Commentary

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Interview: Tom Solomon CBE FRCP FMedSci

Professor Tom Solomon took up the role of academic vice president of the RCP in August 2024. He is a professor of neurology, seeing patients in secondary and tertiary care.

Based at the University of Liverpool, he studies brain infections and is director of the UK's emerging infections research unit, funded by the National Institute for Health and Care Research (NIHR). He leads The Pandemic Institute and is also vice president – international at the Academy of Medical Sciences. He shares his reflections on his first year at the RCP, and the work he has done – including recently launching the RCP's research resource kit.

Can you tell me a bit about your background and what drew you towards neurology and infection research?

I trained in Oxford, where a lot of people were doing research, and became interested in overseas health problems. I had the chance to go to South-East Asia for a Wellcome-funded PhD. There were really interesting health problems; patients with undiagnosed brain infections, which we discovered were due to Japanese encephalitis and dengue.

I also spent time working in the USA, with a Wellcome career development fellowship, and then set up the lab in Liverpool. I increasingly became involved in emerging infections research and global health.

In 2014, the government put out a competition for the UK's emerging infections research unit, funded by the NIHR. We won that competition in Liverpool, and I became the director. We were thus heavily involved in the UK research response to Ebola in Africa and Zika in Latin America. Then of course, when COVID-19 emerged, we were right at the forefront of the research response.

In your role as academic vice president, what are your main hopes and what do you want to do?

As academic VP I oversee the RCP's Communications, Policy and Research directorate. The comms work includes events – the most recent Med+ and Medicine conferences had the largest in-person and online audience since the pandemic, and some brilliant speakers. Both were a great success. The second important item is that there's an inequalities issue. The people who are producing the least pollution are often those who are most sensitive to it; these are people living in the disadvantaged communities of our society, but also the extremes of life – those very young (from conception) to the very old, who can develop diseases like dementia later in life.

The policy side is really important and interesting work, engaging with politicians and other stakeholders; putting the college's agenda forward, for example around medical workforce issues, smoking, alcohol, junk food, and climate and health. I have a lot of policy experience at the most senior level of government, and working with the RCP team who are very experienced in this area, plus our special advisers and advisory groups, is really rewarding. I would like to see the RCP grow its influence.

In terms of research, there are three areas we are focusing on: research for all; supporting clinical academic careers; and AI and digital.

The 'research for all' initiative builds on the fabulous work of my predecessors, Ramesh Arasaradnam and Cheng-Hock Toh. It's clear that more people want to do research, including resident doctors, but they are not getting the opportunities. We have to push and make this happen. It is not just because clinicians want to do it, but because of the vital importance of research to the NHS. Research-active teams mean better outcomes for patients. The pandemic brought this into focus, but almost everything we do in the NHS is underpinned by research. And this isn't just about fancy new treatments. It is also about different models of care to help the NHS; this is where RCP members and fellows have a great deal to offer. It is important that the medical community is joined up here, and we have already led on a position paper on research, which is endorsed by the Academy of Medical Royal Colleges.

The second area is protecting clinical academic careers. The numbers of doctors employed by universities is declining sharply. Every step of the pathway is being threatened. We need to fight that. I am convinced that the RCP has a greater role to play here.

The third part is the AI, med tech and digital piece. There is tremendous potential. It is rapidly becoming reality to help us address some of the issues faced by the NHS. But you can't just introduce things without showing how they work, why they work, that they are cost effective. There are questions around the role and responsibilities of clinicians as newer technologies are introduced. If the computer says something [incorrect], and therefore the treatment is wrong, where does the responsibility lie? There's a role here for the RCP and

other colleges to ensure that clinicians and patients are involved in these critical discussions.

Those are the three big research agenda items. And we're already making progress on all of them.

What can RCP members and fellows do to start engaging with academia and research?

We have members at all levels, from medical students through to resident doctors, consultants, and of course specialist, associate specialist and specialty (SAS) doctors and international medical graduates. I think there is scope for all of them to get involved.

We are working to increase flexibility for residents to get time for research; it is also about finding the right mentor or role model, talking to people with experience and following in their footsteps. The NHS has a statutory duty to facilitate research, and the NIHR gives trusts research capability funding to support NHS clinicians' research. In job planning, consultants should ask about resources and funding.

Our recently produced Making the case for research: resource kit for doctors helps doctors at all levels to make the case for undertaking research as part of their training programmes of job plans.

There are other funding mechanisms, like the NIHR Research for Patient Benefit programme, which I chaired previously. We funded some brilliant NHS consultant-led studies.

There is increasing recognition that more clinicians should do research, because it helps strengthen the NHS and helps with staff retention. They are happier, and happier doctors work longer and better. People enjoy research time; developing ideas, going to conferences, talking to colleagues, and seeing the value of their work impacting on patients' lives.

You've often worked in engaging non-doctors and the public with healthcare and scientific research. Which has been the most fun approach that you've taken?

One of the most fun things I did was run the London Marathon. A charity, Encephalitis International, had a place – which is hard to get – and their runner dropped out. So they phoned me and said: 'Tom, you run a bit, don't you?'. I didn't run much back then, but I could just about make it around the block.

The charity had about 2 hours to name their runner, or lose their place. I was flying and when I turned my phone on at Johannesburg airport, messages came through saying, 'Congratulations, you're signed up!'.

I started training there and then; I was sort of panicked. My wife recorded me running, then we stitched it together. I was training everywhere, in Malawi, Liverpool, on the beach. The video got a lot of coverage; we raised £21,000 for charity, but it was a good way to engage the public.

My training included running between hospitals in Liverpool, wearing my white coat. People assumed I was running dressed as a doctor – so I thought I better had. I got the Guinness World Record for the fastest marathon dressed as a doctor.

But that record was beaten. Somebody ran it faster. So we created the world's largest organ made of people; the 'world's biggest brain' for World Encephalitis Day. That got another Guinness World Record. We did it as a science–art project, explaining encephalitis, producing a video.

Public engagement is fun, but it is also really useful; not just educating people, but learning from the public what they want us to do, and getting them involved in research.

I'm looking for my third Guinness World Record – so if any of the readers have a suggestion, they should let me know. Maybe it's something we could do at the RCP …

What is the secret to engaging resident doctors to become involved with the work of the RCP?

Resident doctors are having a really tough time. They are right at the frontline of all the NHS pressures, which impact the balance between service provision and training. The team spirit of the firm structure, that close relationship with other colleagues, is largely gone. Many struggle to maintain work–life balance and they are paid considerably less than previous generations.

The RCP has been helping address these issues, not just for the benefit of the resident doctors, but for the benefit of the NHS as a whole. We are looking at this through our 'Next Generation' initiative led by PRCP Professor Mumtaz Patel and Dr Sarah Logan. Residents at all levels are on the 'Next Gen' oversight group. Other opportunities include the RCP Resident Doctor Committee and many other college committees and activities; and of course the fantastic Chief Registrar Programme, run by education and quality improvement colleagues.

Beyond that, we engage resident doctors through the regional Update in medicine days, other conferences, and the incredibly popular RCP Player. There is so much fascinating stuff on there. It's brilliant for CPD and an excellent member benefit. Getting people into our buildings, the RCP at Regent's Park, London and at The Spine, Liverpool for the conferences and other meetings, is really important. They need to feel that these buildings are theirs.

