Commentary

September 2026 Issue 4

Royal College of Physicians

Membership magazine of the Royal College of Physicians

September welcome: Professor Mumtaz Patel

Welcome to the latest edition of Commentary. I hope you've all had a restful summer. It has been a busy and productive period for the RCP, and this issue showcases some of the work and achievements from across the college.

I enjoyed reading the conversation between Professor Dame Jane Dacre and Dr Seán Coghlan on phase 2 of the medical education and training review. Supporting doctors at the beginning of their careers is a vital part of what we do at the RCP. This month, we removed membership fees for foundation doctors, making membership more accessible and helping to support the doctors who are the future of medicine.

Shaping the future of medicine is also at the heart of our RCP strategy 2026–30, and this issue of *Commentary* explores how it was shaped by our members.

This edition also features several celebrations. Congratulations to all the winners of the Excellence in Patient Care Awards in July, who I was delighted to meet at The Spine in Liverpool, and to the Pulmonary Rehabilitation Services Accreditation Scheme, which has recently reached 50 accredited services.

There have been other successes featured in Commentary this summer, which I am proud that the RCP has supported. Dr Jack Parry-Jones wrote an article to mark the founding of the College of Intensive Care Medicine, of which the RCP is one of eight parent colleges. In a thoughtful piece, Dr Wajiha Rizwan shares how she founded the Medical Women's Foundation Pakistan and how the RCP's Global Women Leaders Programme in Pakistan helped to support that work. I have had the pleasure of meeting and working with Wajiha and some of the wonderful delegates on the Global Women Leaders programme in Lahore, Pakistan. I am so proud of what she and they all have achieved. The feature on the Jeelani Drabu Palliative Care programme also highlights a valuable course which is supporting physicians across the globe.

The value of this global work is also explored in an interview with Professor Keith McAdam, discussing his work with ECSACOP and tropical medicine, and in a piece by Dr Andrew Blanshard on the Tuanku Nazrin Travelling Fellowship. It is wonderful to read about the variety of work that physicians do across the world, and to hear from both a resident doctor and someone reflecting on decades of a medical career. It has been a privilege being involved in the global work over the years and supporting our colleagues at ECSACOP and the College of Physicians of Malaysia.

Finally, Dr Chris Packham, RCP special adviser on public health and prevention, makes a compelling case for why physicians must lead the prevention agenda. His article share the work of the RCP public health and prevention advisory group and is a reminder that of the work that needs to be done to build a healthier future. Prevention and addressing health inequalities is something close to my heart and I am pleased as a college that this is one our top three policy priorities.

Thank you to all our authors and contributors to this edition and our lovely *Commentary* team.

I hope you enjoy reading this edition.

Wishing you all the best,

Mumtaz.

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September welcome: Professor Ollie Minton

Here in the UK, we continue to swelter through a summer of heatwaves, pausing only to bring you our September edition of *Commentary*.

I hope if you end up delving into this on a beach, it will support the fact we have all subscribed to continuous professional development in its many guises. In the words of Douglas Adams, author of the *Hitchhiker's Guide to the Galaxy*: 'It can be very dangerous to see things from somebody else's point of view without the proper training.'

This is most readily applied to medical education, and the next iteration of reviews led by past RCP president, Professor Dame Jane Dacre, where the ongoing debate about how to maximise supportive experience while ensuring there are enough posts and supervision without overwhelming competition is a perennial challenge. Jane is chairing phase 2 of the national medical training review, following the diagnostic phase led so ably by Professors Sir Chris Whitty and Sir Stephen Powis. Now is the time to look to implementing solutions: making training more flexible, building on excellence beyond formal routes, addressing damaging bottlenecks and rebuilding inclusive team structures where doctors feel valued. Speaking of which, a very warm welcome to all our new foundation doctor colleagues who took up an NHS post earlier this month. It's good to have you on board – and don't forget that RCP membership will now be free for you!

I imagine Douglas Adams would also have had some thoughts on our new strategy but as but as he did not live long enough, we can only surmise what he may have done with honorary fellowship. Thought experiments aside, the RCP has always been the home of physicians – a place that connects, supports and represents the values we share. My hope is that *Commentary* complements this with continued input from all our readers.

While we may not have an intergalactic presence (yet), one of the great things the college does is maintain an international role – both in person and virtually, given world events. Maybe Douglas Adams did get it wrong when he said, 'anything invented after you're 35 is against the natural order of things,' – possibly with the exception of NHS IT.

However, when possible, the college works best with advocacy and connections that only come from being face to face – both for the individual and for travelling fellowships or medical societies. Measuring impact is one of those nebulous concepts, but when you read about infectious disease management in Malaysia or the Medical Women's Foundation Pakistan, you get a sense that change is possible, with college support being central.

The College of Intensive Care Medicine was also formally launched in July. 'An intensivist is a physician with specialist training in intensive care medicine who possesses the expertise required to direct the multidisciplinary care and organ support for critically ill patients…' – the working definition goes on for some time; so, to conclude with more *Hitchhiker's Guide* wisdom: 'don't panic'– there is always one (or more than one) member of the multidisciplinary team ready to help.

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Interview: Professor Keith McAdam

Professor Keith McAdam is past RCP associate global director for Sub-Saharan Africa. Over the course of his 5 decades of working in medicine he has worked internationally with his wife Penny and their three daughters, all of who enjoy sport – including cricket.

He shares his experience of working in global healthcare systems, creating the charity Music for my Mind for people affected by dementia, and helping to establish the East, Central and Southern Africa College of Physicians (ECSACOP) with *Commentary*.

What was your experience of studying medicine after spending your formative years in Uganda?

I went to Uganda, aged less than one. My father trained as a surgeon in Edinburgh and worked at Makerere University teaching hospital for nearly 30 years.My mother was a psychologist at the university's Department of Education.

Undoubtedly, my parents were role models and there were bright students in our home all the time. I recall my father encouraging research and doing surgery at all hours. It was a very exciting and influential time in my formative years, but my dreams were to be a game warden or a district commissioner. I went to school in Kenya, where Latin and maths were my favourite subjects, but I secretly knew that science was the exciting future.

