Commentary

February 2026 Issue 1

Royal College of Physicians

Membership magazine of the Royal College of Physicians

February welcome from Professor Ollie Minton

I am really pleased to take up the role of clinical editor and work with the wider team on *Commentary* and kick off 2026 with the February issue.

We live in interesting times; many things are more unstable and uncertain since I became a doctor (now 28 years ago) and a fellow for the last 14 years. I do, however, still enjoy my day job as a palliative medicine consultant and my focus on providing excellent end-of-life care, preparing people for a good death.

I need to get that out of the way, because the last time I was allowed to influence *Commentary* there was a whole issue on death but, as we are all mortal, I will let this stand as a reminder and move onto the current issue highlights (including *Munk's Roll*).

It is great to be an active part of college life as far as possible, as it will repay the favour. *Commentary* is one way to streamline those possibilities and be aware of where you can fit in at any stage of your career. I would also give a loud mention to the work being published in the RCP journals – *Clinical Medicine* and the *Future Healthcare Journal* – which also reflect the fantastic real-world work being done and its impact. I, for one, like sharing work and knowledge with the aim of, if not changing, then influencing practice.

We are all competitive and also – I like to think – supportive, even if we cannot all be award-winning. I would like to encourage submissions to the Excellence in Patient Care Awards.

This is where *Commentary* has a clear role for me; to guide us in daily work, with features on the Fracture Liaison Service Database and Chief Registrar Programme bringing clinically relevant work to all, and advocacy of the skills that we all bring into the wider multidisciplinary team.

I hope the range of features treads a line between education, research and advocacy. I hope you will find them useful, even if it is only a high-level summary or a tip on how to improve things in a world of limited resources. All of our work will be influenced – as will we all – by the looming spectre of AI. In 2026, I am yet to see the daily impact at work – bar the offer of Copilot rewriting my emails or summarising a meeting – but we do need to know how to adopt the advantages within the RCP.

Hopefully we will be guided by the RCP's new CEO, Jono Brüün ('deeds, not words' he explains in his interview) and of course robust governance with our college registrars. I try and avoid too many strategic aims, but we all need a plan and to ensure that whatever we do is focused on improving patient outcomes – not just surrogate markers. This is where Dr Alexis Paton, chair of the RCP Committee on ethical issues in medicine, has focused her work, on the social determinants of health.

As doctors, we all have biases based on training, specialty and life experiences. Therefore, it is important to read with a wider perspective. That comes from the stories being told on the work that the RCP does globally – with a feature on the British Infection Association and ECSACOP influencing and supporting wider networks across the globe.

We want this magazine to be an introductory, friendly face of RCP life that is fun and easy to read. We welcome feedback on how to ensure that we capture the wide range of roles and responsibilities that the RCP has, to support and advocate for all of us while being the go-to voice of authority.

February welcome: Professor Mumtaz Patel

Welcome to the first 2026 edition of *Commentary*, the RCP's membership magazine. I hope you have all had a wonderful start to the year.

I am pleased to welcome Professor Ollie Minton as *Commentary*'s new clinical editor. He'll be leading a Commentary advisory group, which will look at planning interesting and exciting content for our readers over the year.

The RCP is also delighted to welcome our new CEO who started his role in January; Jonathan Brüün. It has been lovely to work with him so far, and you can read all about his vision for the RCP in his *Commentary* interview with Ollie.

This edition looks forward to some upcoming events, like the 2026 Excellence in Patient Care Awards – with some advice on what you'd need to put together an application – and the Chief Registrar Programme.

This edition of *Commentary* also includes a piece on the Peer's breakfast held in December where I spoke to members of the House of Lords about our members reporting seeing increasing impacts of the social determinants of health. Huge thanks to our special advisors, Professor Sir Stephen Holgate who gave a short talk on air quality, Dr Kath McCullough on obesity and Professor Sanjay Agrawal on tobacco and vaping harm.

Dr Alexis Paton, Chair of the Committee on Ethical Issues in Medicine, medical sociologist and bioethicist, also explores the social determinants of health in her interview about her new book on the topic. I read her book before it was published at the end of 2025 and really appreciated the in-depth exploration of the vital links between health, society, politics and economic status – all of which she touches upon in her interview.

I also enjoyed hearing from my RCP colleagues, Dr Omar Mustafa and Dr Ben Chadwick, in their joint interview about the registrar and deputy registrar roles. They look back on 2025 and offer some insight into the RCP's work. Two other articles touch on completely different areas of RCP work – looking at how to improve fracture care and the history and purpose of Munk's Roll.

Finally, looking globally, we have an interview with two resident doctors who took part in an international exchange fellowship between the East, Central and Southern Africa College of Physicians and the British Infection Association which has been a fantastic initiative. It sounds like an amazing experience. In another article, a displaced doctor shares how support and mentorship have helped him find his feet in the NHS.

As we head into 2026, I would encourage you all to fill in the publications survey which will help us make sure that the RCP journals and *Commentary* magazine continue to feel useful, interesting and relevant to you. Thank you all for your continued support for the college.

Commentary news round-up: February 2026

Since the last edition of *Commentary* in December the RCP has been working to represent our members and support the work of physicians. Read our summary of the news from the last 2 months and the upcoming opportunities.

King Charles III 2026 New Year Honours list

A huge congratulations to all those named in the New Year Honours List, for their continued dedication and work contributions to improving health and care across various specialties.

Most Excellent Order of the British Empire

Dames Commander of the Order of the British Empire (GBE)

Dr Suzannah Claire Lishman CBE, Hon FRCP
Lately president, the Association of Clinical Pathologists and senior advisor on medical examiners, Royal College of Pathologists.
For services to the medical examiner system and to patient safety.

Commander of the Order of the British Empire (CBE)

Dr Edward James Baker FRCP
Chair, Health Services, Safety Investigations Body.
For services to healthcare.

Professor Jill Jannette Freda Belch OBE, FRSE, FRCP
Professor of vascular medicine and consultant physician, Ninewells Hospital and Medical School, NHS Tayside.
For services to medicine and public health.

Officer of the Order of the British Empire (OBE)

Professor Alan Keith Fletcher FRCP
Lately national medical examiner for England and Wales, NHS England.
For services to the NHS.

Dr Anna Lisa Mary Jenkins FRCP
For services to life sciences.

Member of the Order of the British Empire (MBE)

Professor Michael Kevin Almond QVRM, VR, DL, FRCP
Professor in veterans and families studies, Anglia Ruskin University and chair, Essex Reserve Forces and Cadets Association.
For services to service personnel and veterans.

Professor Alan Keith Boyd FRCP, FMedSci
President and chief executive officer, Boyd Consultants.
For services to gene therapy and medical education.

Professor Neil Reginald Poulter FRCP
Professor of preventative cardiovascular medicine, Imperial College London.
For services to hypertension prevention.

Overseas and international list

Knight Commander of the Order of St Michael and St George (KCMG)

Professor David Christopher William Mabey CBE, FRCP
Professor of communicable diseases, London School of Hygiene and Tropical Medicine.
For services to global health.

Professor Anthony Damien Redmond OBE, FRCP
Founder of UK-Med and professor emeritus of international emergency medicine, University of Manchester.
For services to humanitarian medical assistance.

Companion of the Order of St Michael and St George (CMG)

Professor Nicholas Philip John Day FRCP
Director Mahidol-Oxford Research Programme and professor of tropical medicine, Oxford University.
For services to global health.

Dr Dwomoa Adu FRCP
Honorary consultant nephrologist and senior research fellow, University of Ghana Medical School.
For services to treating kidney disease in the UK and overseas.

RCP governance matters

Read the latest updates on RCP governance matters and find your opportunities to get involved.

Central elections 2026

- At January Council all nominations received were agreed and now proceed as candidates in forthcoming elections.
- Professor Mumtaz Patel, the incumbent president, was the only fellow nominated in the annual election of the president. An uncontested election will therefore take place on College Day – further details below.
- The lists of candidates standing across elections will be published on the election area of the website on 16 February 2026 (provisional date). Direct communication with the membership will accompany this so you can see who is standing and find out about each candidate (personal statement, photo, DOIs).
- The publication of the candidate lists marks the start of the allowable 6 weeks of canvassing, in line with guidance. You can access the election arrangements, guidance and timetable on the election section of the website.
- Elections will be held concurrently and online – with voting opening on 2 March 2026. Eligible fellows and collegiate members will be emailed by Civica Elections Services (CES) and the RCP at this time to mark the start of voting. Voting will close at midday on 30 March 2026. Regular reminders will be sent from CES and the RCP during the voting period – **please use your vote**.
- You can visit the RCP election page to find out the full timetable.

Summary of January 2026 Council meeting published

RCP Council met in open session on 28 January 2026 to discuss social media and digital harms and hear updates about the RCP's campaigns work on training reform, workforce pressures and corridor care.

Full Council meeting minutes (open section) are published in the member-only section of the RCP website once they are approved at the following meeting – the full minutes of the November Council (open section) have now been uploaded. The closed section of the meeting will be reserved for fellowship and business-sensitive information. For more information, please contact Council@rcp.ac.uk.

Central elections 2026

- As previously notified, the SGM will be held on Monday 30 March 2026 as required by section 6 of the Medical Act 1860. A dinner will follow in the evening for pre-booked fellows. Fellows will shortly be invited to attend in person/online once arrangements are finalised - details will also be available on the website.
- The programme will include the Fitzpatrick and Samuel Gee lectures with direct communication to the membership to follow on options for attendance. The lectures will be available on demand after the event.

Annual General Meeting (AGM) of fellows 2026

Please note that the AGM is scheduled for Tuesday 22 September 2026. It will be a hybrid meeting held 5–7pm and followed by a dinner (for pre-booked fellows).

RCP opportunities – you're chance to get invovled

Our officer, committee and other clinical volunteer roles are an ideal opportunity to support the RCP, guide our decision-making and ensure the voice of the membership is included across all activity. Visit the RCP website to see the latest opportunities.

Recent RCP work

Read more about our work, from publications, award winners and responses to healthcare reports, on our News and opinion page – and see some of the recent highlights below.