How have healthcare and research changed in recent years, especially during COVID?

Some things have changed for the better, and some for the worse.

[One thing] that has changed for the better is more use of remote consultations; that saves time, money and travel. Face-to-face contact will always be important – people need choice – but the remote approach is good for the planet and increases accessibility. There's been greater recognition of disparities and health inequalities, highlighted [during the pandemic]. That gives us increased impetus to address it and the RCP has been calling for a cross-government approach to addressing health inequalities.

The whole system has been strained to breaking point – and has broken, sadly … For years we've talked about the point when the NHS can't cope, but it's not really coping now. The pandemic tipped it over the edge. A system with no slack can't cope when strained.

We saw the value of the NHS as a research system, studying major questions that the world struggled to address. We showed how quickly we make good decisions about what research to fund, get work done and results out … we learned how to do regulatory stuff quicker. We now have to hold on to those benefits.

New technologies, like mRNA vaccines, were teetering along slowly and exploded during the pandemic. Now these vaccines are being used to treat cancers. That's a leap forward. Home diagnostics, a lot of the big data projects. They've really now come of age … There are so many areas of science that have leapt forwards, it's been really exciting.

And finally – if you weren't a doctor, what would you be doing?

I wrote a book, called *Roald Dahl's Marvellous Medicine*, about my time with the world-famous author. As a house officer in Oxford, I looked after Dahl and became a family friend. He was often asked; if you weren't a writer, what would you have been? .

He said he would be a doctor, because he was very interested in medicine and even invented some medical devices.

When I wrote my book, about my relationship with Dahl and his amazing medical interventions, my editor said: Dahl was a writer who wanted to be a doctor, and here you are a doctor who has become a writer. It was true, I think if I had not been a doctor or scientist, I would have done something creative.

As well as writing, I have had a couple of family shows at Edinburgh Festival Fringe. The first was based on the book, and it had a sell-out run. Unheard of! The second was about COVID and had 5-star reviews. I put both shows on at the RCP. In addition, I have done quite a bit on radio and television. Not just tough encounters on *The Today Programme*, *Newsnight* or *Question Time*, but also fun stuff like *Christmas University Challenge* – mind you, that was more terrifying than anything else!

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A breath of fresh air – what Professor Sir Stephen Holgate has to say about air pollution

A breath of fresh air: responding to the health challenges of modern air pollution **was published in 2025 and showed that air pollution was costing over £27 billion annually and was linked to 30,000 UK deaths in 2025.**

Commentary speaks to lead author, **Professor Sir Stephen Holgate**, the RCP special adviser on air quality and UKRI clean air champion, about why air quality is so vital to health – and what can be done to improve air pollution in the UK.

What is the background of this report?

This report was published as a direct consequence of the rising concerns about how air quality, both indoors and outdoors, is affecting human health. The RCP originally published a report – *Every breath we take: the lifelong impact of air pollution* – in 2016, that I had the privilege of chairing. That brought to the attention the issues around how poor air quality is creating adverse health.

But between 2016 and now, we've had an amazing increase in scientific and medical knowledge that's really emphasised the importance of exploring the ways that we can improve human health by cleaning up the air.

The main message of the report – which has 19 recommendations, contributed by 30 people, over 2 years – is that air quality should now be seen more as a health issue than an environmental issue.

That may sound rather trivial, but until now the air quality agenda has been run as an environmental issue – which it is, of course. But the fact that it's impacting human health really hasn't penetrated into how we diagnose, prevent or treat human diseases.

The new report, published on 19 June 2025 – Clean Air Day – is to draw everyone's attention to that fact. This is a serious issue, but one that's remedial and needs action now; not only by government, but by all of us, including health professionals. This is why we felt an imperative to publish this new report.

What are the key findings? How have they changed since 2016?

There are a few items that I'd like to draw attention to. The first is – as said in our first report – air pollution affects every single tissue in the human body. This is not just a lung and a heart issue; this is an every-organ issue.

You can name a disease, such as rheumatoid arthritis, diabetes or dementia. Air pollution has a definite effect on it. Indeed, nearly 700 diseases have now been identified that are associated with poor air quality. This amazing increase in our understanding of how air pollution gets into the bloodstream and alters the trajectory of all these different diseases sets the alarm bells ringing.

The second important item is that there's an inequalities issue. The people who are producing the least pollution are often those who are most sensitive to it; these are people living in the disadvantaged communities of our society, but also the extremes of life – those very young (from conception) to the very old, who can develop diseases like dementia later in life.

The third area that's important, and becoming increasingly so, is that the health professionals across different disciplines have a responsibility to push for cleaner air. The diseases that they're managing in the hospitals, primary care and public health are the very diseases that air pollution is making worse.

The difficulty with all of this is that it is 'out of sight, out of mind'; we can't taste or see modern air pollution. Yet day by day, year by year, we're seeing the impacts of air pollution on premature ageing of tissues and the effects on the underlying disease processes of non-communicable diseases.

People often say that it's very difficult to do, because introducing measures to clean up air interferes with people's lives. Yes, of course, clean air zones or low traffic neighbourhoods can be very inconvenient for people, but now we're beginning to see the health benefits of those interventions. They're really quite remarkable.

For example, we are witnessing London's Ultra Low Emission Zone, introduced in 2019, having major effects on improving lung growth of children born within the London area. We're seeing hospital admissions for acute respiratory illness reduce and consultations for cardiovascular diseases improve.

Thus, if we take some steps to clean up the air, albeit sometimes inconvenient, then we begin to see the health benefits. We're only just starting on that road.

How can physicians communicate to their patients effectively about air quality?

Our report contains a nice table of about 10 points that doctors and health professionals can use to help them. But we need to get more into medical curriculums at all levels to get pollution better understood.

Many readers will know about the little girl, Ella Roberta Kissi-Deborah, who died of asthma in 2013 – where air pollution was a major contributing factor. The 2020 Prevention of future deaths report stated that health professionals at the time didn't have the knowledge that air pollution could have contributed to her asthma. That was the start of the realisation that our health community hasn't been educated in air pollution and its impact on disease.

Therefore, now we need to try and introduce this in a constructive way. One of the report's final sections gives physicians advice about having conversations with their patients, taken directly from the World Health Organization; what patients can do to limit their own exposure – and having a broader discussion about the importance of air pollution within their community, and influencing local and central policy. So, patients, as well as health professionals, can help to drive change.

The UK is trailing behind on this issue and it's time we realised that, as practitioners, we have a responsibility. These conversations come naturally – as they do with tobacco smoking, which has been a spectacular success as a public health intervention.

What considerations are there about the indoor environment and air pollution in this report?

It is one of the things that we feel quite strongly about. Up until our last report in 2016, we didn't do so much on the indoor environment. Indeed, government had very little influence on what people did 'behind their front door'.

That's changed now. We know that tragic cases have occurred; little children being exposed to high levels of fungi and damp in poor housing, and the chemicals accumulating in indoor spaces as we seal houses to conserve heat.

