Commentary

October 2025 Issue 5

Royal College of Physicians

Membership magazine of the Royal College of Physicians

Excellence in Patient Care Awards: how to run a patient-centred improvement project

The RCP's flagship award ceremony, the Excellence in Patient Care Awards (EPCA), returned in 2025 to recognise and celebrate the groundbreaking work of our fellows and members in medical education, quality improvement and clinical research.

Professor Mumtaz Patel, PRCP, said: 'These awards highlight the extraordinary ways in which our fellows and members are improving the lives of patients every day. From doctors on hospital wards to academic researchers in our universities, the stories at this year's awards have been truly inspiring – shining a spotlight on the very best of the NHS.'

For physicians and healthcare teams, this recognition is rewarding validation of the hard work that they have done and an opportunity to share the impact of what they have achieved.

Dr Ian Cormack, a 2025 EPCA winner, stated: 'Having the support from the RCP means a lot. That endorsement is a big deal, personally … I'm delighted and grateful for the opportunity to promote the positive impact of our programme.'

Commentary guest editor, **Dr Cleodie Swire**, spoke to three EPCA winners to learn more about their projects. They offer advice to physicians undertaking similar work, on how to run innovative projects that improve care for patients and drive change in a pressured healthcare system.

The Medical Protection Society award for patient safety

This multi-team collaborative project, led by Dr Ian Cormack, clinical lead at Croydon Sexual Health Service, introduced opt-out HIV testing in the emergency department (ED) in 2020. This has improved patient safety and outcomes – and addressed significant healthcare inequalities. He explained why they undertook the project:

> 'HIV physicians see the consequences [of patients not being tested] … we saw cases including a mother-to-child transmission where the husband had attended the ED many times with various problems including chest and urinary tract infections and so could have been diagnosed earlier, preventing transmission to the mother and baby.'

A 97% testing rate has been sustained for the last 5 years and over 100 additional patients have been engaged or re-engaged through the programme. Alongside the testing, a specialist mental health team was introduced to help people who may struggle to access HIV care without their support.'We have gone from a fear of HIV testing, to it being normalised and accepted within the hospital,' Ian told *Commentary*.

> 'Our approach in Croydon to introducing opt-out testing was a multi-disciplinary team collaboration with close involvement of the ED, HIV, IT and clinical laboratory leads and teams. An HIV test was added to every ED order set. All patients aged above 16 were included in the programme, without upper age cut-offs; 60% of our HIV patients are over the age of 50 years and one is now over 100 years of age. 48,000 tests are done a year; results are provided within 48 hours. All non-negative results are sent directly to the HIV team. There is no ED involvement at that stage, recognising that they are very busy at the frontline. Any patients with a non-negative result are invited to attend the department and are offered an immediate point-of-care test to confirm status, reducing patient anxiety by avoiding further delays.
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> 'Early diagnosis has had a transformational impact on patient outcomes. Not only are we reducing AIDS-defining illnesses and associated disability, reducing critical care admissions and reducing mortality, but we have also shown an impact on transmission of HIV. We had a case of an individual who was in multi-organ failure with haemophagocytic lymphohistiocytosis. They had been tested for HIV in the ED – when the result came back positive, they were started on antiretroviral therapy within days which contributed significantly to their survival.
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> 'It's like night and day with opt-out testing in terms of patient safety. It's a different world compared to when I started here as a consultant in 2005. We diagnose HIV early into their admission, which improves survival if they have an AIDS-defining illness. The rate of potentially life changing AIDS-defining illnesses has reduced to half that of the pre-testing era, reducing hospitalisation of patients and disability. Once diagnosed, patients can live to over 100 years of age with antiretroviral treatment.
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> 'Getting the funding for testing was difficult, but

eventually we got an agreement for 2 years. There was frequent uncertainty about future of our funding; stressful once when you've invested so much and people are employed. If you believe in the goal and the project, you have to persevere. For me, it took 15 years and then it all seemed to happen at once. It's been very rewarding seeing the patient outcomes improving so much and knowing we are involved early in anyone's admission ensuring that they get the best care and treatment.

'As part of the national bloodborne virus program we're also opt-out testing for hepatitis B and hepatitis C contributing to the hepatitis elimination targets. The opt-out model of testing could be used to test for other conditions and has exciting potential given the continuous advances in diagnostics.

'Areas with low HIV prevalence still present challenges, as the national guidance does not currently endorse opt-out testing. Algorithms or automated approaches that link certain blood results or clinical indicators associated with HIV could be useful in reducing risk in these areas. In late diagnosed patients there is very often a familiar pattern of blood results that could be used to trigger HIV testing. Many presentations such as septicaemia or screening for pyrexia of unknown origin are examples where testing could be incorporated.

'Stigma and mental health issues are really important and can affect engagement with HIV services, and there is still a lot of work to be done ensuring patients have the best quality of life.'

'We are proud to have signed up to the HIV confident charter as an organisation to help fight HIV stigma and we are grateful to have an embedded specialist mental health team to help support our patients' mental health and maximise engagement with care.'

The Medical Practice Management award for developing workforce

Rotherham Hospital is a medium-size district general hospital that (like many other hospitals) over the last few years has been dealing with more patients and more complexity, with minimal chance in funding and not enough staff to provide the care. They also had National Training Survey data from 2021–2022 which had responses that were significantly below the average for medicine. Through a collaborative effort and multiple small changes, the experience of resident doctors has been significantly improved without an increase in financial support.

Dr Matthew Roycroft, an internal medicine / geriatric consultant and the project lead, said: 'Resident doctors are an absolutely phenomenal part of our workforce. We need more registrars; they make huge differences to patients, they're the people who keep our hospitals going 24/7. As we get more patients with more complexity, we need people of that seniority. We need to expect this and plan for it, rather than realising their importance when it's too late. There's nothing that we have done that is unique. It is the cumulative approach that is unusual. The RCP's *Keeping medicine brilliant* highlights the psychology of what people need to have a positive job experience, which underpins the overall approach.

'We increased our registrar workforce by 50% and have said yes to every foundation doctor offered. We have created a junior clinical fellowship programme that supports people through an alternative certificate pathway. We made the computer system more usable. We reviewed our staffing levels and aligned these with the RCP *Guidance on safe medical staffing report*, and increased our targets further when local experience showed that there was still too much work. This had to be balanced by smoothing out variability in staffing levels, so there are also fewer 'over-staffed' days now. Our educational supervisors get paid time for that role. We have lunchtime education 5 days a week for our foundation doctors, 4 days a week for everybody else.

'It's been a massively collaborative effort; with huge involvement of our finance, education, HR and medical workforce department.

'We've got a phenomenal resident doctor forum in the trust. Trust executives are at every meeting, as well as senior clinicians. We cannot fix everything that people come up with, but we can take the really problematic things away

'Even if you take a robust approach, you can make mistakes. We changed our shift start time, thinking that was going to make things better on one ward. It achieved this, but introduced complexities and negative impacts for other staff that led to this decision being reversed.

'With a complex initiative like this, it's possible that you will miss a group who are impacted, even if you think you have spoken to everyone. Everybody wants loads of staff around them because then you can do a really good job. When we were redistributing staff, the areas with better staffing which lost people found this hard. I learnt the importance of keeping everyone aware of what is happening and why.

'One of the things we've really pushed for was increasing training posts. We have applied for basically every training post at every level that we were offered, and we've even pushed for training posts that we haven't been offered.'

Sustainability – reducing the environmental impact of healthcare award

Cartridge (reusable) insulin pens have a lower carbon footprint, produce less plastic waste and a lower cost than disposable pens. The project winning this award has had a measurable impact on prescribing behaviour in Devon, shifting practice towards using cartridge pens. To date 4,000 disposable pens have been saved, which has an equivalent carbon footprint to driving 1,000 miles in a

car. This project has attracted national attention and the team are now focusing on driving this change on a wider scale.

Dr Vincent Simpson, a registrar in diabetes and endocrinology at Torbay and South Devon NHS Foundation Trust, and **Dr Deepthi Lavu**, a GP and an Exeter Collaboration for Academic Primary Care research fellow at the University of Exeter, reflected on their award-winning project:

'A lot of diabetes-related care is done by diabetes specialist nurses in primary care, so involving them was important, as they will have many of the conversations with people living with diabetes about their insulin pens. GPs highlighted that the disposable pens come up as the first option within their formulary. Guidance has now been provided that outlines equivalent cartridge and disposable options with PIP codes, and GPs seem open to making this change.

'We have taken an ad hoc approach, which meant that we would realise things that we should have done things 2 months ago. Now that we've got into the thick of it, we've started to think ahead more.

'We need to have a better understanding of the impact of our interventions. For instance, insulin pumps are becoming the standard for type 1 diabetes care. We have absolutely no idea which one is better from a sustainability perspective. Some kind of quantification needs to happen before you can start making any kind of decisions about how to improve sustainability. We were very lucky with the pens that the information was already out there.

'The RCP *Green physician toolkit* and the Royal College of General Practitioner *Green impact for health toolkit* have some suggestions of things for people to consider. As clinicians, prescribing is the part that we have the most power over, and this includes deprescribing as well.'

Tips for people considering similar work

Start small

Vincent and Deepthi recommend starting local: 'By focusing on Devon, we were able to demonstrate an impact and talk directly to people to increase engagement. Consider your realms of influence. As an FY1, you may be able to impact what you do within the department you're working in, but as you get further along in training, you get more and more influence. Always look at what is within your realm of control.'

Similarly, Matthew recommends starting in smaller, more manageable ways rather than tackling an entire project head on: 'You can't jump straight to where we are now. Pick elements of it. Pick the people who you want to work with, work with them.'You can't expect rapid change, he says. 'There are a few easy changes you can make, but most things take a lot of time. Expect setbacks and variation.'

Don't go at it alone

Ian places teamwork at the heart of starting patient-led improvement projects.

'Prioritise good relationships and trust with all the key personnel within the multidisciplinary team. Communicate your goals clearly. Long meetings are a waste of time, 20–30 minutes maximum.'

Matthew also encourages seeking out the best possible team members as a starting point: 'I am very much an educationalist by background, and … I believe that all you need to do is get good people in front of good people. Others get really interested in showing people what processes they should follow. My approach is to … let them work out how to do it.'

Get the word out there

Getting good engagement with relevant teams and spreading the word are vital to keeping your project going. 'There's still a lot of anxiety over testing. Testing saves lives. They're going to find out at some point if we don't test them in this way, but it will be once they're in ITU with an AIDS-defining illness,' Ian says. He recommends using positive messaging throughout.

He uses pre-intervention data, from HIV inpatient and outpatient databases from 2005 onwards, to demonstrate the need for testing and that the approach was acceptable to patients. This has also allowed them to describe the impact and to update people on good progress. 'Now we go and feedback the good outcomes to the ED team.' He also emphasises how important it was to create opportunities to talk to colleagues about his project – including cupcakes on World AIDS Day: 'I'd go and visit the ED, put my foot in the door and say "I brought you some cakes. Can I talk to you about this idea?"'

Deepthi once overheard someone talking about the ICB on a train, introduced herself and secured an introduction to the local formulary team. She and Vincent said: 'It's important to take every opportunity to find people who are engaged. Over and over again, we will talk to people about this. If they show an interest in it, we get them on board and contributing in whatever way they can. Keep yourself open to opportunities and seize whatever you can get.'

It is also important to put yourself out there for opportunities like the EPCA. Vincent and Deepthi stated: 'We thought there was no reason why we should have applied for this RCP award. We often have imposter syndrome, and we don't realise how big the syndrome is until someone else points out how much you have achieved. Throw yourself out there and it might be much bigger than what you think it is.'

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Meet your new RCP clinical vice president Dr Hilary Williams

Dr Hilary Williams, a consultant in medical oncology at Velindre Cancer Centre in Cardiff, took up the role of RCP clinical vice president in August 2025. She was previously RCP vice president for Wales and an active founder member of the UK Acute Oncology Society. Hilary trained in Sheffield before completing a PhD in Edinburgh in immunology and oncogenic viruses, and is a mentor for the RCP Emerging Women Leaders Programme. Guest editor Dr Nicola Maddox spoke to Hilary to find out how she is finding her new role.

What first inspired you to become a doctor?

It was a mixture of things. I wanted a practical career, where I could do something useful. But it was a late decision for me; I actually applied after my A-levels. Medicine is in the family – that might subconsciously influence you, but I didn't grow up wanting to be a doctor.

I did A-level maths, and I was only the only girl in the set. Some of the boys wanted to be doctors. As teenagers, their communication skills were a bit limited – they are probably great doctors now, but I just thought that you would need a range of experiences in medicine. I met a few people at medical school who seemed different from the traditional role of doctor. Seeing medical students who I could identify with made me feel that it might be the role for me.

Are there any women leaders who have inspired you – either in medicine or in other areas of your life?