Summary of January 2026 Council meeting published

Dr Ollie Minton has been appointed as the clinical editor for *Commentary*, the RCP's membership magazine. You can read his opening column for this edition.

Ollie is a consultant in palliative medicine and an honorary professor, based in University Hospitals Sussex and Brighton and Sussex Medical School.

He has been a fellow of the RCP since 2012, guest edited a special issue of *Commentary* on end-of-life care in 2018 and, more recently, been a member of the Communications Reference Group.

On his appointment, Ollie said: 'I have been an active member of the college for some time and a doctor for even longer, so am delighted to contribute to its voice and that of medicine with the *Commentary* role as clinical editor. I very much subscribe to the aims of research, policy, advocacy and communications being interlinked.

'I hope to provide an insightful clinical voice and encourage wider collaboration, as I have done throughout my career. The college has rightfully been going for over 500 years and continues to develop and

adapt, and I am proud to contribute to the current and future iterations.'

Ollie formally started the role in January 2026, and will chair future meetings of the *Commentary* advisory group, membership of which comprises a diverse range of fellows, members and RCP staff.

The *RCP view on digital and AI* published

The new *RCP view on digital and AI* exposes a disconnect between doctors' demand for AI and institutional capability and raises serious questions about the NHS's readiness to adopt AI tools safely. It recommends that the government and NHS must optimise digital systems, ensure digital interoperability, and provide robust regulatory frameworks to protect patient safety, while ensuring doctors and patients can safely benefit from the potential of AI.

RCP welcomes announcement of Bill to prioritise UK medical graduates for training places

The RCP has responded to the announcement of a bill which will see UK medical graduates prioritised for training places.

Professor Mumtaz Patel, RCP president, said: 'We welcome government action to tackle specialty training bottlenecks – an issue the RCP has been raising consistently through our next generation campaign for the past year. Now we need to see the detail of these proposals. For too long, talented doctors have been left stuck in a system that does not give them fair or timely opportunities to progress.

'International medical graduates already working in the NHS are our colleagues and friends, providing vital care to patients every day, and they must be properly supported to develop their careers.

'But this cannot be addressed in isolation. The medical training system needs a fundamental reset – with more postgraduate training places, genuinely flexible career pathways, and sustained investment in high-quality training and supervision – if we are serious about securing the future physician workforce and delivering excellent patient care.'

You can read more about the report.

Updated Green physician toolkit

The RCP has published an updated Green physician toolkit amid rising climate and health risks. You can explore the updated toolkit on the RCP website.

In January, Dr Mark Harber RCP special adviser on healthcare sustainability and climate change, presented to the Pan-European Commission on Climate and Health on how clinicians can accelerate climate action. In his contribution, Dr Harber highlighted the RCP's leadership in supporting NHS net zero goals – including developing practical resources like our Green physician toolkit.

The RCP also published our final 2025 sustainability report card in December, showing our progress to improve its environmental sustainability as an organisation.

RCP Medicine podcast reaches 100 episodes

The RCP has reached a major milestone with the publication of the 100th episode of its RCP Medicine podcast. Since its launch, RCP Medicine has been downloaded almost 900,000 times, building a substantial and growing audience across the UK and internationally. The podcast has become a trusted source of insight on the clinical, educational and policy issues shaping modern medicine, featuring voices from across the medical profession and wider health system.

The 100th episode, 'Shaping the future of medical training: insights from the Next Generation Oversight Group', focuses on the pressures facing resident doctors and the need for meaningful reform in postgraduate medical education.

Episode 100 is available on the RCP Player and all major podcast platforms. You can take a behind-the-scenes look at the RCP Medicine podcast in a 2025 *Commentary* article.

New issues of Clinical Medicine and Future Healthcare Journal

The December issue of *Future Healthcare Journal* focuses on symptom-based disorders.

This themed issue places a strong focus on conditions characterised by ongoing, distressing symptoms, often experienced without a clear or single diagnosis. These include fibromyalgia, persistent physical symptoms, functional neurological disorders and post-COVID syndromes.

Dr Andrew Duncombe, editor-in-chief, notes that many of these conditions are united not just by clinical uncertainty, but by prolonged delay: 'Waiting for a diagnosis, waiting for explanations, waiting for recognition, waiting for support and treatment and waiting in hope for recovery.'

The January issue of *Clinical Medicine* features a CME section on diabetes, commissioned by Dr Tahseen Chowdhury. Completing this CME activity allows RCP members to earn two external CPD credits. This issue also features articles on patient safety, meningitis, chronic obstructive pulmonary disease and more.

Award winners

Did you know we distribute around £350,000 in RCP funding and awards to our members and fellows every year?

Thanks to historic donations, we are able to recognise and invest in the expertise, innovation and leadership of our members, celebrate their impact and achievements, and support our global community to make real change and shape the future of medicine.

Our latest award winners are Dr David Lindsay (Linacre Lecture 2025 with 'Schrödinger's CAT remembered') and Dr Farah Latif (Whitney-Wood scholarship with a project on renal research). Find out more about RCP funding and awards.

Upcoming events and opportunities

There is plenty more to look forward to in 2026, including a variety of events for resident doctors and new consultants. Here are a selection of educational programmes, webinars and other opportunities to look out for in the next few months.

Medicine 2026

Join us at the RCP annual conference, Medicine 2026, a 2-day event dedicated to exploring the three transformative shifts outlined in the 10 Year Health Plan for England: fit for the future.

- From hospital to community – the neighbourhood health service
- From analogue to digital – the digital revolution in care delivery
- From sickness to prevention – healthier, longer lives for everyone.

Wednesday 13 – Thursday 14 May 2026 at the RCP at Regent's Park and online system. **What to expect**:

- **Keynotes and discussions:** dive into the future of AI and neighbourhood health and hear from Professor Ben Goldacre MBE, renowned for his work on evidence-based medicine and data-driven healthcare.
- **Specialty and policy updates:** stay informed on the latest developments shaping clinical practice, and health policy. Expert speakers from across the UK and around the world will deliver vital clinical updates across various specialties. Including acute medicine, cardiology and neurology.

Medicine 2026 is open to all career stages and specialties and will be CPD-accredited.

Do you have a story of local innovation to share with us?

We're looking for RCP member stories for our Spotlight on local innovation series, where we showcase how physicians across the UK are improving patient care and delivering high-quality medical training. If you've been involved in a local change that's worked – big or small – we'd love to hear from you: comms@rcp.ac.uk.

Excellence in Patient Care Awards 2026

These prestigious awards celebrate the outstanding contributions of RCP members and fellows worldwide, who are driving improvements in patient care through education, clinical practice, research and policy. Find out more about how to submit your entry online. Entries must be submitted by 16 February 2026 – read more in *Commentary* about how to put together an application

RCP medical student elective bursaries

Up to 12 grants of £500 each are available each year to undergraduate medical students at UK universities who will be undertaking a medical elective overseas. Applications are currently open to RCP members. Email your application to fundingandawards@rcp.ac.uk. The deadline for applications is Saturday 28 February 2026.

Free publication in a globally ranked journal

Clinical Medicine is among the top 15% of general medical publications worldwide. By publishing open access with *ClinMed*, you can:

- expand your reach
- amplify your visibility
- connect with collaborators across the globe
- contribute to high-quality educational resources supporting clinical practice.

As an RCP member you can publish in the journal for free. That's a saving of up to £1,850 per article (depending on exchange rate).

Join our many members who have published original research for free, including RCP fellow Professor Trisha Greenhalgh, who told us how the fee waiver has benefited her: '*ClinMed* processed our paper promptly and we were delighted to discover that we were exempt from the publication fee because we were members and fellows of the RCP. This was a significant benefit at a time when our grant had run dry. The paper has been highly accessed and widely cited.'

Medicine 2026 abstract competition

The Medicine 2026 abstract competition is now open for submissions!

The abstract competition is one of the highlights of our conference, offering delegates the opportunity to showcase their research to healthcare professionals from around the world.

By participating in the Medicine 2026 abstract competition, you'll get the chance to:

- have your work evaluated by a respected panel of leading clinicians
- have your research showcased on the Medicine 2026 platform
- be published in one of the RCP publishing streams.

There are prizes of up to £1,000, so don't miss out. Submit your abstract online. Submissions close Sunday 1 March 2026 at 23.59pm (GMT).

Deceased fellows

***Munk's Roll* is the RCP's collection of biographies of deceased fellows, published online as Inspiring Physicians. To write an obituary or notify the RCP of the death of a fellow, email munksroll@rcp.ac.uk.**

Over the period of 7 December 2025 – 8 February 2026 the RCP was informed of the deaths of the following fellows:

- Brian Wharton
- Gilbert Richard Thompson
- Mahabaleswara Maiya
- Babatunde Osotimehin
- Paul Neill
- Richard John Dobbs
- Eileen Margaret Phillips
- William Nicholas Trethowan
- Michael Morgan
- Kenneth Davison
- Andreas Christopher Stylianides
- John Bolton Ridyard
- Annamma Kochummen Dorai Raj
- Janet Dacie
- Ali Ashraf

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

Jono Brüün: meet the RCP's new CEO

Jonathan (Jono) Brüün joined the RCP as CEO in January 2026, after working in the role at the Royal College of Anaesthetists (RCoA) and the British Pharmacological Society (BPS). Dr Ollie Minton, *Commentary* clinical editor, speaks to him about his career journey and the challenge of a new role at the top of the RCP.

Ollie: To kick off with your CEO journey, you've come from the RCoA and the BPS. What has led you to work within medical royal colleges rather than another CEO role?

Jono: I started off not necessarily wanting to be a CEO; it's more that I was a generalist. I came from an arts background, then into communications, but I was interested in a broader management challenge.

CEOs in the charitable sector are, obviously, less motivated by stocks, shares, and profits than those working in the private sector. I started off by wanting to have an impact and to help people, so science and medicine were obvious places to start – first in pharmacology and clinical pharmacology, then into anaesthesia. As a specialty, it really interested me; it's fascinating to me that anaesthetists are willing, let alone able, to hold their patients in a state of suspension, managing their entire physiology for a brief period.

