the Local Housing Authority. A referral cannot be made without the service user's consent. This 'duty to refer' was introduced in the Homeless Reduction Act of 2017.

Pippa says: 'It was reported last year that in 2022/23, over 4,000 homeless people were discharged from the hospital "to no fixed abode". It does not make any medical or economic sense. We should not send people back to the very problem that precipitated their admission. These discharges drive up readmissions, self-discharges, poor compliance and premature death.'

'Hospitals can and must do so much more before discharging homeless people back to the streets to give them the best chance of survival before handing back to community care.'

How physicians can support homeless patients

Pippa advises practical steps for physicians on how

to care for homeless patients and to take to identify their needs and ensure that there is aftercare in place, following government and NICE guidance:

- > All healthcare workers should show compassion, empathy and kindness to engage with sick homeless people.
- > Identify the homeless by asking one simple question: ‘Do you have somewhere safe to go when you leave here?’.
- > Make a phone call or send an email to the Local Housing Authority to refer the patient.
- > Ensure that every trust fights for a specialist housing officer or nurse who will make all appropriate referrals.
- > Review data on admissions and readmissions of the homeless to empower the appointment of a local expert.

Dr Chris Sargeant, the medical director of the Faculty of Homeless and Inclusion Health, shared guidance and resources to help patients who are homeless in the RCP *Commentary* magazine earlier this year.

More often than not, people experiencing homelessness will have a range of health issues and will require the help of multiple services outside of hospital, including mental health support and addiction services. Timely care that joins these services is vital to keeping these patients in the system and breaking the cycle.

At Amin’s surgery, his team has found that providing holistic, trauma-informed care in a setting that is accessible and non-judgemental is key. This could be as small as offering food, clean clothes, or a safe and warm place to sit. It’s been crucial to building trust and encouraging patients to engage with their services.

The surgery also hosts events as a way to encourage

engagement and build rapport. Amin says these gestures offer a sense of hope and show that someone genuinely cares.

Healthcare’s role in tackling homelessness

As the RCP continues to call for a cross-government strategy to reduce health inequalities – spanning housing, education, employment, transport – it is clear that health services cannot solve this issue alone. But the health service does have a key role in ensuring that no patient is discharged back onto the streets without care.

In Pippa’s words: ‘Welcoming people experiencing homelessness to hospital, treating them well, and giving them all the support needed will go a long way to helping them recover and survive. No one chooses homelessness or addiction; it is our job to treat patients.’

If you’re a clinician, patient, or work in the NHS and have experienced or witnessed health inequalities, please get in touch to share your story and help us shed light on this issue by emailing comms@rcp.ac.uk.

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Interview: RCP's educational opportunities – Dr Alex Crowe

The RCP aims to deliver impactful education that equips doctors to lead, grow and thrive at every stage of their career. Commentary speaks to Dr Alex Crowe, a consultant nephrologist in Liverpool, NHSE Responsible Officer appraiser and RCP censor who has contributed to several RCP courses, and Philip Welsby, RCP joint head of education and delivery. They share the exciting RCP courses that they have worked on, and Alex discusses why effective medical education is so vital to physicians throughout their whole career.

Why are you interested in medical education?

Alex: So much of medical education is about understanding that our consultants and resident doctors are such important future contributors to healthcare. Therefore, we need to support and look after them. It's really important that we create robust, comprehensive medical education at all levels of clinical leadership for them; and the RCP is an organisation that is interested in maintaining and developing national and international standards for professional development. Current RCP workshops are opportunities for teaching and training to maintain consistent high quality healthcare and rigour across the country and internationally.

It is also important to be cognisant that people have different lenses of interpretation of healthcare, depending on their cultural background, eg age, sex – this is an opportunity to allow cross-fertilisation of knowledge, enriching the content of learning and education. Being able to meet delegates in different specialties, across the country you get an idea of what different people are up to, and it keeps your creative thinking broad. As a doctor, that's really important so that you don't get stuck in a rut; as well as helping others, teaching also helps me.

We are lucky to have got so many people in the NHS who are so clever, able and skilful. To give them an opportunity to share their experiences and knowledge with people is amazing.

It's the anecdotal knowledge and shared experiences that always seems to stick and prove so useful – and training gives delegates a chance to ask questions about little, thorny issues; circumstances like difficult conversations, revalidation or job planning. There is always someone who has been there and done it and can give you a useful answer.

All of this activity should connect with patient safety and experience. If individuals within the healthcare system are well trained and educated – lifelong learning – that helps us to look after our patients, respect their perspective and support shared decision making. A common golden thread links education and learning of professional standards and leadership with how we look after our patients.

Could you tell me a bit about the programmes that the RCP offers and the needs for physicians that they address?

Alex: The educators themselves are very wise, influential and engaging with their teaching. It works really well for the delegates with the synergy of clinicians and educators working together. The RCP identifies speakers with experience and wisdom on the subjects that they're talking about, which helps to provide a two-way, question and answer, information sharing presentation with the delegates.

Then there is the pertinent subject matter included within the workshop programmes, which help and support professional development throughout one's career – either as a resident doctor or as a consultant – they all provide intuitive, relevant support. The topics chosen by the RCP can be very useful to a doctor at any stage of their career and the workshops available are designed to complement each other.

Tell me about the programmes you have worked on.

Alex: I'm currently a clinical facilitator, but more recently I've taken on the role of helping with content development – particularly for 'The role of a clinical director' workshop, Quality improvement for consultants and the Aspiring medical director programme.

I help with developing the slides, activities and supporting information for those particular courses, and also identifying high impact speakers who contribute to that structure.

Philip: Alex and I have worked together on the delivery and ongoing development of 'The role of a clinical director' workshop. It is designed for newly appointed clinical directors (CD) or senior clinicians aspiring to the role, and offers them practical tools and knowledge needed to excel in this demanding role within the NHS. The topics covered in the workshop include appraisal,

revalidation and professional standards; job planning; clinical governance and risk management; responding to acute clinical service pressures; professional development and wellbeing; and writing a short business case.

As Alex mentioned, we have the pleasure of working alongside expert colleagues in the delivery of the workshop, which offers us the opportunity to support the development of delegates from a wide range of specialties, empowering them to lead clinical services confidently and competently in their organisations.

Alex: I became involved with the CD workshop because, when I started as a CD, I noticed how important it is to hit the ground running. The NHS requires match fit clinical leaders; not ones who are learning fundamental skills on the job; understanding their roles and leading from the outset.

It's the same with the Aspiring Medical Director programme; when you go into a significant executive role, there are things that you need to know about from the outset—these are things that no one really understands until you've actually done it and such experiences can be pre-emptively highlighted by highly qualified and experienced speakers.

Philip: I have worked closely with Alex and other colleagues on the development of the Aspiring medical director programme from its initial conception a couple of years ago, to having the pleasure of welcoming the second cohort of delegates to The Spine in Liverpool in October 2025. We had realised that there were some key components of a medical director's (MD) role that aspiring MDs should know and designed the programme to have a unique practical focus, with the aim of helping delegates to develop the skills and knowledge required to manage the real-world issues encountered working at executive level in the NHS.

The programme covers a wide range of topics including the MD role and responsibilities; function of trust board; leadership styles; principles of equality, diversity and inclusion; effective communications and media training; management of serious incidents; development of professional relationships and an effective team; having difficult conversations; the Responsible Officer; culture of disclosure; challenging unacceptable behaviour; creation of an inclusive workplace; preparing for interview; effective succession planning; preparation and presentation of a short business case and transformation projects. Similar to the CD workshop, delegates learn from a wide range of experts from the NHS and related organisations.

Alex: Both of these workshops have been highly influential. People can immediately use the information and skills as clinical leads, clinical and medical directors. I know what it is like to be learning on the job and it can

be a bit haphazard. If you provide people with a little bit of information first, then they can function within an organisation very well and also learn at a quicker rate, as they'll know what they require to add to their knowledge.

What are the RCP's approaches to teaching in these courses?

Alex: The joint educator–clinician approach of these programmes is hugely beneficial. Sometimes as clinicians, we think that we know how to teach. But using the expertise and advice of the RCP medical educators reminds yourself how to maximise effective engagement with learners. We make sure that, within the programme, the slides, activities and the timetable give opportunity for delegates to ask questions and have discussions about the subject matter. There are a lot of courses where you see back-to-back lectures with very little time for discussion – but a lot of thought has gone into giving flexibility for the delegates to get involved. We also have high-quality speakers contributing to educational material or presenting. That's a really vital part.

Philip: Our teaching is based on current theory and best evidence, but always with a focus on practical application, with activity-driven learning being key to our delivery. Our workshops and programmes recognise the importance of moving beyond passive learning, and look to enable delegates to apply knowledge and to develop skills and a deeper understanding in a safe environment. This approach ensures that the learning is directly relevant and transferable to the challenges that they face in the workplace, and helps to foster critical thinking and problem solving.

What's been your favourite part of working on these programmes?

Alex: My favourite part is probably the interaction with delegates. I feel honoured and privileged to meet so many able, enthusiastic, creative people in our NHS – whether a patient, medical student, resident doctor or a volunteer – or someone who is a university chair. There are people out there who are very skilled, and it's really important to look after those people and support them with appropriate professional development and education.

I've enjoyed going to different parts of the country to different hospitals; seeing how people work differently and deal with similar problems or challenges in slightly different ways, which you can learn from.

What's next for RCP education?

Alex: One thing that we've talked about, which is exciting, is to follow up after the education events with

delegates about how they have taken the information back to their organisations, and how it helped them develop – introducing potential networks, getting feedback and understanding what roles and projects previous delegates have become involved with, to see definitively whether workshops or programmes have made a meaningful difference.

The immediate feedback that we get is excellent, but it is really nice to see what happens after 3 or 6 months, or even a year down the line. Some of the delegates even come back as RCP clinical facilitators, getting involved in education themselves.

