Commentary

June 2026 Issue 3

Royal College of Physicians

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June welcome: Professor Mumtaz Patel

Welcome to this new edition of *Commentary*. It was wonderful to see so many physicians gathering at the RCP in London for our flagship conference in May. Medicine 2026 brought together hundreds of physicians, and it was lovely to have the chance to meet so many of our members and fellows.

June's edition of Commentary covers some of the great events that took place over the 2-day conference. Our clinical director for improvement programmes, Dr Aklak Choudhury, looks at the sessions through the lens of improvement, and we also congratulate the winners of the abstract competition – always a highlight of the conference.

Several of the topics covered in sessions at Medicine 26 are featured in articles this month, from how we can use AI and digital in the NHS, to our global work with the RCP Iraq Network and improving end-of-life care; reflecting the work that is being done across the RCP to shape better health for all.

I was also excited to launch our new strategy, which sets our direction for the years ahead. It reflects what our members, both in the UK and internationally, have told us they need from their college.

However, as we move forward, there is also important work being done to protect the RCP's past. Our 'Adopt a treasure' campaign, launched last year, has helped preserve and conserve several beautiful historical objects. Thank you to all those who have generously supported this initiative so far.

In this edition we also welcome Dr Dan Furmedge, who was elected as vice president for education and training, in his interview with Professor Ollie Minton, Commentary clinical editor. Previously, he was an RCP censor; a role which is explored in this edition by Dr Anita Banerjee.

Finally, I am delighted to share a piece on the Pan Arab Women Physicians Association from founding president and consultant gastroenterologist, Dr Maisam Akroush, as she explores how the RCP helped shape her vision of medicine.

As we head into the summer, I hope that you enjoy reading this edition.

Wishing you all the best,

Mumtaz

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June welcome: Professor Ollie Minton

I am a big fan of opera, even with its improbable coincidences, plot twists and sometimes unnecessary tragedy. The foolhardy prince in Turandot is saved only by the 'heroics' of act 3 (*Nessun Dorma*) – its subsequent crossover into the footballing world zeitgeist at the 1990 World Cup was a surprise. In retrospect it could feel like an AI artifice, but we know came from years of mastering the craft and expert teamwork – plus some inspired marketing with the three tenors.

I make this connection to highlight our interview with Dr Anne Kinderlerer on the RCP view on digital and AI and its conclusion that we all need to find the right application(s) for any new technology, avoiding optimism bias while ensuring live patient-reported outcomes and data are managed with confidence. There are unlikely to be any magic shortcuts. Unsurprisingly AI was also front and centre at Medicine 2026; with reflections from the clinical director for improvement programmes, Dr Aklak Choudhury, sharing his thoughts on where AI fits into neighbourhood health, among other things, and not just waiting for Skynet to be switched on.

While we may yet all embrace the chatbot, the interview is still best done as a human interaction so was great to chat to Dr Dan Furmedge to hear his plans as the newly elected vice president for education and training, what brought him into the college and how he juggles his multiple roles.

I also took the time to talk through the implications of the new Tobacco and Vapes Act and the RCP report on Tobacco, health and social justice – with it being nearly 65 years since we published the landmark Smoking and health in 1962. The tobacco company tactics apparently remain the same in promoting smoking, the cost and health implications are still frightening and of course, it is most likely to start in areas of deprivation – locally and globally. Overall, even if fewer people now smoke than in the 1960s, we cannot relent in the promotion of smoking cessation services.

Despite the looming AI ubiquity, we are all unique and not everyone though takes the same path through their careers. There is an excellent illustration of this in the piece on specialist, associate specialist and specialty (SAS) doctors, through discussion with four proactive members and fellows who illustrate how you can carve out your niche to be equivalent to your consultant colleagues, without the associated title.

As always, we have our global perspective, including some insights into service provision and innovation with the development of the Pan Arab Woman Physician Association, demonstrating that, with RCP support, medicine is not only a profession, but also a humanitarian mission. This links into developments in Iraq as part of our global educational role – geography, culture and availability of services may differ but, as the 2021 RCP Iraq Network tagline suggests and reinforces, 'Together, we are stronger and smarter'.

Who knows where AI will feed into these global connections, or indeed tagline generation, but anything that offers the opportunity to spread these messages and help people to network can, hopefully, only be a positive thing.

We want to encourage ongoing submissions from across the whole RCP population – from medical students to past presidents – as we approach the 60th anniversary of our magazine later this year. Please do get in touch with ideas – they can be multimedia, but we mainly want your human perspectives. Email commentary@rcp.ac.uk to get involved.

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Smoking out inequality: *Smoking, health and social justice* – a new RCP report

Since the 1960s, the RCP has been a leader in campaigning to prevent tobacco-related illness. Professor Ollie Minton, *Commentary* clinical editor, speaks to Professor Sanjay Agrawal, RCP special adviser on tobacco, about the changing landscape, after the latest report *Smoking, health and social justice* was published this May.

It's been nearly 65 years since the RCP published the landmark report, Smoking and health in 1962. What is the impact of smoking and tobacco on UK health at the moment?

Over many decades, tobacco has been the leading cause of ill health and death. It's entirely preventable in the UK; if people weren't driven to become addicted to tobacco, they wouldn't develop tobacco-related disease. The public and policymakers can become desensitised to the numbers because they're so enormous, and they switch off. So, the RCP tries to shine a light on the ongoing tobacco epidemic still affecting every country in the world.

The use of tobacco is ubiquitous; there are about 1.3 billion people worldwide who use tobacco regularly and at least 8 million deaths annually. In the UK, we have approximately 70,000 people who die from tobacco-related disease every year – a wholly preventable disease. If this was the case with any other disease, especially infections, we'd be acting urgently on prevention.

If someone smokes, they lose 10 years of life on average and are one-third more likely to be admitted to hospital or to see their GP than someone who does not smoke. Tobacco-related disease costs the health service about £2 billion per year. It has always been an enormous problem, and it remains one today.

Around 90% of people don't smoke, and many of them ask, 'why don't people just quit?'. People who don't smoke don't realise how strong nicotine addiction is. This addiction usually starts early in life, shaped by societal norms. If your family or friends smoke, you're far more likely to start smoking yourself. Unless we break that cycle of addiction by supporting smoking cessation treatment at every opportunity, tobacco can become a lifelong addiction, transmitted between generations.

In some ways, the UK has done a cracking job in reducing smoking prevalence. In the 1960s, about 80% of men smoked – now it's about 12%. That's great, but that's still many people smoking, despite people and society knowing the harms.

There is a constant threat in the background. The transnational tobacco industry is powerful and influential, lobbying at the very highest levels of government; ultimately, industry wants to maximise profit for shareholders. They want to perpetuate tobacco use and introduce new products and strategies to overcome or mitigate regulation and public health policy, utilising an 'industry playbook' to delay, dilute or block measures that would harm their interests.

If tobacco companies can't use a tactic in the UK, they certainly use them in other countries; 80% of the world's tobacco is used in low- and middle-income countries. Use is declining in Western countries, but it's growing elsewhere; it's the same companies working in all areas. Everything we do, they will try to counteract.

Over the last 62 years, what's been the RCP's strategy and approach?

In 1962, the RCP published *Smoking and health*, a seminal report that linked tobacco use with lung cancer and emphysema. Unusually for the time, the report didn't stop at scientific observation. It made recommendations to the government to combat the harm from tobacco, a strategy not previously not previously employed by the RCP.

The report set out recommendations that have become the pillars of tobacco control ever since; reducing the promotion and advertising of tobacco, implementing treatment for tobacco addiction, educating the public on the harms of tobacco, limiting the availability of tobacco, making products safer where possible and making tobacco less affordable.

Since then, the RCP has remained at the forefront of tobacco control.

During the 1970s, the RCP established the advocacy group 'Action on Smoking and Health' (ASH). Since then, we have continued to work closely with ASH on campaigns to advance tobacco control and promote public health. Our 2026 report and recommendations to government were developed through the RCP's tobacco advisory group (TAG) which has developed many RCP

reports on key areas of UK tobacco policy over the past 30 years.

The RCP's 2024 report, *E-cigarettes and harm reduction*, presented an evidence review on the place of nicotine alternatives in helping people quit smoking. It also looked at what regulations were needed to prevent young people or those who don't smoke taking up vaping. Prior to that, *Smoking and health 2021* looked at the entirety of tobacco control measures, including pricing, tobacco industry tactics, and greater media and advertising controls.

How does smoking fit into wider trends of health inequalities?

The burden of tobacco use falls on those who can least afford it. That's true in every country. People who smoke are more likely to be living in poverty, have low-paid jobs, living in social / rented housing or be homeless, or have mental health disorders. People with multiple sources of stress are more likely to smoke and less likely to quit.

People who smoke are around 10% more likely not to be in work, more likely to be off sick and earn around 9% less, on average, than those who don't smoke. Tobacco addiction is a vicious circle. To improve social justice (ie to provide a fair distribution of health, wealth and opportunity), we need to break the addiction to tobacco at every opportunity.

What is the purpose of the new RCP report? What are the key findings?

The RCP wanted to produce a new report because there is a danger that people think that the 'job is done', now that smoking prevalence has declined to around 10%.

We wanted to make it clear that the average prevalence hides the existing disparity between population groups. The report presents data on smoking prevalence by protected characteristics and by other markers of economic status, such as the Index of Multiple Deprivation (IMD).

Through this, we can see that the smoking rate is three times higher in the least advantaged communities, compared with the most advantaged communities. Smoking rates in people with mental health disorders are 30–60%, for people in prison, they are 80–90%. For the LGBTQ+ community, or routine and manual workers, smoking rates are often double the average.

This is an issue of social injustice; many members of our society are disproportionately affected. We need to invest more and take action, because these vulnerable groups carry the greatest burden.

We looked at the wider determinants of health; what is influencing this higher prevalence of smoking in different groups? We established that a lot of the reasons are structural aspects of society – poverty, employment, education, housing etc.

The report goes through the trends for each protected characteristic, and looks at localities and regions across the UK – highlighting large differences in smoking prevalence between population groups and geographies.

We've made the case that we need more data on local and regional smoking prevalence; that granular data can be used to introduce locally delivered measures. When you know your local population, you can target treatment; in my town (Leicester), we have parts of the city where smoking prevalence – particularly, in maternity – is really high. If we have those data, then we can target interventions.

The report also found that there is a huge swathe of people that we do not collect data on. There are probably around 2 million people that national surveys don't include, because they have no fixed abode. There are hundreds of thousands of 'sofa surfers', living temporarily with relatives or friends, never captured by national surveys. People with mental health disorders may be more likely to have no fixed abode. Similarly, asylum seekers, prisoners, people living in institutions or communal dwellings often have a much higher smoking prevalence. Our national statistics are probably not capturing about a million people who smoke.

What does the report say about the tobacco industry and their 'industry playbook'?

In this report, we've tried to shine a light on industry tactics and how we counteract them.

We looked through the lens of the 'commercial determinants of health'; what is industry doing to, essentially, target people in more deprived communities?

Tobacco companies use social media to advertise their products through influencers and product placement, on parts of the internet, gaming and streaming services that current tobacco advertising and promotion regulation does not sufficiently cover or enforce.

This means that many people are attracted to or continue smoking because of messages and exposure to tobacco imagery on these online platforms. The report also highlights the pricing strategies of commercial actors, who make tobacco products less expensive for people on low incomes, so as to maintain their tobacco addiction.

There are other recommendations to mitigate industry influence, eg not allowing industry actors have any role in governmental decision making on tobacco policies, and ensuring clear and transparent records of meetings between of industry actors and government.

What are the recommendations of the report?

There are approximately 50 recommendations in total. Key themes include cross-government coordinated action to prevent health-harming industries widening health inequalities, doing more work on the availability and pricing of tobacco products, introducing opt-out models for treating tobacco dependency across the NHS, and gathering better quality data on smoking and deprivation to really target resources.

The report talks about what we can do to counteract tobacco companies making tobacco more affordable for low-income groups – for example, introducing minimum unit pricing for tobacco (effectively introduced for alcohol in Scotland), or setting a minimal excise tax. The RCP has recommended retail licensing schemes be introduced to limit the availability of tobacco products, which the new Tobacco and Vapes Act will have the power to introduce.

We also recommend introducing opt-out treatment models across every point of contact in the NHS, recently introduced in hospitals in England for inpatients and maternity services. Now we should extend this to other NHS settings such as primary outpatient and emergency care; automatically referring people to services, making treatment more accessible and less stigmatising.