Over time, the membership element of what I do has become more and more interesting to me. I've ended up in a position where I can support a kind of virtuous circle where the patient benefits through good care from doctors, who achieve high standards of practice through organisations like the RCP, which benefit from the contributions of their members.

I've come on a journey, moving from an interest in the subject matter through to an interest in members' expertise in that subject matter. As I approach my time at the RCP, [my interest] has been refined so that it's about how I can better apply my experience to support the expertise of our members, so they in turn can better care for patients.

Ollie: The RCoA is fundamentally focused on anaesthetics. With the RCP, we've got over 30 different medical specialties – it's much more heterogeneous. If you compare and contrast the two – what do you bring from that that role?

Jono: I've learned, as someone who is not a scientist or a doctor, that the subject matter doesn't really matter. I'm not necessarily going to have improved my knowledge of the cardiovascular system at the end of my time at the RCP. I'll pick up the odd thing, but [the focus] is not about that. It's about the management challenge.

With a single discipline, like in the RCoA (although we also looked after the faculties of pain medicine and intensive care medicine), we were able to focus in depth on those specialties – but my job is not about advancing standards or speaking on behalf of the profession. It's more like an engineering job. I have to ask myself: are the systems and structures working?

The big difference and big opportunity – one I'm really excited about – is that it's obviously more complex in a multispecialty organisation like the RCP. That complexity provides more opportunity to deliver more impact at a wider scale.

Ollie: At the RCP we have a lot of history – how are you going to be thinking about the history and traditional structures, and what are you going to be changing in the first 6 months of the job?

Jono: The RCP's history and its scope are among the big, attractive things about being here. This is the oldest, among the largest and – from my perspective – the grandest college. That's really exciting; there's so much opportunity here because of its history and because it's one of the first organisations that government turns to.

Those 500 years of getting the RCP to a point where it has 40,000 members, this beautiful estate and the ear of government make this opportunity fantastic. But I'm very aware and focused on a reset because there have been some challenges, some ongoing, that need to be addressed.

Those challenges are about the systems and function of the organisation; how efficient we are, how careful we've been with our member subscriptions.

My job is to get the mechanics working really well, so that the fantastic clinical leadership can thrive.

Ollie: As you say, fundamentally, we're a membership organisation that is standing on the shoulders of giants. But how do you continue to advocate for the membership and ensure that the college maintains all its other relationships?

Jono: Medical royal colleges and the RCP, given their traditional leadership role, are in a really tight spot at this moment in time.

The government may want you to support one direction of travel, but your membership may be pulling in another direction, with concerns from professional, career, future generation, patient safety or standards' perspectives. You will have different organisations and financial pressures pulling you around. The third factor is [our role] as a charity, because we have a public benefit. That's the investment that our members make – an investment in patient safety and public health so that patients are the ultimate beneficiary of what we do.

It's an incredibly complex role. It's going to be my job, among others, to help the RCP to remain solid, innovative and relevant, a place where our members feel represented, connected, listened to and supported, and where we can manage those broader environmental tensions with ease.

Ollie: We also want the next generation to join the RCP so that we keep representing the generational ranges of physicians. Do you have a pitch to get people to join up and stay members, and to be a more active part of the college?

Jono: The point that I would make is around contribution rather than receipt; medical royal colleges provide an unparalleled opportunity to contribute to your specialty and to the generation that's going to come after you. Without medical royal colleges, that contribution and advancement – the good clinical governance, innovation, safety and efficacy – can get lost, and there is no better organisation waiting in the wings to deliver that core purpose.

There are, of course, CPD opportunities, exams, assessment and education opportunities. There are opportunities to get involved in leadership and be elected to national posts. Those are really important. But I think it's the community and the paying it forward aspect of it, that we should recognise and celebrate. That's why members stick with organisations like RCP, in my experience. When it comes to paying their subscriptions, members are ultimately facing a binary choice: do I really want this organisation to exist? Do I think this organisation is, overall, a force for good? Would the world be better without it? That's probably what wins in the end

Ollie: You've talked about being a force for good, so what – using your engineering metaphor from earlier – would you hope to build or construct in the long term at the RCP?

Jono: I would say that I want the RCP to be the best possible version of itself. I want that for its members, the public and for policymakers.

I'd like to leave the organisation as the epitome of a well-managed, well-run modern charitable organisation.

I would like to make the area that I have control over – the middle of the organisation, its finances, resources, estates, staffing, charitable governance, the interactions and services that we offer our members – the best that they can be.

I rely on the fact that Mumtaz [Patel, RCP president] and others at the college will lead and inspire the specialties, and those working within them. If I can make the mechanics of the college better, then the specialties have more chances to thrive. That would be what I hope to achieve.

Ollie: Obviously you're settling into the role and you've got a sign up in your office that says 'deeds, not words' – the first thing that you've chosen to put up. Any significance to that?

Jono: I haven't properly settled into my office yet – that's the only picture hook so I thought that I'd pop it there. And yes, that's the challenge for me.

I don't want to be the kind of CEO who talks a good game and uses all the right language but maybe doesn't see things through, maybe doesn't live the values, maybe doesn't deliver on promises. I want to be the kind of CEO who values the progress that we make, the direction of travel, the effort that people put in and the excellence that they bring.

I've been in post less than 2 weeks, but I've been so, so impressed by the staff here – their professionalism, their desire to do the right thing for members and their hard work. ['Deeds not words'] is about them as well. I'm expecting people to make a difference, not just sit around and talk about it. Let's make something happen. Let's be proactive and productive.

My challenge to the team before I arrived was 'fix one thing'. At work, there's always going to be something that's frustrating, that doesn't function properly. Often, we can get into a state of learned helplessness where everything feels too difficult. If we're going to build a culture of excellence and conscientiousness, then it has to be a culture where we are unaccepting of poor standards, poor systems or poor performance as well. I want everyone to understand their individual responsibility to improve things as they go.

Ollie: There's great passion in what you're talking about, but you're not on call 24/7, so what do you do when you're not at work

Jono: I'll sound incredibly boring! I have three kids – I'm very passionate about them and their development. I like football, but my team is Tottenham Hotspur and we're an absolute mess, so that's not much fun at

the moment! I'm a big fan of hot yoga and I'm most comfortable being active in my spare time. I'm not very good at sitting around and twiddling my thumbs.

I really love running and I tend to do it without podcasts or music. It's a good mental health break and a good opportunity to think about things. I usually work best in an active way and tend to find solutions to problems out on a run that otherwise might baffle me! So, I'm looking forward to some long, contemplative runs in Regent's Park before heading back to the college to crack on with the job.

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

‘Investing in your own people’: how chief registrars benefit a hospital

The RCP Chief Registrar Programme is a flagship scheme which aims to develop future medical leaders. Dr Sarb Clare MBE, acute medical consultant and deputy medical director, and Dr Anna Lock, deputy chief medical officer and palliative care consultant, spoke to *Commentary* about how the role has worked at Sandwell and West Birmingham Hospitals (SWBH) NHS Trust – and what advice they offer to other trusts considering the role.

The programme was born out of the RCP’s 2013 Future Hospital Commission report, which recommended creating a senior leadership role for resident doctors, focused on delivering high-quality, safe patient care. The role provides protected time for senior resident doctors to practise leadership and quality improvement (QI) while remaining in clinical practice, supported by a bespoke 10-month development programme designed and delivered by the RCP.

SWBH NHS Trust was part of the RCP’s first chief registrar cohort in 2015. ‘As years have gone by, the chief registrar has become an absolutely key person in the organisation,’ says Sarb, ‘they’re the eyes and the ears of the hospital. If we don’t listen to them, we can’t find out what the problems are, and they often come up with solutions.’

Sarb has mentored six resident doctors in the role and Anna is currently mentoring her first, so both work directly with the chief registrars over the year-long course.

The benefits for a hospital

In 2015 ‘it wasn’t initially very clear what the role would be,’ explains Sarb – but over the past 10 years, it has become a critical and popular role. ‘It’s competitive. There have been many years where we’ve had to interview quite a few people. It’s really gaining momentum.’

The role is multifaceted; chief registrars continue in clinical training, but also work directly with hospital leaders – becoming a bridge between senior clinical leaders and the resident doctor workforce. They also have time set aside to work on QI projects throughout the hospital. Anna sees the role as a key investment for a hospital that will save money in the long term: ‘We need people who are going to do our jobs in 10 years’ time.’

Having resident doctors who have been exposed to medical leaders makes for a smoother transition up to consultant and medical leader roles for individuals and the trust, says Sarb. ‘They need to be exposed to this, rather than the traditional method that Anna and I have gone through where you’ve never had any training … These doctors are going to be well suited. They understand the organisation.’

Out of the chief registrars that she has worked with, one has become a consultant at SWBH NHS Trust, with several others planning to. ‘You’re just investing in your own people.’

In the short term, they are ‘absolutely core’ to the team. They act as an essential bridge between the hospital leadership and resident doctors. Sarb says there is a ‘massive impact … they are the person that the residents will go to if there’s an issue… [it leads to] happy residents because they feel part of the conversation, that they’re being heard and have got somebody that they can go to.’

Chief registrars have been key in helping the trust through the COVID-19 pandemic and a hospital move in 2024. They helped to communicate and coordinate resident doctors through the day-to-day confusion and offered advice to the hospital leadership about what resident doctors needed. Sarb notes that they were a critical way of getting messages to resident doctors through those times; chief registrars sit on several boards and forums that make management decisions, so can simultaneously offer feedback from resident doctors and report back to their peers.

As they are working in clinical roles, they are still ‘on the coalface’ says Sarb. ‘In times of crisis, they’re coming up with solutions because they’re living and breathing [clinical work] every day.’ Anna strongly agrees; her chief registrar mentee has been key in working out issues, such as access to clinical guidelines. ‘He has authority because of his authenticity as a resident. I have authority as deputy CMO, but it makes a message much stronger coming from him.’