We are looking to expand the job planning component of the CD workshop, which has been such a success. That's going to be a really important area; concentrating on transforming from individual job planning to team job planning and looking at how job planning can be a beneficial conversation rather than a mandatory, dry or sometimes threatening conversation. We are also looking at training around 'difficult conversations'; our angle is that it is not about 'difficult' conversations, but successful 'persuasive' ones that are actually credible and bring people along.

There are some interesting opportunities to understand a more global point of view. The Emerging Women Leaders Programme has been taken abroad, which is fantastic.

One big area that still requires a degree of awareness and interweaving within medical education is artificial intelligence (AI) and technology. Technology is moving forward at pace, but we need to make sure that we are moving with it – in a way that it is appropriate, easily rolled out and everyone can use. Otherwise, there could be pockets of misunderstanding and lack of progress. Being fit for purpose and being able to move at the speed that technology is moving is a big topic for everyone, including the RCP.

This feature was produced for the December 2025 edition of *Commentary* magazine. You can read a [web-based version, which includes images](#).

Meet the virtual poster competition 2025 winners

The RCP virtual poster competition showcases the best in medical research, audit, education and innovation.

This year's competition received a record number of applications (351) from medical students, foundation doctors, resident doctors and equivalent roles across England, Scotland, Wales and Northern Ireland, with 50 shortlisted entries.

The lead author of the winning and highly commended entries from each category will receive a free virtual delegate place at the RCP's annual flagship conference, Medicine 2026. Shortlisted posters are also considered by the RCP's editorial team for publication in one of its peer-reviewed journals, *Clinical Medicine* and *Future Healthcare Journal*.

Thank you to all panel judges, who reviewed all verified abstract submissions and who took part in the competition panels.

'It was fantastic to be a judge to and hear the presentations from our NextGen doctors. I enjoyed learning about their educational improvement projects and questioning them on their conclusions. It was fascinating to hear their thoughts on the project's positives and improvements that they could make in the future for each of their projects. They all had a passion for improvement in education and I hope they can take this forward in their careers,' said Dr Nigel Lane, RCP regional adviser for the Severn region and a member of the judging panel.

Applications for the 2026 virtual poster competition open on Saturday, 28 March 2026, and you can [register your interest](#) now.

Meet our winners

Quality improvement and patient safety / audit

Winner: **Dr Pharveen Jaspal**, IMT3 at Warwick Hospital, South Warwickshire University NHS Foundation Trust (West Midlands region) for their poster abstract titled *From broad-spectrum to broad thinking: frailty-based antibiotic stewardship in action*.

Pharveen said:

'Winning the competition has been a notable career highlight. It formally recognised the work that my team and I have done in quality improvement and patient safety ... it was an excellent platform to highlight our work on antibiotic stewardship

for older adults living with frailty. I am grateful to the care of the elderly team and the antimicrobial service at the trust for their collaboration. The experience strengthened my leadership and quality-improvement skills, connected me with colleagues tackling similar challenges and reinforced the impact that well-designed projects can have on patient care.'

Highly commended: **Dr Lorita Krasniqi**, IMT1 at University College Hospital, University College London Hospitals NHS Foundation Trust (London region) with coauthors **Dr Nikhil Kadam**, **Dr Nicoleta Lotca**, **Dr Lylah Irshad** and **Dr Tehmeena Khan**, for their poster abstract titled *A multidisciplinary approach to increasing utilisation of hospital at home services*.

Lorita said:

'It is a real privilege to be recognised among such talented and inspiring colleagues. Receiving this award has strengthened my confidence in presenting and communicating my work and it motivates me to continue delivering projects that make a meaningful difference for patients.'

Education, training and medical professionalism

Winner: **Dr Dominic Mears**, IMT3 at Worcestershire Hospital, Worcestershire Acute Hospitals NHS Trust (West Midlands region) with coauthors Dr Ming May Chung, IMT3, and Dr Emily Robinson, IMT2, for their poster abstract titled *Medical registrar acting up scheme for internal medicine trainees*.

Dominic said:

'It has hugely developed my skills, from academic writing to thinking about audit procedures and given me great insight into how to structure a useful and impactful quality improvement project. Don't hesitate to apply. At the end of the day, you will always gain something from the experience.'

Highly commended: **Dr Claire Froneman**, ST4 at Darent Valley Hospital, Dartford and Gravesham NHS Trust Kent (Surrey and Sussex region). Presented by coauthor **Dr Emma Moore**, IMT1, for their poster abstract titled *The need for respiratory bootcamps*.

Emma said:

'The respiratory bootcamp started as a simple idea to help new doctors feel less anxious on the ward,

so seeing it acknowledged by the RCP is incredibly motivating. It's given a little confidence to keep developing educational projects and to get more involved in teaching and quality improvement.'

Research: clinical, translational and innovation

Winner: **Dr Ioannis Perros**, foundation doctor at the Royal Devon and Exeter Hospital, Royal Devon University Healthcare NHS Foundation Trust (Southwest (Severn and Peninsula) region), with their poster abstract titled *The association between biological therapies and the risk of major adverse cerebrovascular and cardiovascular events in ulcerative colitis: a meta-analysis of level 1 evidence*.

Ioannis said:

'The RCP virtual poster competition is unique; it provides an outlet for young researchers to showcase their work. Such opportunities not only inspire us to continue contributing to meaningful research, but help shape us into better clinicians.'

Two joint highly commended winners: **Justine Tin Nok Chan**, medical student at Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust (Eastern region) for their poster abstract titled *Glycated haemoglobin (HbA1c) thresholds for microvascular and macrovascular complications: insights from a population-based study*.

Varnika Shankar, medical student at Macclesfield District General Hospital, East Cheshire NHS Trust (Northwestern region) for their poster abstract titled *Urine Albumin-Creatinine ratio home testing; how can AI shape the future of screening for chronic kidney disease in patients with diabetes?*

Justine said:

'This award has been a wonderful opportunity to deepen my understanding of cardiovascular and metabolic medicine, connect with like-minded researchers and strengthen my journey toward becoming a clinician academic.'

Clinical / case reports / digital health

Winner: **Dr Yee Mon Thee**, junior clinical fellow at the Royal London Hospital, Barts Health NHS Trust, (London region) with co-authors **Dr Ali Altahiry**, clinical fellow, and **Dr Christos Nikola**, ST3, for their poster titled *A case of acute hemichorea secondary to ischaemic infarction in the right lentiform nucleus*.

Yee Mon Thee said:

'I would strongly encourage other resident doctors

to apply. It's a great opportunity to share your work, learn from peers, and gain recognition for your clinical contributions.'

Two joint highly commended winners: **Dr Paul Njoku**, IMT1 at Wexham Park Hospital, Frimley Health NHS Foundation Trust (Oxford and Thames Valley region) with co-author **Dr Dorette Ngemoh**, clinical fellow for their poster abstract titled *Weathering the VT storm; a case of difficult-to-manage ventricular tachycardia (VT) storm in newly diagnosed cardiac sarcoidosis*.

Dr Victoria Floyd-Ellis, IMT2 at Morriston Hospital, Swansea Bay University Health Board (Wales region) with co-author **Dr Opeyemi Gbadegesin**, foundation doctor at University Hospital of Wales, Cardiff and Vale University Health Board, for their poster abstract titled *VF arrest secondary to immune checkpoint inhibitor (ICI) associated myocarditis; improving patient outcomes by maintaining a high clinical suspicion for ICI toxicity*.

Paul said:

'Receiving this award is an incredible honour and a significant milestone in my early medical career. It reinforces my commitment to academic medicine and strengthens my motivation to pursue a career in cardiology. Being recognised by the RCP for a unique and complex case is very rewarding and I look forward to being involved in similar clinical research competitions in the future.'

The benefits of getting involved

As we look towards the start of the 2026 competition in March, our winners share the benefits and opportunities that have arisen from taking part in this conversation – and encourage young doctors to take part too.

Several of our competition winners are even brand new members of the RCP, signing up to take part – including Pharveen, Lorita and Justine.

Pharveen said: 'The process is straightforward, the feedback is valuable and it is an excellent opportunity to share your work beyond your immediate team. It helps you refine how you present your project, gain recognition for your efforts, and connect with others who are tackling similar challenges in quality improvement and patient safety. I would strongly recommend applying.'

Claire and Emma both said that taking part in the project and competition had developed vital skills in for their career, including academic writing, working and teaching across different professional groups, thinking about audit procedures and structuring the useful and impactful QIPs.

Meanwhile, Lorita emphasised the benefits to her communication skills: 'This experience has really helped me refine how I communicate key messages clearly and

concisely both visually through a poster and verbally in a short presentation. I've also learned the importance of engaging your audience by focusing on outcomes and patient impact.

'I would strongly encourage others to apply. The process offers an excellent opportunity to refine presentation and poster skills within a very supportive environment. It is also a great platform to share learning, gain confidence and be inspired by the work of others.'

Paul said: 'This experience has enhanced my ability to critically appraise the evidence related to the topic, distil complex clinical information into key learning points and present cases clearly and concisely to both specialist and generalist audiences. The constructive feedback from the judges improved my confidence in academic presentation and communication – skills that are invaluable in both clinical practice and clinical case presentation.

'I would certainly encourage others to apply. The process provides an excellent opportunity to share your work, gain feedback from experienced clinicians, and develop presentation skills in a supportive environment. Regardless of career stage, the competition is a great platform for professional growth and networking.'

Register your interest in the 2026 virtual poster competition today – or share with your colleagues.

This feature was produced for the December 2025 edition of *Commentary* magazine. You can read a [web-based version](#), which includes images.

Get to know the 2026 Turner-Warwick lecturers

The Turner-Warwick lecturer award celebrates excellence in clinical research, medical education and quality improvement – and offers resident doctors a unique opportunity to present their research at the RCP’s Update in medicine conferences.

As the award scheme reaches its fifth year, *Commentary* spoke to the 2025–2026 lecturers about their work, upcoming lecture and what the opportunity means for them.