There weren't that many female consultants then, or many women in leadership positions. Through the RCP, it's been great to connect with people like Professor Dame Carol Black, Dame Jane Dacre and Dr Linda Patterson. Now there are women around me, older and younger, who are great to connect with.

I did my PhD with Professor Dorothy Crawford. I didn't realise quite what a trailblazer she was – she had this great sense of humour about how challenging it was in her world. She did some of the very early work on T-cell immunotherapy in cancer – it's led to such amazing changes in cancer treatment, and sometimes we forget those early pioneers. Her lab was full of really bright women, but it was really fun as well.

When I did my foundation training, I had great support from Professor Anthony Weetman, the professor of medicine in Sheffield. He was very encouraging. The people around you, who believe in you, are really important.

Can you tell us about how you first became involved with the RCP?

When I moved to Wales, I was looking to extend my career beyond being an oncologist. I was always interested in public health policy; how doctors are represented and how we improve the NHS. That's why I became an RCP regional adviser in Wales and I really enjoyed it. I spoke at a Cardiff Update in medicine. It was a great meeting; people seemed to be having great fun connecting and they seemed like normal doctors. That burst that 'bubble' the idea that the RCP was a bit of an 'old boys' club'.

What would you say is your biggest achievement?

Sometimes it's just staying sane as a doctor, isn't it? I'm really proud of where I've got to, but I don't think I've compromised my values, which feels important.

For practical things, hopefully helping to 'right the RCP ship' after the physician assistant (PA) issues, which caused big fractures within the college. I do feel very proud that I brought voices together where there was a lot of discord. We have had very real challenges, but we bought some collaboration and consistency. I'm really proud of what we delivered to the Leng Review and I think we represented resident doctors well; I hope that's what they feel as well.

In this new role of clinical vice president, what are your aspirations?

First, we have to build back better, haven't we? We've got to get better structures and be much more real to our membership, and engage with people on the ground. We need [our decisions] to be based in reality for people delivering care every day. It is important to re-establish the RCP as a strong, professional voice of integrity for the profession, and a respected voice to policymakers. We need to take our members with us on that journey.

Then there are the things that, throughout my career, have interested me clinically.

My role is very much around improvement. There's some big focuses I want to bring around improvements in end-of-life care – cancer care is my background. We

need to recognise the skill sets around complex conversations and holistic patient care. I think we were undervaluing really vital 'soft skills', which are just as important as being able to do a procedure.

Then the real challenge that we've got is workforce. Physicians are really, really busy – especially in training – so much so that they don't have optimal time to care for patients. If you've got a stable workforce, and you know your team well, then people are a lot happier and you can improve things a lot more. But if every time you go to work, you find gaps in the rota, you don't know who you're working with, you don't know where anything is, then you're surrounded by chaos. I think we're risking patient safety with that, as you're much less able to make good decisions within that type of environment.

Training in stable teams and feeling a part of something is valuable; you can learn a lot more. That is something that we've lost in some places. Feeling valued, being part of the team and always putting patients at the heart of what we're doing is something that, perhaps, today's resident doctors have lost out on.

It's probably leading to burnout. I really enjoyed my training years, but many of us feel like we've lost teams and continuity. We've got to work out the modern version; what gives physicians better work–life balance and fits in with modern patterns of care. It's a hard one to crack. We've definitely lost some things around teamwork, continuity of care and decision making. We've got to rebuild that.

The RCP being regional is really very important to me; that links to recognising the real-world problems that people are experiencing and how we can advocate, articulate and amplify those issues. I'm really passionate about regional work from my Welsh experience. I often talk about the RCP connecting people from Carlisle to Cornwall, Bodmin to Bangor to Belfast. Those smaller hospitals are absolutely brilliant, but they can be where the most challenging workforce problems are; recruitment's tougher and it's harder to retain people. The RCP has got to get out there and understand the challenges both in big and small hospitals.

We need to think about the right workforce for the right bits of the UK; bigger cities might need highly specialist units, but a smaller hospital might need a bigger generalist skill set and a larger range of procedures. I don't think training has got that quite right at the moment.

What advice would you have offered yourself earlier in your career, especially about leadership?

Everyone's got leadership skills; finding the bits that you enjoy is probably the most important thing. You're not going to go above and beyond unless you feel personal satisfaction in your work. You need to know what the value is in what you are doing – particularly when feeling stressed or burnt out.

Don't be afraid to try things. I've taken the wrong job. I've hated a job. I've left places. That's absolutely fine. I've been a full-time and part-time academic, had career breaks, been a locum. We are not all going to go on a perfect pathway – it is a long and twisting road. If you take a pathway and it doesn't work out, that's fine; you'll find your place within it. But recognising when things aren't good for you is quite important as well; take that step back and get some support. Find people around you who you can connect with and talk to. I love talking to and collaborating with people – that's always been a real way of reducing burnout for me.

How do you achieve work–life balance?

The hardest time for me was probably when the kids were young. At that point my other half travelled a lot, so home life was quite busy.
It's a really tough one, isn't it? Especially for women, because it can be a career point where perhaps you want to be a more ambitious, but your home life may mean that's quite hard. You don't need to do it all at once; at some points, just getting to work and back, eating and sleeping is enough.

I've also always tried to do other stuff [outside work]. My perfect day is probably out on a Scottish or Welsh mountain with friends and family, a swim at the end of it – and hopefully some vaguely nice weather! I do try and build that in; being out in the fresh air is therapy for me.

I have done some leadership training; it was helpful to actually understand what I find hard and quite irritating, and understanding which certain situations are going to stress me out.

As doctors, we are perfectionists and very driven. I've learned to be a lot better about thinking how I will feel in 3 minutes, 3 weeks, 3 months or 3 years from now. If I feel like I'm banging my head against a brick wall, sometimes that helps me find perspective.

Why would you encourage resident doctors to become members of the RCP?

For me, it's about community and having your voice heard. I'm a great believer that we can all moan, but you've also got to do something about it.

Making those connections, meeting professional colleagues and friends; that's really important. The RCP's work and events bring that ability to connect with people in real life, when we've lost that old team structure – working different shifts, virtual working and not doing as much connecting on the

shop floor.

The RCP should also be about giving resident doctors a voice and making sure that they're able to be heard in a very busy system; influencing everything from training and exams to policy.

The present leadership team really value people's views; hearing from the people who have retired, those who are starting as consultants or in training. We value our connection with our members as much as we value our connection with senior policy makers. We're a much more vibrant and effective community when hearing all those voices, in a professional and productive way. Listening to all the voices in the room is really vital.

We are working on the RCP strategy at the moment and want to hear from people – so do get in touch by emailing clinicalVP@rcp.ac.uk. There's lots of ways to contribute; please let us know what you want us to focus on and if you've got things that you want to highlight in your local hospital. I'm particularly keen to hear from smaller hospitals and teams, and to just get to know people and see the brilliant stuff they're doing. I've enjoyed the aspect of getting out and about in Wales in my previous role, so if you want us to come and visit your hospital (if you've got a unit you're really proud of, or something that we can help with), then reach out.

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Training in Iraq: interview with a resident doctor

The RCP–Iraq Network was founded in November 2020 to improve education, health service provision and research for Iraqi physicians – from undergraduate students to newly graduated doctors, all the way to consultants.

Dr Mustafa Zubaidi is a resident doctor, currently training in a public hospital in Iraq, who works within the RCP–Iraq Network to improve medical training and research. He shares his experience of training with *Commentary*.

Can you tell me about your medical background and training so far?

I'm a graduate doctor from Wasit University's College of Medicine. I graduated in the first rank of my class in 2022. After that, I started working as a teaching assistant there – mainly I was in small group teaching and helping students in clinical teaching; the bedside, specifically. After that, I started my rotations; the medicine, surgery, paediatrics, emergency medicine rotations took about 12 months.

I returned to my college to work as a teaching assistant, but now my main role was clinical teaching and bedside teaching. One month ago, I started my residency programme, training in internal medicine, and also successfully completed my full MRCP(UK) exam.

Can you tell me about how medical training is structured in Iraq?

Basically, we have 6 years of medical school. After that, there is a year of rotation, meaning that you have to be part of internal medicine for 3–4 months, then other specialties. After this year you have to serve in the peripheral areas of Iraq and the health sector for 1 year. So 2 years after graduation, you can apply for residency training programmes. There's high competition branches, as usual, and you can train outside Iraq. Then there are differences in the training years, according to the programme and specialty.

What challenges do resident doctors face at the moment in training?

The main problem is the workload, which makes it very hard for doctors to stay in a calm and safe atmosphere for training. In recent years there's a new problem, which is the very high competition rate, especially in surgical branches, ophthalmology, orthopaedics and also nowadays in gynaecology.

This problem is due to the very large number of students graduating from medical school in Iraq. There's a very large number of graduates and very limited spaces for their training.

This is a problem that I think will be solved in the future by the ability to offer new training centres in different specialties; these centres will solve the problem of the workload for the doctors.

How is the RCP–Iraq Network helping to develop better health service provision in Iraq?

The RCP–Iraq Network works mainly to provide a better health services by focusing on the scientific activities, providing a better medical education programme, research guiding for medical students and graduates, and lastly providing an elective training outside Iraq. The RCP–Iraq Network helps a lot of students and graduates to develop their scientific activities by the meetings, every 2–3 months to discuss challenging cases. They also provide courses for the MRCP exam and in-person courses.

And as a part of the medical education team, we have conducted many workshops to talk about the basics of medical education for medical students.

One small project, the young educators, is unique and important. We focused on the students who attended all sessions provided by the medical education subgroup. We took these participants into a small group – the young Iraqi educators – and gave them extra sessions with senior doctor specialists in medical education. The main idea of this project is to create medical educators who will lead their colleges in the future. We will see the good from this programme in the next 5–10 years, as it provides more structured and professional staff in the colleges.

Another project is the peer-assisted learning project. We conducted a workshop with 10 students from each medical school in Iraq. This was a big gathering of many students and senior experts in medical education. There were full-day workshops to talk about peer-assisted learning; we were surprised by the fact that some medical colleges have a very structured programme, starting from the first years of being a student.

I am a part of the RCP–Iraq Network Scientific Steering Committee subgroup. Also I had a chance of going to the UK for a month, in Bristol's Southmead Hospital, for training in the summer with other doctors. I have had

that opportunity of exposure to an NHS system, recently after graduation, and I started to prepare for the MRCP exam as soon as I returned to Iraq. These opportunities changed my life and my perspective toward health provision.

The RCP–Iraq Network also cares about research. We have a very large deficit in research in Iraq. The network tries to fill that gap by providing a research course about two or three times a year – actual training and practice for that. We also conducted a smaller group of medical students who attended the sessions provided by the research subgroup, and provided them with research projects. A few of them started to work on actual projects. I was one of them; I studied cardiovascular system risk factors in Iraq. We completed the project and published it in a journal.

We have training for postgraduate students or doctors. We are providing advice on medical training initiatives and programmes – we help students or graduates apply, and many of them got the job.

As we reach the 5-year anniversary of the RCP–Iraq network, what are some of their successes and highlights?

The main successes are in term of medical education. We have the young educators, we have the basic course of medical education and we have peer-assisted learning. We have signed a memorandum of collaboration with many medical colleges in Iraq and we are trying to provide them with courses for students and staff to elevate and lift their level of medical education.

We have provided many, many workshops talking about the multidisciplinary team (MDT) and its importance – and also we are providing courses for examinations a few times a year. We have the next course in Suleimani, Iraq.

In terms of research, we have many research projects and a basic course in conducting and publishing medical research.

For elective training in the UK, we have sent about 15 medical students a year to train for a few months in the UK, for the last 3–5 years. So around 60–80 medical students across the years, and we support graduates in applying for posts in the UK.

These are the main pillars of success in the RCP–Iraq Network.

What does the future hold for the RCP–Iraq Network and young doctors in Iraq – what changes are happening?

TThe changes provided by the RCP–Iraq Network are now very visible. The establishment was very difficult, and you have to work hard to create a very large network. But now the future is very bright for the RCP–Iraq Network. We are aiming to host PACES exams in Iraq – this will be a very great success. It has never happened in Iraq since the establishment of the exam.

The future also looks very bright because we are sending more students and more graduates to train in the UK, and they are returning to help Iraqi people and to save the Iraqi health system. There has been a raise in the awareness of medical students and teachers about medical education and principles of medical education, alongside the accreditation programme.

This programme supports the ideas of the RCP–Iraq Network; if you want to get accredited, you have to apply the basic principles of medical education in your school. So now it is a must for the deans of medical schools to think about the course of medical education, for their staff members and for the students.

In term of research, we are aiming to provide a very large centre to conduct medical research. We will have other projects in the future, and we'll talk about them soon.

Do you have anything else that you'd like to say?

I want to provide advice for young doctors. I graduated from university in 2022, and worked very hard to try to be extraordinary by taking the MRCP exam. I started my preparation as soon as I graduated and I completed it before starting my residency training. This was a great success story. You have to work hard but there's nothing impossible. It's in your hands, but you have to work for it.