The report also talks about financial incentives for smoking cession. This has been hugely effective in maternity care, increasing quit rates 2–3 fold. We would like to see a greater use of incentives across other less advantaged populations. The report also talks about strengthening the accountability of smoking cessation services in the NHS and local government, to ensure that we get every bit of value from that investment.

The RCP welcomed the government's Tobacco and Vapes Act. How will it deliver a truly 'smoke-free generation'?

The Tobacco and Vapes Act is a landmark piece of legislation that the UK should be proud of. It's going to reduce younger people's accessibility to tobacco – young people get hooked into tobacco addiction at an early age and smoke for life. The legislation will raise the age of sale by 1 year, every year, such that people born after 1 January 2009 will never legally be sold tobacco in the UK. This is an important way of preventing the cycle of addiction and life-long tobacco-related ill health and social injustice.

The Tobacco and Vapes Act will introduce other measures such as retail licensing to reduce tobacco availability and regulating other nicotine-containing products such as nicotine pouches, vapes, oral tobacco or heated tobacco products.

However, the legislation may do little for the 5.3 million people who currently smoke in England. We know that people who smoke have children who are more likely to smoke and be exposed to second-hand smoke. If we're going to make the 'smoke-free generation' work, we've also got to support people to quit.

This report is about is social injustice and making sure that the most deprived communities – where smoking prevalence is the highest – are not forgotten. So, we need to think about addressing the other drivers of smoking, like homelessness, mental health disorders, or the use of alcohol or drugs.

What would be the impact of stopping smoking across society?

People often say that the government couldn't do without the revenue from tobacco. That's just not true.

We estimate that the cost of tobacco to society in the UK is approximately £52 billion pounds per year. That includes productivity losses, and social care and health costs. The revenue raised from tobacco is just £8 billion. Taxpayers are essentially subsidising a £44 billion gap.

Most of the profit from tobacco sales goes to transnational tobacco companies. Local shops take less than 8% profit on tobacco products that they sell, whereas the transnational tobacco companies have a 70% profit margin on tobacco products, which goes to shareholders – rather than going back into local communities.

If smoking were made obsolete, it is estimated that we could put £11 billion back into families and communities and around 250,000 children would be lifted out of poverty if their households became smoke-free.

Breaking the addiction to tobacco is cheap, effective and life-changing and will make a difference to children, communities and our society, helping to restore social justice.

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Interview: meet the new vice president for education and training

Earlier this year, Dr Dan Furmedge was elected as RCP senior censor and vice president for education and training (VPET) and will formally take on the role later this year. As a consultant physician in geriatric and internal medicine at Guy's and St Thomas' NHS Foundation Trust, with experience as a college tutor, training programme director, PACES examiner and, most recently, RCP censor, he will bring a wealth of experience to the role.

Commentary clinical editor, Professor Ollie Minton, interviews Dan about why he ran for the position and what he is looking forward to as he takes on the role as VPET.

You're a geriatrician, but what college roles have led you to stand for election as VP for education and training?

Dan: I'd always wanted to work with undergraduates – once upon a time, I saw myself as dean at an undergraduate medical school. But that rapidly changed and I ended up working more in postgraduate medical education. This work opened up a gateway to becoming an internal medicine training (IMT) stage one regional training programme director (TPD).

I didn't really get involved in any RCP work until I became a college tutor at St Thomas' Hospital in London, when I first became a consultant. Before that, I'd been a resident doctor representative on an MRCP committee and had done the RCP MSc in medical education. I was responsible for the local delivery of internal medicine training with one of my colleagues, and doing that got me linked with the RCP – particularly with the associate college tutors and the then-Linacre fellow, Dr Jo Szram. That allowed me to develop local leadership skills and was a positive role for me in my local trust; it allowed me to build contacts and a network outside general and geriatric medicine.

At the same time, the censor role was advertised. That was probably the first time that I saw the wider workings of the RCP and realised the extent of the educational and CPD offering. I saw much more of the RCP's national voice, the lobbying, and it opened my eyes to the work they do on public health and other issues.

The issues around the extraordinary general meeting and physician assistants turned the censor role into something quite different from previous years. It was interesting to observe the governance of such a big organisation, but also take on some leadership around what was going on.

That made me realise that the RCP was somewhere where you could make a difference. You can make a difference locally for a while, but the RCP has a voice nationally. So it seemed like a great place to be.

Education seems to run through the various roles that you've had – so what is the challenge of this one?

Dan: It feels like an extension of what I've already done, but also much broader. My focus has mainly been on IMT stage one and general internal medicine training, alongside some geriatric medicine. This role is obviously much broader, covering all specialties within the RCP.

The NHS England medical training review is coming up; the RCP is going to have a huge voice within that process and it will be one of the key things to look at during my years in this role. It's been really important for me to hear the voices of other specialty groups about what their challenges are, and I hope to be able to advocate for them all in any change.

People often conflate the RCP with setting exams and curricula – when actually that's done by the Federation of the Royal Colleges of Physicians of the UK, in which we have a very significant voice and stakeholder role. But people write off the RCP because they think that is all that we're about – we contribute significantly, but we don't have direct responsibility for it.

The RCP tries to represent everyone, from medical students to retired fellows – and it's difficult. Where do you feel your role falls and what are the bits that you want to focus on, or think you can build on?

Dan: It's important to aim to do something for everybody. When I stood for this position in the election, it became very apparent to me that many of my friends, colleagues and peers don't necessarily see what the RCP does for them or why it is worth paying for membership or fellowship, and that is such as shame as I have quickly learnt that the RCP is doing a huge amount.

We have to start becoming involved with people's training and being visible at undergraduate level, so

that people who go on to be physicians feel like we are a part of their training. For example, every UK region is delivering training days and events for their doctors, and a large proportion is lecture-based training. I can't see why we're asking regions to deliver those individually. The RCP could have a big role in delivering some of that core, didactic education – leaving local areas to deliver more practical aspects, like peer-based facilitated discussions.

Then, if physicians have seen the RCP delivering and being part of their training, all the way through, they might feel more invested and see what we have to offer.

Responding to and working with the medical training review and the new RCP strategy, including the education strategy, is going to be really important.

Other smaller, specific things for me would be bringing back teach-ins if possible, which we used to run. I remember coming to those on Tuesday evenings at the RCP as a registrar and thinking they were brilliant.

What do you see being the outcome of the RCP's new strategy and the medical training review? Do you feel that there are going to be concrete differences for resident doctors?

Dan: Strategies can feel a bit like just words, but – based on what I've seen of the senior leadership team so far – there is a real desire to move things forward and change things for the better. Since I have been a censor, communication from the RCP to the censor group has been rapid, transparent and in search of improvement.

The RCP's 2026–30 strategy is going to be the background structure of that, and I'm hoping that it will lead to some positive further changes. All the core work that the RCP has been doing in the background will continue, and that is often what is underrepresented to the RCP membership.

My peers, colleagues and resident doctors don't see all the things that we are lobbying for; the direct one-to-one relationships and meetings that the RCP has with chief medical officers, NHS England, the health secretary and all the other groups. They don't always see the quality, standards and clinical guidance that the RCP is creating or contributing to. They don't realise that we are being asked to respond to national issues in real time; they don't see us being vocal about the medical training review, assisted dying or corridor care. There's a huge amount of work going on and we need to make it known and get people involved.

But, via word of mouth, I have been seeing a change. I encounter resident doctors and PACES examiners regularly and I've heard much more positive feedback about changes in the last year than previously. Three years ago, I would never have put myself forward, but seeing the ability to make these positive changes – and the ethos and vision of the team in the RCP now – has made a difference. We really do want to get things right and make sure that members and fellows feel that the RCP is doing something helpful for everybody. For me, that is underpinned by the strategy and the governance.

That's really nice and it's great to see that work being done – but as you said, it can be hard to inform people. How could we inform people about RCP work – and how do you plan to update people about what you're up to as you start the role?

Dan: It's so hard, isn't it? The communication team are already amazing and use every possible route, but we can keep engaging people through direct involvement in their training, being more visible in that. Why isn't the RCP giving guest lectures at locally arranged training days? The trust visits that happen are great, but it is really hard to reach physicians who have busy lives.

Continued good work, word of mouth, encouraging people get involved, nurturing physicians and making people feel like we are a part of their training are all really important.

What would success in the role look like in a few years' time? What would you be happy doing?

Dan: Better engagement in some visible form – in the actual delivery of training. Trying to get people involved, spreading more opportunities about what they can get involved with and working out how that work can be rewarded. Productive work coming out of the medical training review that really has an effect. Increasing membership and fellowship subscriptions through positive engagement and increased relevance.

The huge networking and global work that's happening with the RCP abroad and the international reputation that we have is something I want to work on. We've got PACES examination centres in 20 countries and a range of global workshops. There's also the networking side – we've supported the development of the East, Central and Southern Africa College of Physicians (ECSACOP) – and we have a great working relationship. I'd underestimated the global impact of the RCP and the support that's given to local networks, and helping medicine develop internationally – as well as benefiting from their expertise too. It's been really interesting to see how that has developed and what the educational opportunities are, both ways..

How are you going to balance it all, especially when you have to hold down a day job?

Dan: That is a problem! I do clinical work; acute take,

inpatient geriatrics, inpatient general medicine, care home work, acute frailty and a few other areas – alongside a few other roles that are not reflected in my job plan. I'm trying to reduce clinical activity, although everyone will understand how difficult that is and I absolutely do not want to become someone who does no or very little clinical work, at any point in my career.

I'm quite an efficient person, and can move through things quickly, but – as many people do – I can end up taking on far too much. I'm going to have to evolve it over the next 3 months; it will be a mix of both roles, but I will have to be a bit more cut-throat about reducing things, because already my diary is full of meetings.

I can only imagine there are going to be more unavoidable meetings to come, and lots of new people to meet!

Dan: Definitely. But it has been really great to meet people and amazing to network with influential people in very high positions, realising that I'm now coming to the table, where I can hopefully influence change.

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Interview: what it means to be a censor

Dr Anita Banerjee is an obstetric physician, a diabetes and endocrinology consultant and an honorary reader in obstetric medicine at King's College London. For the last 3 years, she has worked as an RCP censor. As her term comes to an end, she shares her experience in the post with Commentary – and encourages RCP fellows to apply.

> 'I'm coming to the end of my 3-year term. It's a privilege to have had this role, and as censor we always want to know how can we serve you better, and get the RCP to hear that.'

What does the role of an RCP censor involve, and what have you enjoyed most about it?

I'll be honest with you; it's quite hard to define! As a censor, we have a number of roles. We meet the senior officers regularly. We're involved in college conduct and disciplinary action, reviewing cases and supporting the registrar. We're involved in looking at the bye-laws and the election process, ensuring that we've got the process right. We are invited to many different working groups and roundtables; specifically, I've been involved in a lot of prevention work. I've worked on RCP podcasts as well; for all the podcasts that are uploaded, one of the censors will make sure that the content is correct. We're involved in the fellowship ceremonies, both for members and fellows – being part of that celebration is a great honour. The role of a censor is so wide.

I was not a PACES examiner but, when I became a censor, I was asked to train to be an examiner. Now I go across the country in that role – and I will continue doing that when I finish as a censor. It's a great privilege to go across the country, examine people and later congratulate them for passing.

You have a wide range of opportunities as a censor. It's someone who can be inquisitive, using that professional curiosity and ability to ask questions. You have a voice, you are involved in writing and understanding guidance and supporting senior officers.

In the past 5 years – particularly with COVID – supporting physicians with burnout and sustainability is really, really important. We have to get everybody's ear, and support everybody in different phases of their career. You've got to understand the whole lifecourse of a doctor. I've been really interested in that.

It does take time to get used to the role – 6–9 months, maybe. In any big organisation, you have to learn what to do. That's the beauty of having a group like the censors; there are eight of us and the role turns over every few years, so everyone is at different stages and very supportive. You learn from each other and take different responsibilities.

I've also enjoyed being involved in areas of medicine that I have a passion for; I have a particular interest in women's health. As a diabetologist and obstetric physician, I was one of the founding members of the RCP obstetric medicine diploma. I wrote the curriculum and I've been involved in it from the beginning. I was very aware of the inequity in women's health, and as a censor, I've really enjoyed putting together the flagship educational offerings for women's health over the past few years. There's an ongoing cardiovascular disease prevention summit that I have been involved in, both as a censor and as somebody who's interested in women's health. I probably wouldn't have had the chance to get involved, had I not attended Education Board and Council meetings in my role as a censor; getting a far better breadth of what's happening across the RCP.