- > Quality improvement: **Dr Jun Yu Chen** is an academic clinical fellow in internal medicine and cardiology in Birmingham. Her lecture, Novel preventive cardiology clinic associated with reduced risk of recurrent major adverse cardiovascular events for patients with prior acute coronary syndrome, will be presented at the Update in Medicine – Birmingham in February 2026.
- > Medical education: **Dr Stephen Joseph** is a ST5 respiratory medicine in East London and Resident Doctor Committee co-chair. He will be presenting Addressing the elephant in the room: diagnosing and treating unprofessional behaviour amongst doctors at the Update in medicine – London in March 2026.
- > Clinical research: **Dr Sarah Bowers** is a palliative medicine and internal medicine resident doctor based in central Scotland. She will present her talk, Navigating healthcare at the end of life: exploring the experiences of people with multimorbidity, at the Update in medicine – Liverpool in June 2026.

Could you tell me a bit about your career and clinical background?

Jun Yu: I’m a clinical doctor in Birmingham who went to school in Northern Ireland, then university in Glasgow. During medical school, I did a degree in cardiovascular studies. That’s when my interest in research came about. After graduating, I went to London and did the academic foundation programme, so I had more time to do research on cardiology and some on genetics.

I’m in Birmingham now, on a cardiology training programme where part of my time gets dedicated to research. So that is how I became involved in the prevention clinic and how I am able to continue to be involved in research in Birmingham.

Stephen: I am about 10 years into working now, so coming towards the end of training – I’ve got 2 years

left to go. I currently work as a registrar in respiratory medicine and internal medicine in London. I’ve been mostly here since I graduated from medical school. I found out about the Turner-Warwick scheme through the RCP newsletters and thought it’d be really interesting to apply for. I recently finished my master’s in medical education and had this weird feeling of ‘what comes next?’. It was quite exciting for me to see that there was a medical education category; often when it comes to award schemes, they often focus on more traditional scientific research. It was quite encouraging to see that there was something else out there.

Sarah: I’d had a taste of research through a couple of widening participation schemes at university; we got exposure to different careers, including a research and laboratory-based setting. I found it such an interesting way to approach medicine.

I did an intercalated degree in cancer studies, but realised that I really liked palliative medicine and the holistic aspect that it gives patient care. I always wanted to do research, and had applied to a few fellowships, when someone sent me a PhD opportunity in multimorbidity – which I’d never really thought about, but was core to palliative care. I realised that it was a new avenue to explore and a good niche for me to develop. I liked that the PhD gave me exposure to multiple methodologies; I’ve done big data research and really in-depth qualitative studies as well. A core part of it was patient and public involvement, which I’m really passionate about.

Towards the end of the PhD, the Association for Palliative Medicine sent round the Turner-Warwick scheme. I admit that I wasn’t a member of the RCP – but I was going back into training, so I joined and applied for the scheme. It’s great that there are opportunities for people to find out about the RCP’s work, because the Turner-Warwick scheme was something I had never heard of before. I’m a Scottish resident doctor, so I probably wouldn’t have automatically looked at the RCP as my natural college. But it’s opened up my network, with the opportunity to not only speak to people within Scotland but also elsewhere in the UK. These opportunities do exist for people throughout the UK, not just in England.

What is your upcoming Turner-Warwick lecture about?

Jun Yu: My lecture is on my recent research as part of my academic clinical fellowship, looking at a prevention clinic. Prevention cardiology isn't a huge subspecialty in the UK; it's bigger in the USA. Essentially, it looks at trying to prevent new or further cardiovascular disease. Usually, patients who have had heart attacks are followed up in clinic, but we implemented a new prevention clinic, specifically focused on optimising medications and lifestyle advice – including diet, exercise and smoking. It provided an opportunity for counselling about their lifestyle and how to take the initiative in looking after themselves.

We compared how many prevention clinic patients had cardiovascular events vs how many in the standard clinic. We found that prevention clinic attendance was associated with a 48% reduction in cardiovascular events. My lecture will be presenting these results and explaining the future implications for this research.

I'll be presenting at the Birmingham Update in medicine in February, which will be nice as I've been based here and the research was conducted with the Queen Elizabeth Hospital Birmingham. I was at a clinical service for over 5 years, and I used to pride myself that there were no extra patients on the corridors. People did, however, wait longer in ED. The problem is that the longer it takes to see a senior decision maker, the higher the likelihood of much poorer outcomes.

Stephen: My lecture builds on my master's research; I did an 18-month project looking at unprofessional behaviour among doctors.

I'd spent time working at strange hours, seeing people [with strange behaviour] and I'd read an article which really stuck with me; US resident doctors were surveyed and could easily identify unprofessional behaviours on a list. But then quite a sizeable percentage – the majority – said yes to having done several of those behaviours. My project used qualitative research – phenomenography – to look into why people do unprofessional things, even when they know that it's the wrong thing to.

My lecture looks at the factors that affect whether doctors behave professionally or not; some purely to do with personality, through to the wider healthcare system. I've pulled in strands from social sciences to figure out what happens, from a cognitive standpoint, when someone does something unprofessional; is it an instinctual reaction or something they thought through? Does it make sense to have professionalism focused on the individual, or are there other things that need to be addressed? In my interviews, people witnessed unprofessional actions in the hospital at night, often in quite high-stress environments. I'm not excusing bad

behaviour, but if you focus purely on individuals, then you might ignore other, equally important factors.

When we teach professionalism, we often just focus on what the GMC says. The literature suggests that doctors fully know what the GMC says – the issue is that sometimes they don't go along with it.

Sarah: My research is about how people with multiple health conditions use healthcare services towards the end of life. As a palliative medicine resident doctor, I realised that so much of that care isn't just the remit of specialist palliative care. My research highlighted that people are accessing healthcare in a really disorganised, chaotic, unscheduled way; there's a real opportunity to learn and think about where we all fit in that puzzle.

The RCP covers several medical specialties and holds events throughout the UK, highlighting different research from all sorts of medical specialties, which is great. There has also been really great support within the RCP to take that next step; not just sharing research locally or within my specialty, but translating my research so that it's accessible and of interest across medical specialties.

What led you to apply to the scheme?

Jun Yu: To be honest, I hadn't heard of it before receiving an email from the hospital and I thought that it sounded like a good opportunity. Firstly, it helps get the research out there – which we're trying to do, because it's a good project to roll out. Secondly, I thought personally that it was a good opportunity to try applying for something. I did not think that I would get it at all – I just wanted to see what might come of it.

Stephen: When you finish a master's in medical education, there's not a direct career pathway afterwards. There aren't huge groups of medical education researchers that are looking for resident doctors to get involved in clinical lectureships or research collaborations. Within medical education, we're a lot less evidence based than the rest of medicine; to a certain extent, we all just assume that things should be done how we were taught. But there is scope for things to evolve. So, an opportunity to have a conversation with a large group about my work was really encouraging. The main incentive was to have dialogue with other professionals about my findings and their thoughts.

Sarah: I wanted the lecture to be an opportunity for my research to be more widely disseminated. I've been fortunate and had the chance to discuss it at a few palliative care conferences; but I wanted to get the message across that actually providing palliative care to people with multiple different illnesses is the work of various specialties – not just specialist palliative medicine.

I think the RCP is a brilliant forum for that, and the support to get that up and running has been fantastic.

How do you feel about being selected? Has it given you any new opportunities so far??

Jun Yu: Very honoured and very grateful to the RCP. It is a huge opportunity; probably one of the biggest I've had in my academic career so far. I didn't realise the amount of opportunities that would come out of it. It's exciting because I haven't presented such a long lecture before, and we get constructive feedback as well. It's one thing presenting, but to know how to improve before the actual conference is really exciting.

In my wider circle, it's helped my supervisor and his team with the project because it brings it out into the open. More people will know about the prevention clinic work; we're hoping to be able to roll similar projects out at more hospitals, at a larger scale.

The Turner-Warwick lecture will help recognise that it's an important project and hopefully bring about more understanding. If more prevention clinics are put in place, then more patients can benefit in the future.

Stephen: I felt very honoured and quite surprised – I wasn't really expecting it. I'm very excited about the prospect of being involved. I've had a few consultants who I've worked with previously reach out to congratulate me and say they're looking forward to hearing the lecture, which has been really encouraging. The prospect of doing a full lecture is exciting, but it's also something I've never really done before, so a little nerve-wracking at the same time.

Sarah: I feel absolutely honoured. It feels a bit surreal and I definitely have imposter syndrome, but the team have been really supportive and encouraging. I get to present at the Liverpool Update in medicine, which is fantastic, and the RCP team has been helping to nurture and develop the talk. Just having the title of being a Turner-Warwick lecturer has already sparked a few conversations with people; it's given me real opportunities to just informally chat about my research, and have it shared on social media.

What are you looking forward to about being a 2025–26 Turner-Warwick lecturer?

Jun Yu: I'm looking forward to meeting people at the conference. While I won't necessarily see the other Turner-Warwick lecturers at their respective RCP Updates in medicine, it's been really nice to talk via email and feel like we're in it together. It will be really interesting to hear about their projects as well, whether online or in person. Then just having this new connection with the RCP is good too and very beneficial.

Stephen: I'm looking forward to having a chat about professionalism within medicine. It's something which is a bit taboo – we focus on big, egregious stories in the news, but I think low-level unprofessionalism is more corrosive at times, because it's so pervasive.

I'll also hopefully raise the profile of academic medical education; there's a lot of focus on teaching, but it goes a lot further. There are a lot of questions which, as physicians, we don't tend to ask because they're not easily solvable with our normal statistical methods; if we could use a different way of thinking about the world, then we might find out a lot more about it.

I'm really glad the scheme exists, and the way that it's tied to a regional Update in medicine is definitely a strength. Often there is a risk with national bodies becoming too London-centric; the fact that this scheme is happening around the country is a really good thing.