Medicine at Cambridge was full of opportunities. University cricket was full time, so keeping up with medical studies meant working from 4–8am, going to lectures at 9, practicals at 10, before getting to Fenner's cricket ground for an 11 o'clock start.

Somehow, I passed and was thrilled to get a distinction in medicine, or 'physic' as it was called at Cambridge.

How has working internationally shaped your medical career?

My long-suffering Cambridge roommate and I agreed to meet up in 10 years in Papua New Guinea, by closing our eyes and pointing at a world map.

In my third year of clinical training at Middlesex Hospital Medical School, two colleagues and I chose to do a literature review – becoming world experts on a very rare topic; amyloid. It was a pathological curiosity and only had two pages in the medical textbook at the time.

Imagine my delight when I picked up an Australian medical journal and found that the highest prevalence of amyloid in the world was in Papua New Guinea! It led to an exciting 3 years at the Medical Research Institute in Goroka. I saw more amyloid than almost anyone else in the world had ever seen!

I then had 2 wonderful years on a Medical Research Council (MRC) travelling fellowship at the National Institute of Health in the USA, studying serum amyloid A protein. I worked in experimental medicine and geographic medicine at New England Medical Center, Boston and stayed for 8 years, relishing clinical investigation. I was thrilled to be appointed to the Wellcome chair of tropical medicine at the London School of Hygiene and Tropical Medicine; I learnt a lot from teaching and particularly enjoyed meeting students from all over the world.

After 10 years, I became director of the MRC laboratories in West Africa. The MRC unit in The Gambia was involved with all sorts of tropical conditions, renowned worldwide for its study of vaccines. There were about 800 staff by the time I left, and four different research stations. It was a wonderful opportunity to work with both Gambian and international staff.

How did you end up working with patients with HIV?

I was due to go back to the London School of Hygiene and Tropical Medicine but, in fact, ended up on a sabbatical visiting Stanford and the Gates Foundation in the USA. There, I was told that a new Infectious Diseases Institute (IDI) was being developed in Uganda.

This was a massive circle back to my home, 30 years previously.

I spent the best part of 4 years there – building, recruiting and setting up a new institute. It was set up to teach physicians how to treat people living with HIV, with new antiretrovirals. It was a joy to work with people who saw this epidemic as an opportunity to serve about 20 million people in Africa, and it was remarkable to recruit really outstanding staff.

The number of people outside the clinic door each morning rose to 500; we couldn't possibly get through them by the evening.

We asked the people outside what they wanted to be called. They said 'not patients and not clients but *mikwano gyaffe*,' which is 'our friends' in the Luganda language.

We had a sign over the door saying, 'welcome, our friends'. That made a big difference to exhausted staff and to people waiting for up to 8 hours. We started a creativity initiative and electronic queuing – allowing people to do interesting things while waiting, not just hiding so they wouldn't be recognised with this stigmatising condition. There was music, art and board games, social and spiritual support, and entrepreneurial life skills taught.

It certainly helped with stigma and got people involved in trying to be part of the solution. Quite quickly, this spread throughout Kampala as best practice. The clinic changed from being like a morgue to being like a marketplace, with drumming, singing and dancing. Very few people came to visit the clinic without being moved by the experience.

Was this what inspired you to start the charity Music for my Mind?

Upon returning to London, I applied for a role in the RCP's global department as the associate global director for Africa and had to give an inaugural lecture. I spoke about the creativity initiative and afterwards, then-PRCP, Sir Richard Thompson challenged me to do something that would allow the creativity initiative to blossom in a clinical setting.

After about a year of investigation, it became obvious that degenerative brain diseases, including Alzheimer's, were all associated not only with amyloid but with a response to music. With an inspiring group of trustees, we launched a charity called Music for my Mind

People living with dementia may lose cognitive function, but they still remember music from their past. Their faces light up, and they may even sing the words to a song, although they can't otherwise speak.

Over the last 10 years, we've developed an algorithm that creates a personalised playlist. We started with a preliminary study on what music people remember; the teenage years are when we most readily remember songs that we can at least hum.

It made a massive difference in trials in care homes. Even with severe Alzheimer's disease, people were able to respond positively. Quality of life assessments improved for a condition where it would normally decline with progression. The difficult behavioural and psychological symptoms of dementia were also improved by listening to personalised playlists.

We've now been working with AI to read facial expressions for assessments and to create personalised playlists that are genuinely useful for people living with dementia, and the people around them – care workers, families and friends.

We're hoping that we can interest the big tech companies in taking this forward; it's non-invasive, non-pharmaceutical, yet helps people enormously.

It would be lovely if everyone admitted to a care home had a personal playlist created as part of their onboarding process. It would make a difference, and it doesn't take much effort to produce a personal playlist; it's free and takes about 5 minutes on the Music for my Mind website.

In your time with the RCP, you were involved in setting up ECSACOP – how did this come about?

There aren't enough physicians to do the work that's required across East, Central and Southern Africa. Physicians are often isolated – they don't know colleagues in other parts of the region.

More medical schools are being created, but there are no common standards or examinations. You have no idea how the quality of medical education compares between different organisations.

Surgeons set up the College of Surgeons of East, Central and Southern Africa in about 1999, but physicians didn't have anything similar.

We worked with the associations of physicians in the first six countries, to set up a new regional college and a common examination, available to all medical institutions, allowing graduates to be assessed against a relevant curriculum that met the needs of a practising physician in that part of the world.

It's done amazingly well. The original six countries have now become seven, and several other countries have expressed interest. This has become a very wide fellowship, an organisation of physicians who meet every year. There is a shared curriculum and online learning programme that is based on training people in district hospitals rather than in capital cities, which increases the chances that they will stay there and continue to help local communities. There is also the joy of having a young colleague join and help physicians in isolated district hospitals.

ECSACOP is a wonderful organisation, led by very altruistic people. It is a highly effective way of creating more physicians for Africa. The cost is only a fraction of training physicians through a traditional medical school system. Initially there was some opposition from medical schools, but that has largely disappeared as people have seen the advantages of a common examination, common standards, a relevant curriculum and inspiring teachers.