I've been involved in mentor–mentee leadership, women's health programmes and the Emerging Women's Leaders Programme. These educational workshops are done remarkably well; we get people from all across the country, and you get to learn from people who are working across the country, not just in your own hospital.

Has the role influenced or supported your professional development?

As a censor, you're working with other consultants across the country and hearing their challenges. That has influenced who I am and who I want to be in the next years of my career – what I want to still be involved in. There'll be opportunities to strive and grow..

The active listening and learning that you need as a censor support you with your own professional development. That's a key skill of a health professional; everybody needs to be actively listening. You go into meetings with no fixed ideas and you have an opportunity to listen and learn. That's definitely changed my practice and what I bring back to my own hospital and other external projects, whether locally, regionally or globally. The role makes you a better physician. It gives you an opportunity to see things that you would never have seen otherwise. That enables you to reflect on your own work, who you are and what you are able to do.

In the role of the censor, being invited to different meetings – locally, regionally and sometimes nationally

and internationally – enables you to share that knowledge back on the ground. Most of us are still working as physicians.

Sometimes you do need to step in and help out with unexpected things. Sometimes you will be taken out of your comfort zone. As someone who's coming to the end of my term in the role, I would not have imagined getting involved in some of the things I've done when I first interviewed.

What experience does a censor need? Who makes a good censor?

Having a real range of expertise, experiences and opinions is really valuable as a censor. If we're all clones, it's boring and change can't happen; you're too fixed. You're never too young or too old to be a censor. It's part of your journey and it's your time to contribute. It's important that you get an opportunity to see things that you don't always get involved in, seeing those specialties or topics with fresh eyes.

Being a censor is not a paid job; it's done as an extra. So, your time on the shop floor doesn't change in the years that you are a censor. That doesn't mean that you're busy all the time, as there are eight of us sharing the role. Being a censor is not measured in how many things you've done in a year; it's more about what you've been involved in and where you've taken it.

That's why it's important to have a breadth of people joining us as censor, enabling them to grow. That will make people less afraid to apply and be part of the RCP. The RCP needs to evolve and grow, and we are part of that. The role as a censor is a real privilege.

On College Day 2026, we had all eight censors together and we are all different. Our strength is that we have different opinions and we enable everybody's voice to be heard. Being a censor is to be someone that people want to speak to and confide in, so we have to ensure that we maintain that integrity.

What advice would you give to someone considering applying to become a censor?

We're not looking for someone who wants to take on what Anita has been doing, but someone coming with fresh ideas.

Being a censor is not like your IMT1 where there's a curriculum; you have to take off and move it forward. It's an opportunity to listen, learn, grow and then be part of moving the RCP along. And you're not alone in that, you're part of the team and there's lots of support.

So why would you apply? Because you want to be part of a team, you want to grow, you want to listen and learn. If you have different medical interests, there's always an opportunity to work on projects related to that. I've got a much stronger 360-degree lens than I had at the beginning of my censor role.

There's something new every day – that's the beautiful thing. Things are evolving in the RCP, and that agility and being part of it is really exciting. You're not just hearing about change, you're a part of steering it. It's a great opportunity and everyone should consider it.

What inspired you to apply for the role of RCP censor?

When the college was founded over 500 years ago, the censors were the people who held vivas (spoken exams) and granted licences to those allowed to be doctors. The Censor's Room at the RCP at Regent's Park in London is a beautiful place to be.

I've been a member of the RCP for years. I started first as an associate college tutor, then college tutor, then regional adviser. When the advert went out for the censor role, I thought that it was a really interesting position because you are not a senior officer, but you are an important part of college life.

As a doctor, you end up relooking at things every 3–5 years; you're always trying to do better, make a change, be a part of something and ensure that you're bringing everybody together. When the advert came out, it was a great opportunity to be part of something new.

For me, the role meant that you're part of a group, you're listening and you're a barometer of bringing back understanding of what's going on with physicians. You're a voice of reason, listening to members and then providing advice and support to the president, registrar, the vice presidents and to RCP Council. Censors don't take sides; we listen and support. That's really important in a big college.

If you've been involved in the RCP in different ways – as a tutor or regional adviser, or in the Updates in medicine conferences – you've got that bigger picture of what's happening across the country, where the challenges are and what is changing. The role of the censor enabled me to think about what can we do differently and better. When I interviewed for the role, it felt very utopian; what could be, what medicine could look like and what could I do. It wasn't about me as a censor, it's about what I can do for people and for the RCP.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images.

AI and digital: how physicians are impacted

Earlier this year, the RCP published a new landmark report – *The RCP view on digital and AI* – which looked at what would be needed to fix the digital foundations of the NHS and ensure that digital solutions, including artificial intelligence (AI), solve real-world clinical problems. The report made 10 recommendations to government and the NHS in England.

Dr Anne Kinderlerer, the RCP's digital health clinical lead and the report's main author, speaks to *Commentary* about the NHS analogue to digital shift, and how digital and AI tools can be implemented in a way that is safe and effective for patients and clinicians.

Can you tell me a bit more about the ambitious vision of the analogue to digital shift in the 10 Year Health Plan for England?

Essentially, the analogue to digital shift is a key enabler of being able to deliver the healthcare envisioned in the 10 Year Health Plan; healthcare that will focus on patients, target risk, tackle health inequalities and deliver healthcare closer to patients. The shift is essential for the plan's vision of being able to deliver care to patients at neighbourhood level, allowing collaboration between doctors in primary, secondary and tertiary care and therefore to deliver better health outcomes, without massively increasing the costs of the health service. It has the potential to democratise healthcare, allowing patients to be more involved in decisions about their health, allowing clinicians to respond to risk and supporting shared decision making.

Despite all the hype about the analogue to digital shift, the tangible changes have been slow and have not delivered the transformation that many of us have hoped for. There's a lot of optimism in government that introducing technology will reduce workload, allowing the workforce to be more productive. But much of the evidence, particularly around hospital electronic patient records (EPRs), is that the technology currently available in the NHS reduces productivity and makes it harder for physicians to do their jobs.

Digital infrastructure is something that is very important to physicians; we heard clearly in our 2025 consultant census that poorly functioning IT is one of the top three things that make physicians' jobs more difficult – and that fixing it would make things better.

> 'Digital systems vary widely between hospitals, and it really affects how we work … These inconsistencies make processes much less efficient than they could be.' – RCP fellow, 2025 census

There is more of a government focus on interoperability across systems. In part to tackle this problem, the government has proposed a single patient record. The detail of this is starting to emerge – but the hope is that, if implemented well, it will allow clinical data from multiple EPRs to be visible to patients and clinicians to support care.

Improving communication and the ability to share data should improve referral pathways for outpatients, making it possible to determine which patients need to be seen and which would be better supported by advice. There is good practice in some places that allows patients to be referred directly to diagnostic tests. Work on messaging systems, already widely used in primary care, is beginning to allow three-way conversations between referrer, specialist and patient to support better pathways.

This kind of work supports the vision that the RCP described in our *Prescription for outpatients*, allowing patients to be part of conversations around referral and appointments, deciding whether time or place is more important to them, and whether they would travel further to be seen faster.

What are the potential benefits of the shift for physicians? What will it take to get it right?

Healthcare is already digitally delivered in most places, with only four acute trusts still relying on paper-based records and lacking an EPR system. Primary care has had universal coverage by EPR suppliers for much longer, but community and mental health trusts lag behind acute providers. This means that complete datasets that would support new models of healthcare don't yet exist and will require focused attention to develop. To add to the complexity, the electronic records that we do have are poorly usable, which causes risk to patients and contributes to burnout of clinical staff.

If we can build digital tools – which are easy to use and which support decision making by providing all the information that physicians need, in an easy way that doesn't require a lot of effort or multiple systems – then we will be able to deliver better, more evidence-based care, with less effort.

The fact that datasets are incomplete, potentially

biased and lack clear definition for individual datapoints will make the development of AI systems that will improve diagnosis outside image analysis more difficult. It seems likely that if we concentrate on building the fundamentals, better AI will deliver on its promise. If it is possible to predict the likelihood of ovarian cancer from a patient's shopping data, surely, we should be able to start to use predictive tools to better direct pathways of care.

The analogue to digital shift is dependent on having an implementation plan; being clear about how systems are going to be procured at the right scale. For instance, some regions have demonstrated successful innovation by bringing acute hospitals' EPRs together onto a single domain, allowing investment in more usable systems and allowing better data coordination, leading to improved knowledge and better care. We should be building an innovation pipeline that allows 'test and learn' approaches, then finding ways to spread the adoption of successful applications.

What are some of the risks highlighted by the RCP that the government and the NHS must address?

We are worried about optimism bias in government and the view that digital and AI will somehow fix all issues in healthcare. The RCP is clear on the importance of guidelines for good implementation, which would include better standardisation in many systems – particularly around introducing AI.

There also needs to be standardisation in how systems work to reduce cognitive load on clinicians. You shouldn't have to think about whether results are on the left or right of a timeline – it's often different within the same EPR at the moment, let alone standardised across different systems.

I have championed focusing on usability of the EPR to improve patient safety. It is easy in digital systems to add 'safety clutter' in response to patient safety incidents, such as alerts that interrupt workflow. We know that distracting people from the task at hand reduces both their ability to complete that task and focus on what the alert was about.

We want to see the Department of Health and Social Care and the NHS establish central repositories of NHS-approved algorithms, AI tools and patient-facing apps that meet national standards, and clear NHS guidance on what AI tools are approved and safe to use.

The analogue to digital shift can't be allowed to be a complete 'wild west' where individual trusts buy any app or system. This would create an infrastructure where systems don't talk to each other well – and when trusts have multiple legacy systems, they are often not well maintained.

There needs to be a focus on interoperability; products sold to the NHS need to be able to communicate with other electronic records in a defined, structured way. As each trust buys an EPR, it must ensure that the system provides the minimum core datasets required and that it meets NHS standards. We need to share good practice; when one trust has built an EPR and workflow that functions well, it should be easy to move it across into another trust.

We also must recognise that patient data belong to patients; they have the right to consent to how their data are used and understand what that might mean. We need to ask if they give permission for clinicians to see data to look after you better – and if it can be used to improve care. Can we use anonymised data for audits or for medical research, which might be done by pharmaceutical companies for profit?

The report includes findings from a snapshot survey of RCP members; what did that survey tell us about how AI and digital technology are being used in the NHS?

Around 70% of physicians are either somewhat or very supportive of AI tools being widely implemented. But they're very sceptical about whether the basic infrastructure foundations are in place to allow it to work well.

37% of physicians are already using AI in clinical practice at least monthly and 16% use it daily. AI is being widely used in many tasks, particularly for image interpretation in radiology and pathology.

Many clinicians are using personal ambient voice technology (AVT) to generate notes and clinic letters. Just under 30% of the physician respondents who were using AI for clinical tasks said that they were using AVT for letters or notes in outpatient settings.

There are a few uses for generative AI within the EPR – to be able to search or summarise information for discharge summaries. Almost seven in 10 of 305 UK physicians said that they were using personal access to general AI tools like ChatGPT and Microsoft Copilot to answer clinical questions, in the way that we've previously used Google. We think that particular finding suggests that the NHS is not moving quickly enough to provide clinicians with AI tools that are useful, efficient and safe. It is a risk, because those tools were not designed for use in healthcare, and we have to recognise it as such.

Most physicians think that AI will improve care and improve their ability to look after patients. But only about a third of respondents were somewhat confident in using AI tools – just 8% were very confident. About 80% thought that they needed training in using AI – but most clinicians do not have access to that.

What are the RCP's recommendations about AI use in the NHS? Which recommendations will apply to physicians reading this?

Our recommendations are that AI tools should – like any digital introduction – be part of a process of transformation that focuses on real problems. Often, people are encouraged to buy the 'shiny machine', then look for a use case. That is not a good way to deliver transformation of any kind. We should identify problems and then the design of an AI or digital tool should be done with physicians and patients.

We need clear routes to allow innovation and partnership with companies that are building safe tools. Then, we need clear ways of evaluating tools and gathering evidence that that is – and remains – safe.

Organisations will need a way to monitor their AI tools, as those tools can learn, evolve and drift away from their original function, becoming less effective over time. At the moment, our hospital digital teams are poorly equipped to monitor data and see changes. Our ability to monitor digital systems is a significant risk. We can see that patients are getting lost on pathways and not followed up; we don't have a monitoring system which flags that.