We're creating a situation where the indoor environment may be equally or even more as dangerous as that of the outdoor environment. We've got to find out more about the indoor pollutants and their adverse effects on health and start encouraging responsible behaviours in how we build and ventilate our homes – and also what chemicals we bring into our homes, which are often inadequately for their possible health consequences.

We shouldn't be living with any mould. In countries like Germany, environmental health officers are very strict on this. But we've allowed things to slip in this country; we've got accommodation such as old warehouses and offices which are absolutely unfit for human habitation. Yet, for some reason, it is seen as reasonable to develop for families to live in. In the twenty-first century, this is just unacceptable.

This links into health inequalities and the relationship with air pollution; how is that explored in the report?

People are often disadvantaged in multiple ways – economically, through diets, educationally and in their access to decent and safe accommodation.

Air pollution feeds into all of this. Unfortunately, those living in more economically disadvantaged environments are often exposed to the highest levels of air pollution such as industrial sites and areas closest to our highways and roads. These are also sites where people live very close together, so locally produced pollution has a very important impact on them.

In this country, the people living in these environments are often at the greatest risk from the social determinants of health that must include air pollution; it includes immigrants, ethnic minority groups, the vulnerable groups at both extremes of age.

What response have we seen about the report so far and what would you like to see going forwards?

I was pleasantly surprised to have a very good response from a wide variety of people.

Good publicity, television, radio and the news, which is excellent. But, more importantly, people agreeing with what we have said.

Part of this journey is to get a clean air campaign going in this country – like we did for tobacco smoking. If we get people to recognise the issues we can build awareness, so that we can all work towards cleaner air.

We have upcoming meetings with healthcare professionals who are responsible for education, and with those in government who are responsible for delivering the clean air agenda – so we'll see how that goes. But so far, they've been quite positive. That's a good sign and I hope that, through the RCP and other professional groups, we can generate the impetus that's going to be needed for change.

What policies and changes should we be seeing in the next few years that will help improve air quality?

Cleaning up the air is on the same route as Net Zero carbon dioxide emissions by 2050. 46% of agents that are cause climate change are the common air pollutants

that we're trying to reduce to protect health. If we are able to impact black carbon, ozone and volatile organic chemicals in a serious way to reduce global warming, then we'll also benefit health. Replacing energy dependence from burning fossil fuels, to renewable and nuclear energy, has to be seen as a good thing.

An important step is to make people understand why cleaning up the air is important – for them not only as individuals, but also as families, communities, schools, industrial organisations and transport. No single organisation is going to be able to do this on their own. Getting that recognition is an important step. This is a multidisciplinary problem; no single action is going to make the difference; it's multiple small actions by everyone that will make the biggest difference. If we all do our bit, we will make substantial progress.

At a governmental level, we need to generate a National Health Service true to its name; as opposed to a national illness service. We need to take steps out in the community, in houses, schools and workplaces to prevent the diseases causing pressure on the NHS. By taking air quality to a better place, we will impact on the health of the nation. In the mission towards prevention, clean air sits firmly in that agenda space.

There is so much added value to be gained in parallel with the cleaning up of the air not least of which is a more pleasant environment to live in. We depend on the air we breathe for our very existence, so cleaner air means a better and healthier life.

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A body of knowledge: new exhibition at the RCP at Regent's Park

By Katie Birkwood, rare books and special collections librarian.

A new exhibition at the RCP at Regent's Park reveals the depth and breadth of 500 years of book collecting undertaken by the RCP and by its fellows and members.

500 years of book collecting

The RCP has maintained a library ever since its foundation in 1518. Built from generous donations of books and money, it reflects the interests and expertise of RCP members and fellows across the centuries.

But it has not all been plain sailing: the RCP library has faced many crises over its lifetime. It was almost completely destroyed in the Great Fire of London in 1666, it stuttered through periods of neglect, embezzlement and homelessness – and it sustained bomb damage during World War II.

'Groundley lerned'

The books in the RCP Heritage Library reflect the wide interests of physicians of the past. They valued and wrote about a vast range of different topics – and they also read, studied and owned books about them. Rules for running the library published in 1660 specified that, aside from medical books, it should include works 'that pertain to Geometry, Geography, Cosmography, Astronomy, Music, Optics, Zoology, Physics, Mechanical Engineering, and Travel to the more remote regions of the earth'. In fact, the topics represented in the library extend well beyond those areas into literature, history and religion.

Tools of the trade

Despite the wide interests of the physicians, medical education in the 16th, 17th and 18th centuries was founded on key texts by a small number of ancient Greek, Roman and Arabic medical writers. Consequently, the Dorchester Library holds hundreds of texts by authors such as Hippocrates (5th–4th century BCE), Celsus (active 175–177) and Avicenna (Ibn Sina, c.980–1037), which formed the basis of the medical curriculum.

There were 17 works from the enormous output of the Roman author Galen (129–c.216) nominated as the set texts for the RCP licensing exam, during which examinees were required to demonstrate their in-depth knowledge and understanding of Galenic theory. They supplemented this learning with newer works by contemporary theorists and illustrated anatomical treatises that brought the human body to life.

Knowledge keepers

The content and character of the doctors' library largely reflects the society in which it was created – where wealthy, White, non-disabled, European men occupied a position of great privilege.

European colonial expansion was partly motivated by the search for natural resources that could become profitable crops and effective medical remedies. A consequence of this drive to increase medical knowledge was that indigenous peoples, and their knowledge of their environment, were exploited without acknowledgement. They were also presented to European audiences as ignorant or barbaric.

Because large-scale book ownership was costly, a market for cheaper medical books for lay people – including women – flourished. Printed in vernacular (local) languages rather than in Latin, these volumes were smaller and less sumptuous. They did not enter the doctors' library until the late 19th and early 20th centuries, when collecting them became fashionable.

Making the invisible visible

To accompany the main exhibition, an innovative new art installation in the Dorchester Library will for the first time reveal the contribution that women have made to the RCP's library.

In 'Making Visible', artist and historian Catherine James will carefully wrap hundreds of early printed books in conservation-grade paper, making a sweeping visual statement foregrounding the contribution of women hitherto overlooked in official histories.

This installation is one output from Catherine's ongoing doctoral research project 'Women's ownership of medical knowledge in Tudor and Stuart England, 1485–1714', funded by the Arts and Humanities Research Council via the London Arts and Humanities Partnership. During this project she has examined nearly 7,000 books from the Dorchester Library page by page, searching for evidence of their past owners and readers.

The library today

Today, the Dorchester Library is a focal space in Denys Lasdun's acclaimed RCP building at Regent's Park, London. It is central to the RCP's ceremonial life, and its contents inform the work of students and researchers from around the world. Featuring an enthralling collection, spanning a wealth of subjects, it is an embodiment of the value that physicians have always placed on knowledge and learning.

RCP members and fellows worldwide can access clinical and professional development information, through ejournals, ebooks, databases and literature searching provided by the RCP Library.

In person and online

The exhibition will open at the RCP at Regent's Park on 10 September 2025, running until 23 July 2026. Normal opening hours are Monday to Friday, 9am – 5pm, but anyone making a special trip to see it should check for any closure days online in advance.

If you can't get to London to see 'A body of knowledge' in person, an online version will go live on the RCP museum website from 10 September 2025.