It was born through active and helpful support from the RCP; to think that our 508-year-old college has helped spawn a new college is an exciting reality. I am very proud of the RCP for supporting it and there are so many people in the RCP and ECSACOP who deserve essential appreciation for the work that has been done there.

It's also a wonderful opportunity for people anywhere who want to help; there are opportunities for mutual learning, teaching, mentoring and specialist training. As ECSACOP matures, it will continue to need support. This isn't a short-term partnership. It's a long-term love affair.

What do you think UK-based physicians can learn from a global healthcare system?

Your exposure to medicine in less-resourced places doesn't start when you're qualified. It starts when you do your elective or a gap year. Many people are profoundly influenced in their future careers by those experiences.

When I worked with the RCP on 2-week placements in West Africa, I encouraged physicians to think about three things. First: make a local friend and have a meal with them in their home. Second: take note of all the brilliant people they observe. And third: to laugh with people.

Those may sound like strange goals, but people came back, telling me about the lifelong friendships they had made. People exchanged ideas and opportunities.

There are tremendous opportunities in linking with less-resourced settings; for teaching, research and epidemic preparedness. Epidemics often emerge from less-resourced settings – both infectious and non-communicable diseases.

One thing I strongly emphasise is the importance of strengthening trust in institutions and people. It requires a team spirit in which everyone is committed to maintaining high standards.

Research is another area I'd highlight. The opportunities are enormous and require expertise from different disciplines; joining collaborative research teams is an incredibly rewarding process. Team building is also vital. Many of the challenges we face require integrity, technical competence, impact, resilience, evidence-based decision making and a strong team culture.

Working globally brings tremendous benefits – working together, celebrating partnerships, sharing resources and learning across different cultures and languages. It's an opportunity people shouldn't pass up. Experiences like those can be life changing.

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Interview: medical training at a crossroads

The way that doctors are trained shapes not only their own careers, but the care that patients receive. As the medical profession considers how to create a training system that is fit for the future, the ongoing NHS England medical education and training review is examining how postgraduate medical education can better support resident doctors, strengthen the workforce and ensure patients continue to receive high-quality care.

In this conversation, Professor Dame Jane Dacre, chair of phase 2 of the review, and Dr Seán Coghlan, chair of the RCP Student and Foundation Doctor Network (SFDN) discuss the challenges facing medical training and how to build a more flexible, supportive and sustainable system.

Seán: How is the review is going and what can the medical community tackle collectively? What's the one problem you're most determined to fix?

Jane: The problem is that there isn't one problem; all of it needs to be fixed – but some things that are more fixable than others.

The culture within medical education and training has drifted. That culture that has crept into the profession is really about a lack of agency and a lack of value.

Actions have been taken for well-founded reasons, without taking an overall strategic view. As a result, we've ended up with a system that has too many rules, is too inflexible and nobody is happy with it.

Seán: Yes, cumulative changes have shaped that. Training feels unrecognisable compared to my senior colleagues' descriptions. Many things have changed for the better, but there's longing for that past sense of community and camaraderie.

Jane: If you look at the evolution of medicine, medical education was a huge part of what great philosophers and early physicians did. Gradually, as medicine has become more complex to deliver, we've ended up losing sight of the core magic that constitutes what a doctor is.

The rigid structures were introduced in good faith and for a reason, but they have not produced a cohesive, strategic whole for the profession.

Cultural change takes a long time. We've got a short time frame because of the politics – the dissolution of NHS England and its merger into the Department of Health and Social Care; everything is a bit chaotic. There are some advantages; if we have a clear view, there will be fewer bureaucratic barriers.

Seán: What role should medical colleges play in a reformed training system?

Jane: Colleges have a huge role. They are the cultural home of specialty groups. Many necessary changes are not about statutory change or formal structures. The hearts-and-minds work is very much in the bailiwick of the colleges.

Phase one showed how everybody is blaming everybody else. If all organisations worked in harmony, we'd be more likely to achieve a positive outcome.

The colleges set curricula; several that say almost the same thing and an enormous amount of commonality. To create resident doctors who understand medicine's holistic nature, colleges must identify what can be shared – what every doctor needs to know.

Seán: That leads into the topic of generalism, which has come up a lot recently. We hear from many resident doctors that, the general internal medicine component is perceived as having limited educational value. Where do you feel the balance should lie between generalism and specialism?

Jane: We need both. I have been a generalism advocate since I was RCP president. There are generalist skills that every doctor needs. As a medical registrar, it was the best job in the hospital. You saw an incredible range of patients and got to work with a varied mix of colleagues. It grieves me that that is no longer the case.

There are some doctors who are happy with a greater proportion of generalist skills, and others who only ever want to be specialists. When I created my training diagram, there are some pathways that go directly to the top but most lines allow flexibility.

We need flexibility for people on a specialist training track; to have the opportunity to rethink professional direction.

I would like to see a system where everybody is guaranteed employment until they reach CCT. That would help with bottlenecks; you wouldn't necessarily get the wanted job or region, but you wouldn't have to worry about unemployment.

Seán: That has been the number one concern that I've heard as SFDN chair. People are unable to focus on exams and training because of unemployment fears.

Jane: It's not right for people who have invested so much time and money to be at risk of unemployment. There must be a way of finding a job for everybody. We ought to look more at market forces: where can jobs be created? Where do people need to go? But, if you want to achieve high employment, there has to be flexibility about where doctors live and what they do.

Seán: It would be unreasonable for people to assume they'll get their top specialty and geographical location. When you look at population demographics, there will need to be more understanding from doctors about working where patient need exists. If that came with guaranteed career security and progression, it could be broadly supported.

Jane: I hope so. Phase 1 of the review was a fantastic piece of work; however, it didn't look enough at the changing demography of the profession. The profession has become more diverse; more international medical graduates and, last year, the profession became majority female. I would guess that geography is becoming increasingly important, so the balance between specialty and geography might change. That could help empower employers in areas with ageing populations and few doctors – if employers could make working in that part of the world attractive.

Another issue to fix is making sure that the training experience standard is uniform. That comes from giving employers agency; encouraging them to be the best employers and educators of resident doctors. Employers often feel that training is managed elsewhere, so they don't worry about it. Well, they need to start worrying.