Physicians will need to think more about how they input data. You can enter free text in an EPR, but we will get more out of electronic systems if we pay attention to structured data entry – AI tools may support us to do this better without adding to the documentation burden. Physicians should be involved in the design of new systems and thinking about the problems that AI might solve.

How can physicians assist in this evolution? What is your advice to RCP fellows and members who want to keep up to date?

Get involved with your own trust's digital teams. Work with them to design the workflows that you need. Speak to your business intelligence people and work to design the data that you want out of systems. Be involved in the conversations around the single patient record and what should be in it.

There's a recommendation in the report for specialist societies to start thinking about condition-specific patient dashboards; for example, what sets of information might you need for rheumatoid arthritis? Do you include patient-reported outcome measures, blood results, drug history laid out over time? Ask yourself, if you could build a perfect longitudinal patient record for a clinic, what would it include and how would it look?

What work is the RCP continuing to do in this area following the report's launch?

The RCP is having a lot of conversations with the NHS, to try to influence what the government's promised roadmap for AI and health looks like. We actively engaged with the Medicines and Healthcare products Regulatory Agency regulation consultation and brought a focus group together.

Developing this report and engaging with clinicians has enabled us to use their voices to influence policy. The RCP is meeting with leaders in the NHS, with MPs, the Select Committee for Health and the Office for Life Sciences.

We are starting to discuss what specific digital education we should be providing as a college, and we're working with the Federation of the Royal Colleges of Physicians of the UK to influence the curriculum for undergraduates and postgraduates, following the government's commitment to reform curricula to 'provide comprehensive training in the use of AI and digital tools'.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images and videos.

Spotlight on the Medicine 2026 abstract competition

Last month, as part of the RCP annual conference, we hosted the Medicine 2026 abstract competition, welcoming authors from all career grades to showcase their ideas and hard work to the RCP community.

This year we were delighted to receive 540 abstract submissions, 303 of which were shortlisted into the second stage of the competition and asked to submit a poster. With many candidates presenting their work on site at Regent's Park, the occasion reflected an impressive breadth of research. Judges praised the excellent standard of presentations, noting how enthusiastic, engaging and clearly passionate presenters were about their work, which fostered lively discussion among attendees and expert judges alike.

The competition would not have been possible without the generous support of more than 70 volunteer judges, who gave their time and expertise throughout. Judges described the experience as a privilege and a joy, highlighting the energising conversations and the opportunity to learn from work beyond their own specialties.

Judges also commented that opportunities like this matter enormously: they give resident doctors a platform to share their ideas, build confidence, and engage with the wider medical community in a meaningful way.

That was certainly evident in our winner of the best presentation award, Dr Stefan Sepamalai, who is currently a foundation doctor.

Stefan shared that he 'thoroughly enjoyed participating in the Med26 abstract competition, where the high standard of presentations and diverse research were truly inspiring. The conference offered a welcoming yet intellectually stimulating environment, with excellent opportunities for discussion, networking, and learning. Winning was an unexpected honour and a significant confidence boost, making the recognition especially rewarding.'

'I would highly encourage other resident doctors to take part, as it's a great platform to showcase work, develop skills and connect with peers.'

Congratulations to Stefan and all our other winners and runners up, who you can find on the Medicine 2026 platform alongside our virtual exhibition that showcases all of our participants' posters. Don't forget to take a look at the conference photos too!

Looking ahead, the next opportunity to submit an abstract and share your work will be in the Med+ 2026 abstract competition. Submissions open this summer, with the competition concluding at the RCP's largest specialty conference, Med+ 2026, taking place on 23–24 November 2026 at the RCP at Regent's Park and online.

Medicine 2026 may be over, but the learning doesn't stop

Across 2 days of expert-led sessions, Medicine 2026 brought together leading voices to explore the biggest challenges and opportunities in modern healthcare, from the rapid evolution of AI to the realities of delivering care in communities.

If you couldn't make every session live, want to revisit the insights that matter most to your day-to-day practice or buy an online pass now, Medicine 2026 content is still open to access. On-demand access is available until September, keeping you connected to the conversations shaping the future of medicine.

Access, pause, replay whenever it suits you. Secure your online ticket today.

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Adopt a treasure: early impact and inspiring stories from our supporters

Earlier this year the RCP launched 'Adopt a treasure', a campaign inviting members, fellows and friends of the RCP to play a direct role in preserving the extraordinary history of medicine held within the college's collections.

We are delighted to share that the first iteration of the campaign has already raised just over £10,500, with eight items adopted for conservation by 10 generous supporters. Thanks to our first 'Adopt a treasure' supporters, conservation work is now well underway, ensuring that some of the RCP's most fragile and significant artefacts can be preserved for future generations.

A personal connection to medical history

One of the most powerful aspects of Adopt a treasure is the personal connection that it creates between supporters and the history of medicine.

Professor Diana Walford CBE FRCP, chair of the Board of Trustees at the RCP, chose to adopt Anatomia del Corpo Humano, a richly illustrated anatomical text. Her decision was inspired by a lifelong fascination with medical imagery:

> 'I decided at a ridiculously early age to study medicine because my beloved grandfather, who was a GP, and my favourite uncle, his son, who was studying surgery, kept a stash of old medical and surgical textbooks in the attic of their house. I spent hours and hours looking at the anatomical and other pictures, which were pretty gruesome and which I found quite fascinating. That's why I decided to adopt Anatomia del Corpo Humano, and it also chimes with the fact that I am currently learning Italian!'

Professor Diana Wood FRCP, emerita clinical dean at the University of Cambridge School of Medicine, adopted *The Quack Doctor* print because of her great fondness of the artist's work:

> 'I love the work of Thomas Rowlandson, who was one of Britain's greatest satirists. To this day, his comic art is instantly recognisable and remains extremely funny. In his extraordinary caricatures he lampoons all Georgian life, from the royal family to politicians, the military, and the professions and wider society. Inevitably we came under his scrutiny, and *The Quack Doctor* is a great example of his work. It is always good for us to see ourselves as others see us at whatever point in history!

Dr Timothy Chambers OBE FRCP chose to adopt two prints depicting leprosy cases treated by Dr Bhau Dajee, an Indian physician in the 19th century, because of his connection to the Military and Hospitaller Order of St Lazarus of Jerusalem, which has always supported, and continues to support, all aspects of leprosy care – clinical, pastoral and research. Timothy also wanted to recognise the RCP and its officers for their support during his career:

> 'Many years ago, when serving as a college officer, I was proud to serve a long-established institution, well respected as a learned body of scholarship. Adopting a treasure is a way of repaying that privilege and thanking the senior officers who taught me so much.'

The granddaughters of Dr Una Ledingham FRCP, Dr Joanna Ledingham, Catherine Marsh, Clare Bowron and Sarah Ledingham, chose to adopt her portrait:

> 'Una's portrait hung in the dining room as we grew up and was a source of great pride and inspiration. It was the wish of our father, Professor John Gerard Garvin Ledingham, that it be donated to the RCP on his death in honour of his mother, of whom he was immensely proud. His four daughters have been delighted to cover the restoration costs allowing the portrait to be exhibited and to inspire, we hope, future generations of female physicians (including Una's own granddaughter Joanna and great-granddaughter Maddie). We are so pleased that it is in such good hands.'

Stories like this reflect the unique way in which the campaign connects personal journeys in medicine with objects that have shaped the profession over centuries. This is an issue of social injustice; many members of our society are disproportionately affected. We need to invest more and take action, because these vulnerable groups carry the greatest burden.

From fragile objects to lasting legacy

Each adopted item represents not just a piece of history, but a commitment to its future. Conservation specialists like Plowden & Smith are now working to stabilise and restore the adopted treasures, such as the Alexander Fleming sculpture that was sitting on a badly damaged base. A new base is being created and the bronze bust will get a gentle clean and wax to get it in the best condition, to be put back on display at the RCP.

This work ensures that these objects remain accessible for research, learning and public display, continuing to inform and inspire physicians, historians and the wider public.

Building a more inclusive medical story

Alongside preserving historic collections, 'Adopt a treasure' also supports the RCP's wider ambition to ensure that the story of medicine is more inclusive and representative. Future adoptions will continue to support both conservation and the commissioning of new works that reflect the contributions of women, migrant doctors and other historically underrepresented figures in medicine, ensuring that the RCP's collections evolve alongside the profession itself.

An invitation to be part of the story

The early success of the campaign demonstrates the strong connection that RCP members and supporters feel to the RCP's heritage, and the importance of preserving it. With many more treasures still in need of care, there are further opportunities to get involved and to support the conservation of objects that have shaped the history of medicine.The Tobacco and Vapes Act will introduce other measures such as retail licensing to reduce tobacco availability and regulating other nicotine-containing products such as nicotine pouches, vapes, oral tobacco or heated tobacco products.

Explore the collection and find out how to adopt a treasure.

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From recognition to progression: strengthening SAS careers through specialist roles

Specialist, associate specialist and specialty (SAS) doctors are an essential part of today's medical workforce, yet their roles, career pathways and senior potential are still inconsistently understood. By bringing together the perspectives of four specialist doctors, and exploring the value that they bring to services, we hope to shed light on what these specialist roles look like in practice – and how doctors and employers can enable progression into these posts.

Their reflections align closely with the new RCP SAS priorities 2026–30, which were launched in April. This emphasises recognition, development and leadership for SAS doctors. Initiatives such as the newly established SAS forums further underline a renewed commitment to visibility, engagement and a collective voice within the RCP and across the profession.

Dr Naeem Aziz FRCP

SAS lead and Council member, associate specialist, SAS advocate and clinical director at Aneurin Bevan University Health Board, and clinical director and strategic workforce planning lead for Powys Teaching Health Board.

For many doctors, the specialist SAS role remains misunderstood. As an associate specialist who is now also a clinical director, Naeem explains, 'The rules are there. They have always been there. What we lack is not regulation, but understanding and the confidence to use what already exists.'

Having trained overseas and worked at consultant-equivalent level before joining the NHS, Naeem chose a permanent SAS route rather than entering UK training. Over 2 decades in the same organisation, his role has evolved in line with experience and service need. 'There is no upper end to scope of practice,' he says, 'It depends on what a doctor can safely do and what the service needs.'

Now with responsibility spanning multiple hospitals, he brings a dual perspective as both a senior leader and an SAS doctor. He challenges the way that scope of practice is often discussed, warning that it can unintentionally reinforce bias. 'It is talked about as if it is specific to SAS doctors,' he notes, 'but I define scope of practice for consultants as well. It applies to everyone according to their skill set. Scope of practice is defined, not restricted.'

From an employer's perspective, Naeem believes that workforce planning should begin with a simple question: what does the service need?

Where the requirement is senior, autonomous clinical care focused on service delivery, he believes that specialist roles are often the most effective solution. 'Specialist job plans focus on direct clinical care,' he explains, 'They help retain experienced doctors, reduce reliance on locally employed doctors (LEDs), especially locum consultants and improve continuity. At the end of the day, it is about quality of care.'

For specialty doctors aspiring to progress, his advice is direct: 'Clinical knowledge alone is not enough. You must be proactive, because you are outside a formal training structure.'

Leadership skills matter too. 'Communication, confidence, adaptability and leadership are what make the difference when employers consider you for senior roles.'

Reflecting on his journey, he describes himself as a 'living example' of what is possible within the SAS framework, observing that the pathway already exists. What is needed now is consistent understanding and the confidence to use it well.

Dr Helen Bonwick OBE FRCP

Associate specialist in palliative medicine at Marie Curie Hospice Liverpool and Liverpool Heart and Chest Hospital, and past RCP SAS representative for the Mersey region.

Helen is an associate specialist in palliative medicine, with senior clinical and leadership responsibilities. Reflecting on more than 2 decades in the specialty, she describes building a career through sustained experience at a time when palliative medicine was not yet formally recognised. When structured training routes emerged, she deliberately chose not to pursue them, finding that the SAS role offered 'a better way of maintaining my work–life balance' while allowing her to focus on teaching and service development.

That choice, she notes, is still often misunderstood. She is clear that senior SAS and specialist doctors are not working at a lower level than consultants. 'In a specialist role, I can really do everything a consultant does,' she says – but she often needs to remind people of that. Remaining in a single organisation over time allowed her

to build credibility, institutional knowledge and trusted relationships. 'That is the experience you can't replicate,' she reflects.