Sarah: Meeting other Turner-Warwick lecturers over email and getting to hear about the work that they're doing really showcases what good work resident doctors are doing in medicine, even when things are really tough. It's an amazing opportunity, especially getting to go to Liverpool – somewhere that I probably wouldn't have had the chance to present otherwise. It definitely gives me the chance to expand my wider network and to challenge myself. As much as it's exciting, it is a bit daunting – but it's good to do scary things and to push yourself.

Join us at an [RCP Update in medicine conference in 2026](#) to see our Turner-Warwick lecturers in person. If you are unable to attend, our Turner-Warwick lecturers will deliver a digital lecture for RCP Player which can be viewed from February 2026. The Turner-Warwick scheme will reopen for applications in 2027 – [register your interest](#) and be the first to hear when it's open for submissions.

This feature was produced for the December 2025 edition of [Commentary magazine](#). You can read a [web-based version](#), which includes images.

Shaping the future of healthcare: the RCP at party conferences in 2025

In late September and October, the RCP darted across the country to attend Liberal Democrat, Labour and Conservative party conferences. In Bournemouth, Liverpool and Manchester, senior officers and policy and campaigns staff delivered a wide-ranging programme of successful events and meetings – engaging ministers, shadow ministers and parliamentarians on key RCP priorities.

These conferences are a fantastic opportunity to bring priorities and questions shared by our members and fellows directly to MPs and other influential voices in the health sector. It is an important chance to directly engage the UK's political leaders and decisionmakers in conversations about the future of healthcare, and what the RCP thinks this should look like.

Liberal Democrat conference

In late September, Dr Hilary Williams, clinical vice president, represented the RCP at a sunny Liberal Democrat conference in Bournemouth 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.

Hilary met with Danny Chambers MP, who is a member of the party's health team. They spoke in detail about the upcoming 10 Year Workforce Plan, including what we would like to see within it and the RCP's views on physician assistants. In July, the Liberal Democrats welcomed the 10 Year Health Plan for England, so Hilary emphasised that we must ensure that the government has the right workforce to achieve the goals set out. We know that, at the moment, there is not enough staff to meet demand; fixing this is the key to delivering care sustainably. Hilary stressed that the RCP would like to see measures to support early career and the next generation of doctors, as well as measures to reform postgraduate training, included in the new workforce plan.

Hilary also met with some Liberal Democrat backbench MPs, including Marie Goldman MP, David Chadwick MP and Susan Murray MP. They discussed the NHS workforce, digital health services and health inequalities, especially around prevention and the ability of their

constituents to access services.

Our time at the conference was productive; it was clear that health is a priority area for the Liberal Democrats, and the RCP was able to engage in wide-reaching conversations relating to health, social care and the NHS.

Labour party Conference

RCP president, Professor Mumtaz Patel and Professor Tom Solomon, academic vice president, represented the RCP at a busy Labour party conference in Liverpool at the end of September. We hosted two events at the conference on social care and air quality, which gives the RCP a direct opportunity to engage with decisionmakers and shape public opinion.

Mumtaz hosted our event on social care, in collaboration with the King's Fund and Alzheimer's Society. Alongside her on the panel were Stephen Kinnock MP, minister for social care; Sarah Woolnough, the King's Fund CEO; and Corrine Mills, interim chief executive of Alzheimer's Society.

Minister Stephen Kinnock is responsible for the government's policy on social care; on the panel he spoke about the independent commission into adult social care by Baroness Louise Casey and how important it is to ensure people's access to the social care system.

Mumtaz spoke about how social care is a vital issue for the government to tackle. Issues with access impact the wider health system as a whole, exacerbating problems such as delayed hospital discharges, a shortage of capacity and the use of temporary care environments that are unfit for patient care.

The RCP hosted a joint panel event with the Royal College of Paediatrics and Child Health (RCPCH) on the ever-increasing public health risk of air pollution. Professor Sir Stephen Holgate, RCP special adviser for air quality, led the charge – following the publishing of RCP report, *A breath of fresh air*, in June. This groundbreaking report demonstrated the sheer scale of air pollution's health impacts; round 30,000 deaths per year in the UK are estimated to be attributed to air pollution.

Stephen was joined by councillor Susan Hinchcliffe, leader of Bradford Metropolitan District Council; Rosamund Adoo-Kissi Debrah CBE, chief executive of the Ella Roberta Foundation; and Dr Mike McKean, RCPCH vice president of policy. Each panel member shared their

understanding of how low air quality impacts people's lives and health – and expressed frustration at the lack of action so far. The RCP will continue to raise these issues and work with our partners to push for constructive solutions, in both central and local government.

At this conference, Tom and Mumtaz spoke on several roundtables, which had a range of health leaders and parliamentarians present. They represented the RCP at a British Medical Association (BMA) roundtable on workforce and the 10 Year Health Plan; a NHS Providers roundtable on the relationship between neighbourhood care and health inequalities; and a roundtable by thinktank Re:State on NHS productivity and technology.

Mumtaz met with backbench Lizzi Collinge MP, who is keen to work with the RCP closely on health inequalities. Mumtaz explained the RCP's belief that prevention is better than a cure and how we would like to see a cross-government strategy dedicated to reducing health inequalities. The government have committed to tackling the social determinants of health in a cross-government way as part of their health mission delivery board, but Mumtaz explained that we would like to find out more about the government's current work on this commitment. Lizzi Collinge agreed to champion health inequalities in parliament.

Mumtaz stated:

'I was encouraged by conversations I had with a number of Labour MPs on the importance of clinical engagement on the upcoming 10 Year Workforce Plan. I welcome the government's decision to consult on this plan, following our calls earlier this month, and we will be contributing to that process in the coming weeks. If the government is to deliver its 10 Year Health Plan and associated three shifts, a well-resourced workforce will be critical.'

Conservative party conference

In October, Mumtaz represented the RCP at the Conservative party conference in Manchester. There, she met with the shadow secretary of state for health and social care, Stuart Andrew MP, who holds a key role in holding the current health secretary, Wes Streeting MP, to account the current. They spoke in detail about the policy priorities of the RCP and how we can work with closely with the party on these.

Onwards to 2026

With party conference season now over for 2025, the RCP will continue these conversations and work to ensure that the voice of members is heard by the government and opposition parties. Throughout the year, we will work with the parliamentarians that we met to table parliamentary questions, and work with them

to ensure that the RCP's key priorities are heard within parliamentary debates.

Influencing the way that healthcare is designed and delivered is one of the RCP's three key strategic aims. As this year ends, we will continue to listen to our members and fellows, and take your priorities to the government, the NHS, our royal college partners and others.

This feature was produced for the December 2025 edition of *Commentary* magazine. You can read a [web-based version](#), which includes images.

Spotlight on the RCP Medicine podcast: celebrating 100 episodes

How much do we learn from having time for engaging discussions with colleagues? How often do we engage with issues where we just need a little bit more expert knowledge? The RCP Medicine podcast is a platform that brings listeners into the heart of contemporary medical discussions.

As 2025 draws to a close, we're excited to share that our 100th podcast episode will be published in January 2026. This milestone is more than a number – it reflects a journey that began in 2019 and has grown beyond expectations. We're proud to be among the top 5% of medical podcasts worldwide, with over 850,000 downloads to date. We're aiming to hit the 1,000,000-download mark in 2026. To celebrate, we're offering a behind-the-scenes look at how the podcast comes together, featuring insights from some of the incredible physicians who have shaped and contributed to recent episodes.

Hosted by experts in the field, this podcast mirrors those invaluable conversations we have with colleagues over coffee, or the snippets we catch as we walk past a lively discussion. This unique format allows listeners to feel like they are part of the ongoing dialogue around pressing issues in medicine – learning, reflecting and applying this to their ongoing practice.

The strength of the RCP Medicine podcast lies in its ability to engage listeners in meaningful conversations on a wide range of topics relevant to physicians. Each episode delves into real-life contemporary topics, explores new evidence and addresses specific issues faced by physicians in the modern healthcare environment.

Whether you're looking to stay updated on the latest medical advancements or seeking insights into everyday clinical challenges, the RCP Medicine podcast offers a rich and engaging listening experience.

Dr Rohan Mehra – former RCP clinical fellow

'Hosting the RCP Medicine podcast was in equal parts nerve-wracking and exhilarating – and, hands down, one of the most rewarding things I've done in my career.

'Having the chance to chat with some truly brilliant minds (and wow, have we had incredible guests!) about topics that they're genuinely passionate about is a real privilege.

'What makes the podcast special is its knack for spotlighting issues that are shaping the future of healthcare – but too often stay in the shadows. Our health inequalities series is a prime example, tackling everything from racial inequities in health with Professor Habib Naqvi, chief executive of the NHS Race and Health Observatory, to the commercial forces influencing health with Dr Chris van Tulleken. These are vital conversations that deserve to be heard. Yes, I was slightly terrified the first time we hit record. But with our editor-in-chief / genius-in-residence Michael Weston at the helm, it was smoother than expected (honestly, he makes it easy to sound smart).

'On a personal note, it's been an unexpected goldmine for growth – a creative outlet, a learning opportunity and a chance to dive deep into conversations that I actually care about. The fact that these chats are then heard by thousands? Humbling. And let's be honest – thank goodness the guests always know what they're talking about, and Michael has edited out my numerous "umms" or pauses!'

Dr Vasiliki Thanopoulou – former RCP clinical education fellow

'Stepping into the role of podcast host was exciting and nerve-wracking. My prior experience was limited, and I had only engaged with listening to a few highly specialised podcasts for my specialty. I prepped for the role by binge-listening to RCP Medicine episodes, reviewing conversational styles while ensuring that our original podcasts were still clinically relevant.

'The process surprised me. Conversations flowed naturally, especially with guests I already knew – it felt like lively chats about topics that we both cared about. Huge credit to Michael, our learning technologist, whose relaxed vibe and editing skills turned raw recordings into real gems.