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Improving diabetes inpatient services: the successes of the Diabetes Accreditation Programme

The Royal College of Physicians (RCP) Accreditation Unit and Diabetes UK set up the Diabetes Care Accreditation Programme (DCAP) to provide assurance that national standards for diabetes care in hospital are being met equally across hospitals in the UK.

The programme officially launched in May 2023, with the aim of improving inpatient care for people living with diabetes – ensuring that all inpatient services are meeting excellent standards of care. The pilot programme showed that DCAP helped teams review their services and identify gaps in care provision, further developing collaborative working and increasing their ability to evidence the care they provide.

There have been 14 participating services across England and Wales, with three having achieved level 1 accreditation so far. To achieve level 1 accreditation, each team must follow certain standards within different areas, or 'domains'; these include leadership and operational delivery, clinical effectiveness and clinical processes, person-centred care, safety and risk, improvement and workforce. While achieving level 1 accreditation, the St Helens and Whiston Hospital team were congratulated on having an exceptional operational policy for their service, while the Princess Royal University Hospital were congratulated on having an e-prescribable hypo bundle and hypo simulation training.

Now 2 years later, our clinical leads had this to say about the programmes progress and our aims going forward. Dr Daniel Flanagan, DCAP clinical lead said:

> 'We are at a very exciting point in the development of the accreditation programme. We are starting to see hospitals completing the work for level 1. After so much work by the departments, it is great to see real improvements in the care of people with diabetes in hospital. I would strongly encourage other hospitals to sign up and start the journey with us.'

Esther Walden, senior clinical adviser, said:

> 'It has been both rewarding and deeply motivating to witness – and be part of – the development of the DCAP programme, from its initial launch to the first trusts achieving level 1 accreditation. This milestone is a true testament to the dedication and passion of our diabetes inpatient teams.
> 'Together, we've built robust standards, trained a committed pool of assessors, piloted both the standards and the remote assessment process, and created resource materials to support teams in streamlining their evidence submissions.
> 'The collaboration and generosity shown by inpatient teams – sharing ideas, paperwork and processes – has been genuinely heartwarming. Highlights of this journey include the resource development workshops, the pilot assessments, and the opportunity to provide positive feedback. Seeing the first services reach level 1 accreditation is a proud and inspiring moment for us all.'

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The relaunch of the Excellence in Patient Care Awards 2025

The RCP was delighted to relaunch the Excellence in Patient Care Awards (EPCA) which recognise, celebrate and reward the hard work done by physicians and multidisciplinary healthcare teams in the UK and across the world.

This year's awards saw finalists and winners invited to The Spine in Liverpool, for the first in-person ceremony since 2019.

We believe that it is more important than ever to celebrate the remarkable work done across our healthcare community, as RCP members and fellows around the world have continued to lead the way in improving patient care through education, research, clinical practice and policy.

The awards

Following a short break due to the COVID-19 pandemic, we expanded the 2025 awards to ten categories, reflecting the changing healthcare landscape.

We invited the top five teams and individuals in each category to deliver a short online presentation earlier this year, before joining us at the evening awards ceremony on 10 July 2025.

The winners displayed an inspiring breadth and quality of work, all modelling excellence in patient care and fully deserving of their awards.

The winners

The Alliance Medical Health inequalities award – working towards inclusive care for all

This was awarded to #MoreThanAHospital – the Midland Metropolitan University Hospital (MMUH), a new acute hospital that is acting as a catalyst for improved health outcomes via regeneration, increased employment, education and local opportunity.

Team members: Dr Sarb Clare, Rachel Barlow, Liam Kennedy, Marsha Jones and MMUH company.

The Lean enabled service improvement award

This was awarded to the DISCARD3 study at St Mark's Hospital and NHS England's Optical Diagnosis Implementation teams for their work on the national implementation of optical diagnosis in the English Bowel Cancer Screening Programme (BCSP).

The study showed that optical diagnosis with a 'resect and discard' strategy is a greener, leaner, more efficient and cost-effective way to perform colonoscopy and is both safe and acceptable for patients and clinicians.

Team members: Ahmir Ahmad, Brian Saunders, Stephen Hearing and Lee Adams representing the teams.

Sustainability award – reducing the environmental impact of healthcare

This award was given to 'Pen switch', an initiative by University Hospitals Plymouth NHS Foundation Trust and Amicus Health (Tiverton). Team members have been promoting sustainable insulin prescribing by switching to reusable pens in Devon.

Disposable insulin pens generate 60 tonnes of plastic waste and CO2 equivalent to around 2.5 million car miles annually in England. Using reusable pens reduces 89% of the plastic waste and 40% of treatment carbon footprint.

Team members: Dr Vincent Simpson and Dr Deepthi Lavu.

The Medical Protection Society award for patient safety

This award went to team members at Croydon Hospital Emergency Department for their work on opt-out HIV testing, an initiative which saves lives, reduces healthcare inequalities and tackles stigma.

Since 2005, the team has been collecting data on all HIV inpatient and outpatient activity in Croydon to better understand the problem of late HIV diagnoses. The programme has dramatically improved patient safety and reduced inequality.

Team members: Dr Ian Cormack, Dr Sarah Horne, Dr Wendy Armstrong, Andrew Widdowson, Dr Leslie Perry and Carl DeSouza.

The Alliance Medical education – improving patient focus

This was awarded to DigiBete CIC and NHSE diabetes team for their work in implementing a self-management education solution for children and young people's diabetes.

DigiBete is a nationally commissioned, patient-led, clinically approved app which offers digital self-management education for families managing type 1 and type 2 diabetes. Supporting 95% of NHS paediatric diabetes clinics, the clinic portal enables over 2,000 healthcare professionals to connect with 35,000 patients,

filling a critical gap in out-of-hours care.

Team members: Professor Partha Kar, Dr Fiona Campbell, Frances Hanson, Caroline Muller, Dr Nivedita Aswani, Dr Fulya Mehta, Maddie Julian, Rob Julian, Salma Mehar and Hilary Nathan.

The Medical Practice Management award for developing workforce

This award, which recognises innovative ideas to improve group working, was given to members of the Rotherham NHS Foundation Trust for their multi-year project enhancing resident doctor experience and productivity within a district general hospital medical department.

Team members: Dr Matthew Roycroft, the division of medicine senior leadership team (especially Paul Stewart, Dr Jeremy Reynard and Nicola Colley), the medical workforce team (especially Karen Backhouse, Anisa Ali, Joanne Freeman and Abigail Fairhurst), and the division of medicine service managers and finance team (especially Kerry Gedney and Alison Beard).

The Harold Thimbleby award for digital transformation

This was awarded to members of Chelsea and Westminster Hospital NHS Foundation Trust for their work in pioneering cardiac digital care through virtual wards.

An ageing community living with chronic diseases challenges the abilities of traditional care models to provide high-quality care. This project showcases how the use of digital technologies, integrated into care pathways and with a focus on all-user inclusion, have enabled us to improve outcomes and use of resources.

Team members: Sadia Khan, Jasjit Syan, Grant McQueen, James Bird, Sarah Pearse, Jodian Barrett, Mike Wright, Keenan Saleh, Rahim Kanji, Cindy Supan, Nawale Janati, Jose Padernal, Dianne Dela Cruz, Jonathon Valabhji, Emma Barron, Hussein Al Hakem, Morana Johnston, Angela Murphy, Gary Davies and Roger Chinn.