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Next Gen Physicians: the Next Generation Oversight Group

Let us briefly draw a stark vignette of the scenario that a resident doctor starting to work for the NHS today may face.

They often spend much of their day job simply scribing and completing admin tasks, sometimes without even seeing patients. This acts as little or no training and only serves to demoralise previously well-motivated new doctors and medical students. Conversely, on call at night, the same people are suddenly left to their own devices; expected to carry risk alone, without having had such experience in the daytime when well supervised. This tends to leave them stressed and overstimulated, at risk of making poor decisions. At no point in or out of hours do they spend time at the midpoint of the stress / performance curve, which is optimal for learning, performance and job satisfaction. It is no wonder that this unfortunate dichotomy leaves them feeling unprepared for more senior roles.

Meanwhile, portfolio requirements are often ticked off with a minimum of constructive feedback, accompanied by infrequent meetings with supervisors who struggle to provide holistic support due to service pressures. Combined with frequent nights on call, this results in very little feeling of continuity and belonging. Outside work, autonomy is again lost as these residents struggle to plan the lives of their young family around rotas provided at short notice, barriers to flexible working and training bottlenecks – which offer minimal assurance about where it may be possible to work in future.

Resident doctors feel undervalued, under-supported and under- trained. They understand why patient safety and provision of care must remain crucial for the health service; however, they reject the idea that their own wellbeing, career progression and development as clinicians should be de-prioritised for good patient care to be achieved. In fact, a positive working and learning environment for residents is crucial to ensuring that the consultants and specialists of tomorrow are well motivated to continue working for the NHS and delivering world-leading medical care.

Enough talking: what have we done so far?

Following on from concerns about resident doctor training experience raised in the 2023 *Shape of medicine* report, the RCP decided to make 2025 the year of Next Gen and to create the Next Generation Oversight Group (NGOG).

The NGOG has provided a space for open and passionate debate about key topics affecting resident doctors today, including recruitment, generalism, alternative training pathways and flexible working. Crucially, around half the group are resident doctors, alongside senior members of RCP leadership, providing an rich forum for discussing frustrations and influencing RCP strategy. The above vignette is drawn from a combination of discussions held by the NGOG and the national 'next gen' survey, which was completed by over 1,000 resident doctors. As we reach the final quarter or 2025, we can share some of the positive work of the NGOG, as well as where it should go in future – and how you can get involved.

Perhaps the most daunting and acute issue facing resident doctors today is the exponential increase in competition ratios for training posts. For internal medicine training (IMT), the post-to-application ratio has gone from around 1.4 in 2019 to 5.27 in 2025. We have reached a point where it is extremely challenging for many doctors to even get an interview for IMT, let alone a place on the programme. The NGOG has driven the RCP to advocate strongly on this topic, including via public position statements, discussion with government and a formal submission to the National Medical Training Review. We have been clear that it should never be the case that doctors need to spend multiple years out of programme simply to build a CV to get back in again. Such a system is entirely counterproductive and drives residents to consider other specialties, countries or even professions. At the same time, alternative pathways need to be made more uniform and straightforward to take some of the pressure off the application process.

Many residents feel that the application process is lacking in fairness and transparency. While looking for solutions to the recruitment challenges, one recurrent proposal has been the introduction of the Multi-Specialty Recruitment Assessment (MSRA) for IMT applications. However, the NGOG survey has shown clearly that this approach is not supported by the majority of residents. Hence, we have continuously rejected calls for its introduction. Should the MSRA be imposed despite reservations, then we will work to demand strict safeguards around its use, including a detailed review process.

Outside the regular formal meetings, the NGOG has provided a range of opportunities for resident doctor voices to be amplified when speaking on vital themes, including a series of blogs on topics such as outpatient experience, flexible training and mentorship. The

culmination of this year's work was an extremely well-attended and well-received next generation panel discussion, hosted by resident doctor members of the NGOG at the RCP's annual conference, Medicine 2025. It provided a space for open discussion about where we stand, what needs to change and how we achieve this. Hopefully some of you reading this article were in attendance and felt inspired.

Our vision for the future

The challenge for the NGOG is to turn excellent discussions into concrete actions and strategy. The next year is an ideal moment for such action, given that many changes are on the horizon for resident doctors and the NHS as a whole. The 10 Year Health Plan for England will focus on shifting care to community, preventing ill health and implementing digital solutions. The NGOG needs to look in detail at the proposed changes and ensure that the RCP lobbies for prioritisation of resident doctor wellbeing and training during the reforms. A clear example is in workforce planning – the government has promised an increase in national training numbers, but the 1,000 proposed will go little way to addressing bottlenecks, and there is an enormous amount of nuance in ensuring that new posts are appropriately situated and adequately supported.

NHS England's recent 10 Point Plan to improve resident doctors' working lives sets out some key areas of improvement, which align with many of the concerns highlighted in the NGOG survey. It begins the process of holding trusts to account for achieving these goals. However, given the upcoming abolition of NHS England and myriad competing priorities, such as ambulance waits and corridor care, the RCP must continue this work and advocate for mechanisms to enforce good practice. Trusts must be incentivised to deliver good training in the same way that they are to provide good patient care. The NGOG must work on ways in which this can be achieved.

Get involved

There are many ways to contribute to the work of the NGOG – and doing so is an incredibly valuable and rewarding experience.

Jemima Sellicks, an IMT resident doctor at Northampton General Hospital, shared her experience:

> 'Being part of the NGOG committee has given me and my fellow resident doctors a chance to actually make some change. We are all aware of the issues in postgraduate training in the UK; you hear the grumbles every day at work. But turning those frustrations into something constructive can feel impossible. Sure, on a local level we can push for little changes here and there, but there are underlying national problems that need big conversations with people who make the decisions.
>
> 'That's what the NGOG has offered. A chance for resident doctors to be heard. In my role as RCP East Midlands representative on the RCP Resident Doctor Committee (RDC), I've had aspiring IMTs come up to me asking how they can get into training. These are amazing doctors and yet they're panicking about being unemployed next year. I try to help in small ways, but deep down I know that many won't get jobs. It leaves me feeling pretty helpless.
>
> 'I hope that, by being part of the RCP's NGOG, we can push things forward and hopefully make things a bit better for the future.'

If you are a resident doctor (whether in a training post or locally employed) and member of the RCP who would like to contribute towards the work of the NGOG, please let us know which issues you think we should be prioritising for discussion and advocacy in the coming year. If you are working on similar key issues in your local trust or health board, then please let us know – we may be able to invite you to present at an upcoming NGOG meeting. Similarly, if you have completed work that you feel is allied to the goals of the NGOG and would like to write a blog detailing your achievements, then please get in touch: NextGen@rcp.ac.uk.

Finally, there are regular appointments to the RCP RDC – if you are passionate about the future of physician training, then please consider applying!

This feature produced for the October 2025 edition of *Commentary* magazine and published on 5 October 2025. You can read a web-based version, which includes images.

Interview: Managing multiple medications

In November 2024, the RCP launched its an acute care toolkit on Managing multiple medications. This valuable toolkit aims to help doctors in hospital with tackling overprescribing.

Dr Cleodie Swire, our resident doctor guest editor, spoke to three of the toolkit's authors: **Dr Lucy Pollock (LP)**, a consultant geriatrician at Somerset NHS Foundation Trust, **Dr Tessa Lewis (TL)** a GP with an interest in therapeutics and frailty, and **Dr Laurence Gray (LG)**, a consultant clinical pharmacologist and toxicologist working in Cardiff and Vale University Health Board.

Why is managing medicines something that all NHS physicians should care about?

LP: At least one in 10 – probably one in five – acute medical admissions of people over the age of 65 is caused by a problem with medications. If we said that one in five surgical admissions was due to a problem with the previous surgery, we would be up in arms.

Life is complicated and many patients have multiple conditions, so prescribing has become a dense patch of thorns. That means that prescribers need help, good training and support in getting medications right.

TL: The 2023 chief medical officer's annual report reminded us that sometimes we need fewer medicines, rather than more.

There aren't many opportunities like this in the NHS. You can improve patients' wellbeing, reduce harm and reduce waste. It's one of those rare opportunities where you have a win–win.

LG: Managing medications is a great way to empower patients. We have to make sure that any treatment that we give is tolerable and actually helps the patient. It goes back to 'first, do no harm'. We have a responsibility to look after and respect our patients. Making decisions around their care, rather than just giving another medication, is key to that. This drives a stronger patient–clinician relationship, which is fundamental to our practice.

LP: One thing I say to resident doctors is 'a prescribing pad is my knife'. It's my equipment, my equivalent of a surgeon's knife. So, I should think as carefully about prescribing as a surgeon would about an operation. This is my intervention; it's so important to get it right.

This also relates to cost and waste. There's an extraordinary statistic that about 20% of all healthcare activity globally is of no value to the patient. A huge amount of that will be unnecessary and wasted prescriptions. Imagine the environmental effect and financial cost to the NHS. We have a moral duty to address that, as well as a medical duty.

What are the main harms from problematic polypharmacy?

LG: Problematic polypharmacy is when medications that are no longer appropriate are potentially causing harm. The more you take, the higher the risk.
This may be due to a prescribing cascade; patients have adverse effects, then to counteract these side effects they are prescribed more medications. This leads to a vicious circle. We need to think about the root cause [of symptoms] and consider medications when doing so.

LP: The big hitters for geriatricians include medications that cause falls, constipation and confusion. Then there are the hidden, long-term downsides of some medications – like chronic use of a proton pump inhibitor increasing your risk of osteoporosis. Another factor is anticholinergic burden; we now know that we're prescribing anticholinegic medications associated with a 10–20% increase in dementia risk.
What is the impact for the patient? They have to take their five, 12, 18 different medications every day; collect them from the pharmacist, remember which to take before or after breakfast, which they can't take with tea, coffee or grapefruit juice … It's a very dominant part of life. Most older people do not want to spend this extraordinary amount of time every day dealing with the complexities, anxieties and sheer burden of managing that many medications.

LG: As the number of medications a patient takes increases, it is likely that their understanding decreases. This disempowers the patient, and they become more passive in their healthcare.

TL: I agree. People are struggling to understand what they're taking now in a way that they didn't 10 years ago, because of the sheer number of medications.

LP: From a positive angle, you are making the most enormous difference when you get prescribing right. It makes a patient happy; almost every patient will say 'yes please' to cutting down on medications. They will feel better, safer and happier. It's a rewarding exercise.

It is all about balance. We don't want to force people

to be responsible for their medication, as it is complicated. At the same time, they need the information to make an informed choice about their medications.

That's the direction we want this toolkit to help doctors take; empowering patients, but making it our responsibility to get this right, not theirs.

What are the main aims of the *Managing multiple medications* toolkit?

TL: 'Think medicines!' It's an opportunity for doctors to check their thought process, it includes lots of ideas and resources. It encourage us to 'think medicines' when seeing patients, including recognising medicines-related harms.

LG: Addressing polypharmacy can be daunting. This toolkit gives an 'on the shop floor' approach; you pick advice that is appropriate for your time and resources. If you can't do a full medications review, you could use the APINCHS tool to screen for high-risk medications.

LP: The toolkit provides lots of useful links and tools to improve prescribing. It doesn't do the job for you, it doesn't tell you which drugs to stop or start. What it does is give teams and individuals ways of improving their practice. Different people will find different tools useful.

Pharmacology is a complicated field. With competing pressures in medical school curricula, some prescribing knowledge is learnt on the job – which can feel very overwhelming for resident doctors. Physicians already practising must stay abreast of emerging medications. Anything that helps confidence in prescribing can be valuable.

OOnce you get your head around managing medicines well, it quickly becomes pattern recognition. You learn to read a drug chart and become familiar with the common problems; certain drugs leap out, you see obvious interactions and ones you need to question. This toolkit is partly to help build confidence quickly.

Can you give examples of how you implemented the toolkit approaches to address polypharmacy?

LG: I always think of medicines as a potential cause when looking at the patient's presenting features. Get up the drug chart and actually look at the medications when you see a patient.

I use a simple question about whether they are taking their medications as a starting point. From that you can understand the relationship that the patient has with their medications. Question what the medications are, and why they are prescribed. Screen for any APINCHS drugs, to ensure that the most high-risk medications are being used appropriately. What I have suggested is not resource intensive.

LP: Two tools that I use are GP Evidence and BRAN.

GP Evidence is a fantastic shared decision-making tool. It shows a patient or their family – and doctors – the benefits and downsides of a medication.

BRAN helps you frame conversations, such as when we're choosing whether to prescribe anticoagulation for somebody with atrial fibrillation who is frail and falls often. Doctors often calculate a CHA2DS2-VASc score, then prescribe anticoagulation. But what are the benefits, the risks, the alternatives? What happens if you do nothing?