Seán: Do you think it's a case of soft diplomacy or needing a mechanism to enforce uniform training standards?

Jane: I am a great believer in soft power and encouraging medical professionals doing what they believe is right. People don't get up in the morning intending to do a bad job in the health service. Therefore, we need to focus on encouraging, supporting and engaging people – perhaps encouraging them to compete with their neighbours.

Seán: One of the biggest concerns is that training has been squeezed by service pressures. How do we rebalance that in an overburdened system?

Jane: It's a difficult balance. The division between service and training is artificial. Properly supervised service is educational. You don't reach mastery in anything without a great deal of experience.

One way to reduce that gap is to empower educators and increase educational time. That's within the gift of trusts. A challenge for trusts is that they're constantly dealing with today's crisis. We need to help them think beyond that; to consider tomorrow's workforce.

If service activities became supervised opportunities – running a clinic, delivering a list, undertaking other clinical work – they would develop expertise.

Seán: Among my cohort there is a sentiment that a move away from rotational training might incentivise trusts to invest more educator time, expertise and training. Is that worth exploring?

Jane: There is evidence from US training that environment, people and bonds with colleagues are more important than seeing every specialty. Longer placements based around one team could be beneficial.

Medical education is a lifelong pursuit for doctors. You're not fully formed when you become a consultant; if you have training gaps, you can fill them later.

There is a rotations group, separate from the review, exploring increased flexibility. Some NHS regions are very large. You might have to move a long way for training rotation. That's simply unhelpful – especially with changing workforce demographics and caring responsibilities. Rotational training needs to be looked at with a better understanding of the lives of resident doctors.

Seán: With the core structures of training, particularly foundation, do you have any thoughts?

Jane: There are clearly two schools of thought. One argues that the foundation programme is excellent; it equips people with transferable skills, valuable beyond medicine.

However, there seems to be an equal and opposite view that medical schools should be preparing graduates for clinical practice – that foundation year 2 shouldn't exist in its current form.

There will need to be difficult discussions and to arrive at an evidence-based consensus.

Seán: Many foundation doctors are interested in clinical academia, but early-career clinical academic numbers are disheartening. They feel that foundation programme and rotational training shortcomings hinder clinical academia. How

do we reinvigorate that?

Jane: One of the largest, most active working groups is the Clinical Academic Working Group who will come up with proposals that we can then evaluate.

Clinical academia isn't only an NHS issue, but a challenge for medical schools, universities and the wider academic sector. We need to work together. We need to increase clinical academic medicine opportunities but also support people if they haven't developed as many clinical competencies as needed for other paths.

The prior learning recognition has been agreed by the steering group; making it easier if somebody reaches a career progression barrier and moves roles. If you can accumulate recognised competencies , it makes those challenges a little easier – and makes the prospect of not making it as a clinical academic less frightening.

Seán: It is certainly a big task. I'm reassured to hear that you're not afraid to tackle big issues and engage in blue-sky thinking.

Jane: Well, I'm not afraid to start. This is a major culture change. We won't do it in a year. I want to make sure that, as we work through this review, we give it the best possible chance of success; understanding why good ideas falter and not going down those same roads.

When I was RCP president, a senior politician said to me: 'The problem with doctors is that you're always jeering from the sidelines and you don't get on the pitch.'

I thought that was incredibly rude. But I've thought about it ever since, and it's time that we got onto that pitch.

If we don't sort ourselves out, we'll be sorted out in a way that doesn't suit us. We need to act together across all branches of the profession, and be clear about what is right for education and training. It's really important that we bring people with us; that we work together to develop solutions and stop looking at our own bit of the system in isolation.

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Celebrating the creation of the College of Intensive Care Medicine

On 1 July 2026, the Faculty of Intensive Care Medicine (FICM) – of which the RCP was one of eight parent colleges – officially became the College of Intensive Care Medicine (CICM). To mark this event, the new CICM president, Dr Jack Parry-Jones FRCP FCICM, shares his reflections on the changing landscape of intensive care medicine and why this brand new college has so much value for physicians.

It is a pleasure, as president of the new College of Intensive Care Medicine (CICM), to write an article for *Commentary*.

All the medical colleges face significant challenges in a post-COVID world – financial, governance and political – but there are also very good reasons why colleges continue to exist, and also very good reasons why we need a college dedicated to intensive care medicine. Our new college council's vision is for us to 'lead excellence in intensive care medicine' with a mission to deliver that by developing professionals across a diverse intensive care medicine (ICM) workforce, advocating for the specialty and our members, listening to public, patient and family voices, and supporting a sustainable and dynamic college. Our college's values – which in the current world are so important – are compassion, courage and excellence. We need to live up to and work to these values.

Some colleagues and I recently wrote a short definition to try and encapsulate what, and who, we believe a modern intensivist really is. We came up with the following:

> 'An intensivist is a physician with specialist training in intensive care medicine who possesses the expertise required to direct the multidisciplinary care and organ support for critically ill patients. This includes caring for patients at risk of developing multiple organ failure, overseeing diagnoses, admission, treatment, organ support, discharge and recovery across a broad spectrum of critical illnesses while also providing holistic support for patients and their family. This supportive care includes those who don't respond to treatment and transition to end-of-life care. An intensivist is cognisant of the ethical and legal framework in which we work, is sensitive to religious and cultural beliefs, and is mindful of changes in societal and professional expectations of what is felt to be realistically achievable.'

Intensive care has evolved significantly in the UK, to the point that being a stand-alone specialty with our own college became increasingly obvious and important.

Intensive care is often said to have started in 1952, with the polio epidemic in Copenhagen. There is good evidence to say that it started much earlier but it is convenient, however, to have that start point. The world's first intensive care society started in the UK around 20 years later. The Faculty of Intensive Care Medicine (FICM) formed in 2010; at that time, in the UK almost all intensivists were also still anaesthetists. Those days are long gone. Instead, we now have increasing numbers of either single-specialty intensivists, or intensivists with a medical specialty – be that respiratory, emergency, renal or acute medicine.