'In a world that's always rushing, podcasts are a quiet superpower. They're like sneaky learning tools: listen while commuting, running, cooking or folding laundry.. 'My episodes focused on topics aligned with my personal passion and the RCP's goals or collaborations like the British Society for Rheumatology (BSR), which made the work feel meaningful. The real win? Seeing listeners engage and catching the spark in my guests' eyes when they shared their ideas and their smile at the end of the

recording. At the end of the day, sharing knowledge and expertise doesn't have to be stiff, it can be as natural as a good conversation!

Dr Ben Chadwick, RCP deputy registrar

'Being asked to contribute to the RCP Medicine podcast was both an honour and mildly terrifying. It was not something that I'd done before, so the whole idea was more than a little daunting. It was a great opportunity to think about topics that could be covered, and also to encourage a resident doctor from my specialty to get involved.

'I was lucky to find one of the acute internal medicine registrars in my trust who was willing to take part. We sat down together and thought about three topics that we felt were important to cover, and sketched out a rough idea of the content.

'The team at the RCP were great at explaining how the process would work and arranged a date for us to come up to the RCP to record the three podcasts in one recording session. My co-host, Dr Racheal Cheek, thankfully had done a lot of work to think about some structure for our discussion, and we talked through how we would go about it on the train up to London.g how people work differently and deal with similar problems or challenges in slightly different ways, which you can learn from.

'When we arrived at the RCP, we were met by one of the producers of the podcasts, who had booked a room for the recordings. He was great at settling our nerves and getting us started. Once we'd started, we rapidly settled into a clinical conversation about the topics we'd thought about in advance. It was easy to forget that we were being recorded and that what we were saying would be published!

'In all, it took about 2.5 hours to record the three podcasts. Once we'd recorded, the producers asked us to re-record some sections where we'd talked over each other or the conversation hadn't recorded well.

'Once the recording was complete, the team set about editing the material that we'd recorded, and making it suitable for broadcast. We had a final opportunity to listen to ourselves in the finished version before they went live on RCP Player. All in all, it was a very enjoyable process and I hope that what we produced was helpful and informative.'

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Post-fall medical examination: a brand-new resource to support healthcare professionals

The RCP's National Audit of Inpatient Falls (NAIF) has produced a brand new post-fall medical examination resource that – for the first time – provides detailed guidance for healthcare practitioners (HCPs) assessing inpatients following an inpatient fall. Dr Sarah Howie, consultant physician in general and senior health medicine, explains how this new resource will help improve care on the wards.

Inpatient falls are a frequent, but potentially devastating, incident in healthcare organisations. Patient outcomes after a fall in an inpatient setting are much worse, especially if the fall results in an injury – 13% of patients who fracture their hip as an inpatient will die within 30 days.

The National Audit of Inpatient Falls, part of the Falls and Fragility Fracture Audit Programme (FFFAP), plays a crucial role in identifying how we can reduce harm for these patients. NAIF collects information about significant injuries sustained in inpatient settings in patients aged 65 and over, focusing on multifactorial assessment to optimise safe activity (MASA) and, if a fall occurs, immediate post-fall management of injuries. Up until 2025, it has focused exclusively on inpatients who sustain a hip fracture – but this year, the audit has expanded to include all fractures, head injuries and spinal injuries.

To support organisations to improve their performance, NAIF has produced a range of supporting resources, the most recent being the post-fall medical examination resource which provides detailed guidance for those healthcare practitioners (HCPs) performing the medical examination following an inpatient fall.

Impact of inpatient falls

Inpatient falls represent one of the most frequently occurring incidents in our healthcare organisations; there are around 247,000 falls in England per year alone (NAIF report 2020). By looking at the National Hip Fracture Database (NHFD) KPIs, we can see that performance in those patients who sustain a hip fracture as an inpatient, as opposed to in an outpatient setting, is worse. Inpatients are more likely to die after their injury and less likely to return to their own home.

There are many possible explanations for this. These patients are more likely to be male, frail and cognitively impaired – all poor prognostic markers following a hip fracture. There is good evidence that surgery within 36 hours improves outcomes, but those who fall and fracture their hip as an inpatient are more likely to have their surgery delayed.

However, NAIF has also been able to show that one in four inpatients who sustain a hip fracture experience a delay in care, including accessing X-rays and orthopaedic assessment (NAIF report 2023).

These data highlight the need to not only prevent these injuries, but also to ensure prompt and excellent post-fall care when they do occur.

Post-fall medical examination: a guide for inpatient settings

In response to documented delays in care after an inpatient hip fracture, NAIF recognised the lack of guidance available specifically for HCPs performing the medical reviews after an inpatient fall. These HCPs have varying degrees of experience and training in the examination of patients who have sustained traumatic injuries, which is made more challenging by their medical complexity and frailty.

In contrast, many emergency department trauma triage systems identify older trauma patients as requiring assessment by more experienced staff. There is increasing recognition that a fall from a height of less than 2m is now the most common mechanism of injury in patients meeting the criteria for major trauma and – in those over 69 years old – the most common cause of trauma-related death.

NAIF has summarised existing guidance and adapted it for use in an inpatient setting for low-trauma injuries. As part of this post-fall medical examination resource, three documents are available:

1. Detailed explanatory notes which guide HCPs through each step of a medical examination. These have been formatted to be available via mobile phone or iPad to allow easy access while on the ward. This covers the following areas:
 - The initial referral – SBAR information, urgency of review and instructions to nursing staff

- > Dynamic risk assessment if the patient is still on the floor
- > Primary survey
- > Secondary survey covering: head, C-spine, thoracic / lumbar spine, chest, abdomen, hips and pelvis, four extremities
- > Prompts to consider analgesia, anticoagulation and antiplatelets, and delirium
- > Appropriate investigations
- > Notes for community settings
- > Checklist for handover to nursing staff, relevant documentation and plan to review investigations
- > Points for parent multidisciplinary teams to consider

2. A proforma that prompts HCPs to address the essential areas and allows appropriate documentation that aligns with NAIF audit requirements.

3. An implementation toolkit that can be used to identify the competencies and training required – and identify any gaps in current provision.

The guidance and related resources were developed by a multidisciplinary task and finish group with representatives from orthopaedic, geriatric and emergency medicine, with experience of both acute and community inpatient settings.

Supporting our HCPs

For the first time, there is step-by-step guidance for HCPs reviewing patients on the wards following an inpatient fall.

This resource adds to guidance for first responders published in 2022. The proforma will support organisations to standardise the documentation of these assessments, and those responsible for training can identify potential areas that need to be addressed using the implementation toolkit. In 2026, NAIF plans to develop two e-learning modules to address training needs and further support post-fall care on the wards.

The hope is that these resources will go some way to reduce the delays in diagnosis of inpatient injuries and facilitate access to prompt specialist care to improve overall patient outcomes.

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Room for improvement: hip fracture care in 2024

This new report discusses how hip fracture care in 2024 improved under the influence of the RCP's National Hip Fracture Database (NHFD), and calls for similar work to improve the care of people with pubic ramus fracture and other fractures of the pelvis.

Each year over 70,000 people in England, Wales and Northern Ireland have a hip fracture and a quarter of them can expect to have another fragility fracture in the future. Unless something is done to prevent such fractures, it has been estimated that the total number of hip fractures could double by 2060.

Room for improvement: hip fracture care in 2024 examines how hip fracture care aligned to key patient goals in admission, rehabilitation and care quality.

This NHFD report shows a huge improvement, in that most patients (58%) now receive bone-strengthening medication while they are in hospital – but, in 2024, ten hospitals (6%) still discharged over three-quarters of their patients without effective bone protection.

Other key findings include:

- > in 2024, it took an average of 15 hours before patients were made comfortable on a ward appropriate to their needs, and 20 hospitals (12%) recorded an average delay of over 24 hours
- > two hospitals still recorded that over 10% of their patients did not receive surgery.
- > 5% of all operations were recorded as having been performed by unsupervised resident doctors, and nine hospitals (5%) recorded that over 10% of their patients were not allowed to fully weight-bear after surgery
- > in 2022, the NHFD found that over a quarter of hospitals were only providing their patients with physiotherapy from Monday to Friday. NHFD data, used in developing the Royal Osteoporosis Society's REDUCE toolkit, show how weekend therapy could lead to patients spending 2.3 fewer days in hospital, a cost saving of £676 per patient.

Antony Johansen, NHFD orthogeriatrician clinical lead, said:

'Patients' experience of care after a hip fracture has improved enormously since the NHFD was created nearly 20 years ago. Most hospitals can be proud of their achievements, but this report shows how a number of hospitals have fallen behind in the care

that they are offering, and discusses how the NHFD is helping them to catch up with the care being offered elsewhere.'

Key recommendations

By April 2026, all integrated care boards (ICBs) in England, health boards in Wales and health and social care trusts in Northern Ireland should:

- > require emergency and orthopaedic departments to agree fast-track admission policies, so that at least one in five patients reach a specialist orthopaedic ward within 4 hours of admission with a hip fracture
- > review each hospital's NHFD data to ensure that at least 95% of patients are able to access surgery, that this is documented as having been supervised by a senior surgeon and that it allows them to get up and fully weight-bear straight away
- > require each hospital to commission appropriate physiotherapy capacity, so that all inpatients recovering from hip fracture can receive at least one session of physiotherapist-directed rehabilitation each weekend
- > require all hospital teams to review their use of injectable bone protection, so that at least half of all patients are known to be on bone-strengthening medication 4 months after a hip fracture.

Mr Will Eardley, NHFD orthopaedic surgery clinical lead, said:

'From a surgical perspective, the care of older people with a broken hip continues to improve year on year. Patients across England and Wales following admission to hospital with a broken hip are often included in trials, which are helping us to make the best choices with our patients around the time of the operation.

'Despite these advances, there remain areas where closer working between surgeons and the wider members of the clinical team could yield further patient benefits. In particular, the seniority of the surgical team and communication around allowing patients to weight-bear following their operation are areas highlighted in this report where improvements should continue to be made.'