TL: I often use Medichec. Not only does this assess anticholinergic effect, but it visually summarises other risks such as hyponatraemia, dizziness and drowsiness. The toolkit also has a table which is useful when assessing patients with common symptoms – like hallucinations, agitation or falls – and makes it easy to determine which medications might be contributing.

The toolkit says that 'continuation of prescription is an "active" act'. What advice do you have for clinicians making decisions about chronic medications in an overstretched acute setting?

TL: It is really difficult in that acute emergency setting. At a minimum, consider what drugs might be contributing to the presentation. If a patient is admitted, you have an opportunity to really look at their medicines; to question whether they're still needed and should be continued. By the time you get to writing the discharge summary, then it is too late to start.

LG: Some of these discussions can require a bit of time, so a good approach is to highlight a medicine as a potential issue in the patient's notes – which may allow it to be addressed later on in the admission. Patients are handed between multiple hospital teams now, so it's crucial to document our thought processes for the teams taking over care, which can include reviews of medications.

LP: My advice is to prioritise medications. This is key information, it isn't a sideline in medicine. This is a core part of being a physician. Give it the attention it deserves.

If you were a surgeon, you would be proud that you can do a laparoscopic cholecystectomy on your own. When you encounter an unfamiliar drug or side effect, look it up. This information is not innate. Grow your knowledge, be proud of growing your knowledge. If you can read a drug chart with 12 different medicines that you're familiar with, that's training to be proud of.

LG: As a consultant, it's really important to be seen, within the healthcare team, to consult resources. Demonstrating that it's the safe thing to do goes a long way to encouraging medicine safety; you set an example and it opens up conversations. Misplaced pride can become a cultural problem.

With specialised medications, such as oncology treatments, there is a danger that they are not recognised as the cause of acute issues. The key is to always consider them and seek further guidance from specialist colleagues.

Another quote from the toolkit is 'don't diss your predecessors'. How do you address polypharmacy without undermining the original prescriber and affecting the patient's trust in clinicians?

LG: I think this is a good motto in general for medical care. The key thing to remember is that things are dynamic. My approach is, 'This medication may have been good, but *at this time*, there's not much benefit from it and it may be causing some harm'.

LP: Sometimes it's worth proactively warning patients that things may change. I often say to older people with heart failure that their body will change, and that means medications will too.

It's not just about avoiding undermining other clinicians; patients can end up feeling guilty or frustrated that they've been taking a useless medicine all this time.

TL: I will often refer to the change in evidence. For example, aspirin was prescribed for patients with hypertension for primary prevention of cardiovascular disease – but the NICE guidance changed. If there are changes such as declining renal function or body weight, it can be helpful to share the rationale.

LG: A key part of this is communication. Something that can affect the patient's trust in clinicians is when one doctor stops a medication, another restarts it, then it's stopped again … The rationale needs to be explained to patients and other healthcare professionals, so that it can inform subsequent discussions.

Transition of care communication is crucial. If medication changes are not communicated to the primary care team, the patient may well end up back on those medications.

What projects would you recommend for clinicians trying to assess or improve the management of medicines in their working environment?

LP: There are excellent related audit and quality improvement projects available. There may be a tool that you could encourage your team to use and then see whether that improves practice.

There's lots in this toolkit, so people can choose what they're most interested in. I'd start with the quality of discharge information. I think that's a lovely subject to audit; for every drug that has been stopped, has the reason for discontinuation been included? If you can work with your IT team to mandate a reason for discontinuation, that could be a fabulous change.

Projects that give the patients a voice can be useful; maybe an audit about whether patients understand their medicines before going home.

LG: Simple projects work well! You could look at antimicrobials; were the duration and indication documented?

TL: Drug huddles, or 'druggles', have been set up in some departments; short multidisciplinary team sessions once a week to talk about what medicine-related issues they've seen and identify learning points. I think this is a nice example of collaborative working and prioritising medicines, which people may be interested to trial on their wards. s.

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Get involved with your RCP region

Healthcare policy and training often revolve around 'national' questions – especially within the NHS. It can be a struggle to ensure that local variations in health and care are understood and addressed.

The RCP UK regional network gives members and fellows the opportunity to change this, offering them the chance to represent their region and ensure that local issues are understood at a national level. The RCP has a network of 18 regions across England, Wales and Northern Ireland, which act as local hubs for RCP activity and engagement.

The dedicated regional teams offer physicians access to CPD activities, training and conferences wherever they live – as well as networking opportunities and a chance to get involved and represent their local area.

Dr Shruti Konda, the RCP's Linacre fellow, shares her work in the RCP regions:

> 'I'm fortunate to collaborate closely with our fantastic associate college tutor (CT) and associate college tutor (ACT) networks across England, Wales, and Northern Ireland, as well as the dedicated regional team at the RCP. I also have the privilege of working with medical students, resident doctors throughout their entire training journey, and consultant colleagues beyond this.
>
> 'My aim as Linacre Fellow is to help bridge education and clinical practice, ensuring that medical training programmes remain both robust and relevant across the UK. I support and help develop the CT and ACT networks across regions. These networks are vital, providing essential peer support, facilitating knowledge sharing, and promoting best practices across institutions and regions. Together, these roles and networks, which help to bring regions together, help to maintain excellence in physician education and ultimately improve patient care.'

Regional roles

There are lots of exciting regional roles and opportunities that are available to RCP members at any stage of their career.

- **Update in medicine conferences**: These 1-day events are held across the UK every year, and are designed to provide high-quality education and networking opportunities. Every conference will include a diverse range of speakers and specialties, as well as an update from RCP senior officers.
- **College tutor (CT) / associate college tutor (ACT) network**: CTs and ACTs provide valuable and important support to the RCP and their trust and health education board, ensuring high-quality training by overseeing and supporting resident doctors through their education.
- **Regional advisers**: These local advocates advise the RCP on a range of training, teaching and health service activities that are pertinent to the work of physicians. They are your local voice and connection to the RCP, and have the opportunity to raise issues on the ground – or share examples of good practice.
- **Join the RCP networks and committees**: The range of RCP networks and committees are often looking for regional representatives at varying stages of their careers. It can be a great opportunity to bring your local perspective to groups that influence national policy – including on the SAS regional representative network, Student and Foundation Doctor Network, New Consultant Committee or Resident Doctor Committee (RDC). These groups focus on a variety of issues, including improving communication between doctors, improving working lives and challenging educational dogma.
- **Other events**: The RCP also offers a variety of opportunities to share your views, ask questions and help shape the strategy and direction of the RCP; these range from virtual 'meet your president' events to trust visits from RCP officers.

Spotlight on RCP regional work in Wales: building community, amplifying voices

From national CT meetings to grassroots forums, resident doctors in Wales are helping to shape training and strengthen networks, supported by the RCP Cymru Wales team. **Dr Nicola Maddox**, *Commentary* guest editor, speaks to **Dr Sacha Moore** and **Dr Charlie Finlow**, RDC representatives for Wales.

'At RCP Cymru Wales we are fortunate to be part of a close-knit team, working all year round to support physicians across Wales. As resident doctor representatives, we feel especially privileged to benefit from the hugely supportive leadership, past and present, of RCP Cymru Wales. Alongside colleagues, we strive to ensure that the resident doctor voice is heard and valued in everything we do.

'Building community and driving meaningful

improvement are key parts of our role. To this end, in the autumn we will host our annual in-person meeting of CTs and ACTs. It is one of the highlights of the year; a gathering that brings together colleagues from every corner of Wales, alongside senior figures including the RCP vice president for Wales, regional advisers, training programme directors and representatives from Health Education and Improvement Wales (HEIW). The day is rich with discussion, ranging from leadership workshops to exploring getting the most out of the supervisor–supervisee relationship. Crucially, it not only provides ACTs with examples of innovative practice to take back and implement locally, but also gives a direct line to senior leadership that ensures feedback is heard where it matters most.

'Looking ahead to December, we are excited to try something new: an evening event for resident doctors held the evening before the Cardiff Update in medicine. Over a shared meal, colleagues will have the chance to network informally and join two open forum sessions hosted by us; these will focus on generating solutions to local priority areas of challenge. Additionally, RCP president Professor Mumtaz Patel and registrar Dr Omar Mustafa will be there, offering resident doctors in Wales the opportunity to engage directly with the RCP senior team. The evening promises to be both engaging and impactful, linking grassroots perspectives with national leadership in a collegiate and relaxed setting.

'Between these events, our Wales-wide WhatsApp group for ACTs provides a continuous channel for connection, advice and shared learning, ensuring that support never stops at the end of a meeting.

'We are looking at applying this method in the creation of a network of higher specialty doctors in training in 2025–26, ensuring that the geographical challenge of working across a whole country doesn't limit our connectivity.

'None of this would be possible without the foundations laid by the hard work of our predecessors, including Dr Alexandra Burgess, Dr Richard Gilpin and Dr Melanie Nana. Nor would our work be possible without the tireless dedication of the RCP Cymru Wales staff.'

Regional managers

Regional managers act as the central focal point of support for RCP members and clinicians within their respective region. They work closely with physicians across the RCP to help communicate with members within the region, deliver conferences, develop relationships with regional membership networks and ensure that their views are heard within the RCP.

The first regional office was piloted in Newcastle in 1996. The minutes of the RCP Council meeting held 12 June 1996 state: 'It was intended to establish more cohesive structures around the country based on the regional office scheme being piloted in Newcastle.' Subsequently, the Manchester regional office opened on 7 May 1998, and the West Midlands office opened 28 September 1998.

Many of the regional events and initiatives are designed to support physicians at specific career stages. However, the RCP also organises a variety of non-career stage-specific events, including Update in Medicine conferences and RCP Player webinars, providing clinical CPD. These events are crucial for providing continuous education and fostering a sense of community among physicians.

Commentary guest editor **Dr Nicola Maddox**, who has worked as an ACT and RDC representative in the south-west, speaks to RCP regional managers about their roles – and how physicians can get involved: **Jacqui Sullivan** (JS), RCP nations manager for Wales and Northern Ireland, **Holly McCarthy** (HM), regional manager for Kent, Surrey, Sussex, London and Wessex and **Jenny Ward** (JW), regional manager for East and West Midlands, Oxford and Thames Valley and Eastern regions.'

How can regional managers benefit RCP members?

JS: We are the link between the college sites in London and Liverpool, and our members in our region/nation. We organise regional events and can signpost our members to others locally, or to colleagues/activities within the college.

JW: We are the connection that links our members to both London and Liverpool, and across the regions that we manage. Regional events are available to anyone across the UK to attend if they so wish and are promoted nationally on the RCP website. We are the point of contact for a variety of queries and if unable to assist will always find someone who can.

HM: Regional managers are often the first point of contact for our members and fellows. We specialise in organising meetings and events that bring people togethe, and we're well placed to highlight opportunities to support you in your role.

What are your suggestions for RCP members looking to get involved with their regional team?

JS: Drop your regional manager an email or come and say 'hello' at an event. If a member is interested in getting more involved with the RCP, the regional manager can talk to them about the relevant opportunities open to them. For example, I have got to know foundation doctors who have taken part in the RCP virtual poster competition. When they ask about opportunities, I talk to them about the ACT role, which is open to all IMTs, and how being an ACT can develop their leadership skills and in turn enhance their portfolio Regional managers are often asked to put members forward to participate in events led by the Regional Services team. By building a relationship with members at a local level, we can recommend people who might be suitable for the opportunity.

JW: Always make contact with your regional manager if you are keen to become involved, always happy to enquire what support is required and where support could be offered in regional activities or in some cases more national events. Interaction with those who express, and interest often leads to many opportunities in either RCP representative roles or other committees, which are all great developmental opportunities.

HM: Start by reaching out to your regional manager! We can connect you with opportunities within the regional team or beyond, and we'll always be able to point you in the right direction.

What would be your top tip for ACTs starting in their role?

JS: Get in touch with your local RCP resident doctor representatives. They are a good source of information and can help you with any issues that are raised by your colleagues. Their role is to raise awareness of concerns across the UK with the national Resident Doctor Committee and college officers. You can find out who your regional representatives are via the regional pages on the RCP website.

JW: Definitely to make contact with others in the same role or RCP resident doctor representatives to be sure how best to develop within your role

HM: Get to know who is here to support you at the RCP. Your regional manager and the Linacre Fellow are just a phone call or email away, ready to help you settle into the role.

What do you love most about this role?

JS: I am now in my tenth year with the RCP and what I love most about this role is witnessing the growth of resident doctors who I met early in their careers. Seeing them develop confidence, step into leadership roles and truly find their voice is incredibly rewarding. It's a privilege to be part of their journey, to support and encourage them as they evolve into capable, compassionate leaders who will shape the future of healthcare.

JW: Having completed nearly 8 years at the RCP, whilst 'every day can be a school day' in learning something different regarding the operations of the RCP, I am fortunate to work with some amazingly team spirited and professional people, always there to support one another when needed. I have also seen those entering at foundation level, become involved in RCP activities and also flourish in their careers as they progress in their medical training.