Intensivists who are also anaesthetists have decreased, to the point that intensivist representation solely within the Royal College of Anaesthetists (RCoA) was no longer optimal, particularly as intensivists who weren't also anaesthetists had no representation. How should non-anaesthetic intensivists get the recognition and representation that they deserve, other than by inclusion in their own college; a college which can recognise all people doing ICM as equal, and advocate for and represent them as equals?

Intensive care as a specialty is a broad church; we want to welcome people whatever their background. This is apparent when you consider that the FICM was formed with eight parent colleges: the RCP, RCoA, Royal College of Emergency Medicine, Royal College of Paediatrics and Child Health, Royal College of Surgeons, Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Royal College of Physicians and Surgeons of Glasgow.

Diversity of medical training on entry to the specialty of intensive care is a great strength. All those completing their ICM training, however, should have reached a common recognised standard with their certificate of completion of training (CCT) in ICM, or its equivalent via the portfolio pathway. All those with an ICM CCT should have the same job opportunities – and nowadays, all critically ill patients should have their care directed by a qualified intensivist.

One of the great things about doing intensive care is its huge variety; each clinical day is different.

Good technical skills are required but it is also

truly general medicine, with the need for a good understanding of infectious diseases, immunology, haematology, rheumatology, endocrinology, cardiology, respiratory, renal, gastroenterology, hepatology, palliative care, rehabilitation medicine etc. You also need a good understanding of the surgical specialties, including trauma, orthopaedics, and obstetrics and gynaecology. Medical training, with its emphasis on diagnosis, treatment and supportive care, is a great entry point for ICM – and if you are planning a career in research there are also ample opportunities.

Technical skills and a good broad medical knowledge on their own are not enough. Communication skills are essential, and that includes communication within the wide multidisciplinary team (MDT) that the consultant intensivist leads, communication with other specialties often involved in the patient's care, and communication with their family and friends. Knowledge, skills and experience in the diseases that we diagnose and treat, and the supportive care that we deliver to patients and their family, lead to better judgement.

With judgement comes the management of risk, about which there has been much debate recently. As doctors, of whatever chosen path, we all need to learn to manage risk better for our patients and ourselves; we need to deliver good training environments, with the right amount of supervision to do this. How we manage risk changes over time; in training and with consultant experience. Judging which patients to admit to intensive care, what tests and radiological investigations are needed and, possibly, the point where further intervention is more burdensome than meaningful can be challenging – but we can make a beneficial difference to patients and their families in life and in death. These judgement calls are common in ICM, which is at the forefront of medical ethics and medical law – especially since many of our patients lack mental capacity to make decisions for themselves.

For patients who survive critical illness, there is often a prolonged recovery period over months to years. In the past 20 years, it has become increasingly clear that, as intensivists, we have a significant role to play in intensive care follow-up and rehabilitation as part of the MDT. A return to outpatient clinics seems a strange thing for some to enjoy, but I personally really enjoy seeing patients, often with their family, helping them to understand their illness and its treatment, and seeking to improve their journey of recovery. Again, we can make a real difference to people's lives.

Visit the CICM website to find out more about the work of the new college and look out for the upcoming summer 2026 edition of 'Critical eye', the CICM membership magazine, which will include an article by RCP president Professor Mumtaz Patel.

Listen to Dr Jack Parry-Jones' 2025 FitzPatrick lecture, 'The history of intensive care medicine – a specialty moulded by infection' on the RCP Player.

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Shaped by you: how RCP members helped to define our 2026–30 strategy

You told us what needs to change, and we listened. From national surveys to face-to-face events and the next generation campaign, members across the UK and globally have shaped a new RCP strategy focused on what matters most to your working lives, your careers and your patients.

At a time of profound change for the profession, the Royal College of Physicians (RCP) has developed a new strategy that is firmly rooted in what members and fellows told us that they need most.

Over the past year, we have undertaken one of the most extensive programmes of member engagement in the college's recent history. This was not a single consultation, but a sustained effort over several months to listen, test ideas and bring together insight from across the UK and our global membership. More than 2,500 members and fellows took part in our membership survey alone, alongside wider engagement through committees, networks and events, providing a rich and robust evidence base to shape the future of the RCP.

A central part of this work was a full membership survey, sent to physicians across all career stages and specialties. This was complemented by targeted engagement with RCP Council, committees, networks and advisory groups, alongside a programme of staff engagement. We also commissioned external research to gather independent insight into how the RCP is perceived by stakeholders across the health system, including NHS leaders, government, regulators and other royal colleges. Taken together, this created a comprehensive picture of member priorities, experiences and expectations.

Alongside surveys, we created space for more in-depth conversations with members through focus groups, committee discussions and Council-led engagement. These sessions enabled us to explore the detail behind the survey findings and to test emerging ideas for the strategy. Insights from regional Updates in medicine and college visits to NHS hospitals, as well as discussions with RCP Council and our Board of Trustees, helped to ensure that the strategy reflects the realities of clinical practice, and our Meet your president sessions provided plenty of opportunities for open conversation with our wider membership.

Reflecting on these discussions, RCP president Professor Mumtaz Patel explains, 'What struck me most through this process was just how honest members were with us. There is a deep pride in the RCP, but also a clear challenge: to be more visible, more relevant and more vocal on the issues that matter to physicians. That honesty has helped us to shape a strategy that is not only ambitious, but rooted in what our members really need in their day-to-day working lives.'

Our engagement programme extended beyond formal consultation. Through the RCP's next generation campaign, members – particularly resident doctors – have shared their experiences of medical training through surveys, blogs, webinars, events and media engagement. This enabled members to contribute ideas for reform in ways that worked for them, whether through structured research or informal discussion, and ensured that engagement reached groups who may not traditionally participate in formal consultations.

Jono Brüün took up post as the RCP's chief executive in January 2026. Coming into role, he was keen to learn more about what members expected from their college. 'The scale and depth of engagement last year was incredibly powerful,' he says. 'We've brought together insight from thousands of members, alongside conversations across the health system, and there is a clear thread running through it all: the need to reconnect the RCP to our members and their day-to-day lives.'

Several consistent themes quickly emerged. Members told us they want an RCP that:

- puts members and fellows at the centre of everything it does
- builds a stronger sense of community and connection across the profession
- continues to provide high-quality education and maintain standards
- speaks with a clear, credible and influential voice on behalf of physicians
- operates transparently and sustainably as an organisation.