‘It’s all just common sense, isn’t it? It’s basic methodology; you get the people who use the system to give you the solutions. But we need reminding of the straightforward things and [the chief registrar role] helps us to spell that out.’

Quality improvement projects

One of the key unique selling points for the Chief Registrar Programme is that it embeds time to do QI into the role itself, ensuring that it is a central part of the year. Chief registrars get to choose their own projects … but all of these projects can have a long-term impact in improving systems within the hospital.

Over the past 10 years, chief registrars have helped to develop hot and cold rotas during COVID, developed the hospital at night programme at SWBH NHS Trust and sorted out on-the-ground communication issues like surgeons' access to phones. They also author the CMO bulletin every month – a key piece of comms for all medics.

Sarb highlights a new leadership course at SWBH NHS Trust called Tomorrow's Leaders, delivered by herself and the chief registrar, which gives other resident doctors the chance to learn leadership skills – job planning, dealing with conflicts and complaints, meeting the executive medical board – which lets more doctors than just the chief registrar step into leadership roles.

One former chief registrar, Dr Laura Pearson – who will speak to *Commentary* about her experience in the next edition – did a programme on teaching QI to foundation doctors, including a competition and awards to encourage even more projects. 'She went to the root of what QI is and stripped it back,' says Sarb, her mentor.

As the 2024 hospital move had been planned for 16 years, each of the chief registrars had some involvement – bringing resident doctors into the process over years. 'Dr Dosu Ayodeji, the last chief registrar, had the pleasure of helping with the move into to the new hospital building,' says Sarb.

She always ensures that chief registrars write down everything they've done at the end of their year, and they're shocked at how much they ended up working on. Overall, there have been 'hundreds of [chief registrar projects], which have been absolutely key to making things work more easily.'

Anna warns that it's important to think long term with these projects, and to ask what structures need to be in place early on to help them last when the chief registrar has moved on from their role. 'Building for the future and making sure that things continue is really important.'

Developing skills: what it can do for resident doctors

'There's an easy narrative that being a medical leader is really hard and really awful,' says Anna. But the chief registrar role can help to dispel this; 'it's a more real exposure to what it really is like to be a medical leader, seeing people who are enthusiastic and really enjoying it.'

'Being the chief registrar is about leadership,' says Sarb, 'It's about finding out who you are as a person, as a leader, as a human … Every single one of the chief registrars has transformed and it's really interesting to see. Each one of them has said that it's the best year.'

The role offers resident doctors the opportunity to come to meetings, like the weekly CMO huddle, and to meet people in leadership roles across different specialties and grades. Sarb ensures that the chief registrars she mentors go to conferences, submit abstracts and papers to journals, and get involved in as many things as possible. 'As you introduce them at meetings and to other people, they naturally get involved in other projects.'

Just having the title can be a real confidence boost, Sarb explains.

'It completely transforms their ability to make decisions. It gives them power and credibility [to make change].'

Anna encourages anyone to apply: 'You'll feel much more competent when you start as a consultant. Med school is not the most useful place that you'll learn things … when you are a consultant, it's more about getting things sorted. This is a great role to play around with it.'

How to run the chief registrar role effectively

Over the past 10 years, chief registrars at SWBH NHS Trust have become 'part of the family' says Sarb. 'If we weren't to have one, it would be devastating because they are absolutely critical.' But how can you make a brand-new role work so effectively?

As the role encompasses so many facets of leadership – QI and clinical work – it can be hard to find balance, says Sarb. 'Often, they get so inundated; our job as mentors is to hold them back and [remind them that they] have protected time and the feedback of the RCP leadership course as well.'

'It's really important to be very clear about carving out time, the clear boundaries and role modelling. As mentors, we have to model how leaders should be behaving.' Having good mentors is key to making the role work effectively; Sarb warns against just using chief registrars to sort out rotas or admin work, rather than letting them work on the problems they see within the organisation.

Both Anna and Sarb say that making connections early on is essential. Anna states that mentoring can be about 'convincing other senior leaders to work with [chief registrars'] usefulness, while making sure they don't get given everything to sort out. That it's sustainable: we can't expect them to fix everything.'

Anna is always looking for opportunities to connect her chief registrar to people across the trust – even if it's outside the initial job description – as that can create new avenues of communication and opportunities. Similarly, Sarb has a checklist to introduce any new chief registrar to directors and leaders across the organisation,

and then go on various committees to see how things are run – and what they are interested in getting involved in.

'They're given huge autonomy because they probably wouldn't do the job as well if they're not passionate … all their [major QI] projects have really come from their own passion, yearning or something that bugs them.' That way, they can do huge transformations, potentially turning around things that have been a problem for 5–10 years.

There are also opportunities for communication and media experience, both internal and external, which can help with confidence. As Sarb says, 'visibility is absolutely a core feature of a chief registrar; meeting people at the coalface, experiencing and role modelling.'

Raising interest and recruiting doctors to the chief registrar role

- Be very clear in the job description about what the role entails, and the protected time that they will have to work on QI and leadership projects.
- Have drop-in sessions for prospective applicants to spread the word, answer questions and encourage interest.
- Have the current chief registrar on the interview panel, so that they can give their advice as someone who has done the role.

An investment in the future of medical leadership

For Sarb, the chief registrars have become 'absolutely critical to the executive team, to the board and to doctors from board to floor.'

'At the end of the day, we are desperate for medical leaders. No one's ever been exposed to how to lead, how to deliver, how to make decisions and do crisis management.' But the chief registrar role allows doctors to learn that early in their career, sometimes years before they move into a formal leadership role.

Both Sarb and Anna are clear that they see a lot of value for their trust in investing in young doctors as leaders. Sarb says: 'It's a privilege to mentor them. These are the leaders of the future, aren't they?'

Find out more about the Chief Registrar Programme on the RCP website. Expressions of interest for trusts and organisations will open soon.

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

Health, illness and society: interview with an author

Dr Alexis Paton is director of the Centre for Health and Society at Aston University, where she is a senior lecturer in social epidemiology and the sociology of health. She is also the chair of the RCP's Committee on Ethical Issues in Medicine and the lead for the social and psychological aspect of health curriculum for Aston Medical School. Her new book, *Understanding health, illness and society: A patient-centred approach to healthcare*, shows how social structures and social norms shape both individual and collective health.

What prompted you to write a book about the sociological determinants of health?

It is something that I've wanted to do for a long time. I've been teaching medical students about how the social world impacts on health for 15 years and it became clear that we need to talk more about this – in particular, in the last 5 years since the pandemic.

I wrote this book to help shed light, not just on how the world around us can impact our health, but how you can't really escape it. It's shaping your health each and every day. If you want to practise good medicine or understand how to be healthy, you need to understand all the different aspects that go into your health – not just lifestyle, choice and genetics.'

Could you give an overview of the topics that you discuss and the key messages that you share in your book?

Understanding health and illness in society is really about looking at those social forces that influence health; things like poverty, class, gender, ethnicity, housing and employment. These don't necessarily seem like they're related to health, but they are what determines who gets sick, who gets well and who stays well. So it's really important to understand them.

The book is about trying to understand everything, from commercial influences, policy and public health campaigns, to where someone grew up and where they work. All of that comes together to influence health. The book is trying to capture that interlinked web, which is tricky.

I introduce the book by asking the question: what is health? Then I show all the different ways that question has been answered over the years; it's really interesting to go back in time to see what health meant in the Middle Ages or the Victorian industrial period. What did health mean 70 years ago, when we were starting to build the NHS? How [society] defines health has changed over time. I wanted to set the stage about how health is really a fluid thing.

I end by talking about what health looks like in Britain in 2025. The conclusion is a story that's quite close to my heart; I share the story of a poor household taking care of a premature baby. It shows all the different ways that the world influences our health, because their housing, their lack of employment, is causing them to be unhealthy. It's all interwoven in a really complicated web.

The book uses lots of real-life case studies. Are there any others which have stood out as you've been researching this book?

I'm a social scientist who goes out and does research. It's a great job – I'm like a fly on the wall, watching how people interact in healthcare settings and asking about their experiences.

I finally had time to look at the opioid crisis in the USA. It's a really good example of the social determinants of health, and brings in other aspects like politics and commercial ventures. When I started to read around the different aspects of the opioid crisis, I started to realise that it is a crisis of political and social making.

It isn't about people making decisions to take an addictive drug and become addicts. It's a story about a country that has no protected sick policy – nothing in federal or state law that requires employers to provide their employees with sickness support. You can lose your job if you take a sick day, so you're setting up an environment where you can't be sick.

If you don't have health insurance, you pay for [treatment] so you doubly can't get sick. If you do have it, not all insurance is the same; a lot of people living in Appalachia [which is a poor area] had insurance that was more likely to cover pills than treatment. Now we're in a situation where, if you are sick or injure yourself, you might really need physiotherapy and treatment like that. Your insurance doesn't cover that – but it does cover pills.

Then we have the final nail in the coffin; a pharmaceutical company decides that it wants to get involved in chronic pain management. It wants to make money, and chronic pain management is long-term money making. So they pour all their money into oxycodone which is cheap, it's a pill and it works. And everyone's been told that it's not addictive.

So now you have your perfect storm. A bunch of people who have to work, even if they're sick, and insurance

companies that will only pay for pills – and everyone thinks that this pill is safe to take. The US Federal Drug Administration (FDA) puts no cap on how much pharmaceutical companies can spend on advertising, so now there's this advertising machine saying that they've got the magic pill. There are very few checks and balances on how drugs are advertised and distributed in this commercial world.

For me, this really crystallises why we need to care about how the world around us influences health. If we let all those things run unchecked, then it can create millions of people who are addicted to a drug, and hundreds of thousands more who die from it.

It's helpful to think about how other countries operate their healthcare, because that comparison lets us understand where those subtle differences lie. The UK doesn't have an opioid crisis in the way that the USA does. That is down to political decisions around health, but also decisions around social care, welfare and how we manage the drugs that we allow into our healthcare system

You cover the evolving question of how we see health. Why is the perception of health shifting from being about medicine and individuals, into looking at the wider social determinants? How long has this shift been happening?