The Eric Watts award for patient engagement

This award was given to members at the Cwm Taf Morgannwg University Health Board for their development of the Wales Lung Health Check Operational Pilot to optimise equitable participation.

Low-dose CT screening for lung cancer saves lives and has been recommended for implementation in the UK, but participation is often low. The team co-developed materials with patient and public involvement to overcome barriers to equitable participation in the pilot for Wales.

Team members: Dr Sinan Eccles, Chris Coslett, Claire Wright, Amy Grace McCutchan, Professor Kate Brain, Dr Samantha Quaife, Dafydd Snelling and Heather Ramessur-Marsden.

Research award – expanding medical knowledge while improving patient care

This was awarded to team members at Great Ormond Street Hospital and University College London, for their work in embedding research into a clinical service to improve outcomes in children with inherited cardiac conditions (ICCs).

ICCs affect young individuals and are associated with lifelong morbidity and mortality, including sudden death. Despite genetic testing advances, clinical management in children has remained largely unchanged for decades. Embedding research into their clinical service aimed to improve outcomes.

Team members: Professor Juan Pablo Kaski, Dr Elena Cervi, Dr Luke Starling, Dr Gabrielle Norrish, Ella Field, Jennifer Tollit, Annabelle Barnes, Helen Walsh, Emma Lord, Nichola French, Sorcha Smyth, Annabel Crompton and Elisha Thompson.

Chief Registrar project of the year

This was awarded to members of the 2024/25 Chief Registrar Programme cohort for their work on establishing a novel international medical graduate training academy for Gloucester Hospitals.

Team members: Dr Mark Jordan and Dr David Baker.

To find out more about the awards, finalists and winners, you can visit the Medical Care – driving change website – and look out for when applications open for the 2026 awards. In our October edition, *Commentary* will be publishing more in-depth interviews with several winners, conducted by members of our Resident Doctor Committee.

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Celebrating the power of philanthropy at the Summer Garden Reception

On a delightfully warm and sunny July evening, the RCP welcomed guests to our Summer Garden Reception; an uplifting celebration of connection, heritage and the power of philanthropy to drive progress in healthcare.

Held in the tranquil medicinal plant garden at the RCP at Regent's Park, London, the event brought together supporters, senior college officers, staff and new friends to learn more about the RCP's mission and the remarkable work that philanthropy makes possible.

Guests enjoyed short tours of our garden and heritage collection, guided by our expert curators Elizabeth Douglas and Pamela Forde, and our garden fellows Professor John Newton and Dr Henry Oakeley. They heard from RCP president Professor Mumtaz Patel, who spoke about the RCP's impact in education, care quality, advocacy and global health. Her remarks highlighted how philanthropic support enables us to go beyond core activity; to innovate, lead and improve outcomes for patients in the UK and internationally.

We were delighted to be joined by some of the generous individuals and families who make this work possible. These include the Drabu family, whose support enabled our Jeelani Drabu Palliative Care Programme in Kashmir in 2019 – which is now entering its second iteration in partnership with Aga Khan University. We also acknowledged Professor Harold Thimbleby, who funds a digital health innovation award, and Charles Perrin who established the Sir Michael Perrin Lecture in 1988 in honour of his father – most recently held during our Medicine 2025 conference in June.

From research fellowships, the Excellence in Patient Care Awards (EPCA), the Global Women Leaders initiative to support for the East, Central and Southern Africa College of Physicians (ECSACOP), philanthropy continues to shape the work of the RCP in vital ways. ECSACOP itself was co-founded with the vision and leadership of Professor Keith McAdam, whose contributions continue to make a lasting global impact.

Our heritage is similarly enriched by supporters like Professor Victor Hoffbrand, whose stunning collection of apothecary jars is currently on display just outside our Treasures Room. It was a privilege to be joined by Lady Estelle Wolfson, who's significant and sustained philanthropic support over many years has made a profound difference across many areas of the RCP's work.

We were also pleased to welcome many of our generous supporters who have contributed by naming a Linacre brick, either after themselves or in recognition of a loved one. Linacre bricks form the Linacre Wall, located just inside the entrance to the RCP building at Regent's Park, London, and are a visible and lasting way to support our work. If this is something you would be interested in, our philanthropy team would be delighted to tell you more.

Events like this serve as a powerful reminder of what we can achieve together. For many guests, it was their first encounter with the RCP as a charity and a welcome opportunity to see how charitable giving supports our vision of better health and healthcare for all.

Thank you to everyone who joined us for such a memorable evening. If you would like to learn more about how your support can make a difference – whether through a gift, legacy or partnership – please do not hesitate to get in touch with Sally Williams, head of philanthropy, at sally.williams@rcp.ac.uk. We would be delighted to discuss further.

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What is important to patients?

The NHS 10 Year Health Plan for England is centred on providing a renewed patient focus. The new RCP strategy development process is commencing, and the Patient and Carer Network (PCN) will be asked to contribute their thoughts to it.

In this moment of considering our future health service, this article considers what patients want from their health service and those who provide it.

The PCN recently held a workshop, where we asked:

- What's important to you as a patient?
- What's important to you in the current healthcare landscape?

The responses were very clear; patients are looking for services that are fair and responsive to their needs, with reduced waiting times. They feel that the care they get should not be determined by where they live and would like an end to the health service postcode lottery.

Being a carer and receiving care

The limitations on support for carers were highlighted; they felt that they never received consideration. People often find themselves becoming carers at short notice, with little former knowledge about how the complex health and social care environment works. They are asked to make decisions quickly – then find little support. They find themselves lost in the myriad pathways for patients with complex care needs. Somehow, we need to make people better aware and more prepared.

When it comes to individual care, patients want to be confident that the person giving them advice and treating them is skilled, able and has empathy. Patients are not medical role driven; it does not matter to them whether the person treating them is a doctor, nurse, pharmacist, specialist. What matters is that patients believe that they are understood and that the treatment is right for their condition.

Ending geographical divisions

Patients and carers want care to be better joined up; they want an end to geographical boundaries that impact on joined-up care and where information from one locality is not joined up with another.

Examples were shared at the workshop where a lack of continuity resulted in additional or missed appointments and things being done in the wrong order; ultimately wasting time and resources of both the NHS and patients. The need to access appropriate healthcare in a timely way was reiterated, whether it be primary, secondary or tertiary.

Communication

Again and again the need for clear communication has been reiterated. Patients need to understand what clinicians are telling them and what happens next – this means that appointments must include enough time to ask questions and for patients to settle their minds. In particular, if someone has spent time in hospital, a proper programme, clear information and support as the patient leaves hospital are crucial.

Patients want to be seen as people. They want health professionals to treat the person, not just the condition, and to be listening fully – looking at the patient, not the screen. They want to have their concerns acknowledged, even if not much else can be done. Patients at the RCP workshop emphasised that health professionals should follow up with the patient if agreed in the appointment. Ensuring that patients feel heard and included doesn't take extra time, resource or investment; but the impact would be immense.