The survey findings behind these themes were clear and consistent. Professional development remains the cornerstone of membership, with more than half of respondents citing access to learning, CPD and resources as their main reason for both joining and staying. Requests for stronger advocacy, greater visibility and

more meaningful engagement reinforce the importance of the college speaking with authority on behalf of the profession. Members were equally clear about where the college should focus next – prioritising practical professional development tools alongside a stronger, more influential voice for physicians on the issues that matter to them.

'We heard consistently that members value the RCP at its best when it supports their professional development and speaks up on their behalf,' says Mumtaz. 'This strategy reflects that. We've placed a renewed focus on high-quality education, alongside a stronger, more confident voice for the profession. Most importantly, it commits us to continuing that conversation with members.'

At the same time, members were candid about where the RCP must improve. Views on value for money were divided, particularly among doctors in the middle of their careers. This reflects a broader pattern seen throughout the engagement – strong support from some groups alongside dissatisfaction from others – highlighting the importance of a strategy that responds to different experiences across career stages and specialties. Jono said: 'What comes through strongly is that members' experiences of the RCP are not the same. Some feel well supported and engaged, while others are telling us that we need to do more. That is exactly where this strategy is focused: improving the day-to-day experience of membership, strengthening our offer and making sure every member sees the value of being part of the college.'

The new strategy also sets out how we will work differently, by modernising the way we work and placing a greater emphasis on transparency. This includes a clear commitment to continue creating opportunities for members to provide feedback and shape the direction of the RCP, not just during strategy development, but throughout its delivery. Listening to members is not a one-off exercise – it is a permanent shift in how the RCP works.

'The launch of this strategy marks the beginning of the next phase, not the end of the conversation,' Mumtaz concludes. 'After all, the RCP is at its strongest when it reflects the collective insight, expertise and ideas of our members and fellows.'

Read and download the new strategy.

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

Why physicians must lead the prevention agenda

Dr Chris Packham, RCP special adviser on public health and prevention, and chair of the public health and prevention advisory group shares his reflections and updates on the RCP's preventative work.

Good health depends on far more than good healthcare alone.

As physicians, we see every day the consequences of preventable illness in our clinics, wards and at the front door of our hospitals. We treat people with alcohol-related liver disease, tobacco-related cancers, obesity-related complications and a wide range of conditions driven by poverty, poor housing, poor air quality and other social factors. The symptoms may present in our hospitals, but the root causes of many of these illnesses lie far beyond the healthcare system itself. That is why the RCP has established a new public health and prevention advisory group to amplify the physician voice on prevention alongside work on other public health issues.

While advances in medicine continue to improve outcomes for many patients, improvements in life expectancy have stalled and health inequalities persist across the UK. People living in the most deprived communities can expect to live almost 20 fewer years in good health than those in the least deprived communities. Last year, 46% of respondents to an RCP membership survey told us that at least half of their workload was caused by illnesses or conditions related to the social determinants of health. Health inequalities must be at the heart of what we do.

The new RCP advisory group will advise on campaigning priorities and strengthen the college's voice and advocacy work on prevention. It brings together national and international expertise in health inequalities, alcohol harm, tobacco, obesity, air quality, homelessness, inclusion health, sustainability and climate change, alongside front-line physicians from different specialties and career stages. Expert working groups will develop evidence-based recommendations that strengthen the physician voice in public debate and support the RCP's efforts to influence national policy and improve population health.

Alcohol-related harm has already emerged as a key concern, disproportionately affecting people in the most deprived communities. We will develop a refreshed policy position on alcohol, focusing on health impacts, service provision, inequalities and the wider commercial determinants of health. We will also campaign on tobacco, air quality and obesity, making sure that our recommendations are heard by policymakers, reflected in public debate and translated into meaningful action to improve health and reduce inequalities.

The group also strongly supported a life-course approach to prevention, recognising that the foundations of adult health are often laid in childhood and even before birth. Early intervention offers one of the greatest opportunities to improve long-term health outcomes and reduce future demand. Physicians must make the case for policies that support health at every stage of life.

We also discussed the growing impact of environmental factors and climate change on health. Clean air, sustainable healthcare and resilience to climate-related health risks must be priorities, particularly as climate change continues to exacerbate health inequalities.

The challenge is clear, but so is the opportunity. If we are serious about improving health, we must both advocate for wider societal conditions in which health can thrive, but also promote the role of the healthcare we provide to support more equitable outcomes of care. Physicians see the impact of inequality every day, giving us a unique perspective and a powerful voice. The RCP will continue to use that voice to help build a healthier, fairer society and help the NHS to play its part to the full.

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Excellence in Patient Care Awards 2026

The Excellence in Patient Care Awards (EPCA) celebrate the outstanding contributions of RCP members and fellows worldwide, who are driving improvements in patient care through education, clinical practice, research and policy.

Relaunched in 2025, following a short break due to the COVID-19 pandemic, the awards celebrate, recognise and reward members and fellows who lead the way in patient care in a variety of areas; including health inequalities, service improvements, sustainability, patient safety, supporting the workforce, digital transformation, medical education and research.

2026 saw the introduction of three new categories, reflecting the three strategic shifts in the 10 Year Health Plan for England:

- Hospital to community
- Analogue to digital
- Sickness to prevention

RCP president Professor Mumtaz Patel said: 'Tonight's winners are a testament to the extraordinary dedication of physicians and their teams, who every day find new ways to improve the lives of patients. From reducing health inequalities to harnessing digital technology, from early disease detection to transforming end-of-life care, the breadth and ambition of this year's winners is truly inspiring. The RCP is immensely proud of each and every one of them.'

Finalists were invited to The Spine in Liverpool on 9 July 2026 to reveal the winners and celebrate the outstanding work of all participants, recognising their innovation and dedication to improving patient care.

The winners

Health inequalities

Celebrating collaborative projects that tackle inequalities, improve access and promote equitable outcomes for underserved or marginalised communities.

Dr Ronak Rajani (Guy's and St Thomas' NHS Foundation Trust) won for a new model of community-based care that is finding and treating heart valve disease earlier, particularly among ethnic groups historically under-represented in diagnosis pathways, backed by strong economic modelling and close engagement with GPs.