Social scientists have known for a long time that that relationship is there. But what's really made the difference is the pandemic – it showed the unhealthiness of our nation.

We've had moments like this in the past. The world wars, where men were being conscripted into the army; they would show up and we realised that half the population was in really [bad] health. COVID-19 is another watershed moment where we realised that a lot more of the population would have not got sick and died if we had been healthier going into the pandemic. So, of course, people start asking: why weren't they healthier?

The answers are about poverty; the kinds of work that people do, and the cost of living – of keeping your house warm or buying good food. Those are the mainstays of health. We just couldn't ignore the data [during the pandemic]. People who had less money were dying more than people who had more money. We couldn't deny the relationship between poverty and death from COVID-19. It proved, again and again, that there was a relationship between where you lived, what you did, who you were and your health – that had nothing to do with genetics, clinical factors or lifestyle choices.

The answer to what it means to be healthy does evolve but [aspects] stay the same – you need a roof over your head, enough to eat, and to stay warm, happy and dry. In 2025, there's a huge portion of the population that can't do that. It's slightly mindboggling that we're still in that situation.

COVID helped to crystallise [the need for public health] in the public imagination in ways that hadn't happened before. My hope is that the groundswell that we're seeing around understanding health inequalities and the determinants of health will help push forward the need to ask for more change.

If you had a busy medical student or professional who only had time to sit down and read one chapter, where would you recommend they start?

It's between chapters 2 and 6 for me. Chapter 2 tackles how the world around us impacts on health from a societal level; health is not happening in a vacuum, it is subject to social, cultural, environmental, commercial, political factors that make up everyday life. Chapter 2 introduces this technical term – the determinants of health – so it is quite useful.

Chapter 6 is all about how politics impacts on health. I don't think medical students or the medical profession realise just how instrumental politics is to shaping individual and population health. It's really important for us to understand that this 'unclinical' thing really drives the direction of our healthcare and the health of our nation.

What are you hoping that the impact of the book will be?

My hope is that as many people as possible read the book. Even though it is written with healthcare professionals and students in mind, I think that – in particular – politicians should read this book. They would have a much better understanding of what health and healthcare mean.

My hope for the book is that it helps the social determinants of health become a totally normal thing for us to talk about at all levels; that people are viewing those as just as important as your daily steps, how much fruit and veg you eat, how many alcoholic units you drink.

We should start to understand health in a much more holistic way. It's really crucial that we do that from the very beginning. Healthcare students are a really important part of my audience because the more that they know about this area, the more they'll pay attention to it. They will develop into healthcare professionals who always have this topic at the forefront of their minds, who consider not just the clinical presentation but all these other factors, to best support patients.

The Sick Society Podcast

Would you like to hear more from Alexis? A new podcast is challenging the medical model head on, showing how housing, work, money, neighbourhoods and political decisions shape health outcomes as powerfully as smoking, diet or genetics – a public health emergency hiding in plain sight. Cohosts Alexis and Sir Andrew Goddard (PRCP 2018–2022) explain – in stark, accessible terms – how modern society itself is driving illness and inequality. Each season's episodes combine expert insight with real-world stories to reveal why most of what makes us sick never happens in hospitals – and why they think we urgently need to start talking about health differently.

Available on all the main platforms (Spotify, YouTube, Apple Podcasts) now.

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

In conversation with the RCP registrars

Dr Omar Mustafa has been the RCP registrar since October 2024, with Dr Ben Chadwick joining him as deputy registrar in March 2025. At the end of 2025, *Commentary* caught up with them both to learn more about their roles within the RCP, their advice for young doctors and their reflections for 2026.

What's the role of the registrar and deputy registrar? How do you end up working with members and fellows?

Omar: There are a number of themes that sit within the registrar role. It includes a connection to the membership and fellowship; managing the process of becoming a member or fellow, and – more importantly – having that connection, listening and putting members' views to the wider college.

The second part [of the role] is about governance; ensuring that the parts of RCP overseen by the registrar function well.

The third part is being an honorary secretary to RCP Council, the body where the profession meets to discuss policy and everything else linked to the profession. I also sit on the RCP Board of Trustees.

Through those roles, there's a lot of interactions across the RCP and with external stakeholders in the UK and internationally. It's a lot of work, but of course it's not a single-person job. I sit within an executive team, so I have colleagues who manage [lots of aspects]. It can't be delivered by one person.

Ben: The deputy registrar is a relatively new role – really only one other person has done it before me for any length of time. I've been in post now since March 2025. One of the main responsibilities is overseeing the fellowship application process, which is much more transparent and visible than it than it used to be. My role includes training people who are going to mark applications and make judgements about whether an application is of sufficient standard, and also overseeing the whole process; that involves working closely with the fellowship administrator, who's brilliant. That's continuous work because there are three cycles per year.

The other bits of the role include engaging with the regional teams; being involved with the regional Updates in medicine and talking to doctors within the UK regions about what medical careers look like these days.

One really nice thing about the deputy registrar role is that it is more loosely defined, as a relatively new role. That gives me the ability to get involved with things; it's a nice combination of the core role – certainly enough to keep you busy – but also helping out where you're needed and developing the things that you're interested in. I've really enjoyed it so far.

Going back much further, what was a defining moment in your early medical career?

Ben: In the early 2000s, acute medicine was being developed as a specialty, and just starting to become a recognised training programme. I was one of the first people appointed to Wessex's acute medicine training programme, back in 2004. I still do a lot of clinical work, I've now been an acute medicine consultant for 17–18 years, and I still really enjoy it. Acute medicine can also be very sessional – it allows me to do other things like being deputy registrar and leading a graduate-entry medicine programme at the University of Southampton.

Omar: I had a slightly atypical journey. I grew up in the UK and various other places, and my medical training was actually in Iraq. I experienced medicine at a time when, practice-wise, resources were limited. I could see how practising with low resources, managing demands, creativity and bringing in teamwork worked. I then came back to the UK. Through that, I chose endocrinology, diabetes and general medicine. I still do and enjoy both, because it provides that holistic view.

Another turning point came after I became consultant. I went for a training programme director role, which opened up a different perspective on training. It was in 2019 when the 2022 'new' curriculum was being written. The national specialist advisory committee was involved in writing that, which opened my eyes to managing training programmes, policies and governance, and managing and evolving resident doctors.

I experienced medicine at a time when, practice-wise, resources were limited. I could see how practising with low resources, managing demands, creativity and bringing in teamwork worked. .

And looking back at that, what advice would you offer yourself at the beginning of your career?

Omar: I'd probably do what I did before, which is stay curious. Develop and have a goal. But the goal may need to evolve, depending on circumstances.

Ben: The main bit of advice would be to take the part 1

exam for MRCP(UK) seriously, please. That might have led to me not having to make four attempts to pass it! I still remember the letter I received after my first fail, that essentially advised me to take some time to do some more work and revision before having another attempt.

So, my advice to myself would be: take it seriously, do the work, believe the letter and you might save yourself a few quid and a bit of heartache.

When did you first come across the RCP? Was it through the exams?

Omar: In training, people talk about MRCP(UK) a lot, so it permeates your psyche. But this was in the days before the internet, so my real first contact was actually in 2002. I went to a careers fair and there was a stand for the RCP, and one of the things that they had caught my attention. It was the original, paper version of a portfolio. Halfway through training came e-portfolios – but that came quite late, so that RCP portfolio was my first contact. I still have the original, light green version.

Ben: My first contact was coming to my MRCP(UK) ceremony. I'm not by my nature a particularly formal person, but I quite liked the formality and history of it, and becoming part of something much bigger. It does make an impression on you and it does make you think about your future.

2025 was a pretty busy period for the RCP. How did you find it?

Omar: It has been busy, as always, and there's been a lot of change. Developing people remains a core part of the college; developing new members, welcoming new fellows, and looking ahead, through development of a new college strategy. It's a year where we have been looking forwards a lot, and there's been a lot of movement to reflect on the past but develop new things. It's about continuing to do what we do, and accepting the challenges while continuing to look ahead.

Ben: Part of this year for me has been about settling into a new role. I started in March and it's been a steep learning curve to get my head round everything. I'm now in a position where I understand the processes, have seen a couple of fellowship application cycles all the way through. That leads me to think about how we can improve things, which is quite a nice position to be in.

Similar to what Omar has said, I've been really interested in balancing the strengths of the RCP as a 500-year-old institution – with that weight of history and tradition – with modernisation and making it fit for the future. Some of the actions that are now happening are really important; more transparency about how Council works, the vote at the annual general meeting to expand the voting franchise to collegiate members.

I've been really interested in balancing the strengths of the RCP as a 500-year-old institution – with that weight of history and tradition – with modernisation and making it fit for the future

If you could wave a magic wand and change one thing about medicine in the UK at the moment, what would it be?

Omar: I have one word: continuity. It relates to patient care and to training, education and development. The continuity of care and continuity of learning, wherever you are. With everything that is happening and evolving processes, there's a lack of continuity of care. Care can be disjointed, inequitable and not provided to the standard which we wish it to be for our patients. Equally, that impacts on how we train the future generation of doctors. So that's my one wish.

Ben: If I could wave a magic wand, I would get the NHS as a system to recognise the importance and the value of medical training. In the past, training has been something that just happens through goodwill; people wanting to go the extra mile, consultant physicians feeling that it is their role to train the next generation coming through. It happens almost as a side effect of the clinical work and everything that we're doing on a day-to-day basis.

It needs to be recognised in job plans more, actually having time for educational supervision and roles within trusts about delivering that education at a strategic level. It's incredibly important, but often assumes a lesser importance than the clinical workload. So my wish would be: don't forget about education, it's really important.

As we look to 2026, what is one thing you think that RCP members and fellows should be looking forward to from the college?

Omar: IAs we move forward, continuing to make the RCP relevant to our members and fellows; maintaining those connections. Without that, the college doesn't really exist. Having our new strategy, which actually answers what our members and fellows feel. A key thing that we should be doing is to continue our modernisation of the governance and engagement programme.

We also need to look after the next generation through the Next Generation campaign and beyond.