The NHFD report also announced two new audit initiatives for January 2026:

1. The NHFD will start recording how long a patient waits after telephoning for an ambulance until they arrive in hospital – so out-of-hospital delays can be included in the picture of the time that people have to wait before being placed on an appropriate ward and before having surgery.
2. The NHFD will start collecting data on all people who present with pubic ramus fracture and any other type of pelvic fracture – so that these people can benefit from the huge improvements that have been achieved for those with fractures of the hip and femur.

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Med+ 2025: celebrating clinical excellence

On 11–12 November 2025, the RCP hosted the Med+ 2025 conference. We welcomed over 400 doctors to the RCP at Regent’s Park for this annual conference, with over 1,000 people joining us online

The 2-day event was a celebration of clinical excellence – including clinical updates, the latest developments in patient care, workshops and cutting-edge insights.

A huge variety of clinical topics were covered, reflecting the clinical interests of the diverse RCP membership; there were sessions on cardiology, obstetric medicine, allergy and immunology, organ donation, dermatology, and much more.

There were also important and engaging discussions on subjects which impact the future of medicine and healthcare.

Throughout both days, there were a variety of hands-on events and workshops which offered practical advice – covering topics from the shift from hospital to the community, how to improve the sustainability of your practice, to how to get your paper published.

Our keynote speaker, Dr Birju Bartoli, chief executive of Northumbria Healthcare NHS Foundation Trust, explored innovation, leadership and the future of care delivery in the conference’s opening session. Professor Kevin Fong, professor of public engagement and innovation at University College London, closed the first day with his talk on *AI: The artificial human: medicine at the edge of intelligence*.

The second day opened with the RCP Resident Doctor Committee deputy chair, Dr Max Thoburn, interviewing Professor Mumtaz Patel, RCP president, on the future of UK postgraduate training. The RCP’s historic Linacre and Goulstonian lectures both also took place on the second day.

We were also pleased to invite many resident doctors to the RCP to join the Med+ abstract competition. This competition offers resident doctors an opportunity to showcase their research to healthcare professionals from around the globe. Resident doctors presented posters on: quality improvement and patient safety, audit; case reports; research including clinical, translational and innovation; education, training and medical professionalism; health services and sustainability, policy and workforce development. The eight winners were announced on day 2 of the conference and you can see all of the posters online.

The event offered over 28 hours of live content,

workshops, early-release videos and more, which is now available to watch on demand via the bespoke platform – whether you missed the live event or want to revisit key sessions. On-demand viewing counts towards CPD credits, including content from our early-release programme.

Online tickets are on sale until 19 December, making it an ideal way to continue your CPD learning and medical discussions over a busy winter.

Experience the full value of on-demand viewing, including:

- Access 20+ sessions: get updates on acute, general and specialty medicine from expert speakers across the UK and beyond.
- Flexible learning: watch sessions at your own pace – with the content available right up to 10 February 2026.
- Earn CPD credits: you can claim up to 22 CPD points for on-demand sessions.
- Download your certificate: once you’ve completed a session, you can download your CPD certificate straight from the platform.
- Wide-ranging content: the programme covers everything from geriatric medicine and cardiology, to oncology and pharmaceutical medicine.
- Wellbeing sessions: visit the instructor-led yoga, pilates, HIIT and meditation sessions on the platform.

We look forward to seeing you at future RCP events soon – including Medicine 2026 and Med+ 2026.

The voice of physicians

Alongside Med+ 2025, the RCP published our Voice of physicians: RCP emerging themes report.

This report, covering October 2024 – September 2025, made it clear that doctors are delivering high-quality care under unrelenting pressure – but are ‘being asked to do the impossible’.

It exposes a system under strain, with rising workload, deteriorating morale and growing patient safety concerns in the NHS.

83% of consultant physicians say that rota gaps are directly impacting patient care, while resident doctors

say ‘the system is broken and we’re burning out trying to fix it.’

Professor Mumtaz Patel, RCP president, said: :

‘We heard powerful stories of dedication, innovation and teamwork from physicians at every stage of their careers. Their expertise must be at the heart of health system reform. Listening to doctors and acting on what they tell us is the only way to ensure that the NHS remains safe, sustainable and fit for the future.’

You can [read the full report on the RCP website](#), catch up with [Med+ content online](#) and visit the [RCP events page](#) to find out future ways to join the discussion about the future of medicine.

This feature was produced for the December 2025 edition of [Commentary magazine](#). You can read a [web-based version](#), which includes images.

Born in Bradford: can a research study change a city?

Professor John Wright, doctor and epidemiologist leading Born in Bradford and the Bradford Institute for Health Research, shares the ongoing work of an 18-year health study that aims to create a healthier city for future generations after presenting it at the December 2025 Update in medicine – Cardiff.

It is a remarkable and sobering fact that two thirds of adults in the UK are now overweight or obese. The consequences of this epidemic are evident in every organ system; insulin resistance and type 2 diabetes, hypertension and cardiovascular disease, osteoarthritis and chronic pain, fatty liver disease, sleep apnoea, subfertility, and cancers of the breast, colon and pancreas. Beyond physiology, the psychological toll is equally profound, contributing to stigma, low self-esteem and depression.

Yet this is not a problem that begins in adulthood. The origins of obesity lie in the earliest years of life. Over the past half century, childhood obesity in the UK has quadrupled. One in four children now leave primary school clinically obese, and the gradient of inequality is striking – rates are twice as high in the most deprived areas as in the least. These are not random variations, but predictable patterns driven by structural disadvantage, environmental exposures and social determinants.

Since 2007, at Born in Bradford, we have been following more than 30,000 children from birth to understand these patterns and their causes. Birth cohorts such as this are among the most powerful designs in epidemiology; they allow us to observe exposures before birth, track biological and social influences across childhood – and reveal how these shape lifelong health trajectories.

Eighteen years of research, ranging from genomics and metabolomics to air pollution and education, have yielded two overarching truths. First, that early life is a critical window in which biology and environment interact to set trajectories for health and disease. Second, that inequality profoundly alters those trajectories, leading to diverging outcomes in health, attainment and opportunity.

Emerging evidence now adds further clarity to how these early-life mechanisms operate. Recent findings from the Born in Bradford cohort show that maternal health in pregnancy can influence children's immune vulnerability for years to come. A recent study found that children born to mothers with higher BMI in the first trimester experienced higher rates of infection across

childhood and adolescence, particularly respiratory and skin infections. The relationship strengthened with age, indicating that the biological imprint of maternal obesity persists well beyond infancy. This reinforces the need to support women's health before conception and during pregnancy – and highlights how intergenerational influences contribute to widening or narrowing health inequalities.

We now inhabit an era of complex causation. The tidy one-to-one relationships between smoking and lung cancer, or viruses and infection have given way to webs of interdependent influences.

Childhood obesity, the most common physical health challenge in young people, and mental health problems, the most prevalent psychological one, both arise from these tangled systems. Diet and physical activity are merely the surface features of deeper forces; neighbourhood deprivation, access to green space, marketing and food environments, family stress, educational opportunity and cultural norms. There is no single cause and therefore, no single cure.

Born in Bradford was established as an applied health research programme, aiming not just to understand, but to act. In the early days, our interventions focused on individuals; advice to eat less, move more, make better choices. Over time, however, the science taught us humility. Individuals make choices, but those choices are made within systems. The determinants of health – income, housing, education, employment, air quality, transport – lie largely outside the clinic. To change outcomes, we must change the system itself.

Inspired by Jane Jacobs' vision of the city as a living laboratory, 'an immense laboratory of trial and error, failure and success,' we have developed Bradford as a City Collaboratory; a real-world testbed for prevention science. Researchers, clinicians, policymakers and communities co-design and evaluate interventions that operate at multiple levels, from the school meal to the urban plan. This approach treats the city as a complex adaptive system; dynamic, self-organising and capable of tipping into healthier states when enough levers are pulled in the same direction.

Central to this work is co-production. Sustainable change requires partnership with the people whose lives we seek to improve. Community engagement and citizen science underpin our interventions, ensuring relevance and legitimacy. Equally important is the partnership with local and national policymakers; evidence from Born in Bradford has informed initiatives from active travel and

school-based physical activity to clean air zones and social prescribing.

None of this is possible without data. Connected Bradford, our linked dataset of over 600,000 citizens, integrates health, education, social care, environmental and crime data. It provides the infrastructure to evaluate complex interventions in real time and at scale, transforming routine data into a population-level instrument for prevention.

Our strapline, 'research that changes a city', captures both the ambition and the challenge. Changing complex systems is painstaking, but systems can reach tipping points.

Through healthier school meals, safer and greener streets, active transport, supportive schools and faith settings, cleaner air and fairer opportunities, we may yet tilt the balance towards a healthier generation.

If the causes of obesity are complex, so too must be the cure. Born in Bradford offers a blueprint for the science of prevention, rooted in data, equity and community, that could reshape not just one city, but the health of a nation.

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Preserving the treasures of medicine: our 'Adopt a treasure' campaign

For over 500 years, the RCP has collected and cared for the treasures of medicine – from apothecary jars and Arabic manuscripts to rare early printed books, portraits and instruments. Together, they tell the extraordinary story of how physicians have advanced medicine, improved health and shaped human understanding across the centuries.

In this autumn, the RCP is inviting members, fellows and friends to play a personal part in that story through 'Adopt a treasure' – a new campaign supporting the conservation of rare and significant items from the RCP's world-renowned collections.

Adopters can choose from a specially curated selection of treasures currently in need of care. Each adoption directly funds professional conservation and preservation work, ensuring that these fragile artefacts remain accessible for research, learning and public display.

Telling the story of medicine

'Professor Anita Simonds, Harveian librarian, says: 'Our remarkable collections tell the story of medicine, its discoveries, challenges and the people who have shaped it. Through our new 'Adopt a treasure' campaign, we're not only preserving fragile books, manuscripts and artworks, but also taking steps to diversify our portrait collections so they better reflect the breadth of those who have contributed to medicine. Every gift helps to ensure that these stories, old and new, continue to inspire and educate future generations.'