She argues that specialist SAS roles should be seen not as exceptional, but as a strategic approach to retaining highly experienced clinicians. Progression, she suggests, often formalises work already being done, 'you are effectively already working at that level.' Clear routes into specialist roles can be highly motivating, strengthening long-term commitment to a service.

Despite this, understanding and support for specialist roles vary considerably. Access to leadership and educational opportunities, she explains, is often shaped by local interpretation rather than national frameworks: 'the barrier is always at the coalface,' she observes.

Leadership development, when it does happen, is frequently enabled by individual sponsorship. Being actively invited onto senior leadership programmes alongside consultants was a turning point, signalling that she was 'just as legitimate' in those spaces. It is why she has committed to supporting the current SAS leadership programme at the RCP.

Her advice to SAS doctors is pragmatic. Evidence should be gathered early, progression treated as a genuine career pathway, and support actively sought. She advises: 'You should look for mentors and sponsors, people who will say your name in a room full of opportunities.'

For her, the case for specialist SAS roles is ultimately one of fairness, sustainability and service continuity.

Dr Emily Millen

Specialist haematologist and co-director of Nottingham Haemophilia CCC (Comprehensive Care Centre), Nottingham University Hospitals NHS Trust.

For Emily, the decision to leave formal training was not taken lightly. Having trained in haematology and passed her first round of specialty exams, she reached a crossroads after a prolonged period of ill health that forced her to reassess what she could realistically sustain. 'At the time, it felt like one of the hardest decisions I had ever made,' she recalls, 'it felt like failure, because you get on this career train and you are not supposed to get off until you reach consultant.'

With hindsight, her perspective has shifted completely. Now more than 5 years into a substantive specialist role, she describes it as 'the best decision I've ever made.' The flexibility of the specialist pathway has allowed her to shape a post around areas she enjoys most, creating her 'perfect combination of subspecialties'; something that she feels would not have been possible through the traditional consultant route.

In her department, parity with consultant colleagues is the norm. Her clinics, patients and leadership responsibilities mirror those of consultants; she has full autonomy, equal access to CPD, job planning and leadership opportunities. However, she recognises that this experience is not universal. 'There is still that assumption that you go into a SAS role because you've failed in some way,' she says, noting that these perceptions can affect confidence even where structural barriers are absent.

One of the most valuable pieces of advice she shares came from an associate specialist early in her career: know your worth and choose your environment carefully. 'As a specialist doctor, you need to know that the place you work really respects your true value.'

Without that respect, even well-designed roles can become frustrating.

Her practical advice is simple. Make your interests known, build visibility within your specialty, and engage in projects, networks and publications. Above all, she emphasises that the specialist route should be recognised as what it is: not a fallback, but a positive and sustainable career choice that supports both professional fulfilment and life beyond work.

Dr Vineet Pant FRCP

Specialist in nuclear medicine at NHS University Hospitals of Liverpool Group, RCP SAS regional representative for Mersey.

For Vineet, a specialist in nuclear medicine with 18 years of experience as a doctor, the route into a specialist post was not widely understood. When he joined the NHS only 4 years ago, he progressed to a specialist role within 2 years. 'It is a difficult path,' he reflects, 'but it is not an impossible one.'

Now working at a major teaching hospital, he describes moving into the specialist role as a natural progression of capability rather than a change in practice. 'I was already doing the work independently,' he explains, 'so, the question was, why not move into a role that recognises that level of responsibility?'

His progression was not through a clearly defined or advertised pathway. Instead, it came through curiosity and collaboration. Alongside a supportive clinical lead, he explored available options and identified the specialist grade as the most appropriate route. 'People are still not very aware of the specialist role, even within organisations, there is a lack of understanding.'

This lack of awareness was the most significant barrier. Despite clear national criteria, navigating the process required persistence, repeated conversations and external guidance. 'For 3 or 4 months, nobody knew how to move it forward,' he explains, 'you are often told to speak to someone else.' Getting local support from your own department helps, 'for me, my clinical lead provided valuable support, then the RCP and BMA clarified the pathway.'

For Vineet, the specialist role offers autonomy, recognition and the opportunity to contribute more fully to service delivery. However, he emphasises that progression into leadership roles requires active engagement.

'Nobody will give you these roles, you must step forward and take responsibility … After getting specialist grade, I was positively motivated and was able to obtain prestigious RCP fellowship, furthering my opportunities.'

He offers practical advice to others; first, develop leadership behaviours early and actively seek opportunities rather than waiting to be asked. 'If something needs doing, offer to do it,' he suggests. Second, prepare evidence for the specialist role carefully and present it in a clear, structured way. 'The person reviewing your application should be able to see everything in one glance,' he advises. Third, use feedback constructively and build relationships with those who can support your progression.

Reflecting on his journey, he highlights the importance of external perspective. The RCP SAS leadership programme has been invaluable in building his confidence; 'engaging with organisations such as the RCP can provide impartial guidance and reassurance'. Ultimately, his message is one of confidence and proactivity. For those willing to seek out opportunities and demonstrate their capability, the specialist pathway is both achievable and rewarding, he says. 'As an RCP SAS doctor representative for the Mersey region, I now want to help others in achieving their goals towards specialist grade.'

Bringing value to healthcare

Specialist SAS roles are essential to a sustainable, high-quality medical workforce and that progression depends on both individual development and informed organisational leadership, and the perspectives of these physicians shows that clearly. The RCP's SAS priorities 2026–30 set out a clear commitment to recognition, progression and leadership for SAS doctors, supported by practical initiatives such as the RCP SAS leadership programme, which equips SAS doctors to step confidently into senior clinical and strategic roles.

Your collective experience

Hear more personal stories like these and celebrate the SAS role at our upcoming SAS forums. These informal online meetings are designed to offer a platform for discussion and a space to share best practice and offer guidance to your SAS peers. All are welcome.

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Viewing Medicine 2026 conference through the lens of improvement

Dr Aklak Choudhury, clinical director for RCP Improvement, is a respiratory physician and medical director for improvement, innovation and research at University Hospitals of Derby and Burton NHS Foundation Trust. He reflects on some of the sessions that he attended at our recent RCP Medicine 2026 conference, and on the opportunities that they highlight for improvement work.

I had the opportunity to attend many excellent sessions at Medicine 2026, and wanted to reflect on some of them through the lens of meaningful quality improvement. What follows is my attempt to tease out the improvement opportunities presented by three of those sessions and share them with you.

Analogue to digital – AI in NHS healthcare

A thought-provoking opening session explored the role of artificial intelligence (AI) in the NHS and was chaired by the RCP's digital health clinical lead, Dr Anne Kinderlerer.

Professor Alastair Denniston, chair of the UK National Commission on the Regulation of AI in Healthcare, challenged us to make informed decisions grounded in evidence that should not be driven by 'imagination', 'extrapolation' or 'desperation'. I'll openly admit that AI still occasionally brings back memories of the ominous Skynet taking over the world in the Terminator films, from nearly 40 years ago!

Alastair described a particularly powerful concept; the 'value intersect' for AI in the NHS, a Venn diagram focusing on:

- What do we need AI for?
- What is AI good for?
- What are we ready for?

The overlap between these areas for the NHS is currently small, but is expected to expand rapidly in the coming years.

Understandably, AI is seen increasingly as a solution to complex NHS challenges, but we are not there yet. Key areas still requiring significant work include how AI is regulated, organisational readiness for AI, digital infrastructure, EPR (electronic patient record) integration, data privacy and how we tackle the minefield of clinical liability.

There is also a real risk of becoming overly solution focused, where AI is seen as the default answer to every problem – potentially leading to poorly judged, top-down digital implementations. Physicians have a crucial leadership role in ensuring that AI is introduced safely, appropriately and meaningfully within our departments.

For successful AI adoption in clinical areas, we should follow a grounded improvement approach. This starts with defining and understanding the local problem, before even considering whether AI has a role. Then we can co-design what good looks like, with the wider multidisciplinary team (MDT) – using iterative testing of AI/digital solutions to deliver in real clinical environments and ensuring a clear plan for sustainability. All this must be underpinned by robust governance and regulation.

We ran a recent RCP Improvement workshop to explore how physicians can better navigate these improvement steps – and what their role is in supporting meaningful improvement that impacts on patients' experience. Read our *RCP view on digital and AI* to find out more about this fast-developing area.

Hospital to community – neighbourhood health in focus

On to day two, which was an eye-opener for both challenges and opportunities for neighbourhood health. The session was chaired and facilitated by Dr Hilary Williams, RCP clinical vice president.

Dr Nicholas Hicks set the scene with the National Neighbourhood Implementation Programme definition of neighbourhood health: 'At its heart, neighbourhood health is about bringing care closer to where people live, strengthening prevention, and making sure services are joined up across the NHS, local government, social care and the voluntary sector.'

He discussed the *Fit for the Future: 10 Year Health Plan* for England, outlining as expected the three 'left shifts' – from hospital to community, from sickness to prevention and from analogue to digital. He also highlighted two broader themes running through the plan: a 'shift to value' and the 'devolution of power'. Together, these may prove to be the key enablers for neighbourhood health, giving communities permission to innovate around the problems that matter most to them.

Dr Emma Rowlandson, an acute physician at West Middlesex University Hospital with an interest in integrated care, shared a compelling example of how

specialty MDTs can reduce the burden of traditional outpatient appointments. Her experience working at the interface of acute and community care has been effective, but also enjoyable. She encourages more physicians to get involved.

Dr Elizabeth Macphie, consultant rheumatologist at Lancashire and South Cumbria NHS Foundation Trust, shared how rheumatology services have embraced neighbourhood health; from community-based diagnostics and infusion suites to virtual specialist MDTs and their work in developing a shared care record. Her work highlighted how specialist care can be delivered safely and effectively outside hospital walls.

The conversation about neighbourhood health did not end there. We gathered with the speakers in the Osler Room to reflect on how neighbourhood health could reshape physician practice for the better. Ideas ranged from immediate practical steps – such as building a repository of physician-supported neighbourhood health initiatives on the RCP website – to more ambitious proposals, including a joint royal college breakthrough improvement collaborative.

Read the *RCP view on neighbourhood health: planned specialist care* to learn more about how physicians are delivering care closer to home.

Modern acute medicine: prevention, innovations and better decisions

Our acute medicine closing session for the conference was chaired by Dr Ben Chadwick, RCP deputy registrar.

An AI-generated image of a 'patient conveyor belt' lingered in my mind. In our drive to streamline pathways and eliminate waste, we have lost the person-centred care (and value) that we once intended. Most of us have experienced this first-hand; lots of investigations, but very little conversation with our patients about what they want. When we describe waste in improvement work, we often draw on Ohno's eight wastes. Below are some examples of how the pursuit of efficiency can inadvertently create waste along the patient journey.

- **The 'just-in-case' bloods taken on arrival in the emergency department, before a patient history has even been taken:** 'Let's do a D-dimer now, it'll save time later.' This is classic overproduction on the waste wheel.
- **Early assignment into diagnostic boxes to move patients quickly to the perceived 'right' area:** 'They'll work out what's wrong with you once you get there'. This leads to overprocessing, unnecessary motion, transport and underutilised staff resources.
- **Multiple specialty inputs with no single care plan, no ownership and no coherent narrative:** An example again of underutilised staff resources, motion and overprocessing.

Being an RCP member and fellow changed my vision of my profession; I continue to look at medicine as a mission. So many of the ideas, innovative thinking and the solid foundation to move forward were inspired by the RCP. This milestone in my career would not have seen the light without the continuous support of my beloved college.

We deeply appreciate all supporters and organisers of this unique, one-of-a-kind multisectoral body in the region, honouring the new generation of health professionals for their resilience, precision, dedication and tireless contributions.

I would like to thank all the women who came from their countries to present as health workers and physicians; the Arab world is moving on towards having women as active partners in healthcare.

Do we need a 'pause moment' in medicine?

Dr Vicky Anne Price, consultant in acute medicine at Liverpool University Hospitals NHS Foundation Trust, spoke about her experience of recognising end of life in the acute medical setting. She described the importance (and courage) to care differently. In 2023, 6.2% of all deaths in England had three or more emergency admissions in the last 90 days of life. Yet the conveyor belt rarely pauses long enough for us to recognise and intervene.

Where in our acute care pathways do we pause to ask:

- Is this person approaching the end of life?
- What matters most to them right now?
- Where and how would they prefer to spend the last few months ahead?

These conversations about uncertain recovery and patient choice are essential. Without them, patients are swept along a system designed for diagnosis, acute management and escalation – not for reflection or person-centred decision making.