Ben: What I'm most looking forward to is running the first election with an expanded franchise. I hope that it stimulates more engagement from both members and fellows. One of the roles up for election is vice president for education and training – that is a key role within the RCP and it would be really good to see the candidates

and what they think about the future of training.

What advice would you give final-year medical students as they prepare to become NHS doctors next summer?

Omar: Medicine has always been described as a marathon, but I'm not a runner. I'm more of a hiker and a mountain climber. I'm going to describe medicine as going through a series of hikes in the mountains; you'll need to navigate to your target, but also work with your colleagues to achieve that. Without those skills, you won't be able to navigate medicine. You may sometimes stall, but you'll have your team around you. They will always support you, get you through and keep you going up the mountain.

Ben: I have not climbed mountains. I'm best at sea level, it's fair to say. I have quite a lot of involvement with medical students at the University of Southampton. One of the things that I really enjoy is acting as a tutor; I meet with a group of final-year medical students and it's really interesting to talk to them about their expectations, worries and challenges.

My advice to final-year medical students is that the transition is a tough one; probably the most challenging that they will do in their career. Often they underestimate the amount that they have learnt over that period of time, because it is a gradual evolutionary process.

Omar mentioned earlier about looking after yourself and getting support from your peers. You're going to be in a group all going through the same thing; it may seem that you're the only one who's struggling and everybody else is doing fine, but that is almost never the case.

Outside the RCP, what is something that you are excited about for this new year?

Omar: Normally at this time, I start looking at booking time off and planning different holidays. The question tends to be about where do we want to walk next? There is a long list which hasn't come down yet.

Ben: I am excited and slightly concerned about my ability to train my younger dog, who is about 18 months old, to not chew the sofa. If I can achieve this, it will be a very good thing and may lead to me buying a new sofa to replace the one that has been mostly eaten.

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

Excellence in Patient Care Awards 2026: why your work deserves to be recognised and how to apply

Across the UK and beyond, RCP members and their teams are quietly delivering extraordinary improvements in patient care. From sustainability initiatives and service redesign, to tackling health inequalities, digital innovation and collaborative working across systems. This work is happening every day, transforming healthcare and the lives of patients, often without the recognition they deserve.

The Excellence in Patient Care Awards (EPCA) exist to shine a light on these efforts. As applications for the 2026 awards close on 16 February, now is the moment to consider whether your project, or one you've been involved in, could be recognised and shared more widely.

If awards feel intimidating, you are not alone. Many previous applicants tell us they hesitated before applying. In reality, EPCA celebrates projects at all stages of development. If your work has made a difference to patients, staff or systems, it's worth telling the story.

In 2025, sustainability award winners, Dr Vincent Simpson and Dr Deepthi Lavu told *Commentary*: '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.'

What are the Excellence in Patient Care Awards?

Run by the RCP, the EPCA recognise outstanding contributions to patient care made by physicians and their teams across the UK. The awards span a wide range of categories, reflecting the diversity of modern healthcare, including patient safety, sustainability, collaboration, digital innovation and improving care for underserved populations.

At a time of significant change across the healthcare landscape, with new policy priorities, system shifts and long-term planning underway, the EPCAs offers a reminder that meaningful improvement is already happening in across the UK and globally. These awards are about celebrating these projects, learning from them, and giving teams the recognition they deserve.

Winning or being shortlisted can also help amplify your work: through national visibility, peer learning and opportunities to inspire others facing similar challenges.

If applying for an award feels daunting, it's worth knowing that the EPCA application is short and straightforward. The form has just a few short sections:

- A 50-word project summary.
- 400–500 words on your approach, actions and outcomes.
- 100 words on scale and spread.

This means it is only around 600–650 words in total. Shortlisted applicants will then be invited to present their project to the judges, with short online presentations taking place 27 April – 8 May 2026.

What the judges are really looking for

All EPCA applications are assessed against five clear criteria. You don't need to structure your application rigidly around them, but keeping them in mind will help you focus on what matters most.

Innovation

Innovation doesn't have to mean something entirely new and high-tech. Judges are looking for evidence that your project goes beyond simply repeating existing practice, whether that's a new approach, a creative adaptation, or an improvement on what was there before. Clear explanations of what changed and why it mattered are often more important than technical detail.

Collaboration

Strong applications demonstrate collaboration beyond a single individual or team. This might include multidisciplinary working, involvement of allied health professionals, or partnerships with other organisations, charities or community groups. Meaningful involvement of patients, carers or families, particularly where they have shaped the project, is especially valued.
Relevance to the award category

Judges want to understand why your project belongs in the category you've chosen. Make this explicit. The strongest applications show clear alignment with the category theme and demonstrate how the project responds to local or national priorities, guidance or challenges facing the healthcare system.

Reach and impact

Impact is at the heart of EPCA. This includes the difference your project has made for patients, staff, services or systems. Impact may be local or wider reaching, and can include improvements to experience, outcomes, efficiency or equity.

Scalability

You don't need to have scaled your project already, but you should show that it could be replicated or adapted elsewhere. Judges look for evidence that the idea is transferable, whether across departments, organisations or systems, and that potential barriers have been considered.

Turning your project into a strong application

If the application form feels daunting, breaking it down into practical steps can help.

Be clear about the problem you were addressing

Start by setting the context. What wasn't working well, and why did it matter? This helps judges understand the need for innovation and relevance from the outset. Describe what you actually did, and what was different Explain how your approach improved on existing practice. This is where innovation often comes through, even in small but significant changes.

Show collaboration in action

Rather than listing who was involved, describe how people worked together. If patients, carers or partners helped shape the project, explain how this influenced the work and its outcomes.

Use evidence to demonstrate impact

This doesn't have to be complex. Simple data, patient or staff feedback, and clear before and after examples can all demonstrate reach and impact effectively.

Think ahead about sustainability and spread

Judges value projects that are designed to last. Briefly outlining plans for sustainability, or how the project could be replicated elsewhere, strengthens your application.

Look at previous examples

Case studies from past EPCA 2025 winners and finalists are available and can be reassuring if this is your first time applying. They show the wide range of projects that have been recognised.

Across the UK, physicians and their teams are improving patient care in creative, committed and often challenging circumstances. Whether your project focuses on sustainability, safety, digital innovation, collaboration or reducing inequalities, EPCA is an opportunity to give that work the visibility it deserves.

EPCA applications close on 16 February. If you are doing something that has made a difference even on a small scale, we want to hear from you. By sharing your work, you're not only gaining recognition for your team, but helping to inspire and inform others across the profession.

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

Breaking the cycle: closing the gap in fracture care

Adults who sustain a bone break after minimal trauma often have life-changing loss of independence, persistent lower quality of life and increased mortality. Half of all adults aged 50 or over who break a bone after minimal trauma are at high risk of another fracture in the next few years.

Professor Kassim Javaid, clinical lead for the Fracture Liaison Service Database (FLS-DB), shares the findings of its recent, based on 2024 data, 'Steps to fracture liaison service effectiveness: importance of treatment recommendations', with *Commentary*.

Fracture liaison services (FLSs) are NHS teams that reduce the risk of future fractures in adults aged 50 or over who have recently sustained a fracture. Patients are identified, assessed and receive appropriate treatment to lower their risk of future fractures. FLSs are based throughout the UK and bring clear benefits to patients and the healthcare system. Despite overall progress across many indicators, significant variation remains across FLSs.

The FLS-DB is a clinically led national audit of secondary fracture prevention in England and Wales, run by the RCP as part of the Falls and Fragility Fracture Audit Programme (FFFAP).

Our challenge is to translate the effective care for some to effective care for all, through better local leadership and accountability: sharing good practice and data-driven service improvement and development in order to deliver prevention, community-based care and digitalisation within the NHS.

What is the Fracture Liaison Service Database?

The FLS-DB is national audit run by the RCP that captures data of patients aged 50 or over who experience a fragility fracture, with the aim of preventing any future fractures. A fragility fracture is a fracture that occurs from standing height or less and can include hip, spine, humerus and pelvic fractures.

Seventy-seven FLSs across England and Wales actively participated in the FLS-DB audit in 2024 and contributed towards the annual report. 83,500 patient records were submitted in 2024 and compared with 2023 patient data. In this year's annual report, we focus on whether the fracture patients at highest risk of osteoporotic fractures are prioritised and provided with appropriate treatment to prevent future fractures, in line with NICE guidance.

Key findings

Performance trends: 2023 vs 2024

A key part of the FLS-DB annual report is its annual comparison of service performance.

This report saw notable differences in performance. In 2024, the identification of patients with non-spine fractures decreased to 50%, from 55% in 2023. However, the identification of spine fractures increased from 34% to 38%. The percentage of patients assessed by an FLS within 90 days of their fracture increased from 65% to 69%. There was also a modest increase in falls assessment in 2024, with 62% of patients receiving an assessment compared to 60% in 2023. The number of patients recommended bone therapy marginally decreased from 59% in 2023 to 57% in 2024.

In addition to the analysis of patient data, the FLS-DB also conducted a facilities audit to create a detailed national picture of how secondary fracture prevention is being delivered. 51 sites took part. In total, 21 FLSs reported that they had no administrator sessions and 17 had no consultant sessions as part of their service. 13 FLSs were not taking part in any formal governance meetings and 43 did not include patients as part of their governance structure. These data demonstrate clear barriers and opportunities for FLSs.

Impact of health inequalities

Health inequalities contribute to poorer health outcomes and preventable health conditions and mortality. Patients from lower-income households are at a higher risk of experiencing hip fractures and face poorer outcomes following identification – including less timely health assessment, falls assessment and lower monitoring. The report analysis also highlights differences in performance for England vs Wales, by sex and by age.

Overall, FLSs in Wales identified more spine fractures than England. However, England had higher non-spinal fracture identification. Wales also achieved higher results in assessing patients within 90 days (81% vs 68%). Adults aged 75 years and over were slightly less likely to have a DXA scan within 90 days, compared with patients under the age of 75. Patients under the age of 75 were less likely to be followed up at 16 weeks, with little difference at 52 weeks (13% in Wales vs 14% in England).