Analogue to digital

Recognising projects that have transformed analogue processes into streamlined digital pathways. This award showcases work that empowers patients and eases the burden on staff.

Dr Kinan Muhammed and the Kneu Health team turned patients' own smartphones into tools for proactive, personalised Parkinson's care, moving the pathway away from occasional in-person snapshots and towards continuous monitoring.

Hospital to community and the Eric Watts Patient Engagement Award

Celebrating teams who have successfully shifted care closer to home – strengthening neighbourhood support, reducing reliance on hospital services and improving access through collaborative, patient-centred redesign.

Dr Aravinth Sivagnanaratnam (London North West University Healthcare NHS Trust) took home two honours, including the RCP's top prize for patient-centred innovation, for a co-produced stroke recovery and prevention partnership that leverages community and peer support, engages local groups from football clubs to faith organisations, and transitions sustainably into community-led programmes at no extra cost to the NHS.

Service improvement

For systematic, coordinated approaches to quality improvement that deliver measurable enhancements in patient care, outcomes or service design.

Dr Barbara Onen (Royal London Hospital, Barts Health NHS Trust) built a same-day emergency care pathway for nitrous oxide-related neurological harm, delivering significant gains in clinical outcomes and patient satisfaction while cutting bed use and cost, described by judges as a textbook quality improvement project.

Research

Research award sponsored by the Bessie Hyslop Trust Fund. Rewarding investigator-led research that advances medical knowledge and delivers – or shows strong potential to deliver – improved health outcomes.

Professor Parth Narendran (University Hospitals Birmingham NHS Foundation Trust) was recognised for ELSA, a screening programme reducing emergency diagnoses of childhood type 1 diabetes and laying the groundwork for a possible national screening programme.

Medical education

Recognising innovation in medical education and training that improves care, equips clinicians with new skills, and supports compassionate, high-quality practice.

Dr Daniel Keith won for Dermoscopea, an open digital education platform building clinicians' skills in dermoscopy and skin cancer diagnosis, praised for its global reach and low-cost, scalable approach.

Patient Safety (Patient Engagement Award)

The Virginia Mason Institute Award for patient safety acknowledges work that strengthens a culture of safety, transparency and continuous improvement – even in the most challenging environments.

Dr Joanita Ocen and the South East Wales immunotherapy toxicity team (Velindre Cancer Centre) developed a dedicated service giving patients safer access to care for immunotherapy-related toxicity, a model now spreading across Wales, the UK and internationally.

Sickness to prevention

Highlighting initiatives that have moved services from reactive treatment to proactive prevention. Through clinical leadership, community collaboration and evidence-based interventions, these projects help people live healthier lives and reduce health inequalities.

Dr Michael Crooks (Hull University Teaching Hospitals NHS Trust) was honoured for FRONTIER, a project finding the 'hidden millions' living with undiagnosed COPD through early identification and smoking cessation support, shaped throughout by a patient advisory group.

Supporting and developing workforce

Recognising teams who prioritise staff welfare, embed flexible and supportive ways of working, and create conditions for delivering high-quality care.

Dr Nicola Johnstone (Mid Cheshire Hospitals NHS Foundation Trust) won for a project empowering resident doctors through effective leadership, with sustainability built in via a structured handover to consultants and local education deans.

Digital transformation (FIXIT) sponsored by Harold Thimbleby

Rewarding innovative digital systems, technologies or AI solutions that improve patient safety, reduce digital exclusion or enhance staff wellbeing.

Dr Baldev Singh (Royal Wolverhampton NHS Trust) won for a digitised, patient-triggered care pathway with immense impact for those with complex needs approaching the end of life.

Chief registrar project of the year

The chief registrar role is a senior leadership role for doctors in hospitals throughout the UK. Chief registrars complete the RCP's bespoke 10-month development programme and present a quality improvement project.

Dr Manasi Jyothish and Dr Rob Monfries (St Bartholomew's Hospital) were named winners for their work through the RCP's chief registrar programme, which supports senior resident doctors to lead service improvement and change.

Sustainability

Celebrating green initiatives that improve environmental impact while also supporting financial efficiency, staff wellbeing and better patient outcomes.

Dr Shun Yin Kong and team (NTWC PBM subcommittee and Hong Kong Red Cross Blood Transfusion Service, with Dr Cheuk Kwong Lee, Dr Ching Ching Alice Wong and Dr Sze Fai Yip) were recognised for embedding patient blood management into everyday clinical culture across Hong Kong, in a data-driven project with global applicability.

Thank you to all who participated and congratulations to the winners. Read more in *Commentary* about how to run a patient-centred improvement project or how to put together your application for 2027.

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

Celebrating 50 accredited services: reflecting on Pulmonary Rehabilitation Services Accreditation Scheme's journey and the road ahead

Reaching 50 accredited pulmonary rehabilitation (PR) services is a significant achievement for the Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS). It represents far more than a number. It reflects years of collaboration, quality improvement (QI) and commitment from services, assessors and stakeholders across the UK – all working towards a shared goal of delivering consistently high-quality pulmonary rehabilitation for patients.

Maria Buxton, PRSAS clinical lead and the programme's first quality lead, has witnessed the scheme's development from the very beginning.

'When we first started, there was quite a lot of learning involved for us as lead assessors as well,' Maria reflects. 'Obviously, you need to start somewhere.'

Over the past 8 years, PRSAS has evolved significantly. What began as a new accreditation programme has grown into an established framework for quality improvement, helping services evaluate their strengths, identify areas for development and embed best practice into everyday care.

One of the most important developments has been the increasing clarity and consistency of the accreditation process.

'We've got better at understanding what is acceptable evidence and what maybe needs to be improved upon,' says Maria. 'As we've evolved, we've tried to share that learning with our assessors and with services so that everyone benefits.'

This continuous learning has informed the recent review of the accreditation standards and guidance, helping services better understand requirements and navigate the process with greater confidence.

As accreditation has matured, services have increasingly recognised its value beyond achieving a quality mark. Instead, accreditation is being used as a practical tool to drive improvement.