The evolving NHS

While supportive, there were concerns from patients around the 10 year plan's achievability, particularly in a landscape of continuous workforce issues and poor wages for resident doctors. There is a mismatch between demands on the NHS and the resources available to support it. Following on from this remains the thorny and as-yet-unaddressed issue of social care and its links to health provision.

Set against the increasing move to digital information and advice, patients and carers want to be confident that no one is left behind. There are groups of patients who cannot access digital information. Not everyone has a smart phone or even an email address – and some who do cannot confidentially access the NHS app. For some patients, the spoken word will remain crucial to their wellbeing.

Working together

There is no doubt to the PCN that patients want, good, trusted levels of service that support their health needs, close to where they live. There is no doubt also that those in the medical profession share the same aspirations.

The key question is what level of commitment, investment and leadership is needed to make this happen. One aspect of what patients want that can be achieved is sharing a culture of patient respect, though change is a long-term ambition and there are no quick fixes in our complex health service.

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The 10 Year Health Plan for England: the RCP's thoughts and response

The UK government's 10 Year Health Plan for England was published in July 2025. While the Royal College of Physicians (RCP) welcomes the creation of a long-term strategy for health in England – and many of the commitments – we have also called for further investment in workforce, education and infrastructure to help deliver the plan. .

Responding to the plan, RCP president Professor Mumtaz Patel said: 'it's good to read the UK government's vision for the NHS over the next decade. We have been pleased to see commitments to a number of RCP campaign calls.'

A number of key areas long championed by the RCP were acknowledged with a commitment to change – but we have since called for more detail and clear timelines on how the government will deliver their plans.

The next generation of physicians

The plan promises to improve medical training and support resident doctors, expand training posts, tackle competition ratios and bottlenecks in specialty training, focus on career progression and increase educator and supervisor capacity.

Dr Anthony Martinelli and Dr Catherine Rowan, co-chairs of the RCP's Resident Doctor Committee, have strongly welcomed the explicit recognition of the challenges and uncertainties that NHS resident doctors face.

They also praised the proposal to expand specialty training places and commitments to update curricula to include AI and digital health.

However, they emphasised that this should only be the beginning: 'In the RCP's recent survey of over 1,000 resident doctors, respondents across the UK told us that postgraduate training is outdated and unsustainable. The review of postgraduate training must be bold to deliver training fit for the future. This is about patient safety. This plan identifies many of the right themes that are facing the future of medicine, but detail will be key. We will push for that detail and radical reform of training.'

The next generation of physicians

The RCP has also been calling for a shift towards community-based care, and the commitments set out in the 10 Year Health Plan for England reflects these. The suggested redesigning of outpatient services reflects our *Prescription for outpatients: reimagining planned specialist care* and our recent toolkit *Time to focus on the blue dots*.

As Dr John Dean, former RCP clinical vice president, explained: 'we welcome the introduction of neighbourhood health centres across every community in England. But this shift must not be seen as simply about buildings – it's about how clinicians and patients work together across traditional boundaries to deliver joined-up, person-centred care. Specialists have a vital role to play in neighbourhood health, and we must ensure that they are supported to work across settings as part of integrated teams.'

Innovation, research and technology

Professor Tom Solomon, RCP academic vice president, said that he was delighted to see the plan's sections on clinical research, which aim to make research, development and innovation part of everyday clinical work. The RCP's *Making the case for research* resource kit sets out our vision in this area, and was reflected in the 10 Year Health Plan.

Tom highlighted the commitment to reversing the decline in clinical academic roles – but called for it to go beyond just funding, and to address systemic barriers that disincentivise clinical research.

He said: 'we particularly welcome the introduction of joint clinical research and innovation fellowships with industry, which can accelerate the development of new treatments and technologies. We need to see detail, but the creation of a Health Data Research Service, in partnership with the Wellcome Trust, is another promising step that could help position the UK as a global leader in health data science. We also look forward to seeing more detail on the proposed regulatory framework for AI and the plan to ensure that all NHS staff are AI-trained – both of which will be critical to delivering safe, effective and future-ready care.'

The RCP's digital health clinical lead, Dr Anne Kinderlerer, also highlighted the shift from analogue to digital in the plan, saying that 'digital transformation is a key enabler of more efficient, responsive services for both patients and staff'. She expanded, saying 'digital tools must be co-designed with clinicians and patients, and existing systems optimised to reduce burden and improve care. We welcome the investment in infrastructure and

standardisation, which will be critical to delivering a truly connected and inclusive digital NHS.

'It's also vital that staff are supported through this transformation. Reforming curricula to include training in AI and digital tools is a welcome move, but we must go further to ensure that all staff have the skills, confidence and support they need to thrive in a digitally enabled health service.'

Obesity and smoking

The NHS 10 Year Health Plan recognises that obesity treatments and ending tobacco dependence are vital parts of population health. Responding to the government's commitment to implementing opt-out tobacco dependence treatment across all routine hospital care, Professor Sanjay Agrawal, RCP special adviser on tobacco, explained that 'smoking remains the leading cause of preventable illness and death in the UK, and this is a vital step toward embedding effective support into everyday NHS care.'

Dr Kath McCullough, RCP special adviser on obesity, added: 'The new mandatory healthy food standards, as well as updated nutrient profiles, have great potential to be a leap forward. This kind of prevention-first thinking is exactly what we need from the government if it is going to deliver the overarching sickness to prevention shift set out in the plan.'

What is missing?

Despite the positive commitments, the RCP has called for more delivery detail and specifics, as well as clear timelines, with president Professor Mumtaz Patel warning that 'it will be a real challenge to translate this ambition into reality without a detailed delivery plan.

'We look forward to seeing the reports of the Leng Review, 10 Year Workforce Plan and postgraduate medical training review in the coming weeks to better understand the detail of the government's plans to ensure that the NHS has the staff it needs.'

The RCP has also called for an NHS AI in healthcare strategy, the measures in the Tobacco and Vapes Bill and a commitment to restrict junk food advertising to children.

While we have welcomed action on obesity and tobacco, we are also calling for further action to tackle the social determinants of health – including calling for a cross-government strategy to tackle health inequalities.

On workforce, Mumtaz noted that 'the suggestion that staff numbers in 2035 will be lower than those projected in the 2023 Long Term Workforce Plan is concerning. We know that we don't have enough staff currently to meet demand – AI and tech alone won't solve the problem of capacity.

'Delivering this vision will only be possible with a medical workforce that is adequately resourced to meet demand, feels supported, valued and is equipped for the future.'

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Learning communication at the Royal Shakespeare Company

Having difficult conversations with patients is a skill that all physicians find themselves needing to use. Dr Chris Farnham is exploring ways to teach these skills effectively with world renowned voice coach, Professor Patsy Rodenburg – using performance techniques taught at the Royal Shakespeare Company (RSC).

Chris, a palliative medicine consultant, has been a doctor for 33 years. He started as a registrar in London, working with patients with HIV. He soon realised that palliative medicine was what mattered to him – working with patients and those around them, often in quite difficult circumstances, led him to start exploring different approaches to communication.

He has led on several pieces of research involving London drama schools, which support clinicians to find communication approaches for their clinical practice. He has looked at placing doctors in actor training and the changes in communication styles. He has an interest in palliative medicine for marginalised populations and recently led the RCP and Association for Palliative Medicine faculty to Lahore, Pakistan.