The range of RCP treasures that are available to adopt is breathtaking – and gives you the opportunity to become part of the areas of medical history that have inspired and shaped your career.

The RCP collection includes texts and prints that were central to the development of medicine across centuries. Texts like Renaissance anatomical engravings or a richly illustrated surgical manual from 1725 represent periods of profound medical transformation. A collection of watercolour prints from the 1860s show the treatment of leprosy cases by Dr Bhau Dajee – a record of early cross-cultural medical exchange, which challenges Western-centric narratives of medicine.

Enduring symbols of the RCP itself are available to adopt – including a portrait of William Harvey, which is one of only two portraits rescued from the RCP's home

in the 1666 Great Fire of London. Harvey, an RCP fellow, revolutionised medicine through his discovery of the circulation of the blood, one of the greatest scientific breakthroughs in history. Similarly, there is the college caduceus, which has served as the president's symbol of office since 1556, and is still carried on formal occasions.

You can celebrate momentous medical discoveries by adopting a 19th-century print by the nephew of Dr Edward Jenner – the physician who pioneered the smallpox vaccine – or engravings celebrating some of the earliest history of modern resuscitation in the 1780s.

There are some more unusual angles to medicine too. The quack doctor is a satirical print from 1814 that mocks some of the 19th century's questionable medical practices – showing an apothecary shop with bottles labelled arsenic, opium and vitriol, and a skeleton assistant mixing up a poisonous treatment. Or you could sponsor the baronetcy costume of Sir William Withey Gull, a prominent Victorian physician, who was erroneously accused of being Jack the Ripper by some 20th-century writers.

Adopting a treasure could help to repair devastating damage to some of these historic objects – from fixing flaking plaster on the bust of Asclepius, Greek god of medicine, to replacing the broken binding on a rare 1517 translation of Galen by Thomas Linacre, the first RCP president. Many of the striking prints that are available to adopt have stains and tears that need to be cleaned and repaired before they are displayed – including one engraving of Sir William Burnett (1779–1861), which has been ripped into four large pieces. Your contributions could help with the vital conservation work necessary to preserve these parts of history.

Adopting an artefact can also be your way not just to preserve an important past, but to shape the future of the RCP – inspiring belonging, representation and change for generations to come. There is the opportunity to support the commissioning of a portrait of Dr Dossibai J R Dadabhoy, an Indian obstetrician, gynaecologist, teacher and campaigner who was the second woman physician formally recognised by the RCP, and the first to receive the RCP qualification of licentiate in 1910. Her story highlights the vital contributions of women and migrant doctors, figures still underrepresented on our walls.

Your way to get involved

Adoptions start from £250, with options to support everything from 16th-century anatomy texts and presidential portraits to early surgical manuals, prints and symbolic artefacts such as the RCP caduceus. Adopters will receive updates on the progress of restoration, and recognition on the RCP website – and, if appropriate, alongside the object when displayed.

Alongside preserving the past, the campaign also supports the RCP's ongoing commitment to diversifying its portrait collections, ensuring that the stories of women, migrant and underrepresented physicians are more visibly reflected within the RCP's historic walls.

The RCP's collections, enriched by centuries of physician donors and collectors, remain a vital record of how science, care and human curiosity have evolved. Through 'Adopt a treasure', that legacy continues; one carefully restored book, portrait or artefact at a time.

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Celebrating milestones in RCP accreditation: 10 years of improving allergy services and 25 years of improving immunodeficiency services

Two of the RCP's accreditation programmes – Improving Quality in Allergy Services (IQAS) and Quality in Primary Immunodeficiency Services (QPIDS) – marked their anniversaries at the RCP at Regent's Park, London with a day of reflection, collaboration and celebration.

The event highlighted key milestones, patient-centred care and upcoming plans for allergy and immunology services across the UK.

Guests included clinicians, nurses, patient representatives and past programme leads whose initial work laid the foundation for today's programmes.

The morning programme offered time for IQAS and QPIDS assessors to share experiences of service assessments, including best practice, and sharing their knowledge. One assessor summed up the sentiment perfectly: 'It was universally acknowledged as a huge privilege to have access to all areas of a service.'

The event reflected on the progress made over decades within both programmes.

Quality in Primary Immunodeficiency Services

QPIDS, now in its year 25, originated as the UK Primary Immunodeficiency Network. It became the QPIDS programme, within the RCP Accreditation Unit, in 2015. The RCP officially launched the QPIDS accreditation scheme on 5 August 2015; opening registrations for primary immunodeficiency (PID) services in the UK and Republic of Ireland.

Today, it supports 22 accredited services, with 17 more working towards accreditation across adults and paediatrics, ensuring patients with primary immunodeficiency receive consistent, high-quality care..

Improving Quality in Allergy Services

IQAS, celebrating its 10-year anniversary, was established as a result of the 2003 RCP report Allergy: the unmet need. This report highlighted inconsistencies in allergy

services and called for standardisation and quality improvements. IQAS formally opened for registration on 25 November 2015, marking the first national allergy accreditation initiative.

Currently, IQAS supports 30 registered adult allergy services, with 21 services still working towards accreditation.

The NHS specialised commissioning report service specification outlines that: 'accreditation involves evaluating a service against a set of standards to promote a culture of continuous improvement, thereby providing assurance to service users, referrers and commissioners about the quality of the service provided.'

Within this document, it is outlined that all centres should be registered and actively working towards – or have achieved – accreditation through the RCP IQAS programme.

Celebrating the anniversaries

Patient-centred care was a recurring theme throughout the day. 'All primary immunodeficiency services should strive to achieve QPIDS accreditation. Doing so requires listening to patients, ensuring person-centred support, and reducing variation in care,' said Dr Sarah Goddard, QPIDS clinical lead

Sarah's statement reinforces findings from Immunodeficiency UK's 2023 Patient Experience Report, which revealed that only 52% of respondents reported a good or very good quality of life post-diagnosis, while nearly 20% felt excluded from treatment decisions.

A recommendation from this report outlines that 'all primary immunodeficiency services should strive to achieve the RCP QPIDS accreditation'.

The afternoon session brought discussion, facilitated by Cynthia Yim, QPIDS senior project manager, where both clinical and lay assessors shared candid reflections on their experiences. They spoke of the privilege of assessment visits, which offer a great insight into service delivery, and the strong sense of team spirit that has been key to success.

Looking forward

Both programmes have ambitious plans for the future. IQAS aims to expand into paediatric allergy standards and encourage dual accreditation for services delivering allergy and immunology care. QPIDS continues to champion access to psychological support, transition planning and home therapy, ensuring that patients receive holistic care.

Throughout her discussion, Nasreen Khan, IQAS clinical lead, summed up the aspirations of IQAS going forward: 'To support services in delivering the highest-quality care, underpinned by standards that evolve with clinical practice and patient needs.'

As IQAS celebrates a decade and QPIDS marks a quarter-century, the message is clear: quality improvement is a journey, not a destination. These programmes exemplify what can be achieved when clinicians, patients and professional bodies unite around a shared vision – better care for all.

Sarah's closing words captured the spirit of the day: 'amazing patients, amazing teams, amazing progress.'

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ECSACOP: vision and strategy from the incoming president

As the East, Central and Southern Africa College of Physicians (ECSACOP) marks its 10-year anniversary in 2025, the college stands at a pivotal moment in its journey – a moment shaped by resilience, collaboration and an unwavering commitment to advancing physician training across East, Central and Southern Africa. Dr Chris Pasi, incoming ECSACOP president shares his plans.

From its 2015 historic launch against the breathtaking backdrop of Victoria Falls in Zimbabwe, ECSACOP has grown from a bold idea into a thriving institution, thanks to the tenacity and vision of physicians from its six founding countries: Kenya, Uganda, Malawi, Tanzania, Zambia and Zimbabwe.

Reflecting on the past decade, ECSACOP's success has been built on the steadfast support of national physicians' associations and the dedication of senior faculty who have mentored and guided trainees through both in-person and virtual platforms. The college's ethos and principles, established by visionary leaders such as Professor Evaristo Njelesani, Professor Innocent Gangaidzo and Professor James Jowi, continue to provide a solid foundation for growth and innovation. That foundation has been galvanised by luminary figures such as Professor Keith McAdam and Sir Andrew Goddard, past RCP president, who were there at the inception.

Having been present at the launch, as inaugural host of ECSACOP and the president of the National Physician Association of Zimbabwe (NAPAZ), I have witnessed firsthand the transformative power of collaboration. The support from the RCP has provided foundational resources and guidance, with the Infectious Disease Institute (IDI) Uganda providing administrative support and the West African College of Physicians (WACP) ensuring the quality and integrity of our examination process. This has been instrumental in shaping ECSACOP's reputation for excellence.

In recent years, ECSACOP has cultivated new partnerships, leveraging the relationships of member national associations with like-minded organisations. Notably, the Kenya Association of Physicians (KAP) has worked with UK partners in the successful delivery of a PACES-formatted 2025 final year clinical examination in Mombasa, while the British Infection Association (BIA) facilitated a valuable exchange programme for fellows between Malawi and the UK. These collaborations have enriched our training programmes and broadened our perspective on healthcare delivery.

Strategic priorities for the new ECSACOP council

As I assume the role of ECSACOP president, my vision is to build on these achievements and propel the college to new heights. The strategic direction for the coming years is anchored in six focused priority areas:

1. Solidifying the ECSACOP brand

ECSACOP must position itself as the preferred training institution for physicians in the region. This involves amplifying our visibility and reputation through strategic communication and regional engagement. By showcasing our successes and the impact of our graduates, we can attract more resident doctors and faculty, further strengthening the college's brand.