We need to create a space to 'step off the conveyor belt' and build 'pause moments'. These are structured opportunities to slow down (or stop) the process, look at the person in front of us, and offer them the chance to be cared for differently.

RCP Improvement has been working on acute management of end-of-life care, emphasising earlier recognition, better communication and truly person-centred MDT planning. We will share some of the outcomes of this work, so we can add value where it matters for people coming towards the end of their lives.

Taking away a lesson

Looking back on Medicine 2026, what stays with me is not a single innovation or headline, but a shared challenge: to think differently about how we improve care. Whether the focus is AI, neighbourhood health or acute medicine, the opportunity is the same – to start with the real problem, work alongside patients and colleagues, and make changes that add value where it matters most.

If we can hold on to that improvement lens, then physicians have a vital role in shaping services that are not only more efficient, but also more considered, connected and person centred.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images.

A growing challenge: end-of-life care in acute hospitals

In February, the RCP hosted a roundtable on how to improve end-of-life care in acute hospitals, bringing together over 40 physicians from a variety of specialties.

Acute hospital admissions are common towards the end of life. In 2025, 290,000 patients admitted to acute medical settings died during, or within 30 days of, admission, while data from 2024 show that over 68% of people who died experienced at least one emergency admission in their last 3 months.

There is growing concern about the quality of end-of-life care in acute care settings as the use of temporary care environments increases, palliative care capacity is stretched and hospice funding is under strain.

For many patients approaching the end of life, acute hospital admissions are unavoidable. Hospitals must therefore be prepared to deliver good quality end-of-life care, in safe settings that are prepared to deliver that care.

Roundtable

The discussions focused on what defines 'good quality' end-of-life care, and the barriers that prevent it from being delivered. Participants identified priority issues and practical recommendations, which will shape future RCP policy and work.

Physicians from specialties including palliative medicine, acute medicine and geriatrics listened to short talks from experts, including:

- **Professor Paul Paes,** vice president of the Association for Palliative Medicine
- **Dr Vicky Price**, president of the Society for Acute Medicine
- **Dr Louise Robinson** and **Dr Antonia Field-Smith,** palliative care consultants and authors of the RCP Uncertain recovery guide
- **Professor Jugdeep Dhesi,** consultant geriatrician in a perioperative medicine for older people undergoing surgery (POPS) service and president of the British Geriatrics Society
- **Dr Zuzanna Sawicka**, RCP clinical director for patient safety and clinical standards.

Breakout sessions focused on key barriers such as a lack of space or planning, to a cultural reluctance to have clear conversations with patients.

Participants felt that the RCP had an important role to play in creating and influencing training, standards and policy on end-of-life care that was consistent across specialties.

Dr Hilary Williams, clinical vice president and roundtable participant:

> 'We met as 40 expert physicians from Northumberland to Brighton, from Derby and Wales. We heard from cardiologists, hepatologists, oncologists, acute medics and resident doctors all really committed to getting care right for people towards the end of life. Everyday we encounter people in the last stages of life and recognising when recovery is uncertain, when dying is approaching really matters. Despite an incredible range of medical innovations sometimes we have to step back from the noise. The most valuable thing we can do is stand still and care.'

What does 'good' look like?

'Death is inevitable, but dying badly, without dignity or preferences respected, should never be acceptable,' writes Dr Kathryn Mannix in her recent *FHJ* editorial.

The roundtable discussed what it means to provide good quality end-of-life care in acute hospitals. Deaths in hospitals are inevitable; while advanced care planning and community-based care reduce it, 43% of the 650,000 UK annual deaths occur in hospitals.

The participants identified areas of good practice:

- **Honest and timely conversations:** Earlier conversations mean that patients and families can be prepared, express preferences and create clear plans about their treatment.
- **Individualised planning:** End-of-life care is a very personal experience. Patients and families should be included in planning – which may deviate from protocol.
- **Joined-up care:** Different specialties must work together, sharing clear information to ease the experience of end-of-life patients.
- **Good settings:** Patients should have access to single rooms; they should not be dying on wards or in temporary care settings.
- **Good staffing levels:** There should be consistent provision of care, including specialist palliative care.

Uncertain recovery

The roundtable explored the 'uncertain recovery' framework which should be adopted by all specialties. Speaking early about uncertain recovery can be a more honest approach which is less threatening for patients and families.

This approach can happen earlier in treatment than an end-of-life discussion and enables parallel planning; hoping for recovery and continuing treatment, while acknowledging risk of death. It gives patients more time to have gentle, iterative conversations about end-of-life plans. It also takes the pressure off physicians, who may feel like having one 'end-of-life discussion' is final and indicates giving up treatment.

You can read more about this approach in the RCP's Uncertain recovery communication guide.

The barriers to 'good'

The roundtable participants discussed the system pressures preventing good-quality end-of-life care in hospitals; temporary care environments and ongoing workforce pressures add strain for all specialties, making it particularly hard to have sensitive end-of-life discussions.

The NHS 'flow culture', with patients moving through the system as quickly as possible, is often antithetical to gentle end-of-life care. Many NHS metrics equate mortality with failure, which can discourage realistic decisions; the things that matter to patients approaching the end of their life are rarely measured in metrics.

To tackle this, the roundtable called for end-of-life care to be included earlier in training and a wider cultural reframing of death. Other steps could include universal treatment escalation plan (TEP) adoption, improved national metrics and recognising advanced care planning as clinical activity.

Alongside this, there are cultural habits and missed opportunities which make it harder to provide good end-of-life care in hospitals. Many doctors outside of palliative care lack confidence in dealing with dying, but good end-of-life care is an approach which all specialties can use. Clinicians can feel like they are 'giving up' by initiating an end-of-life conversation; recognising mortality can be incredibly difficult. Physicians worry about causing distress or giving bad news too early, and every patient is different and end-of-life care often closely involves family, and personal or religious beliefs.

Non-palliative specialities are often better placed to start end-of-life discussions; oncologists, acute physicians or anyone managing a chronic progressive condition can identify uncertain recovery. Delaying that conversation is a missed opportunity that can cause more long-term distress.

End-of-life patients with multiple health conditions can become lost between teams, receive futile but distressing treatments or end up in 'referral ping-pong' in their last few months if there are not joined-up services and shared information, including a clear end-of-life plan.

Palliative care funding and staffing vary across trusts, so other physicians not dealing with death can create geographical inequalities in end-of-life care, particularly prevalent in economically deprived areas.

The roundtable agreed that death is the responsibility of all physicians; accessible advanced care plans for end-of-life patients, and good cross-specialty end-of-life education and support is essential. It also suggested creating cross-specialty guidance and scripts, particularly around patient's cultural or religious considerations, could be a useful tool for physicians.

Next steps

Professor Ollie Minton, *Commentary* clinical editor and roundtable participant, stated:

> 'We know all our services are dependent on established relationships and referral systems which further risk being disrupted in a stretched system. The data presented at the roundtable illustrates how little progress has been made over many years. We know cancer treatment is constantly improving – however, we need to ensure that palliative care and associated supportive services are still introduced in a timely manner and funded to ensure a good death. That is also paramount within the new cancer plan.'

The findings from the roundtable have been submitted to inform the planned new MSF for palliative care which is due to release in autumn 2026. The RCP will continue to work to support physicians in this area, including talking to key stakeholders about how the role of acute hospitals is better acknowledged and understood.

If you have experiences of working in this area, you can contact comms@rcp.ac.uk. We also ask doctors working in acute settings to participate in the CURVE study to help improve communication about uncertain recovery by filling in a 10–15-minute anonymous survey by the University of Cambridge.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images.

Approaching the end: palliative care in *Future Healthcare Journal*

Dr Kathryn Mannix, author, physician and campaigner, shares her experience of putting together an edition of *Future Healthcare Journal* focused on palliative care.

It is an unusual honour to be invited to guest edit an academic journal, certainly when you're not an academic. I had a brief incarnation as an oncology research fellow in the 1980s, but I found that I was more drawn to finding the solution to individual patients' symptom problems than to waking them to draw their blood at midnight. When, after 9 months of painstakingly centrifuging and freezing those midnight samples, the whole lot defrosted over a weekend when the ward housekeeper unplugged the freezer to plug in her floor polisher, the writing on the wall was as clear as the water on the floor.

While I'm making confessions, I should add that I have now been out of clinical practice for 10 years. Yes, it's a whole decade since I attended a ward consult, conversed with an outpatient or led a ward round. So why on earth did the editorial team of our own college's *Future Healthcare Journal* invite me to be a guest editor?

Well, I think it may be because I took early retirement to attempt an odd experiment. As a palliative physician working in hospital, community and hospice settings, I was acutely aware of how unprepared people are – the people who are our patients – for any discussion of their mortal state in general, or of their approaching death in particular. This difficulty consistently wrong-foots clinicians who attempt to broach those important topics, and it reinforces the disinclination to 'go there' of clinicians who are death avoidant. I wanted to do something – but what? – about public understanding of dying.

By a series of unexpected coincidences my campaign took off, initially because I was invited to speak about dying on national radio, a broadcast that was heard by a literary agent. He approached me to ask whether I might be interested in writing a book, *With the end in mind*. The book of end-of-life stories that I wrote (and the contract he negotiated for me) made that book an international bestseller. That's quite a journey from the chaotic puddle of my defrosted research. Being a credible witness about the process of dying from nearly 30 years as a palliative physician has generated myriad other opportunities to speak, write and broadcast on that topic across the UK and around the world. Most of all, it has generated a fascinating postbag, an enormous conversation with the public, and those communications have shown me what people want to know. Their messages have three clear topics.

The first is how freeing and helpful it is to be told, in some detail, what the process of dying looks and sounds like. This deconstruction of the process allows dying people to be less fearful of a much-feared yet unlikely soap opera-style death involving suffering or sudden collapse, and it allows already bereaved people – or those currently accompanying a person during the latter stages of dying – to interpret the changes in energy, awareness, breathing, muscle tone, skin colour etc that are otherwise misinterpreted as terror, suffering or choking. Explaining that dying, like giving birth, is a bodily process with recognisable phases and stages helps them to track its progression, reassure themselves that what they see is 'normal', and place themselves along its timeline. Information is consoling.

The second is correspondents' perplexity at approaching conversations about dying, death, wishes for care, boundaries for interventions, and other important matters pertaining to the care of a family member or friend, or of their own wishes, at the end of life. 'How do I begin?' 'What if they get upset?' 'What if I get in trouble for raising it?' 'Perhaps this is someone else's job?' 'I don't know where to start.' What has become abundantly clear, also, is that healthcare professionals feel that same perplexity, and they ask me exactly the same questions.

Medical perplexity, I think, explains the third topic.

Countless people have told me that when their beloved person was dying, the clinicians gave them medical information, perhaps in lay language: abnormal heart rate, struggling kidneys, under-performing liver, low blood pressure, overwhelming infection, along with explanations of the measures being taken to address these physiological challenges. 'Why didn't anyone tell me that s/he could die?' they demand: the third, and practice-challenging, topic. Somehow, these anxious and non-medical visitors did not interpret the morbid information they were being given as 'sick enough to die'. We know that this is not good enough. At that point in a patient's illness, the possibility or likelihood of dying might be the most important information to communicate.

And so, I've come full circle.

After 10 years of telling death stories to the public, to discover that, far from being taboo, talk of death intrigues almost everyone provided we can speak of it calmly and with insight, I am turning back to my healthcare colleagues. There has been a mass forgetting about the process of dying, affecting both the people we serve and the profession we belong to.

Regardless of specialty, it is time to reclaim that knowledge, to refamiliarise ourselves with dying: understanding, describing, recognising and supporting that process, and stepping up to demystify it for the patients and their companions who are preparing for it. These are skills we must work to acquire, polish and preserve by regular use and reflection, just like so many other medical skills. Palliative care specialists may supplement the care you provide, but dying remains every physician's business.

This, then, is why I was invited to choose topics and commission articles for an 'end of life' themed issue of *FHJ*. I hope that the journal we have curated will enlighten, entertain and provoke. Topics range from a brilliantly illustrated comic of CPD updates in palliative care to an exploration of the potential use of AI for prognostication; a review of the 'state of the art' from palliative care's early beginnings in the modern hospice movement to an established medical specialty that is under significant threat from inequitable commissioning; another paper asks how palliative care might look by 2050 – if it survives. There are insights from the sharp end: experts in emergency, palliative and intensive care medicine regularly meet people experiencing anticipatable crises who had no idea that their medical condition was progressive or life-limiting. Three such experts make a plea to colleagues in all specialties to step up to anticipatory care planning (ACP) conversations – in fact, our debate asks whether failure to offer ACP should be a 'never event.'