HM: Meeting members and fellows in person, especially at our Updates in medicine events. These are fantastic occasions full of learning, networking, and connection.

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Interview: shaping RCP education as a resident doctor

Each year, a resident doctor gets the chance to influence the RCP educational offering by working with the RCP Education Directorate. Dr Vasiliki Thanopoulou has been working as RCP clinical education fellow since September 2024. As her time in the role comes to a close, she shares her experiences with *Commentary*.

What's your clinical background and what made you take up the position of a clinical fellow?

I'm an ST6 in rheumatology and general internal medicine (GIM) in London. I graduated from the Medical School of Athens and moved to the UK at an F2 level. At the beginning, I was focused on exams and getting settled into the NHS. But as I became more settled and realised how things work, I became increasingly interested in medical leadership and improving the training experience of resident doctors, and doctors in general.

That led me to apply for the RCP Chief Registrar Programme. I was chief registrar for the Royal Free Hospital, London a couple of years ago, which was a really fantastic experience. I was fortunate to work alongside two other chief registrars, so we formed a nice, strong team. During this period I realised that my greatest passion was around education; the projects that I felt most interested in were around programme design and teaching delivery. As a result, taking on a teaching role as an RCP clinical education fellow felt a natural step; a continuation and a unique opportunity to dip into medical education – at the national level this time around – and enhance my skills generally.

In your time with the RCP, what sort of projects have you worked on?

My time at the RCP has been incredibly diverse. It has been such an interesting year; one day of the week can be completely different from the previous one.

I've had the opportunity to work on various projects. One main pillar is serving as clinical faculty for several workshops, like effective teaching skills, workplace-based assessment and on-the-job teaching. You get to learn something new all the time when teaching. I was also very fortunate to present a workshop at Med+ in 2024, along with two senior educationalists.

Another important thing was reviewing and updating educational resources, making sure that they are up-to-date with current guidelines and adding in references.

I have also created a few extra podcasts, which was really rewarding as I was interacting with colleagues and consultants outside the RCP, to empower and inform people of interesting topics that come up every day in our clinical life.

I also became part of the RCP Advisory Group on Health Inequalities. It's doing an amazing job. Every clinician is aware of health inequalities, but whether they have the time or can provide solutions to tackle them is another thing. I had the luxury of time and flexibilities to explore different avenues, of how I can potentially make an impact. We've created a video, to share with the upcoming Chief Registrar Programme cohort, around quality improvement (QI) projects that address health inequalities.

Drawing from my experience as an international medical graduate (IMG), I have been involved with the RCP Global team, creating a website with useful information for people coming to the UK to work for the first time.

I was also involved in the Medical practice in adult learning disability postgraduate certificate; I served as a tutor for a few of the students, not only doctors, but nurses, pharmacists and occupational therapists. That gave me a wider understanding of why people want to make changes, and helped me see NHS problems from different angles.

What opportunities has this role given you?

Personally and professionally, you grow during your time in this job. While I was doing this fellowship, the RCP was also funding the Postgraduate certificate in medical education, done in partnership with University College London.

It was transformative, as I learnt fundamental theories of education that I could link back into my own work and see how I can actually implement the theory, in order to provide better teaching or be a better supervisor for junior colleagues. The role also helps develop managerial and organisational skills, presenting in meetings, justifying why you want certain changes or specific funding, and why actions are going to be important. These are all tools that you can take back into your clinical practice.

It's a different world from the hospital. In hospital work, we are very focused in the now, on the patient in front of us. That's our job and our role – to provide an immediate solution. Working at the RCP, my mind shifted to more long-term goals and projects, like policies implemented

years down the line. That was quite interesting, because it's a different perspective of timelines.

Having a platform to influence and create things to be disseminated to a wider audience was something I was fortunate to have. You don't really have that opportunity usually. Networking with senior clinicians, educationalists or RCP leadership was good. It was nice to hear firsthand their points of view and seeing how they deal with uncertainties or incidents – it was an important learning experience for me.

The role has also given me the opportunity to develop my own interests. The health inequalities projects or IMG work is not something that the previous fellows were doing, but equally they have worked on different policies and areas that I didn't have to take on. In general, there are some tasks, like developing the RCP podcasts or support as clinical faculty in the workshops, that every clinical fellow does, but at the same time you have the unique opportunity to find the areas that you want to explore. That flexibility is quite valuable and not really something you have very often in clinical life.

How has this role helped the RCP focus more on the experiences and needs of resident doctors?

The fellowship serves as a bridge between the RCP's Education team and the hospital life of resident doctors.

I was able to provide real-life experience; everyone in the Education team is incredibly knowledgeable, but if you are a doctor, you can be very helpful to the team as you have the insight and authentic perspective of the needs of different groups of doctors. I also believe that my engagement with the Resident Doctor Committee, even as an observer, has also helped towards this. Being an IMG was also a unique opportunity – I was the first clinical education fellow who had not graduated in the UK, which may have given me extra perspective in understanding this group of colleagues.

As this year comes to an end, what are you planning next?

I will be returning to clinical training; I'm very excited to join the rheumatology team at University College London Hospitals NHS Foundation Trust. I'll be going back part time, partly to give me time to progress in the diploma of medical education. A very exciting opportunity has also arisen – I will be able to continue working with the RCP, one day a week in one of my non-clinical days. I am really happy about that. I will continue to serve as a clinical faculty when needed and carry on with some of my projects.

This feature was produced for the October 2025 edition of *Commentary* magazine and published on 5 October 2025. You can read a web-based version, which includes images.

Reimagining the hospital as a learning ecosystem: reflections across two generations

The hospital has always been more than a place of diagnosis and treatment; it is also a crucible of learning and professional identity formation. From the first lessons in history-taking and examination to the challenges of breaking bad news and leading resuscitation, the hospital environment shapes not only what we know but who we become as doctors.

As an international medical graduate (IMG), I've seen hospitals with robust medical education, and hospitals where it is fragmented or barely exists – with direct implications for patient care.

Now, as a cardiology resident, medical educator and clinical researcher, I stand between two eras; the structured outcomes-based approach of today and the immersive apprenticeship model of the past. Both have strengths and limitations. The real challenge is how we integrate them and encourage intentionality in training.

To explore this, I spoke to two colleagues: **Dr Aishwarya Viswanath**, a current internal medicine resident at Northwick Park Hospital, London, and **Dr Emma Vaux OBE,** an experienced nephrologist and RCP global vice president, who completed graduated from Charing Cross and Westminster Medical School in 1993. The differing responses offer a vivid lens on how hospitals function as learning environments.

The learning environment

The differences between how teaching is today versus decades ago are stark. The accounts highlight the spectrum of training: structured timetables versus immersion. Both routes produced capable clinicians – which prompts the question of whether today's reliance on structure risks crowding out the formative value of immersion.

Aishwarya said: 'In my current hospital, regular clinical teaching happens in both formal and informal settings.

> 'Formally, resident doctors have 1 hour each of acute and general medical lunchtime teaching every week which have been helpful for consolidating knowledge and applying it in clinical settings. There's also weekly rheumatology teaching and weekly grand rounds, which bring a multidisciplinary perspective on complex cases.
>
> 'Informally, there's an active internal medical training (IMT) group chat that's used daily – people suggest useful procedures or patients for examinations. This peer-led aspect has been invaluable for real-time learning and opportunities. Acute consultants also occasionally provide a pearl of wisdom.
>
> 'While there's a good foundation of formal teaching, that informal network really helps embed learning into the everyday workflow. However, my current working climate is well-resourced; this level of formal teaching is definitely not standardised.'

Emma said: 'When I started my clinical training, it was a very different world from the structured education programmes of today. Much of the learning was apprenticeship based. We spent long hours on the wards, often working as part of a small, tight-knit team, which created tremendous opportunities to learn simply by being immersed in clinical practice.

> 'There was less formal teaching than now; much of our development came through observation, experience and the encouragement (or sometimes humiliation) of those around us. It was challenging – there was a steep learning curve, it could be scary and lonely at times, and we didn't always have today's support structures. But it fostered resilience, independence and a real sense of responsibility for our patients.
>
> 'Procedural skills were often learned at the bedside, with a more experienced colleague demonstrating first and then supervising. There was a real sense of gradual, hands-on learning, but there was variability in quality. I shudder as I remember doing liver biopsies. Decision-making developed through exposure – seeing a wide range of patients and listening to how senior clinicians reasoned through difficult situations.
>
> 'One of the great advances in medical education now is the structured approach that we have to skills training and assessment. Simulation, supervised practice and feedback provide safer, more consistent learning experiences. I think that balance – the richness of experiential learning combined with modern educational structure – is what we should strive for today. Structure should illuminate, not eclipse, the human texture of learning.'

Feedback

Feedback is often cited as the heart of good education. Aishwarya shared that today it's typically informal – quick discussions during conversations about patients or when participating in teaching. 'I find this highly useful as I can usually immediately apply it to my current patient.'

There is also structured feedback through acute assessment care tools and ePortfolio. Aishwarya says: 'These can sometimes feel rushed or done retrospectively, which makes them a bit less impactful. I think the most useful feedback comes when there's time set aside to discuss things in detail – unfortunately, that doesn't happen as often as it should due to service pressures. Furthermore, not everyone has had formal training in providing feedback methods.'

Despite decades of educational reform, structured and formal feedback continues to be inconsistent. Aishwarya's experiences echo Emma's from decades earlier: 'Feedback was rare and often informal – you were expected to learn by observing and doing, which meant gaps in skills or knowledge could easily go unnoticed … There was little structure or consistency. Much depended on the team you were placed with and the personalities of the consultants you worked alongside.'

Emma values the advances of structured feedback and simulation but warns against reducing feedback or training to checklists, reminding us that medicine is ultimately learnt through human complexity: 'I would wholeheartedly adopt the focus on structured feedback and reflective practice. These are powerful tools for growth that we simply didn't have in my early years. 'If there's one thing to guard against, it's an over-reliance on checklists or tick-box assessments. While structure is essential, it should never replace the deep, messy, human experience of learning medicine through relationships and real-world complexity. We must always balance rigour with humanity.'

Mentorship and the team

Both Emma and Aishwarya placed mentorship and the sense of belonging at the heart of development, whether encountered formally or serendipitously.

Aishwarya stated: 'Formal mentorship is limited to the random allocation of educational and clinical supervisors … it is a game of chance on whether you get on with them.

'Most of my mentorship has come from informal mentors, who have been instrumental in my success today. That said, due to the structure of our rotations – there's a high team turnover. This can make it difficult to build meaningful rapport or get consistent supervision.'

Emma shared the role senior physicians played in her professional development: 'They were pivotal in shaping not only my clinical skills, but also my professional values. The consultants I admired most were those who took the time to explain their reasoning, involved us in their decision-making and demonstrated the importance of kindness, compassion and integrity in practice.

'Mentorship wasn't formalised how it often is now, but some individuals became role models by example – balanced by those whom I never wanted to emulate. Watching how the good ones approached complex clinical problems, dealt with uncertainty and spoke to patients and families left a lasting impression on me. Those experiences instilled a strong belief in the value of mentorship and the need for senior clinicians to actively nurture the next generation.'

In contrast to Aishwarya's account, Emma highlights the decisive role of continuity: disrupted today by rapid rotational training, but once fostered by stable, close-knit teams and paced rotations. 'The real strength lay in the sense of belonging to a team. We worked closely with the same group of colleagues, which created continuity — not just for patient care, but for our own learning … That continuity fostered strong relationships with patients and colleagues and gave you a real sense of professional identity early on.'

Continuity may be the invisible architecture upon which meaningful mentorship and sense of belonging rests, a much-needed sentiment in today's NHS.

Culture and wellbeing

A positive culture and psychological safety are not optional extras, but the foundation upon which meaningful education is built. Within these different training approaches, do resident doctors feel safe and prepared to face challenges?

Aishwarya describes how psychological safety is vital for learning but can be contingent on local team dynamics: 'The overall culture is supportive. There's a genuine interest from many seniors in helping resident doctors learn and grow. It can sometimes depend on who the registrar or consultant is – some are more approachable than others. I've learned to gauge the environment and feel more comfortable speaking up as I've gained confidence.

'Psychological safety is essential for good learning. When the team is receptive and open, it makes it much easier to ask questions, admit gaps in knowledge and learn from mistakes.'

Emma also emphasises that learning can only flourish where fear is absent – which can be hard when working in a pressured health system. 'Today's resident doctors are working in a much more complex health system, with higher patient volumes … There's also an intensity of scrutiny, with every decision carefully documented and audited, which can feel overwhelming.

'At the same time, resident doctors today have access to far more structured support – simulation, mentorship programmes, clear curricula and protected training time in many settings. The challenge is balancing those structures with the realities of service pressures.

'There were fewer safeguards around working hours and wellbeing. While the intensity built resilience, it could sometimes come at a cost to both doctors and the patients we cared for. One of the lessons we've learned over the years is that quality training requires intentional design, not just good luck and who you may know.'