Chris contacted Professor Patsy Rodenburg a few years ago when using her books, *Presence: How to use positive energy for success in every situation* and *The right to speak*. Over the past 45 years, Patsy has become a world expert on teaching voice, speech and presentation skills to individuals and companies across both corporate and creative industries. She has also had an unprecedented career working with actors in theatre, film and television – changing the way that actors speak on stage and screen.

As an educationalist, her extensive experience in examining human interaction on a theatrical level has given her vast insight into the qualities that are required for success in the corporate world. Outside the realm of acting she uses the humanities, including Shakespeare texts, to build effective communication paths and strong teams in the corporate sector.

Chris and Patsy met and immediately realised that they had a deep understanding of how they can help medical practitioners to survive some of the most difficult conversations.

The course

This course has been established by two practitioners, passionate about communication and voice. It will be hosted by the RSC and run over 2 days as a residential course in Stratford-upon-Avon, giving participants the opportunity to work with one of the profession's top voice coaches and an experienced clinician, to explore their communication skills and gain an in-depth understanding of how they can optimise their voice and leadership skills.

Patsy examines what it means to have 'presence' through greater self-awareness and clarity, and teaches how to rediscover everyone's innate presence both physically and mentally. Her work also explores how to have presence when presenting, both in what one says and how one says it.

Participants are now being sought to spend time with actors from the RSC as well as working in a studio space, using classical text and movement and then applying these new skills to their clinical areas of work. This 2-day course will consist of one day led by Patsy – exploring voice with text, followed by a performance enjoyed by the group in the main theatre. The second day will be run by Chris – applying skills learned with Patsy into clinical practice with the help of trained actors from the RSC.

The pilot in early December is now open for applications. To learn more about this innovative new approach or to apply for this pilot or to learn more, please email Chris at Chris.farnham@nhs.net.

Closing date for applicants is 10 October 2025.

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Selva alta; teaching tropical medicine in the 'high forest'

Learn more about tropical medicine and imported fevers for the medical take in a novel course, run by Dr Austin Hunt, delivered from the temperate Atlantic rainforests of Dartmoor and Cornwall.

I work as a consultant physician in University Hospital Plymouth – one of the largest hospitals in the south-west of England. We provide care in all major specialties (including cardiothoracic, renal / bone marrow transplant services, neurosurgery, major trauma etc) and we are the clinical home of Peninsula Medical School. It had always seemed odd to me that we had no clinical infectious disease service to cater for the needs of our patients, resident doctors and students.

The hospital is located on the southern end of Dartmoor National Park. The local forests are classed as temperate rainforests. Every May, when the ferns are chest deep, they resemble the high montane rainforests of equatorial regions when the altitude reaches 6,000 feet – or Selva alta, as it is known in the Peruvian Amazon.

The forest makes an excellent classroom to bring tropical medicine to life. Over the last 3 years, we have run an annual overnight, immersive course for consultants, residents, allied health professionals and medical students. The last course secured 10 CPD points from the RCP and was extremely well received.

Dr Joshua Baker, an attendee of the course, stated:

> 'I recently attended the overnight tropical medicine course run by Dr Austin Hunt. We were immersed within a tropical environment in which we learnt invaluable skills on basic camp and sleeping set-up. This was followed by an educational hike, which included stations to prompt our learning. We then enjoyed sharing stories around the campfire, before sleeping out on the hammocks. I really enjoyed the whole experience, and felt that it was really well thought-out, and was definitely a good introduction to tropical medicine; providing a great visual reference for further learning. I would highly recommend.'

The course focuses on the common imported fevers seen on the medical take; malaria, enteric fever and the top five imported pathogens seen by the Rare and Imported Pathogens Laboratory (RIPL) team at Porton Down, Wiltshire. These are dengue fever, Rickettsia, chikungunya, Zika virus and leptospirosis. Depending upon the faculty available, we also provide teaching on neglected tropical diseases such as onchocerciasis, leishmaniasis, snake bite etc.

The course is novel; we teach a subject using features of the environment. I believe that this is a great way to bring a disease to life and lodge it in the memory of training doctors. We teach about bat-related disease (lyssavirus, histoplasmosis, Nipah virus etc) down a bat cave and about onchocerciasis on the waterfalls of the river Cad. Lyme disease is covered; it is endemic to these forests and attendees are warned of the risks of acquiring this vector-borne borrelial infection as they walk through the dense bracken that is home to the *Ixodes* ticks.

Saffron Richardson, a course attendee said:

> 'If you have some knowledge about tropical medicine, it's great fun – if you know nothing about tropical medicine, it's great fun ... and you'll learn lots! The best part for me was the way the teaching was associated with activities on the trip, such as learning about lyssavirus whilst walking through a bat cave, or onchocerciasis (river blindness) when swimming around in the river. The immersive experience makes this course stand out from all other modules, I couldn't recommend it more!

The course also teaches health and safety in the forest environment – with basic bushcraft skills, as the students sleep in hammock 'basha' shelters. There is an expedition medicine component to the course, which makes it appealing to global health-orientated clinicians and general physicians alike. The course can be tailored to the needs of a specific group.

Dr Angus Radford, an emergency medicine resident doctor who took part in the course in July 2022, described it as 'well-structured':

> 'The course revolved around multiple "stations", which highlighted specific tropical diseases as well as hazards you might experience in the jungle … taught enthusiastically by Dr Hunt. Rainforest navigation was also taught in order to navigate between the stations. The evening was well organised and allowed participants to learn how to assemble their own camp in the rainforest and advised on simple hazards to consider (eg coconuts / deadwood). Hammocks and tarps were assembled for a night under the stars.'

Dr Rory Heath, an anaesthetic doctor in training said:

> Let Dr Hunt's Selva alta course on Dartmoor transport you to the remote jungles of Belize, with all the hazards of the wilderness but without the air miles. The pearls of wisdom accrued during this evening of adventurous medicine serve to avoid botfly-infested underwear or trenchfoot … Learn to navigate through bracken, armed only with a compass and machete, becoming wary of snakes and the constant threat of Dartmoor ticks. You'll be expected to scale a waterfall, so bring your swimming costume. Finish off the day by cooking over a fire that Valhalla would be proud of, sheltering under a tarp in your hammock and sleeping under the stars.'

You can find out more about the course on the Endeavour medical website, including watching a short video or send enquiries to austin.hunt@nhs.net.

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Roots to Routes: why South Asian Heritage Month matters to the NHS

Article by Dr Binita Kane, co-founder of South Asian Heritage Month.

I grew up hearing my father's stories – his dramatic escape from communal violence that erupted around the 1947 partition of India, his struggles and losses. Stories of his arrival in Britain with just £3.50 in his pocket and his time on the hospital wards in north Wales, where he quietly built a life of NHS service. His journey wasn't unique. It's one of thousands like it that have helped shape the NHS today.

That's why South Asian Heritage Month (SAHM) (18 July – 17 August 2025) matters. It offers an opportunity for NHS organisations not only to celebrate and educate, but to reflect – on the histories, cultures and contributions of people from South Asia's eight countries: Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka.