We have moved the dial on discussions of assisted dying (AD) by offering a thought-provoking, nuanced and calm exploration between an Australian and a British palliative physician of the impact of legalisation of AD in New South Wales on patients, families, staff and the system itself, as the journal's first video article. Another paper examines how best to offer patient-centred and joined-up health and care services across community and inpatient settings as an individual's health deteriorates and their needs change: geriatrics is leading the way.

Meanwhile, recognising the impact on ourselves when we work with patients reaching the end of life is also important: an experienced occupational psychologist offers some challenge, some wisdom and some consolation. There is a paper about how to talk about dying, of course. Most important, in my opinion, is a paper written by a patient: a young man with motor neurone disease, who communicates (and wrote his article) using eye-gaze technology, writes of the importance of understanding what it is like to be the patient, a judgement that only a patient can make and an insight that we can only attain by listening.

It is uplifting and humbling: like every day in medicine.

Read this edition of Future Healthcare Journal.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images.

Why cardiometabolic disease prevention matters to every physician

The RCP is hosting a series of cardiometabolic disease prevention summits to explore how doctors and healthcare teams can better prevent one of the UK's leading causes of illness, premature death and health inequality.

Disclaimer: *Boehringer Ingelheim Ireland Ltd has provided funding for this independent programme. Boehringer Ingelheim Ireland Ltd has had no editorial involvement in, or influence over, the agenda, meeting content, or selection of speakers. Lilly has provided sponsorship funding to support these summits and has had no influence over their content or the selection of speakers.*

Across the NHS, physicians are increasingly caring for patients with complex, overlapping conditions. Multiple health conditions are now commonplace, with cardiovascular, renal and metabolic disease often clustering together and amplifying risk over time. Patients move between services and specialties, frequently receiving high-quality care for individual conditions, but rarely experiencing that care as joined-up or preventive. For clinicians, this can be frustrating; responding to immediate problems while knowing that future illness is already beginning to take shape. All too often, missed chances to avoid the first clinical manifestation of cardiometabolic disease in patients are followed by progression to multisystem complications that lead to disability and premature mortality.

Professor Andrew Krentz, cardiometabolic prevention summit co-lead, said:

> 'Prevention should ideally begin with primordial prevention, which aims to avoid the emergence of cardiometabolic risk factors.'

Cardiometabolic disease sits at the centre of this challenge. Its impact on individuals, services and communities is profound, yet much of it is preventable. Tackling it effectively means rethinking prevention, not as a one-off intervention or the responsibility of a single specialty, but as something that cuts across almost every area of medicine.

The cardiometabolic prevention summits were established in response to this challenge. They bring together physicians from across specialties, primary care colleagues, allied professionals, system leaders and patients to explore how prevention can work better in everyday practice. The programme aligns with the direction of travel set out in the NHS Long Term Plan, supporting a shift away from reactive care, stronger integration around the person and greater emphasis on prevention at scale.

Rather than promoting a single model or solution, the summits were designed as a space for shared learning and open discussion, grounded in real clinical experience. Across the first two summits, conversations have ranged from the drivers of cardiometabolic disease to examples of services already working differently, and more effectively, in parts of the country.

Patient voices have been central throughout. Their experiences of navigating fragmented care have highlighted both the limitations of current systems and the difference that coordinated, person-centred approaches can make.

The aim of the summits has not been to produce a blueprint, but to draw out principles that can be adapted across specialties, settings and local contexts.

Atoshi George, patient speaker, said:

> 'It feels like each part of my care works separately, and you feel like you're the one who's supposed to be the expert.'

Working our way out of silos

A recurring theme has been that traditional, siloed models of care no longer reflect clinical reality. Cardiometabolic disease develops over many years, influenced by biological, social and environmental factors, and often affects multiple organ systems simultaneously. Yet care pathways remain largely organised around single conditions and short-term episodes.

This fragmentation leads to missed opportunities for early intervention, unnecessary duplication and uneven outcomes, particularly for people living in deprived communities and for those whose risk is consistently under-recognised. Prevention cannot sit with cardiology or primary care alone. It depends on a whole-system approach which enables clinicians in different settings to identify risk earlier, act with confidence and work more effectively together.

Speakers and case studies showed how multidisciplinary approaches, often involving pharmacists, nurses and allied professionals alongside physicians, can make a real difference. By addressing multiple risk factors together and clarifying responsibility for follow-up, teams have improved medicines optimisation, reduced duplication and helped patients better understand and manage their own risk. For physicians, this reinforces the value of collaboration and

generalist thinking, even within highly specialised roles.

Professor Indranil Dasgupta, consultant nephrologist, Heartlands Hospital, Birmingham, said:

> 'I sometimes use the ancient Indian fable of the six blind men and the elephant: we specialists working in silos are dealing with different parts of the same beast: cardiovascular, renal, metabolic disease. We need to move from working in silo to a holistic approach.'

Looking for cardiometabolic disease in unexpected places

Another strong strand of discussion focused on the importance of a lifecourse approach to cardiometabolic prevention, particularly for women. Events such as pregnancy complications, gestational diabetes and menopause are well-recognised predictors of future cardiometabolic risk, yet are often overlooked once immediate care has ended.

The summits highlighted how physicians across specialties encounter these moments, sometimes unexpectedly, and how greater awareness could support earlier intervention. Taking a women's health lens does not add complexity for complexity's sake; it helps clinicians recognise risk more accurately and support patients at key points in their lives.

Dame Lesley Regan, women's health ambassador for England, said:

> 'Women are twice as likely to die from cardiovascular disease as from cancer, yet that's not what they think will kill them.'

How we can deliver good cardiometabolic care

Despite the scale of the challenge, the summits have also highlighted what good cardiometabolic care looks like in practice. Effective services shared common features; early identification of risk, multidisciplinary teams with clear roles, continuity for patients, and better use of data to support clinical decision making.

Patient experience ran through these examples. Patients valued fewer appointments, clearer explanations and reassurance that someone was overseeing their care as a whole, rather than focusing on individual conditions in isolation. These approaches improved outcomes while reducing confusion and treatment burden.

Digital systems and data were a major focus of the second summit and were seen as important enablers of more effective cardiometabolic prevention when they actively support clinical decision making and patient care. Discussions centred on the challenge of translating large volumes of data into clear, usable insight that helps clinicians identify risk earlier, prioritise action and work more effectively across teams.

Examples shared at the summit showed how better use of data, including population-level dashboards, remote monitoring and decision support tools, can improve follow-up and reduce variation. However, there was clear agreement that digital must follow clinical workflows, not add burden, and that systems must be designed with equity, usability and human care in mind.

RCP digital health clinical lead, Dr Anne Kinderlerer, said:

> 'Digital systems and data are no use to us unless they enable us, with our patients, to make evidence-informed decisions about risk and about what matters to them.'

What happens next?

For most physicians, cardiometabolic disease prevention does not require a radical change in practice. It is about noticing risk earlier, feeling able to raise it, and knowing how and when to connect patients with the right support. Every contact, whether in acute settings, outpatient clinics or the community, is an opportunity to reduce future illness.

This work is not about asking clinicians to do more in already pressured systems. It is about enabling teams to work differently, with shared language, clearer pathways and the confidence and permission to act at the right time.

The RCP's cardiometabolic disease prevention programme is continuing to develop. Learning from the summits is now informing practical resources, including a toolkit to support clinicians across specialties and career stages to embed prevention into everyday practice.

By bringing together insight from across the system, this work aims to support physicians to deliver care that is more joined-up, equitable and preventive, and to reduce the long-term burden of cardiometabolic disease for patients and communities.

The most recent cardiometabolic prevention summit took place on 11 May 2026 and will focused on strengthening education and training for cardiometabolic disease prevention. The summit explored where learning gaps exist, what prevention competencies physicians need regardless of specialty, and which training approaches are most effective, drawing on clinical experience from across the system.

Dr Anita Banerjee, cardiometabolic prevention summit co-lead, said:

> 'We've got to start talking about cardiometabolic disease, but now it's time for action.'

To find out more about the cardiometabolic disease prevention programme, or to get involved, email Improvement@rcp.ac.uk.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images.

Call the medical registrar: how to put together a conference

Transitioning from a resident doctor to a medical registrar role can be an exciting but intimidating step.

The RCP's Call the medical registrar (CTMR) conference is designed to help anyone taking this step; with content that is aimed to equip resident doctors with the clinical and professional knowledge to thrive as medical registrars, or serve as a clinical refresher for any doctors at any stage of their career.

In previous years, the conference has been held digitally, but this year, the RCP has added an in-person broadcast of the online conference in both London and Liverpool.

The programme has been developed in collaboration with the RCP deputy registrar, RCP Resident Doctor Committee and representatives from across the UK regions at different training and career grades. While many sessions are designed to increase clinical confidence when handling acute medical emergencies, others focus on helping develop leadership skills and confidence.

Dr Muha Hassan, an IMT3 doctor at the West Midlands Deanery and RCP associate college tutor, and Dr Mariyam Adam, a renal registrar working in the Mersey deanery and Resident Doctor Committee member, share their experience of puting together the programme.

Dr Muha Hussan

I was first involved in CTMR in 2025 after being nominated by my clinical supervisor and college tutor to join the organising committee. Having attended in 2024 as an IMT1, I found the conference invaluable in supporting my transition to medical registrar through demystifying the role. I was therefore delighted to be invited and to continue contributing to the programme this year.

Developing the programme is a highly collaborative process. As the committee, we reviewed topics covered in previous years alongside participant feedback to identify areas of greatest educational value. We wanted to ensure the programme reflected both clinical and non-clinical realities of being a medical registrar; where clinical expertise, leadership, communication and operational decision making are all equally important components of the role.

One of the greatest strengths of CTMR is its breadth; the conference brings together expertise from across a wide range of medical specialties and focuses on common clinical scenarios encountered in everyday practice. Alongside clinical content, it includes sessions on leadership, dealing with uncertainty, decision making under pressure and navigating challenging conversations.

A particularly rewarding aspect of developing the programme has been working alongside colleagues from different regions and stages of training. It is important that IMT doctors are represented within the committee, as we can provide valuable insight into the areas that feel most challenging. Our perspectives also help ensure the programme remains relevant and responsive to the needs of future medical registrars.

Finally, CTMR offers not only clinical learning but also reassurance; it provides an opportunity gain confidence in managing the responsibilities that come with becoming a medical registrar. I hope CTMR 2026 continues to support doctors in developing the confidence needed to thrive in the role of a medical registrar.

Dr Mariyam Adam

I first came across CTMR as an attendee prior to starting my ST3 post and it was one of the most useful conferences that I have attended, increasing my confidence for my upcoming role. I was delighted when, in 2022, I had the opportunity of being on the organising committee of CTMR as part of my RDC role. I have also contributed practically by chairing and delivering sessions.

We spend a considerable amount of time discussing the topics and structure of the programme and we use the previous years, attendee feedback in curating the programme. Most sessions and topics are decided by the resident doctor representatives – however, we have immense help from the RCP team who have a wealth of expertise and great suggested speakers. The RCP team especially encourages diversity of speakers in terms of regional representation, sex and ethnicity. We also focus on inviting senior registrars and new consultants, so that the content covered is relevant to the incoming cohort of medical registrars.

This conference remains one of a kind in the way it is targeted at the resident at the junction of becoming a medical registrar. Most others cater for different grades or acts as part of exam preparation. The focus of CTMR is reflected each year in its delivery; it remains a conference with practical knowledge and tips for the new

medical registrar.

We try to balance the medical updates with the personal and leadership skills required to become a medical registrar, and cover the breadth of topics that every resident physician will find useful in their early career years.

In the first CTMR I was involved in, the plenary talk, 'Are doctors superheroes?' was delivered by Dr Sarb Clare. She was a brilliant speaker and her message to future medical registrars was fantastic. It still resonates with me and is a useful reminder to all of us that we are not superheroes and we shouldn't stretch ourselves to be one.

It has been a privilege to be part of this amazing work and I hope it continues for many years to come, remaining a useful tool in preparing residents for the role of medical registrar.

Register online to join us at the live broadcast of the digital conference in London or Liverpool – or online – on 9 July 2026. All delegates will gain full access to the digital conference platform, to watch the events on demand until Friday 27 November.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images.