Similarly, Aishwarya's comments highlighted that service pressures can eclipse learning: 'That is likely the reality across the country. The patient load at my hospital is remarkably high … the pressure to keep up with patient flow can often overshadow learning opportunities. Similarly, the impending load of paperwork can directly impede our time in practice.

'While the intention is to balance both, in practice, the service demands usually win. It can be difficult to step away to attend teaching sessions or clinics when you're aware that the team is stretched.'

Without better staffing and protected time, education risks being marginalised. Both Emma and Aishwarya agreed that training should be structured, patient centred and protected.

Emma also emphasises another culture change: 'What strikes me most about this generation is their courage to speak up – about wellbeing, equity and patient safety. That's something we didn't always feel able to, or even know to we could, do. I find it incredibly inspiring.'

Visions for the future

I asked both physicians to imagine the ideal learning hospital. Aishwarya emphasised the need for well-balanced protected teaching time and learning opportunities for all resident doctors – which need adequate staffing and rota coordination. 'This shouldn't just be a goal on paper, but something that is achievable. Continued learning and professional development is part of GMC good practice, and for good reason – our abilities as clinicians and providing quality care are directly related to our ability to learn and grow.'

She also emphasised that this needed to be a national, standardised approach: 'No matter which trust or deanery you're in, everyone [should have] equitable access to high-quality academic teaching. Equity is a timetabled reality, not a policy statement.'

There was a sense of generational harmony in this as both physicians shared the same vision of training as an intentional, visible and valued core function of the hospital.

Emma also envisioned education woven seamlessly into daily practice: 'It's a culture where every patient interaction, every handover, every multidisciplinary meeting is seen as an opportunity to learn and teach and improve.'

Emma offered the advice that she would give to her younger self, which can help guide learning and development for young doctors: 'I would tell my younger self to be kind – to patients, to colleagues and to myself. Early in our careers, we can be our own harshest critics, and medicine is demanding enough without that internal pressure, and you will make mistakes. Hold onto your values to guide you through – mine are thoughtfulness, authenticity and integrity.

'I would tell myself to embrace uncertainty rather than fear it. Early in our careers, we often think that good doctors always have the right answer – but the truth is, medicine is full of grey areas. It's completely normal to feel unsure, and learning to navigate that uncertainty thoughtfully and safely is one of the most important skills you will ever develop. Stay curious, reflective and compassionate, and you will grow into the doctor you aspire to be.

'I would remind myself that always going back to the patient reminds you why you are doing it all. And to find things that you love to do alongside the clinical work, as this will help you grow and keep you interested; finding the key ingredients that will sustain you in what is hopefully a long and fulfilling career.'

Reflections: between two worlds

As I listened, I found myself both grounded and unsettled. Aishwarya reminds us of the daily realities: high workloads, uneven teaching and the fragility of mentorship. Emma reminds us of the virtues of immersion, belonging and the art of navigating uncertainty. Together, they paint a picture of tension and opportunity.

As someone trained in the modern model but mentored by giants of the traditional one, I believe that hospitals can be reimagined as dynamic learning ecosystems, designed with intentionality to balance service and education, foster psychological safety and integrate both formal and informal spaces of learning. The ongoing national debate on the quality of training suggests the need for fresh perspectives. If we were to approach hospitals as ecosystems, what dimensions would be essential to their design?

If we take seriously the idea of the hospital as a learning ecosystem, we must move deliberately away from a service-only mindset towards one where service and education are mutually reinforcing. Hospitals are not just workplaces. They are where future doctors are shaped, not only in skills and knowledge, but in values, resilience, and identity. If we are to honour this responsibility, we must move beyond the binaries of old versus new, service versus education, structure versus freedom.

Emma and Aishwarya shared five intentional habits for busy teams to start transforming your hospital learning environment that resonate with RCP resource *Never too Busy to Learn*:

- Open the ward round with roles and a learning aim.
- Cold-call kindly: each person asks one question, and any approaches (cold calls) are in a way that is respectful, empathetic and considerate to ecourage engagement.
- Close with 'three learning points' and 'so what next?'.
- Offer micro-feedback in the corridor (60–90 seconds).
- Log one assessment linked to a real case within 24 hours.

Do you have anything else that you'd like to say?

We must invest in hospital learning ecosystems that integrate the strengths of both eras: the resilience of immersion with the safety of structure, the richness of human mentorship with the opportunities of digital innovation. As Emma says: 'Ultimately, a great learning environment benefits everyone: resident doctors grow, teams thrive, and patients receive better, safer care. It's a reminder that education is not separate from service delivery – it's integral to delivering excellent care.' After all, we are fortunate to do what we do.

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Global events over the summer

Professor Mumtaz Patel, PRCP shares her 2025 visits to support global physicians' work over the summer.

Fourth Jordanian Women's Physicians Conference

Over the summer, I had the pleasure of attending the fourth Jordanian Women Physician's conference (23–25 August 2025) in Ammam, Jordan organised by Dr Maisam Akroush, an RCP fellow. Maisam and I share the passion of empowering and supporting the next generation of physicians and particularly female physicians and enable their progression to senior leadership positions.

During this conference, I delivered sessions on our RCP Global Women Leaders programme, e-learning, leadership and research. I did an RCP networking session led by our International Advisor for Jordan, Dr Ala' Al Heresh which went very well. I was privileged to meet with and be on the stage with HRH Prince El Hassan Bin Talal who was hugely appreciative of our RCP collaborative work. During my visit, I had very productive meetings with the British Embassy, and the international committee of the Red Cross and Red Crescent who are doing amazing work to support the humanitarian efforts in Gaza, Syria and regional conflict zones.

The speech I did for the opening ceremony was titled *Growth and excellence*. **Growth** in the sense of seeing the conference grow from strength to strength over the last 5 years since the first Jordanian Women's conference in 2021 to the development of the Pan Arab Women's Association in 2022 and now to the breadth of activities and the programme of work that has followed as part of it. We launched the Global Women Leaders Programme in Jordan on International Women's Day, 8 March 2023 under the patronage of Princess Dina and have since delivered workshops to both to develop champions of the programme and individual to develop, support them in their early career journeys.

The **Excellence** aspect represents what has been achieved so far. The development of the Jordanian Women Physicians Conference, the development of the Pan Arab Women's Association and their activities have achieved the highest quality of excellence. The programmes have been so innovative and breadth of activities has been amazing; from the prevention agenda, leadership, supporting the Next Gen, AI to sustainability.

I am looking forward on building our partnerships and supporting the next generation of physicians and reducing the gender equity gap and addressing the health inequalities in Jordan and beyond. Thank you, Maisam and the whole team for being such wonderful, dedicated physicians and partners to work with.

10-year anniversary of ECSACOP

I was delighted also to be able to go to Mombasa, Kenya to support the East, Central Southern African College of Physicians (ECSACOP) exams, conference and join their 10-year anniversary celebrations (26–29 August 2025).

ECSACOP has been our key organisational partner in Sub-Saharan Africa for a decade now. It has been a privilege and pleasure to support ECSACOP in their efforts to advance postgraduate medical training and support the next generation of physicians in Sub Saharan Africa. ECSACOP covers Zimbabwe, Zambia, Kenya, Malawi, Uganda and Tanzania.

The founding aspiration of ECSACOP was to double the number of physicians being trained in the region by 2030 and this includes clinicians, leaders and educators. The RCP has been part of their journey since its inception and supported development of the common curriculum, standardised training pathways, quality assurance of the programme and educator development. The ECSACOP programme aims to increase medical capacity, harmonise standards across the region and positively impact 200 million lives.

During this visit to Mombasa, I examined for the FCP Part 2 examinations on the 26 August 2025 which went very well, and I supported the ECSACOP conference, council, annual general meeting and committee meetings during my visit here. It was wonderful to be part of the graduation ceremony of those resident doctors who had just completed the programme and share the celebrations and achievements. Thank you to Professor Jowi (president of ECSACOP), Dr Erick Njenga (president of the Kenyan Association of Physicians) and the whole team for their kind hospitality. A massive thank you to the whole ECSACOP team for their brilliant work, unwavering efforts and commitment towards the programme. We are proud to be on the journey with you and will continue to support you in your future endeavours.

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Make health your lasting legacy: supporting the RCP with a gift in your Will

The RCP recently took part in Remember a Charity Week. This national scheme encourages everyone to think about how they'd like to be remembered – and to consider leaving a gift to charity in their Will, alongside family and friends.

Leaving a gift in your Will is the most important charitable donation that you will make. It is an expression of the values you have lived by and creates a legacy to carry on these values. In creating your Will, naturally your first thought will be to take care of your family and friends. After doing so, you may wish to leave a portion of your remaining estate to the RCP. .

The RCP has a long history of legacy giving, dating back to our first president, Thomas Linacre, who bequeathed his home to the college in 1524. Leaving the RCP a legacy will have a powerful and lasting impact on the charitable work that we do, and support physicians in the future to provide better healthcare for patients. All legacy gifts, no matter what size, are immensely important to allow us to plan for and invest in the future. A gift in your Will has the power to shape the future of medicine, particularly by growing our endowment fund so that the impact of your donation lasts in perpetuity. A gift in your Will can help us continue to educate, train and support future generations of physicians to strengthen health systems and improve medical standards across the globe.

We understand that leaving a gift in your Will is something you will want to think about very carefully. We have a legacy booklet that will answer many of your questions – do get in touch with our head of philanthropy, Sally Williams, if you would like a copy.

How your legacy gift will help

The RCP is a registered charity, independent from government, led by doctors for the benefit of all. Independence allows the RCP to act on health matters and to speak out about public health threats that affect us.

The RCP has a proud history of philanthropy and has become what it is today thanks to the generous support of benefactors. We have been at the forefront of patient care for over 500 years. Through advocacy, education and research, we drive improvements in the diagnosis of disease, the care of individual patients and the health of the whole population, both in the UK and across the globe.

By donating a gift in your Will, you can have a tangible impact on the successful delivery of the RCP's strategic and charitable aims; providing us with the necessary support to advocate for public health, improve healthcare practices for both doctors and patients, and support the next generation of doctors. All legacy gifts – whether large or small – are vital to allow us to plan for the future. You can create your legacy in an area that you feel passionate about supporting, such as the RCP's educational and training work, and these funds might be applied to immediate priorities or invested in the longer term within the RCP's endowment.

Our legacy pledger programme

Thank you for taking the time to consider making a contribution to the RCP's important work. We appreciate that leaving a legacy gift is a personal decision that you may prefer to keep private, but we would be delighted to thank you if you are happy to share your intentions with us. Please be assured that the information you choose to share with us will be held in confidence and is in no way legally binding. Knowledge of forthcoming gifts helps us to plan for the future and enables us to keep you updated about our achievements. More importantly, by letting us know, we are able to acknowledge your contribution, thank you for your incredible generosity and celebrate the legacy that you have pledged.

We would be honoured to have you join our group of legacy pledgers and would be delighted to invite you to our annual summer garden party for RCP supporters.

Please get in touch

If you have any questions, we are here to help and answer any questions in confidence. For more information, please call Sally Williams (head of philanthropy) on 020 3075 1535 (direct line) or email Sally.Williams@rcp.ac.uk.

This feature produced for the October 2025 edition of *Commentary* magazine and published on 5 October 2025. You can read a web-based version, which includes images.

Alternative training pathways: a radical shift in mindset

When Dr Simon Patten, deputy director of medical education at the Royal Devon University Healthcare NHS Foundation Trust, reflects on the future of medical training, one theme stands out: flexibility.

For him, alternative pathways, like portfolio pathway submission, into medicine are not a fringe experiment, but a necessary response to the shifting priorities of today's doctors and the workforce challenges facing the NHS.

'People's priorities have changed,' he says. 'We see that in the focus on less-than-full-time working, where time is often valued more than money. People want to settle, put down roots, and still have a meaningful career. Traditional training programmes don't always make that easy.'

A changing landscape

Work–life balance is not new to the medical profession, but it has become harder to ignore as younger doctors make different choices about how, where and at what pace they want to progress.

Two-doctor households face particularly difficult decisions. One partner may be placed in Exeter, another in Essex – leaving families split between locations. For others, the desire to settle in one place, buy a home and build a support network is paramount.

Simon argues that training models need to catch up with these realities. 'For some, moving across the country every year is fine – they want to advance rapidly and they're happy to go where the work is,' he says. 'But others want to develop their career in one place or at a different pace. That doesn't make them any less ambitious, and it certainly doesn't make them any less valuable as doctors.'

Why alternative pathways matter

So what do alternative pathways offer? In short, stability, consistency and the opportunity for deeper professional development. Rotations in traditional training programmes provide breadth, but they can also mean leaving projects unfinished and relationships unbuilt.