What's new?

This year we have included five graphs in appendix A that compare identification and treatment recommendations by FLS, showing unreasonable variation in care depending on local practices.

In 2024, the FLS-DB extended its online reporting to include service-level and integrated care system (ICS) data on the number of patients who are not receiving the FLS-DB standards for identification, initiation and continuation of appropriate secondary fracture prevention, including areas that do not participate with the audit.

'This annual report celebrates the step change in secondary fracture prevention delivered through FLSs in England and Wales. The variability of care delivery between FLSs clearly demonstrates how FLS can be delivered effectively in the NHS. Our challenge now is to translate the effective care for some to effective care for all through data-driven service improvement and service development using the shifts of prevention, community-based care and digitalisation,' says FLS-DB clinical lead, Professor Kassim Javaid.

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Breakfast at the House of Lords: the power of prevention

In December, the RCP hosted its annual Peers' breakfast at the House of Lords. The Peers' breakfast gives the RCP the opportunity to bring together senior officers, special advisers and members of the House of Lords to discuss our members' priorities.

This year, the theme of our breakfast was 'the power of prevention'. Peers heard from, and spoke with, our special advisers on air quality, obesity and tobacco. We sought to set out the RCP's priorities around these policy areas and demonstrated how peers could better support the RCP's calls from parliament.

Prevention as a focus

The RCP has a long history of leading public health advocacy. Over 60 years ago, our landmark 1962 report on smoking was the first such publication to definitively state the link between tobacco smoking and lung cancer.

Today, prevention remains an RCP priority, as we continue to campaign on preventable ill-health and the public health response. In 2025 we published a new report outlining the harms of air pollution, a new position statement on obesity and gave evidence to the public bill committee for the Tobacco and Vapes Bill.

Professor Mumtaz Patel, RCP president, opened the event by outlining the experiences of members, saying that the impact of the social determinants of health is something that physicians are increasingly seeing in their practice. Our recent snapshot survey of our membership, carried out in June, found that 94% of over 500 physicians see patients whose conditions are caused or worsened by smoking, obesity or alcohol dependence.

Social determinants of health are systematic drivers of ill-health and inequality. While the 10 Year Health Plan acknowledged the role of the social determinants of health, we are yet to see a comprehensive plan for tackling them. At the Peers' breakfast, the RCP stressed to peers that we would like to see decisive, cross-government action on prevention, which will improve public health.

Air quality

Professor Sir Stephen Holgate, RCP special adviser on air quality, stressed that air pollution is 'one of the biggest threats to human health' and must be treated as a health issue – not a solely environmental one.

Peers were moved by the findings of our June report, *A breath of fresh air*, which highlighted the health harms of air pollution. It estimated that around 30,000 deaths will be linked to air pollution in 2025 and that the annual cost to the government is £27 billion. It also found that pollution affects every organ in the body, damage starts before birth, worsens chronic conditions and contributes to dementia.

We encouraged peers to hold the government to account on its manifesto commitment to bring forward a new Clean Air Bill and to treat air pollution as a public health issue, not just an environmental one.

Obesity

Dr Kath McCullough, RCP special adviser on obesity, spoke about obesity being 'one of the UK's most pressing health challenges' and urged peers to advocate for further action towards tackling the root causes of public health.

We highlighted the results of our snapshot survey, which found that 80% of physicians who responded have seen more patients with obesity over the past 5 years. Nearly half reported that obesity reduces the effectiveness of treatment for other conditions.

As obesity is strongly linked to deprivation and driven by wider social factors like unequal access to health food and physical activity, tackling it will require more than just individual actions or weight loss treatment. Wider action is needed to create an environment where healthier choices are available for all.

We asked peers to push the recommendations of the House of Lords Food, Diet and Obesity Committee's report, *Recipe for health: A plan to fix our broken food system*. These include there being a comprehensive food strategy, mandatory regulations for business and healthier local food environments.

Tobacco

Professor Sanjay Agrawal, RCP special adviser on tobacco, stressed that smoking is 'a public health crisis driven by addiction, inequality and industry tactics that strip away personal choice'.

We demonstrated to peers the impact of smoking, with it being the leading cause of preventable illness and death globally. In our snapshot survey, 53% of respondents said at least half of their average caseload was made up of patients whose conditions have been caused or exacerbated by smoking.

Professor Agrawal also discussed vaping and its role in harm reduction by drawing on our 2021 report that found e-cigarettes are more effective than patches or

gum tobacco cessation, but after that, patients should also seek to quit vaping to avoid unknown harms. We outlined our concerns around the rise in youth vaping and that this being driven by child-focused marketing.

We urged peers to support the Tobacco and Vapes Bill's progression through parliament, and to speak and vote against harmful amendments to the bill.

Next steps

The RCP will continue to build on this engagement with peers in the House of Lords, working with them to ensure that the views and experiences of RCP members are heard within the legislative process.

If you would like to keep updated on our policy and campaigns work, or would like to support further, you can sign up for our fortnightly RCP Digest email.

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- Be very clear in the job description about what the role entails, and the protected time that they will have to work on QI and leadership projects.
- Have drop-in sessions for prospective applicants to spread the word, answer questions and encourage interest.
- Have the current chief registrar on the interview panel, so that they can give their advice as someone who has done the role.

Rebuilding identity and establishing a career in the NHS: the power of proactive support and mentorship for international medical graduates displaced by conflict

Dr Mohammed Rashwan, a Palestinian doctor from Gaza currently working in London, and Dr Aicha Bouraoui, consultant rheumatologist, share what it means to be a displaced doctor – and how mentorship is vital for navigating the NHS.

Resilient roots, healing hands: my journey from Gaza to the NHS

When I first walked into the A&E department in Gaza, I was not just beginning my clinical career – I was stepping into a war zone. Working amid constant air raids, resource shortages and overwhelming trauma cases shaped the core of my resilience. But it wasn't until I arrived in the UK that I encountered a different kind of complexity: navigating the NHS as an international medical graduate (IMG).

Starting over

After passing the PLAB exams and registering with the GMC, I moved to the UK with a clear goal – training in internal medicine. What I didn't anticipate was how steep the learning curve would be. Clinical practice in the UK is not only structurally different; it's deeply shaped by systems, communication styles and professional expectations that were new to me. I often found myself unsure: How should I structure my portfolio? What makes a candidate competitive for training posts? How do I navigate NHS culture?

The turning point: mentorship

That uncertainty began to lift when I met Dr Aicha Bouraoui, a physician and mentor who understood both the challenges of being an IMG and the standards of the NHS. Her guidance was pivotal. She guided me on how to make the best use of my clinical attachment and build my portfolio. She also introduced me to research, quality improvement and clinical audits – areas that were under-represented in my prior experience. With her support, I engaged in collaborative projects and began building a CV that aligned with UK training pathways.

The also pointed me toward accessible online learning platforms like RCP e-learning resources and EdX platform, where I could deepen my clinical and academic knowledge in a structured way.

What I didn't anticipate was how steep the learning curve would be. Clinical practice in the UK is not only structurally different; it's deeply shaped by systems, communication styles and professional expectations that were new to me.

The role of the RCP

Support from individuals is invaluable – but institutional support is equally essential. The RCP has played a key role in making the UK medical landscape more accessible to IMGs like me.

Through educational initiatives, webinars and the 'UK medical careers for IMGs' programme, the RCP provides essential guidance on progression through the internal medicine training pathway. The college's inclusive stance – through its Resident Doctor Committee and equity, diversity and inclusion approach – has helped to normalise IMG-specific challenges and offered a space for advocacy and practical advice. Access to these resources has made the NHS feel less foreign – and has helped transform confusion into clarity.

A new chapter

I recently secured a junior clinical fellow post in acute medicine at Queen's Hospital, London. It's a competitive environment, but one that I now feel equipped to navigate. I am currently preparing to apply for internal medicine training and view this role as the first step toward a long-term career in the NHS.

My message to fellow IMGs

To those starting this journey: it's not easy, but it is possible. Seek mentorship. Use the resources available through the RCP and other networks. Remember that your background is not a barrier – it is a foundation of strength. The NHS thrives on diversity, and your story belongs here.

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An international exchange: the BIA-ECSACOP fellowship

The East, Central and Southern Africa College of Physicians (ECSACOP) is an independent organisation comprising member colleges in Kenya, Malawi, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe. The RCP has supported ECSACOP since its inception in 2015 and continues to provide mentorship, technical and fundraising support and access to a range of expertise.

The British Infection Association (BIA)–ECSACOP fellowship gives resident doctors from the UK and the ECSACOP region the opportunity to experience medicine in a different setting and exchange knowledge. The idea of a fellowship came about after Dr Jo Herman (BIA–ECSACOP lead), as part of the BIA Council, attended a reception for ECSACOP hosted by RCP Global in London pre-pandemic. Discussions were put on hold for a while during the pandemic, but the past few years have seen the development of this new collaborative global health partnership, including the launch of the first fellowship last year.

Commentary speaks to **Dr Matthew Beaumont**, a registrar in infectious diseases in Sheffield, UK and **Dr Samantha Musasa**, an internal medicine resident in Zomba, Malawi about their experience.

What prompted you to write a book about the sociological determinants of health?

It is something that I've wanted to do for a long time. I've been teaching medical students about how the social world impacts on health for 15 years and it became clear that we need to talk more about this – in particular, in the last 5 years since the pandemic.

I wrote this book to help shed light, not just on how the world around us can impact our health, but how you can't really escape it. It's shaping your health each and every day. If you want to practise good medicine or understand how to be healthy, you need to understand all the different aspects that go into your health – not just lifestyle, choice and genetics.'

What is your clinical background and how did you get involved in the fellowship?

Matt: I am a third-year infectious diseases and medical microbiology registrar based in Sheffield. I saw an advert through the BIA – of which I'm a member. They have developed a new partnership with ECSACOP including setting up an international exchange programme, and I thought it would be very exciting to be a part of it.

I find that, in my clinical role, one of the most stimulating aspects is seeing returning travellers with fever and travel-associated infections. So the opportunity to go and gain further clinical experience of infectious diseases that could be imported to the UK really drew me in.