2. Expanding regional membership

Our goal is to extend ECSACOP's footprint beyond the founding six member countries. At the 2025 annual general meeting South Sudan was accepted as a new addition to the college, taking the membership to seven nations. By fostering inclusion and collaboration with new and emerging national chapters, we can create a more diverse and dynamic community of physicians. This expansion will not only enhance the quality of training but also promote the sharing of best practices across borders.

3. Enhancing financial sustainability

Financial sustainability is critical to ECSACOP's long-term success. We must streamline subscription systems for fellows to ensure seamless payments and improve financial transparency. By unlocking alternative funding sources and developing new revenue streams, we can strengthen the value proposition for members and ensure the college's financial health.

4. Investing in training excellence

Quality assurance is imperative as the number of resident doctors continues to grow. We will implement faculty development programmes using the Training of Trainers (ToT) model and administer high-quality, respected examinations to ensure that graduating fellows are competent and confident. A comprehensive review and refinement of the curriculum will ensure alignment with recent examination changes and evolving healthcare needs.

5. Strategic renewal and partnership strengthening

With the conclusion of the 2021–25 strategic plan, it is time to conduct a comprehensive review and develop a bold, responsive strategy for 2026–30. Reinforcing partnerships with institutions such as the RCP, BIA and WACP will be essential. We will also galvanise national physicians' associations to champion ECSACOP's mission and foster a culture of collaboration.

6. Strengthening governance

Effective governance is the backbone of any successful organisation. We will undertake a review of administrative processes and governance procedures, refining and clarifying existing processes and introducing new guidelines where necessary. This will ensure that ECSACOP remains agile, transparent and accountable as it grows.

Into the future

ECSACOP's journey over the past decade has been marked by growth, resilience and a commitment to excellence. The largest intake of resident doctors since inception – 52 out of 70 applications in 2025, a fourfold increase from our start – is a testament to the college's reputation and the value that it offers. As president, my responsibility is to further entrench the gains made in this first decade and take ECSACOP to new heights, where fellows are proud to belong and contribute.

To achieve this, we must continue to nurture relationships with institutions, fellows and member national associations that share our vision. The leadership that has come before us has cultivated these partnerships and it is our duty to sustain and strengthen them for posterity.

We must also develop systems that make it easier for fellows to pay membership dues and receive updates on college activities. This will cultivate a sense of belonging and improve the financial position of the college.

Identifying additional revenue streams and funding opportunities will be a priority for the ECSACOP council.

As we embark on the review of our strategic plan and curriculum, we must ensure that ECSACOP continues to deliver the physicians that our region needs. The evolving landscape of healthcare demands adaptability, innovation and a commitment to continuous improvement.

The next chapter for ECSACOP is one of opportunity and promise. By taking the steps laid out in this article, we can build on the foundation laid over the past decade.

I am honoured to lead ECSACOP into this new era, alongside a council of motivated members. Our warm collegial relationship with RCP president Professor Mumtaz Patel – a great supporter of ECSACOP, who

served as external examiner for 3 years – will further cement collaboration between our two organisations. Professor Victor Ansa's wise counsel from the WACP as external quality assurer has also cultivated a long-term bond.

Together, we will further entrench the gains made and take the college to new heights – where every fellow is proud to belong, and every resident doctor is empowered to make a difference.

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A rewarding exchange: my journey as an external examiner

Dr Seif Salem Al-Abri, RCP international adviser shares his experience of travelling to Dhaka, Bangladesh, as an external examiner on behalf of the RCP; from what he experienced in Bangladesh, to what he learned about the global mission of medical education.

A warm welcome to Dhaka: bridging worlds in medical education and culture

The symphony of rickshaw bells on a bustling Dhaka street, the rich aroma of spices in the air and a welcome so genuine that it felt like a homecoming. Long before I entered the examination halls on behalf of the RCP, Bangladesh began to teach me its first, most profound lesson – the power of human connection.

I had arrived in late July 2025, with a mission of quality assurance for the Fellowship of the College of Physicians and Surgeons (FCPS) final examination, but I quickly discovered that this would be a far richer journey – one of mutual learning, vibrant cultural immersion and hospitality that has left an indelible mark. My time in Bangladesh was so captivating, I'm already dreaming of a return visit for a holiday!

The scale and spirit of the FCPS examination

The FCPS final examination is a truly comprehensive assessment, encompassing written papers, objective structured clinical examinations (OSCEs), interactive oral examinations (IOEs) and extensive clinical components. My involvement spanned the OSCE, IOE, and the long and short clinical case examinations.

What struck me immediately was the sheer scale and meticulous coordination involved. Imagine 173 candidates being assessed across six exam halls, each featuring ten OSCE stations and five IOE stations. The logistical undertaking by the Bangladesh College of Physicians and Surgeons (BCPS) was nothing short of impressive. Witnessing this level of organisation for such a high-stakes exam was a masterclass in itself, offering valuable insights into managing complex educational events.

Discovering commendable practices: a two-way learning street

My time in Dhaka was overwhelmingly positive, marked by a profound sense of collaboration and dedication from my BCPS colleagues. I observed numerous practices that truly resonated with me, highlighting the significant

strengths in their examination system and offering valuable insights for all involved in medical education:

- > Heartfelt hospitality: From the moment I arrived, the BCPS staff and faculty extended an exceptional welcome. Their open communication and genuine cooperation made me feel truly valued and supported.
- > Operational excellence: The administrative and logistical teams were incredibly efficient. Their punctuality, flexibility and seamless arrangements for travel, accommodation and in-country transportation ensured that everything ran like clockwork.
- > Visionary leadership: I was particularly inspired by the open-minded and welcoming approach of the BCPS president, Professor Mohammad Shahidullah. His eagerness to explore opportunities for improving the examination process signals a strong foundation for future collaborative initiatives.
- > Organisational prowess: The sheer effort invested in preparing and organising the OSCE, IOE and clinical examinations was palpable. The entire process was remarkably well conducted and coordinated.
- > Rigour in assessment: Across all clinical exams, I observed a consistently rigorous assessment methodology, reflecting a serious commitment to evaluating candidates' competencies.
- > Smooth execution: The exams proceeded smoothly in all centres that I visited, a hallmark of detailed planning and execution by the BCPS.
- > Rich clinical material: The availability of suitable clinical material was outstanding. Cases were thoughtfully selected, presenting relevant histories and physical findings.

Beyond the exam hall: a journey into Bangladesh's soul

My visit was not confined to the exam halls; it was also a profound personal exploration of Bangladesh's rich culture. I dedicated a full day to touring iconic places in Dhaka, immersing myself in the city's vibrant pulse. Visiting the National Museum and the Military Museum was particularly mesmerising; I was deeply moved by the nation's history and the pride with which its people recount their past.

To truly understand daily life, I ventured into rural areas, navigating charming villages using traditional rickshaws and 'toktoks'. The welcome that I received was incredibly generous; villagers invited me into their homes, sharing

glimpses of their daily routines. I witnessed firsthand the peaceful rhythm of life along the Ganges Delta, exploring picturesque riverside villages, lush guava gardens and unique floating timber markets. The natural beauty of the delta, where homes open directly onto the water, was truly captivating. And, of course, I thoroughly enjoyed the rich and diverse Bangladeshi curries and the aromatic masala tea, which became a delightful daily ritual.

Reflecting on opportunities: growing together

While my experience was largely positive, I also observed areas where further collaboration could lead to enhancements. These are not criticisms, but rather opportunities for shared growth.

- Enhancing the patient experience during exams: It is important to create environments that fully support patient comfort and privacy, a universal consideration in clinical assessment and a valuable area for shared learning.
- Reinforcing best practices in hand hygiene: Reinforcing the paramount importance of hand hygiene in clinical practice, and ensuring easy access to sanitisers, is a simple yet impactful area for collaborative focus.
- Optimising the examiner–candidate interaction: We can discuss optimal examiner roles and timing management to ensure a more consistent and supportive assessment environment for candidates.
- Encouraging deeper clinical reasoning: We can encourage examiners to delve deeper into candidates' critical thinking; moving beyond textbook recall, to explore how they formulate management plans relevant to local contexts.
- Improving the clarity of assessment forms: We can optimise the clarity of the comprehensive assessment forms to enhance their transparency and consistency.

These observations are not unique to Bangladesh; they are part of the continuous improvement journey that we all share in medical education.

What was truly remarkable, however, was the spirit in which these reflections were received. In my final debriefing with the BCPS leadership, Professor Mohammad Shahidullah leant forward and said; 'We are really interested in hearing your feedback for how we can do better.'

That simple, powerful statement wasn't just a courtesy; it was an open invitation to partnership. It transformed feedback into a shared mission for excellence, which I found incredibly encouraging and inspiring.

The power of partnership: looking ahead

My visit to the BCPS as an external examiner, on behalf of the RCP, was an invaluable and deeply rewarding experience. It provided a unique opportunity to observe their rigorous examination processes and identify areas where the RCP's expertise can contribute to further enhancing their medical education standards. The collaborative spirit, warm hospitality and remarkable openness to improvement demonstrated by the BCPS leadership and staff are truly inspiring.

This mission has reinforced the profound truth that we can learn from each other. The strengths observed in the BCPS's organisational capacity and dedication to assessment are commendable, while the identified areas for improvement present clear pathways for a fruitful partnership. I am confident that, by jointly addressing these recommendations, the BCPS can further elevate the standard of its FCPS final examination, reinforcing its position as a leading institution for postgraduate medical training in the region.

This collaboration will undoubtedly strengthen international ties, foster a shared commitment to excellence in medical education and, ultimately, benefit patient care globally. I eagerly look forward to the continued dialogue and potential for future joint initiatives, and extend my sincere gratitude to both the RCP and the BCPS for this exceptional opportunity.

The genuine welcome that I received in Dhaka was more than just hospitality; it was a reflection of a shared purpose and a powerful lesson in cultural humility. It reminded me that, while our resources and systems may differ across the globe, the fundamental standards that we strive for are universal. Our core mission is identical: to serve our communities with excellence and to uphold the highest standards for the good of our patients. This universal commitment is the true heart of our global medical community.

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