'If you rotate every year, it's hard to get to know people well enough to spot development opportunities,' explains Simon. 'Lots of projects start but never finish. In contrast, staying in one place for 3 or 4 years lets you complete projects, test ideas and build the relationships that help you take on future roles.'

The benefits are not only for doctors themselves. Departments also gain from having long-term colleagues who understand the local system, smoothing the annual August handover period and improving continuity of care. Employers, meanwhile, get to see what candidates can deliver before making consultant appointments – making job planning more sustainable.

The approach also allows earlier and more consistent leadership development. Resident doctors in longer-term positions can take on responsibilities sooner, giving them valuable experience before they become senior decision-makers.

Lessons for training programmes

Alternative pathways are not intended to replace traditional training. Rather, Simon sees them as complementary – two routes working in parallel.

'It's not that one is better than the other,' he stresses. 'Training programmes bring cross-pollination of ideas and experience, while alternative pathways bring stability and depth. Together, they create a more robust and diverse workforce.'

This diversity is particularly important in areas like the south-west of England, where the population is older and often living with multiple chronic conditions. The skill set needed locally may not always be reflected in who succeeds through competitive national recruitment.

By comparing outcomes across both models, trusts and health boards can also learn valuable lessons. For example, the early cohorts of alternative pathway doctors struggled with General Medical Council (GMC) submissions because they lacked structured annual reviews. In response, the Royal Devon programme introduced its own portfolio reviews, strengthening supervision and progression.

Similarly, acting-up opportunities are harder to arrange outside traditional programmes. To bridge the gap, the trust used the new specialist grade role as a transitional step – allowing doctors to demonstrate consultant-level work before formal appointment.

Lessons for training programmes

The project began at departmental level, focusing on specialties with recruitment challenges. Acute medicine, with its small training programme and high service demand, was an early test case.

Departments had to commit to 4-year posts, shifting away from the short-term mindset of annual trust-grade recruitment. Crucially, consultants also gave unfunded time to supervise and support, recognising the long-term value.

'The mindset shift was moving from "I just want to fill a

rota gap" to "I want to recruit and train a future consultant colleague",' says Simon. 'That's a very different approach.'

Support at divisional and hospital level followed, along with the development of internal rotations and partnerships to meet specialty requirements. The early success in acute medicine encouraged other departments to follow suit.

What went well – and what didn't

- **Departmental buy-in**: clinicians quickly saw the merits and invested their own time.
- **High-quality recruits**: the first cohort felt valued, driving them to develop new projects and embed themselves in the unit.
- **Spillover benefits**: other departments noticed the success and were more willing to create internal rotations.
- **End-stage submissions**: portfolio doctors initially found GMC submissions daunting without structured reviews.
- **Transition to consultant roles**: there were few acting-up opportunities, which required some creative solutions, including use of the specialist grade role.
- **Negative perceptions**: the term 'trust registrar' often carries stigma, so the trust has worked hard to create clearer, positive progression structures.

Building relationships and resilience

One of the less tangible but equally important benefits of alternative pathways is the strength of the relationships that they foster.

'Because of the longevity, you build closer personal connections,' says Simon. 'That makes it easier to support people when things aren't working out or when they face personal challenges. I don't think medicine has always been good at recognising when people are struggling, but this model makes those conversations easier.'

This pastoral dimension is increasingly relevant as the NHS grapples with burnout and retention. A workforce that feels seen, supported and stable is more likely to stay motivated and deliver high-quality care.

Looking ahead

Simon is clear that alternative pathways are not a silver bullet. They work best in larger hospitals that can deliver most specialty training requirements, or where partnerships can be developed across sites. They also rely on consultant goodwill and a trust-level commitment to long-term investment.

But he is equally clear that they represent an essential part of modern workforce planning.

'There's room for both routes,' he says. 'The more open and flexible we can be, the more chance we have of inspiring people to stay and work with us. People want to work differently now, and if we invest in that, it will pay off.'

> 'I want to recruit and train a future consultant colleague – not just fill a rota gap.'

The experience in Devon shows that with creativity, commitment and collaboration, trusts can design training pathways that meet the needs of today's doctors and tomorrow's patients.

A wider conversation

The RCP's next generation campaign has highlighted growing concerns about training bottlenecks, competition ratios and career progression. In our 2025 national survey of resident doctors, only 44% of respondents were satisfied with the quality of their training. One in four were actively dissatisfied.

When we asked how they felt about rotational training, the answers were stark. 41% said that geographical rotations had a negative impact on their training, compared to just 26% who were positive. 28% wanted them abolished entirely, and 50% said that they should continue only with reform.

Resident doctors are asking for more than clinical experience. They want time to grow as leaders, researchers and educators. They want to develop skills in digital health, financial literacy and community engagement – training that reflects the reality of modern medicine, where doctors lead multiprofessional teams across sectors and settings.

Alternative pathways speak directly to those issues. They provide a route for doctors who want stability, for those who don't fit the traditional mould, and for those whose personal lives make constant relocation impossible.

This is not about lowering standards or creating second-tier roles. It is about offering genuine alternatives – and in doing so, building a workforce that is both resilient and responsive to changing needs. For Simon, the conclusion is simple:

> 'At no point is one inferior to the other. Both are valuable. Both are important. And together, they give us the kind of workforce that the NHS really needs.'

Five top tips

- **Invest in longevity**: 4-year posts foster deeper development and stronger relationships.
- **Support supervision**: Senior doctor time is critical to success.
- **Create clear progression**: Use specialist grade roles and portfolio reviews to support career advancement.
- **Challenge stigma**: Reframe 'trust-grade' roles with structured development and visible outcomes.
- **Think beyond the rota**: Focus on building future consultant colleagues, not just filling a gap.

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Meet the Resident Doctor Committee Co-chairs: an Interview with Dr Catherine Rowan and Dr Anthony Martinelli

Dr Anthony Martinelli (AM) and Dr Catherine Rowan (CR) took up their roles as RCP RDC co-chairs in 2024, having been RDC representatives for the East of England and Yorkshire and Humber deaneries respectively. They are both passionate about advocating for resident doctors about training issues and medical education. Anthony stepped down as co-chair in September 2025.

Dr Nicola Maddox (NM), RDC member and Commentary guest editor, speaks to them about their work as RDC co-chairs. Read Nicola's companion article on the RDC's extensive work, speaking to fellow members of the committee.

What inspired you to take on the role as co-chairs of the RDC?

CR: I've always been invested in medical training and education. I saw this position as a critical opportunity to make a significant impact and represent resident doctors at a time when their voice was needed most.

It's important to me that the RCP reflects what it's like to be a doctor today. I work less than full time, juggle two on-call acute rotas with my husband and have a busy home life with two children. While my situation isn't unique, it gives me a solid grasp of the challenges that many doctors face in managing their working lives.

AM: I stepped up because it felt like a critical moment. The college was facing some really tough challenges, and I believed that the voice of resident doctors was central to finding a way forward. On issues like physician assistants (PAs), we needed a strong, clear direction from our committee to shape college policy. I wanted to be part of making that happen.

How can this role and the RDC help resident doctors?

CR: A key challenge for me on the RDC has been bridging the gap between our work and the resident doctors we serve. The RDC advocates for resident doctors on a wide range of committees, from the Joint Royal Colleges of Physicians Training Board (JRCPTB) to groups focused on curriculum implementation, recruitment and general internal medicine specialty advisory groups. We contribute to educational initiatives such as RCP conferences and podcast series.

Regional RDC representatives connect us to local issues, build networks and ensure that representation is diverse. Our focus is to provide the resident doctor perspective on vital issues in medical training, shaping a better future for the next generation of physicians.

Ultimately, our job is to bring the reality of being a resident doctor into the rooms where decisions are made and to speak truth to power.

AM: We fight to make sure that changes to training, recruitment and assessment help us, rather than hinder us. We can't win every battle, but I'm convinced that without the RDC, things would be much tougher. We can also champion specific causes. For example, I have been focused on setting up work to improve general medicine training, tackle the internal medicine training (IMT) recruitment crisis and ensure that academic medicine has a future. It's all about making our working lives better and securing the future of our profession.

There have been challenges during your time as co-chairs, how did you tackle these?

CR: Since taking on this role in September 2024, it feels like we have navigated one challenge after another, from the ongoing discussions around physician assistants to the systemic issues of increasing competition ratios and training bottlenecks. We also had to respond quickly to urgent situations, such as the MRCP(UK) part 2 exam error.

Throughout it all, my priority has been to ensure that we respond with openness, honesty and clear communication. For example, I advocated directly with statutory education bodies on behalf of the doctors affected by the exam error. The strength of our committee comes from capturing the collective voice of resident doctors and using our different skills to support them when it matters most.

AM: By being persistent and united. We have resident doctor representatives on countless committees but

have only started to see real impact when everyone repeats the same clear messages. That's where our wider RDC has been absolutely fantastic – having such an engaged and proactive committee means that we know we're speaking for the majority, not just for ourselves. We've also had great support from senior figures at the RCP, who have always been willing to listen and engage, even when we're not in agreement.

LP: The toolkit provides lots of useful links and tools to improve prescribing. It doesn't do the job for you, it doesn't tell you which drugs to stop or start. What it does is give teams and individuals ways of improving their practice. Different people will find different tools useful.

Pharmacology is a complicated field. With competing pressures in medical school curricula, some prescribing knowledge is learnt on the job – which can feel very overwhelming for resident doctors. Physicians already practising must stay abreast of emerging medications. Anything that helps confidence in prescribing can be valuable.

OOnce you get your head around managing medicines well, it quickly becomes pattern recognition. You learn to read a drug chart and become familiar with the common problems; certain drugs leap out, you see obvious interactions and ones you need to question. This toolkit is partly to help build confidence quickly.

What are you each most proud of as a co-chair and a representative for your region?

CR: We've been lobbying to raise the profile of rising competition ratios in IMT and training bottlenecks, and have met directly with key leaders such as the chief medical officer, Professor Sir Chris Whitty, and former NHS national medical director, Professor Sir Steve Powis. By writing to the government and speaking to *the Financial Times*, we've amplified these critical issues, which continue to create uncertainty for current resident doctor.

Our efforts have extended across many other vital areas. We influenced the JRCPTB's guidance on self-development time and contributed to the national Medical Training Review via the 'Next Gen' committee. Anthony's dedication to the PA oversight group was crucial in shaping recommendations for scope of practice and name change. Each of these issues is hugely important and this experience has reinforced how valuable a dedicated voice can be..

AM: I'm really proud of the work we did to get self-development time for higher specialty doctors in training formally recommended. There's still a way to go on implementation but seeing it adopted in trusts, and making a real difference to people's working weeks, is very rewarding. More recently, helping to shape the first phase of the medical training review has been a huge focus. This is a once-in-a-generation chance to fix things for the long term, and we need every resident doctor to get involved and have their say on what the future of our training should look like..

What is your favourite aspect of being a co-chair?

CR: I always look forward to our annual July face-to-face meetings with the entire RDC. It's a genuine privilege to work with such an enthusiastic, hardworking and inspiring group. When we meet, I'm always left feeling more optimistic about the future of the profession, as it is clear that there will always be doctors committed to improving it for everyone.

AM: For me, it's meeting the next generation of physicians. Representing the RDC at the MRCP(UK) graduation ceremony and working with the Student and Foundation Doctor Network (SFDN) have been real highlights. You meet so many brilliant, motivated people who are passionate about medicine – and it's a powerful reminder of why we do this. It's our duty to make sure that the career pathways for them are as good as they can possibly be.

How do you think being part of the RDC has helped you develop professionally, with your career and aspirations?

CR: It's a huge privilege to be able to represent resident doctors on a national level. I've always been passionate, but this experience has given me greater understanding of the strategic steps needed to influence policy and create lasting change. I've learned a lot about leadership, recognising that the best approach can vary greatly depending on the situation, and the importance of listening and recognising the strength of others.

AM: The biggest thing has been getting to hear so many different perspectives. You learn so much about how training works (or doesn't) in different parts of the country. It's given me a much clearer sense of how vital good local and regional leadership is for making things better on the ground. I hope that's something I can take with me into my future career as a consultant.

If there are resident doctors interested in being involved with the RCP, what advice would you have for them?

CR: We'd love you to get involved! The RCP offers many opportunities to participate, including annual applications for the RDC and the role of associate

college tutor. For those approaching the consultant level, you can also apply to join the New Consultant Committee. We strongly encourage all doctors to look out for these opportunities on the RCP website and in your emails, to get involved whenever you can.

AM: When we've been assessing applications to RDC, the key criteria we have been looking for are enthusiasm to do the job and a track record of advocating for fellow residents. It is good to take opportunities to do the latter wherever possible – whether through RCP roles or not. We were never worried about people being critical of the RCP or their training experience in their personal statements; as long as it could be directed towards making a positive change. We felt that such passion could actually be helpful.

Is there anyone who has inspired you with regards to leadership?