Additionally, I previously spent 3 months studying in East Africa in 2019, when completing my diploma in tropical medicine and hygiene with the London School of Hygiene and Tropical Medicine, through their East African Partnership. So, when I heard about the new ECSACOP partnership, I was really keen to get involved and collaborate with our colleagues in that region.

Samantha: I am an internal medicine specialist with an interest in infectious diseases as a subspecialty. I completed my postgraduate training in 2023. I was trained under ECSACOP and attained a fellowship, and Kamuzu University of Health Sciences (KuHeS), where I attained a master's in internal medicine. I learnt about the fellowship through an email shared with ECSACOP graduates by Professor James Jowi from Kenya, former ECSACOP president. My interest in infectious diseases pushed me into applying, as this was an opportunity to learn from the developed world and get an experience of the different pathology seen in that part of the world.

Could you tell me about the BIA–ESCACOP fellowship? What was your experience?

Matt: The fellowship involved a direct exchange between the two of us who were awarded the grant – myself, based in Sheffield, and Samantha, who is based in Zomba, Malawi. Initially I hosted Samantha at Sheffield Teaching Hospitals in May 2025 for a 4-week clinical observership. Then I went to Zomba as a clinical observer a few months later in August.

Samantha: I travelled to the UK in May 2025. For the first week of my trip, I attended the BIA 27th Annual Clinical and Scientific Meeting and Spring Trainee Day in Newcastle. There, I gave a presentation on a cross-sectional study I conducted on isoniazid toxicity in people living with HIV on isoniazid preventive therapy in Malawi.

I then spent about 4 weeks in Sheffield, as I did my clinical observership at the Royal Hallamshire Hospital. The hospital has a large infectious disease unit. It was such a great experience for me, as I got to join ward rounds in the unit and intensive care unit. I also joined a couple of outpatient clinics and online multidisciplinary team (MDT) meetings.

My time in Sheffield was memorable, as the team was very accommodating and eager to engage me in most of

the activities. The observership was great, as I got to see a diversity of clinical cases and I also had the privilege of working with some of the world's best infectious disease consultants.

Matt: I spent the first 3 and a half weeks at Zomba Central Hospital, one of four national referral centres. It's a 600-bed teaching hospital that serves a population of nearly 1 million people. Zomba is the former capital of Malawi and a beautiful town, nested in the shadow of a great plateau. I spent time on the inpatient medical wards, outpatient settings and also in the microbiology laboratories.

After completing my time at the hospital, I travelled to Mombasa, Kenya, for the 10th annual ECSACOP conference. I was a speaker and presented a case series of imported infections in South Yorkshire with a One Health perspective, looking at how the cases were linked to climate change and animal health.

Overall, the exchange was great – I received a very warm welcome from my colleagues in Zomba Central Hospital and we learnt a lot from each other through the process of exchanging. It was great to meet my ECSACOP colleagues at the conference in Mombasa too. I have made some wonderful connections, and it would be great to collaborate again in future.

What were the biggest differences you noticed? Were there any unexpected similarities?

Matt: Malawi is a low-income country so although public healthcare is free, clinical services really struggle with the provision of necessary resources to provide important treatments and tests. One of the biggest challenges that I noticed was that common drugs – particularly antimicrobials – weren't available. Additionally, laboratories were really struggling with tests; they weren't always able to offer common blood tests that I do in day in, day out in my UK practice and really take for granted. So, working there is even more reliant on bedside clinical skills, which are vitally important.

As an infection doctor with an interest in antimicrobial resistance and stewardship, I noticed that there are high levels of broad-spectrum antibiotic use, due to the lack of access to appropriate alternatives and cost barriers. I was invited to the antimicrobial stewardship meeting at Zomba Central Hospital to see what we could learn from each other, and we shared strategies from our different local settings to help tackle the global threat of antimicrobial resistance.

There were a number of similarities as well. Being a microbiology registrar, I sought time in the laboratory; many of the same lab technologies and equipment are available – specifically, the machines used for HIV viral load testing, TB diagnostics, and bacterial identification and antibiotic susceptibility testing techniques. However, because of intermittent supply and lack of the necessary resources and reagents, the range of tests performed on these machines was far more limited and the lab team were unable to harness their full potential.

Samantha: Some of the biggest differences that I noted were infrastructure and resources. The UK is a developed country and they have a more developed healthcare infrastructure with better-equipped hospitals, more staff and greater access to diagnostic tests and treatment than Malawi.

The UK also has widely adopted electronic health records and digital systems, which we currently have for few programmes in Malawi. The other main difference was the disease burden, mainly the burden of infectious disease, which is still on the lower side in the UK compared to Malawi.

Despite the differences above, the health system worldwide has a couple of similarities, like clinical guidelines and protocols used to manage specific conditions. Patient-centred care is a similar approach that strives to provide compassionate and high-quality care, as well as similarities in some laboratory diagnostic tools.

What challenges did you encounter along the way?

Samantha: I am very grateful to Matt, Dr Jo Herman and [my host] Dr Danielle Cohen and her family. This team made my trip worthwhile and helped me get through some of the challenges I faced that I would not have handled alone.

My trip was faced with a couple of setbacks, from getting my first visa application denied to experiencing human resource barriers at the Royal Hallamshire. BIA, through Jo, were very helpful and they worked vigorously to get everything in place.

I enjoyed hosting Matt, though at the time of his visit Malawi was experiencing a fuel crisis that limited some of the activities we had planned.

Matt: Hosting Samantha in Sheffield was a privilege – and I am proud that we were able to offer this experience to our colleagues at ECSACOP. However, it wasn't easy to arrange, with bureaucratic hoops impacting Sam's start date. But I'm pleased to say that we were able to overcome them.

I'm grateful to Jo, without whom the exchange never would have got off the ground. As exchange lead, she has been working tirelessly since before the pandemic to set up this groundbreaking partnership and I was glad of her support in navigating any roadblocks and making sure that the exchange was a success.

While I was in Malawi, there was the challenge of an ongoing fuel crisis, which has been a persisting issue for a while. Low levels of foreign exchange reserves have meant

that it's difficult for Malawi to buy in enough supplies of fuel. There were major queues at the pump for petrol – this highlights the economic challenges that are unfortunately facing Malawi and impacting healthcare provision there.

What were some of your main insights and takeaways from this experience?

Matt: Working as a UK infection doctor, it was very helpful to gain unique clinical experience of infectious diseases that are rarely seen in the UK. In particular, I furthered my clinical experience of viral hepatitis, seeing many patients with complications, including high rates of hepatocellular carcinoma. Additionally, I spent time on the ward and outpatient clinic, seeing patients living with HIV and its complications, such as Kaposi's sarcoma or advanced immunosuppression. There were other cases, such as cerebral malaria, that I have learnt from, and will be very beneficial to my future clinical practice. That's a key takeaway.

Working in a low-resource hospital has certainly improved my diagnostic stewardship. I reflexively order fewer tests now, particularly when patients are getting better, and I'm more confident in trusting my clinical acumen alone.

Additionally, as I progress through training to become a consultant, it's helpful to have spent time in differing hospital settings from a management perspective. It made me appreciate the importance of good governance interventions such as having antimicrobial guidelines to follow, and morbidity and mortality meetings.

Samantha: It was a great experience learning different approaches beyond what I see in Malawi. The technological advancement in diagnostics and general ward management were quite insightful for me.

I enjoyed the MDT meetings, which are a very collaborative approach to patient care, and the thorough documentation and handover sessions at the Royal Hallamshire. These are some of the things I would work on implementing in Malawi.

Do you feel that it has changed or developed your career in medicine?

Samantha: Definitely, this fellowship was a prestigious opportunity. It exposed me to a wide range of complex pathology that allowed me to stay up-to-date with some of the latest treatment approaches.

I had the chance to present at the BIA Annual Meeting – this alone, plus my time at the Royal Hallamshire Hospital, provided me with the opportunity to connect with leading experts in infectious diseases, which will help me with collaborations, research opportunities and my career advancement.

Matt: Certainly, it was fantastic to work with my colleagues at Zomba Central Hospital. I was only there for a short time; I would have loved to have stayed longer and for us to continue to learn from each other and develop some of the ideas we shared. Moving into the future, there is a lot that I would like to do as a microbiologist and infection doctor. One next step that we have discussed is the benefits of setting up an antimicrobial stewardship partnership. Zomba Central Hospital currently lacks a medical microbiologist, and I would be interested to help to develop training and support the strengthening of lab capacity and antimicrobial stewardship practices.

The exchange has given me a new perspective. A great number of the patients who I met in Malawi were subsistence farmers, with 70% of the population living on less than $2.00 (USD) a day. It was meaningful to be a part of this health partnership – at a time that international funding, particularly for healthcare, is very uncertain. Big cuts to US aid and to the UK international aid budget are likely to have a very negative impact across the world. In Malawi, they could lose up to two-thirds of the health budget if cuts progress unabated. So, it felt vitally important to be part of a global health partnership now; I'm grateful for Jo and the BIA for driving this from the UK side – and it's something I'd like to help develop in the future.

What advice would you have for any physicians who are wanting to experience similar programmes?

Samantha: Definitely, this fellowship was a prestigious opportunity. It exposed me to a wide range of complex pathology that allowed me to stay up-to-date with some of the latest treatment approaches.

I had the chance to present at the BIA Annual Meeting – this alone, plus my time at the Royal Hallamshire Hospital, provided me with the opportunity to connect with leading experts in infectious diseases, which will help me with collaborations, research opportunities and my career advancement.

What advice would you have for any physicians who are wanting to experience similar programmes?

Matt: This is the first time that the BIA and ECSACOP have run this exchange. They are currently planning for one every 2 years. A good place to start is membership of ECSACOP or the BIA – and keeping an eye out for the adverts for this exchange. Or using their work as inspiration to bring a similar programme to your organisation.

Sam: Learning is a process and this fellowship was a mind-blowing opportunity for me. I would urge my colleagues to apply, should similar opportunities arise.

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