Building capacity in Iraqi medical education and healthcare: the establishment, achievements and future vision of the RCP Iraq Network (2021–31)

Dr Shakir Mahmood Muhammed, consultant respiratory physician and member of the RCP Iraq Network steering committee shares the achievements and the future of the RCP Iraq Network.

Healthcare advancement depends heavily on high-quality medical education, research productivity and effective healthcare delivery systems. Countries undergoing healthcare system development frequently encounter challenges in physician workforce development, access to educational opportunities, research capacity and alignment with international standards.

In response to these challenges, the RCP Iraq Network was established in Iraq in 2021 as an educational body operating in accordance with the principles and standards of the RCP, under the supervision of RCP Global. The initiative was founded by Professor Hilal Al-Saffar, who was serving as RCP international adviser to Iraq, and it was guided by the slogan 'Together, we are stronger and smarter'. This vision emphasised collaboration as a means of strengthening Iraqi healthcare and professional development.

The network's activities were organised around three interconnected pillars:

- **medical education**
- **medical research**
- **healthcare provision.**

Its mission was to create a sustainable framework capable of producing measurable improvements in healthcare delivery and medical professional development in Iraq.

Development and achievements of the network (2021–25)

Expansion of the RCP community in Iraq

One of the earliest indicators of success was the substantial expansion of the RCP community within Iraq. Before the network's establishment, Iraq ranked 36th globally in terms of the number of RCP members and fellows. By 2025, Iraq had advanced to become the first-ranked country outside the UK, reflecting substantial growth in participation and institutional involvement.

Establishment of the MRCP(UK) exams in Iraq

A major milestone was the reintroduction of the MRCP(UK) Part I and Part II exams in Iraq, through collaboration with the University of Baghdad's College of Medicine. This initiative reduced geographical and financial barriers, and improved accessibility for Iraqi physicians pursuing postgraduate qualifications.

The network has also initiated a fruitful discussion with the RCP to pave the way for introducing the MRCP(UK) PACES exam in Iraq. In this field, the network organised four training mock examinations in different Iraqi provinces – Sulaymaniyah, Baghdad, Karbala and Thi-Qar – to demonstrate Iraq's readiness to host the PACES exams. In addition, the network conducted numerous training sessions and workshops to help candidates pass the PACES exams successfully and for Iraqi consultants to serve as examiners.

The participation of Iraqi candidates has not only grown in number but also in success, with pass rates of 65.8% for Part I, 92.1% for Part II and 38.7% for the PACES exam in 2024.

Educational and scientific activities

Medical education represents a major component of the network's mission. Numerous lectures, workshops, multidisciplinary meetings and educational programmes were organised face to face or online. Consultants from inside and outside Iraq, including senior officers from the RCP, have delivered or actively participated in delivering these activities. These have covered a wide range of medical specialties, including medical education, medical research, evidence-based medicine, AI in healthcare, respiratory medicine, endocrinology, cardiology, neurology, nephrology and soft skill competencies relevant to medical careers. Annually, the network has

organised about 35 activities with participation of more than 1,800 participants.

International training opportunities

Recognising the value of international exposure in professional development, the network collaborated with the University of Bristol and affiliated hospitals in the UK to establish elective clinical training opportunities for Iraqi resident doctors and medical students. These programmes aimed to improve clinical skills, strengthen professional competencies and enhance international academic collaboration. The network successfully sent 31 candidates to participate in this structured clinical elective training.

Empowerment of young healthcare professionals

Recognising the need to develop future healthcare leaders, the network established the Iraqi Young Educators Programme (IYEP), aiming to strengthen skills in medical education, research methodology and leadership development.

To achieve the network's aim of connecting relevant institutions, the network has signed collaboration agreements with 14 Iraqi medical colleges across Iraq, including in the Kurdistan region – as well as with the Iraqi Infectious Diseases Society and the Iraqi Red Crescent Society.

Future strategic vision: RCP Iraq Network strategy (2026–31)

Building on achievements from its initial years, the network developed a strategic framework for the period 2026–31 under the theme 'From professional networking to national impact'.

Strategic vision, mission and core values

The vision of the network is to become Iraq's leading professional platform for physician excellence, modernisation of medical education, research capacity development and clinical quality improvement aligned with international standards.

The mission is to strengthen Iraq's physician workforce through the integration of:

- clinical excellence
- innovation in medical education
- research advancement
- leadership development
- international collaboration.

The ultimate aim is sustainable improvement in patient care and healthcare outcomes. The core values to guide the network's strategic framework are professional integrity, evidence-based practice, educational excellence, collaboration, sustainability and national service.

I have had the privilege of being part of the network's journey from its cradle – as an ambitious vision – to its emergence as a leading platform for advancing medical education, research and healthcare development in Iraq. Over a relatively short period, the network has achieved significant successes, made possible by the dedication of our members, the support of our national and international partners, and our unwavering commitment to internationally recognised standards of excellence.

Building on these achievements, the 2026–31 strategy marks the next chapter in our evolution. It reflects our aspiration to move beyond professional networking and educational activities toward generating a broader, more sustainable impact on Iraq's healthcare system.

We are proud of what has been achieved so far and confident that the network will continue to catalyse healthcare workforce development, educational excellence and innovation. By working together, we can further establish a model of success that inspires progress not only in the Iraqi healthcare system, but also in other healthcare systems facing similar challenges.

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Medicine as a mission: The Pan Arab Women Physicians Association

Dr Maisam Akroush is a consultant gastroenterologist in Jordan, who made history as Jordan's first female gastroenterologist and hepatologist. She is also founding president of the Pan Arab Women Physicians Association. In an interview, she spoke to *Commentary*, sharing the story of her career and how she is working to support female physicians in the Middle East.

After graduating from the University of Jordan School of Medicine, I started to specialise in internal medicine and gastroenterology in the Royal Medical Services of the Jordanian Armed Forces. I began a gastroenterology fellowship in the Royal Medical Services, through a scholarship from the Jordanian Ministry of Health. This scholarship was extended to UK hospitals, where I worked for 2 years and sat my PACES exam.

II returned to work in Jordan for 4 years in a public hospital, the Prince Hamza Hospital, where I gained a lot of experience. I then moved to the private sector to start my own practice in Amman. Career development in the private sector was not an easy task, carrying a lot of challenges; I was the first female gastroenterologist in Jordan, it used to be a male specialty. It was not easy initially, but trust from patients and their word-of-mouth recommendations helped everything go smoothly.

I worked as a part-time visiting consultant to Dubai for 5 years, then came back to Amman, Jordan to continue my practice.

Over this time, I had great mentors, who facilitated involvement with professional as well as volunteer initiatives. I joined patient and public health awareness societies, joining the Friends of Liver Disease Patients Society. I became a research, prevention and early detection advocate through the Mediterranean Task Force for Cancer Control (MTCC) in 2002. Over time, with dedication and hard work, I ended up as the vice president of the MTCC. I was particularly proud when my work on cervical and colon cancers prevention, raising awareness through a sticker on sanitary products, was presented globally.

Being so passionate about medical student education, I started a part-time visiting consultant role at Jordan University. Alongside teaching, I lead research, publications and journal review roles in my academic career. I am also an advocate for medical education and youth empowerment; I have been involved with UK medical colleges to guide residents and early-career doctors, helping to strengthen their portfolios and pursue training in the UK with the RCP Medical Training Initiative. In recognition of my work, I was selected by the British Council as the UK alumni ambassador to the Middle East and North Africa region (2024–2025). I have also become a PACES examiner.

Another special milestone was being acknowledged as one of the 50 RCP fellows who made a difference in their region, in a book published to celebrate the 500-year anniversary in 2018 – *Physicians and global health* by Krishna Chinthapalli.

My volunteering and advocacy work resulted in a royal recognition and nomination as a member of the Board of Trustees of Jordan Hashemite Charitable Organization, an initiative that supports people in conflict zones and those affected by natural disasters. I was particularly proud to be appointed to a committee to oversee the Jordan Medical Association. I worked hard to show that women can contribute with dedication, perseverance and the courage to stand by their point of view.

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These roles have reinforced my guiding belief and rule for my career; my work in medicine is not only a profession, but a humanitarian mission as well.

The Jordanian Women Physicians Conference

We first thought of the Jordanian Women Physicians Conference in 2021 to acknowledge the history of women in medicine in Jordan. We acknowledged all pioneering Jordanian women doctors from every specialty and did our best to reach out to the family of the only female surgeon who died while on duty during the COVID-19 pandemic in Jordan. We were trying to raise awareness that women can be just as empowered as men – and can defend their profession until the last minute. The conference also focused on the most pressing scientific topics, as well as issues related specifically to women's health. We were honoured to have the RCP represented virtually by Professor Mumtaz Patel, given the constraints of the COVID-19 era.

We stressed that we had very few women in leadership

positions at the time – despite being 50% of medical school graduates. After that, it was lovely to see so many societies starting to have women presidents. We also had the first female dean of medical school, president of a hospital and deputy minister of health attending.

The Pan Arab Women Physicians Conference

The year after, during the third conference, we launched the Pan Arab Women Physicians Association, the first association of its kind in the region.

The conference continued to be recognised as a well-renowned meeting with a high standard of excellence. We also agreed that future conferences could be hosted by neighbouring Arab countries.

At that third conference, mental health was highlighted as a priority topic; it is still considered taboo in Jordan and not always understood that mental health is a right. It was openly discussed, and real plans were put in place to establish a mental health platform.

Just 6 months later, a platform was launched to provide support for underserved populations affected by conflict and natural disasters (Mentahealth.net). This initiative was guided and patroned by His Royal Highness Prince Al-Hassan bin Talal. We thought that a virtual platform might keep confidentiality and give people the opportunity to be treated, even in conflict zones.

The future of Pan Arab Women Physicians Association and health in the region

Where do I see the Pan Arab Women Physicians Association in the future? I see it as a platform that supports innovation by women in medicine, empowers new generations and young doctors, improves patient care, ensures safety and reduces healthcare burdens by having more helping hands contribute effectively.

We're very proud of the power of the Pan Arab Women Physicians Association. The conference is to be hosted in different countries; we had the second version in Kuwait. It was also an amazing conference, hosted by our colleagues there, and we will keep going on from one country to another. This will open doors for women to start being the heroes of medical sectors all over the Arab world.

We're expanding to work with medical organisations and specialties across the world. We are planning to open doors for higher education in the UK, because we felt how the UK graduates in the organisation had our futures sculpted in a different way. We're opening doors for new groups, like a medical school team; encouraging medical schools to improve on deficits and work on new educational techniques. Next year, the Pan Arab Women Physicians Association is planning to have an Arabian medical meeting, a pioneering idea where every country can partner with us to showcase their achievements in medicine.

We're even trying to modify some laws; at the moment, Jordan does not have health-related driving licence regulation. There is no age limit for driving – people can have different medical and mental health issues, such as epilepsy, and they're still driving. We organised an event with the Directorate of Public Security in charge of licensing and street safety, and agreed to try to connect up medical records and licences to prevent endangering the roads.

We're also conducting research. We had a questionnaire on whether doctors 'walk the talk' at our conference; asking if doctors practise what they tell their patients on exercise, alcohol, smoking, and commitment to medication and screening programmes. The Pan Arab Women Physicians Association is running more research now on antimicrobial resistance and educating the population. A third project, that's about to finish, is on colon cancer and endoscopy – we don't yet have a national screening programme for colon cancer, so we want to showcase that expenditure on screening is much less than treating cases later on.

The support behind this work

I would love to thank my colleagues, male and female, who supported our initiative, attended the conferences and believed that the Pan Arab Women Physicians Association can make a difference.

The Hashemite leadership in Jordan has opened doors for women and their vision moves us forward; the patronage is always a member of the royal family and also you will always find Hashemite Princesses attending our meeting each year.

We are supported by female physicians from across the Arab world who believe in our mission, by Pan Arab Women Physicians Association members, and by medical and non-medical institutions locally and regionally, as well as national and international colleagues who believed in this initiative from the beginning.

Being an RCP member and fellow changed my vision of my profession; I continue to look at medicine as a mission. So many of the ideas, innovative thinking and the solid foundation to move forward were inspired by the RCP. This milestone in my career would not have seen the light without the continuous support of my beloved college.

We deeply appreciate all supporters and organisers of this unique, one-of-a-kind multisectoral body in the region, honouring the new generation of health professionals for their resilience, precision, dedication and tireless contributions.

I would like to thank all the women who came from their countries to present as health workers and physicians; the Arab world is moving on towards having women as active partners in healthcare.

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