CR: I've really enjoyed working with our current president, Professor Mumtaz Patel. She's a great example of kindness and compassion in leadership, and makes people feel valued. You also can't underestimate the smaller, day-to-day interactions with role models during our medical training. They're the people who inspire us along the way. Throughout it all, my priority has been to ensure that we respond with openness, honesty and clear communication. For example, I advocated directly with statutory education bodies on behalf of the doctors affected by the exam error. The strength of our committee comes from capturing the collective voice of resident doctors and using our different skills to support them when it matters most.

AM: Seeing Professor Chris Whitty lead meetings up close has been a real education. You see him on TV, but in person his ability to steer a discussion is even more impressive. We don't always land on the same page when it comes to training, but his thinking is always so clear and long term. I've learned a lot from watching how he identifies the key pressure points to make change happen, while still making sure that everyone feels they've been heard.

Any other comments?

CR: A huge thank you to everyone on the RDC. This important work would not be possible without our dedicated and hardworking group of doctors who volunteer their time. A special thank you to Anthony, who has recently stepped down as co-chair – he has made an huge impact this year and will be massively missed. It's been an incredible opportunity to serve in this position, and I'm really thankful for it. We're committed to continuing our work for all resident doctors, and we welcome any ideas you have to help us be more effective.

AM: Yes – a really important one. Following the annual general meeting that took place on 25 September 2025, fellows are voting on whether to extend voting rights for the RCP president, and other college roles, to members like us – not just fellows. It is not only clearly right that paying members should be able to elect their leaders, but it will also ensure that the resident doctor voice will be central to the college's future direction. It is crucial that this vote passes: so please do talk to your consultants and encourage them to support this reform!

Anthony stepped down from RDC co-chair in September 2025, as he is due to complete training in November 2025. He has been an excellent co-chair and we thank him for his endless hard work and all he has done to support resident doctors. **Dr Stephen Joseph** *(ST5 respiratory medicine and RDC representative for London (Central and North East) has been elected as the new co-chair to work alongside Catherine. He said:*

> 'I am honoured to take over from Anthony as co-chair of the RCP RDC. With the NHS England Medical Training Review ongoing and the development of higher speciality training quality criteria soon to come, we have an excellent opportunity to influence the future of medical training. I look forward to working with the rest of the committee to ensure what comes next is evidence-based, and directly addresses the current disconnect between what's intended for medical training and what actually happens in practice.'

This feature was produced for the October 2025 edition of *Commentary* magazine and published on 5 October 2025. You can read a web-based version, which includes images.

RCP Resident Doctor Committee – spotlight on the issues

The Resident Doctor Committee (RDC) is a vital group within the RCP; it aims to meet the interests and needs of doctors at the important first stages of their career. It offers resident doctors an exciting opportunity to feed into RCP policy development – and to shape education and policy at a national level.

Elaine Storey, the committee manager, says: 'The RCP is committed to supporting and empowering early career physicians to take an active role in influencing the future of medicine, and the RDC plays a key part in this. On this high-profile committee, resident doctors can use their voices, share their experiences, represent their regions, network on a national level, and utilise and develop their many skills to help shape the future of physician training and improve the working lives of doctors.'

There are three annual meetings of the 35 members of the RDC – two virtual and one in person at the RCP at Regent's Park, London, which includes a workshop for committee members. In July 2025, there were group discussions on physician training in general internal medicine and the RCP response to the national medical training review. The in-person workshop and meeting event is an excellent networking opportunity and chance for the members to see each other face to face. Regular communications about different areas of work occur throughout the year.

The committee's remit is to represent the views of resident doctors on all major RCP committees and working groups, and other national health-related bodies if the need arises – and to provide a communication channel between resident doctors on the ground and the RCP. Committee members are central to the RCP's NextGenPhysicians campaign, contribute to RCP conferences and a huge range of RCP committees and advisory boards – as well as much, much more.

Dr Nicola Maddox, *Commentary* guest editor, spoke to current RDC committee members on the hard work being undertaken to improve resident doctor training.

Recruitment

Dr Samuel Hey, ST5 registrar infectious diseases and general medicine and RDC representative for the Northern region:

'This has been a challenging area, we are all acutely aware of the need to improve the internal medicine training (IMT) application process and make it fairer for resident doctors - in fact, it was one of the key drivers for me applying to be part of the RDC after hearing and experiencing the struggles of colleagues getting into IMT.

'We have been part of the push for applicants to IMT receiving a unique score, hopefully improving the opportunity for future physicians to obtain an interview and an opportunity for further training. We also continue to push back against the introduction of the Multi-Specialty Recruitment Assessment in the IMT application process and reduce the burden of examinations on resident doctors. We work closely with the SFDN to provide a strong voice for resident doctors when it comes to application issues.'

Generalism

Dr Stephen Joseph, ST5 respiratory medicine and RDC co-chair and representative for London (Central and North East):

'We often hear that patients need more physicians with generalist skills, especially as the population ages and develops multiple health conditions. However, GIM is consistently rated poorly by resident physicians. Why is that?'

'Much of the dissatisfaction stems from unanswered questions at the heart of GIM training; what exactly do we mean by generalism? Are we aiming to develop skills for managing the acute unselected take, for confidently treating a wide range of medical problems across inpatient and outpatient settings, or both? Can we realistically maintain generalist expertise as medical knowledge expands and becomes more complex? What happens when training in GIM comes at the expense of speciality training? And perhaps most importantly of all, is it even possible to acquire all these generalist skills through the current training programme?

'An RDC subgroup has been trying to explore these questions, and feeding into wider work on generalism and specialism, led by former RCP clinical vice president Dr John Dean. As the Medical Training Review progresses, conversations about generalism will only grow more relevant. It is essential that resident doctors' voices shape the future of training, so that expectations are clear, training opportunities are accessible and assessment is fair. If generalism is to be valued in practice, then training must reflect that in design, support and recognition.

Because it's not enough to tell residents that generalism is important. We need to show them.

'Being part of the RDC, and having the chance to think deeply about these issues with colleagues from around the country, has been a real privilege. If you are passionate about improving training and want to help shape its future, I would strongly encourage you to consider applying to join the RDC at the next recruitment round.'

Study budget and conferences

Dr Mariyam Adam, ST7 registrar renal and GIM, and RDC representative for the Mersey region::

'I have recently been involved in reviewing how the study budget is allocated and accessed across different deaneries. We are currently finalising a report, incorporating insights from the wider RDC membership, to highlight existing discrepancies and the challenges that resident doctors face in accessing and utilising the study budget effectively.

'Postgraduate medical training in the UK is built around learning opportunities in the workplace, which rely heavily on the feedback and engagement of senior doctors. However, these opportunities are increasingly limited due to workforce pressures and competing commitments across the NHS. In addition, formal teaching programmes in many deaneries are delivered remotely, offering limited chances for networking and building professional relationships – elements that are vital for a strong and collaborative future workforce.

'Furthermore, external courses – often essential for development – must be funded through the study budget. Unfortunately, the allocated funding has not increased in recent years, despite ongoing requirements to cover mandatory courses. As a result, many are forced to fund aspirational or career-enhancing courses out of their own pockets, which is neither fair nor sustainable.

'There is still significant work to be done in advocating for better support for resident doctors. Over the coming months, I hope that we can engage key stakeholders and drive progress in this area. We welcome the recently published 10 Point Plan from the government to support resident doctors, particularly its focus on timely reimbursement, an issue that many doctors face when incurring upfront costs for training and development.

'One of my main contributions since joining the RDC in 2022 has been helping to organise three Call the medical registrar conferences. Resident doctors are actively involved at every stage – from choosing themes and formats, recommending speakers, chairing sessions, to delivering presentations. We ensure that all content is relevant to junior registrars and, in recent years, have incorporated both inspirational sessions and clinical talks to reflect the weight of responsibility that many medical registrars experience early in their careers. This has been the most enjoyable part of my RDC journey. I look forward to planning next year's conference, which will be my last.

'I thoroughly enjoy being part of the RDC and having the opportunity to contribute to decisions that affect future generations of physicians. It's also rewarding to help create meaningful educational opportunities through conferences and webinars, specifically tailored for resident doctors.'

Generalism

Dr Hatty Douthwaite, ST7 registrar renal and general medicine and RDC deputy chair:

'As part of the Next Generation Oversight Group (NGOG), I've had the opportunity to work alongside an inspiring group of colleagues to explore and address some of the key challenges facing resident doctors today. Our aim has been to amplify the voices of resident doctors, identify practical solutions to long-standing issues and influence national conversations on how we support, train and retain the future consultant workforce.

'My involvement has primarily focused on interpreting the findings of a national survey of over 1,000 resident doctors. This helped build a clearer picture of what really matters to resident doctors; from concerns around recruitment processes, training quality and workload, to more intangible issues such as belonging, lack of continuity and feeling undervalued within the system. One of the most fulfilling aspects has been helping to translate these findings into concrete recommendations – which are already shaping further policy development and discussions with national stakeholders.

'What I have particularly valued about being part of the NGOG is the collaborative and action-driven ethos of the group. Everyone brings and represents different experiences, specialties and perspectives, yet we are united by a shared commitment to make things better for our peers and future doctors. It is great to be part of a team that does not just talk about change, but is actively working to achieve it; whether that's advocating for rota reform, promoting more equitable training opportunities, or developing realistic and impactful actions for policy makers to adopt.

'Being involved in NGOG has also given me insight into how the RCP operates as a national voice for physicians, and it has been rewarding to contribute in a way that feels both strategic and grounded in real-world experiences. I am excited about what comes next as we continue to build momentum.'

Physician assistants

Dr Ricia Gwenter, gastroenterology registrar and Wessex representative:

'I was one of the RDC members representing resident doctors within the RCP oversight group for activity related to physician associates (PAOG). This was

established in the wake of the RCP extraordinary general meeting (EGM) in March 2024. Its remit was clear but complex: to develop a coherent approach to PA-related work across the RCP and medical specialties, and to produce interim guidance on scope of practice in general internal medicine, as well as guidance on the supervision and employment of PAs. The aim of the interim guidance was to safeguard patient safety and support physicians, PAs and the wider healthcare team until the Leng review reported its findings.

'Being part of the PAOG and writing group were some of the most challenging experiences of my career to date. The group brought together individuals with widely differing perspectives. Weekly meetings revealed the full spectrum of opinion, and discussions were often tense. Yet, with a tight deadline, we had to navigate polarised positions and find workable, consensus-based solution. In December 2024, an interim consensus position was reached and the guidelines were published and later submitted as formal evidence to the Leng review.

'It had often felt surreal to be addressing issues that should have been resolved two decades earlier. Alongside reaching consensus on safe and effective roles for new PAs, the work also exposed uncomfortable truths about the state of our own profession: shortcomings in postgraduate medical training, the destabilising effects of hyper-rotation, the creeping 'taskification' of clinical roles, and the erosion of recognition of the need for years of rigorous training, examinations and experiential learning that are unique to and underpin what it means to be a doctor.

'The publication of the Leng review in July brought, for the first time, a degree of national clarity on many of the issues that had driven the EGM, including the recommendation to rename physician associates to physician assistants. In several key areas, the review's recommendations aligned with the RCP's interim guidance. Where they did not, there was both an implicit challenge and a fresh opportunity for the medical royal colleges to act on behalf of our profession in shaping the path forward. The Leng review is not the end of this journey; it is the beginning. We must maintain momentum, working towards a nationally agreed scope of practice, clear supervision standards and safe, effective integration of PAs, while protecting the integrity and standards of the medical profession.

'I have immense respect for the colleagues who spoke up when constructive dialogue was difficult. The past 18 months have been turbulent for the RCP, but they have also been necessary, and I hope we are stronger for it

'One message from the PAOG was unmistakable: the voice and value of resident physicians are critical to the future of our profession and must remain central to decisions that shape it. I do not believe that the RCP would have reached its current stance without listening to and acting on those perspectives. This is why I value being part of the RDC. It ensures that resident doctors, as the senior decision-makers of tomorrow, have both a voice and a seat at the table when the most significant decisions are made.'

Academic medicine

Dr Sacha Moore, ST5 registrar in renal medicine and general medicine and Wales representative::

'The recent UK Research and Innovation report, Clinical researchers in the UK: Reversing the decline highlighted the significant decline in clinically-trained research staff and the risk this poses to the UK's research design and delivery capabilities over the coming decade.

'Resident doctors in clinical academic training, as well as those who might consider a clinical academic career path, are the key to reversing this decline. Yet many academic resident physicians face numerous obstacles that can make training challenging. In the wake of the report and taking into account its recommendations, I have been working with the RCP's Research and Academic Medicine Committee to propose solutions to some of the common challenges faced by academic resident doctors in training programmes. I am currently working on engaging with key stakeholders to assess the feasibility of enacting these changes within the curricula.

'Being part of the RDC, and having the opportunity to represent both my academic resident colleagues and my colleagues in Wales, is a huge privilege; I am grateful for the opportunity to have our voices collectively heard in a place where enacting real change is possible.'

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