The 2025 theme of SAHM, 'Roots to Routes', is especially resonant in healthcare. It invites us to consider how the deep historical roots between Britain and South Asia have shaped the many routes taken by South Asians to help create, sustain and transform the modern-day NHS. It also compels us to reflect on how these histories – rooted in Empire, trauma and resilience – continue to shape health outcomes and workforce experiences today. With one in every 14 people in the UK being from South Asian heritage, this history is relevant to everyone working in healthcare.

Partition of India and the migration that followed

The roots begin in 1947, with the end of the British Empire in India. After 200 years of British rule, the British divided India on religious grounds, creating the new nations of India and Pakistan – a process that took just 10 weeks. The plan was announced on 3 June by Lord Mountbatten, the last viceroy of India. It received royal assent from King George VI on 18 July. The boundary demarcations drawn by Sir Cyril Radcliffe – who had never previously set foot in the subcontinent – came into effect on 17 August.

The consequences were seismic. 15 million people were displaced overnight, the largest forced migration in modern history. More than a million lost their lives. As borders were hastily drawn and communities uprooted, deep-seated religious tensions erupted into widespread communal violence. The trauma endured by those who lived through it shaped family narratives for generations, including my own story, and many others now working in UK health services.

In the wake of World War II and the founding of the NHS in 1948, Britain looked to its former colonies for help. Recruitment campaigns encouraged Commonwealth citizens – doctors, nurses, midwives and porters – to come to the UK to fill urgent workforce shortages, and granted them citizenship through the British Nationality Act 1948. For many, this was an opportunity and a necessity; driven by political upheaval, economic instability and the need for security after the chaos of partition.

The routes that built the NHS

From the 1950s onwards, South Asian healthcare workers arrived in large numbers, often taking posts that were underserved, underpaid or unpopular among UK-trained peers. Many worked in areas of high deprivation or in roles deemed less prestigious, so-called 'Cinderella specialties' such as psychiatry or geriatric medicine. South Asian nurses and midwives also became integral to the day-to-day functioning of hospitals and community health services.

The contribution of overseas doctors was recognised early on; in a 1961 House of Lords debate, Lord Cohen of Birkenhead remarked that the NHS would have 'collapsed without the influx of junior doctors from countries such as India and Pakistan'. By the 1970s, a third of NHS doctors had been recruited from abroad.

My own father, a partition refugee, somehow survived starvation and abject poverty to qualify as a doctor in Kolkata. In 1969, he and my mother, also a doctor, migrated to the UK, each with £3.50 in their pockets.

Despite being steered away from more prestigious roles, my father forged a pioneering career in geriatric medicine in north Wales. He went on to become the first minority-ethnic MRCP(UK) examiner and elected RCP councillor – and was a founding advocate for the RCP's equity, diversity and inclusion work. He served the NHS for nearly 50 years and was awarded an OBE for his services – Empire, in a sense, coming full circle.

His story is not unique. Thousands of South Asian healthcare workers have similar stories of hard work, resilience and dedication in the face of adversity and racism, pioneering services for the NHS. Yet for too long, their contributions have gone unrecognised or been reduced to footnotes. SAHM challenges us to change that – to tell the full story and to ensure that these contributions are remembered with dignity and respect.

A legacy of inequality

But the legacy is not only one of service. It is also one of systemic inequality, both as patients and as healthcare staff. The disproportionately poor health outcomes among South Asians are well documented, yet inequities also persist within the South Asian community itself. Much of this is rooted in the differing migration journeys, and the conditions and opportunities that migrants encountered upon arrival in the UK.

In the 1950s, many Pakistani migrants arrived from rural regions and entered industrial employment in the north of England, typically following a working-class trajectory. In contrast, Indian and urban Pakistani migrants – often from upper-caste or professional backgrounds – came during the 1950s and 60s as skilled workers, including doctors, engineers and academics. These groups were more likely to enter professional sectors and attain economic stability. Bangladeshi migration, largely originating from Sylhet, peaked in the 1970s – and was frequently driven by extreme poverty and political unrest. Many Bangladeshi migrants found work in low-paid sectors such as catering or textiles, and often settled in deprived urban areas, particularly in east London. These early occupational divides continue to shape access to housing, education and employment today – key social determinants of health.

These distinct migration experiences have contributed to persistent and deeply rooted health inequalities. Bangladeshi communities, in particular, remain among the most socioeconomically disadvantaged groups in the UK – facing elevated levels of unemployment, overcrowded housing and chronic health conditions. While all minoritised communities experience systemic disparities in health outcomes, the burden is especially acute among Bangladeshis. These differences underscore the urgent need to move beyond broad, reductive classifications such as 'BAME' and to acknowledge the intraethnic diversity within South Asian, Black and other racialised populations when addressing health inequalities.

These inequities extend into the NHS workforce itself. South Asian staff, despite their pivotal role in the health service's development, continue to be underrepresented in leadership and disproportionately subject to disciplinary action. These disparities are not relics of the past, but are reflected in current measurable outcomes, from NHS Workforce Race Equality Standards (WRES) data to the ethnicity pay gap. The disproportionate impact of COVID-19 on South Asian healthcare workers – with higher rates of mortality and occupational exposure – further highlights the structural inequalities that remain embedded in the system. These are not incidental. They are the cumulative results of longstanding structural inequalities that remain unresolved.

Progress is undoubtedly being made. As a South Asian woman, witnessing the election of another South Asian woman as president of the RCP was both powerful and profoundly moving – a moment that, not long ago, would have felt unimaginable. This milestone stands on the shoulders of those who came before us; it is the result of the resilience, perseverance and quiet sacrifices of earlier generations. The hardships endured by my father's generation helped to open doors, allowing mine to enter the profession with greater acceptance and opportunity. Representation matters not only because it inspires and empowers those who come after, but because it brings diverse perspectives that strengthen our profession to ensure it better reflects the society we serve. But representation alone is not enough; it must be accompanied by leadership committed to addressing the systemic biases that create unequal outcomes for both staff and patients. Crucially, those who rise must also create space for others.

Why this matters to everyone

This is not just a South Asian story. It is a British story. It is an NHS story. And it should matter to everyone who cares about fairness, inclusion and the delivery of high-quality care.

Understanding the 'roots' of South Asian presence in the NHS helps illuminate the 'routes' by which people came to serve and the systems that have sometimes failed them. It allows us to see health inequalities not as isolated statistics, but as the outcome of policy, history and social context. This is not at the exclusion of other minority ethnic groups; it is about all of our stories, which are deeply intertwined.

SAHM is not merely symbolic. It is a chance to foster cultural competence, acknowledge shared histories, promote integration and cohesion, and challenge the structures that reproduce inequity. When we take time to understand the stories of our colleagues and patients of all backgrounds more fully, we become better clinicians, better leaders and, ultimately, better advocates for change.

Acknowledgements: Many thanks to Riyadul Karim and Dr Rageshri Dhairyawan for their review and thoughtful comments. South Asian Heritage Month was created in after Dr Kane took part in the BBC1 documentary *My Family, Partition and Me: India 1947*, which features her father's story.

Resources:

- Diversity UK. Nurturing the Nation: the Asian contribution to the NHS
- South Asian Heath Foundation. Health inequalities: Full Stop

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