Maria states: 'Services are seeing the benefits of pulmonary rehabilitation accreditation in how they evaluate themselves, identify their weaknesses and strengths, focus on those gaps in quality and drive forward improvement.'

Achieving 50 services

University Hospital Birmingham (UHB) was the 50th service to achieve accreditation. Serving patients across three hospitals, two community wellbeing centres and a virtual programme, the service supports a diverse population with conditions including COPD, bronchiectasis, interstitial lung disease, asthma and pulmonary hypertension.

According to their pulmonary rehabilitation lead Gemma Atkins, QI was the primary motivation for pursuing accreditation.

'We wanted to improve the quality of the service we were delivering and accreditation provided a really clear framework to help us do that,' she says.

However, the journey was not without challenges. Like many services, UHB initially struggled with capacity. While there was enthusiasm within the team, finding dedicated time to review processes, rewrite standard operating procedures, analyse data and prepare evidence proved difficult.

The turning point came when the trust established a dedicated pulmonary rehabilitation lead role, with protected time to focus on service development, quality improvement and accreditation.

'If there's one thing I'd stress to other services, it's that protected time is absolutely essential,' Gemma says.

This echoes one of the key challenges Maria has observed across the programme within her reflection: 'Accreditation absolutely requires a lot of work and I don't think there's any hiding from that. A lot of services are relatively small within large organisations, and they often struggle to find the dedicated time and support locally.'

The challenges facing services were further compounded by the impact of COVID-19, which severely disrupted pulmonary rehabilitation provision across the UK and forced many teams to focus on recovery and

rebuilding before returning to accreditation activities.

The benefits of reaching accreditation

Despite these pressures, the accreditation journey frequently produces significant benefits.

For UHB, one of the most transformative outcomes was the opportunity to review and strengthen existing systems and processes. The team completely rewrote its primary standard operating procedure, created new systems to track audits, training and document reviews, and improved the way it collects and uses data.

The result has been a more structured, efficient and sustainable service.

Gemma says: 'The accreditation process has completely transformed our service. It's made us fit for the future, given us a much clearer structure for development and improved the way we work together as a team.'

Importantly, these improvements have translated into tangible benefits for patients. The service is now undertaking more quality improvement activity, monitoring performance more effectively and, for the first time, seeing waiting lists reduce.

Accreditation has also strengthened relationships beyond individual services.

Recognising that services needed more opportunities to engage with the programme, PRSAS introduced webinars, educational events and direct support sessions. These initiatives have helped build stronger relationships between the accreditation team and services across the country.

'I think that's created a firmer bond between us and the services,' says Maria. 'They can ask questions and ask for support, and we'll try and share examples.'

UHB found that accreditation strengthened engagement with senior leaders, commissioners and stakeholders, Gemma says. 'Accreditation has transformed our relationship with senior managers. We've had opportunities to speak at trust-wide events, share updates with patient groups and engage with senior leaders much more regularly.'

Behind every accreditation award is a wider community whose contributions are essential to the programme's success. Maria is keen to acknowledge the dedication of PRSAS assessors, who volunteer their expertise alongside their own clinical responsibilities. 'We couldn't have got where we are without all the assessors working incredibly hard. They've been very loyal and we want to acknowledge that and applaud it.'

She also highlights the contributions of the wider PRSAS leadership and operational teams, who continue to support services throughout every stage of their accreditation journey.

Going forwards

Looking ahead, both Maria and Gemma see accreditation as an ongoing commitment rather than a one-off achievement.

For UHB, maintaining accreditation means continuing the systems, governance structures and quality improvement processes established through the programme. For PRSAS, the focus is increasingly on demonstrating the measurable impact of accreditation and promoting its value across respiratory services.

Maria says: 'What we need to do now is get a platform where we can shout about why accreditation is worth it and what it brings to services. I'm hoping that as accreditation becomes part of the landscape, what that will do is drive up the quality of pulmonary rehabilitation across the whole country. It would be great to see consistently high outcomes across the UK and no postcode lottery anymore.'

As PRSAS celebrates 50 accredited services, the milestone marks both an achievement and an opportunity. It reflects the dedication of services such as UHB, the commitment of assessors and stakeholders and a growing national movement focused on continuous QI.

Most importantly, it demonstrates what can be achieved when services are supported to reflect, improve and strive for excellence. The first 50 accredited services have laid strong foundations. The next 50 will continue to raise standards and improve outcomes for pulmonary rehabilitation patients across the UK.

Gemma says: 'It's a lot of work, but it's absolutely worth it. The accreditation process has completely transformed our service. It's made us fit for the future, given us a much clearer structure for development and improved the way we work together as a team.'

As UHB's experience shows, accreditation is much more than achieving a quality mark. It provides a framework for QI, strengthens governance, supports service development and helps teams deliver the best possible care for patients.

Get involved

Whether you're considering accreditation for the first time or preparing for submission, PRSAS offers a range of support including guidance resources, webinars, accreditation events and opportunities to learn from accredited services and experienced assessors. Visit the PRSAS website or reach out to the team on pulmrehab@rcp.ac.uk to find out more.

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Enhancing palliative care in Pakistan and Jammu and Kashmir

The World Health Organization estimates that each year, 56.8 million people are in need of palliative care but only about 14% of those currently receive it.

The Jeelani Drabu Palliative Care Programme was developed in 2019 to address this need in Pakistan and Jammu and Kashmir. The first residential training programme, held in Lahore, had a total of 34 participants – with 22 physicians and 12 nurses broadening their knowledge. The training equipped them with practical communication skills, contributing to enhanced quality of care and improved patient outcomes.
On 25–28 November 2025, the RCP has delivered a second course to 29 doctors and nurses in Karachi, Pakistan. Physicians who took part, as trainers and participants, share their experience with *Commentary*.

Establishing the programme

The programme was funded by and named after the late Dr Ghulam Jeelani and Ayesha Drabu, who were highly passionate about improving palliative care in three regions where they lived, trained and worked – Jammu and Kashmir, Pakistan and Great Britain. The courses are delivered in collaboration with partners; the first course was in conjunction with Shaukat Khanum Memorial Trust, while the second was with Aga Khan University (AKU) in Karachi.

Ghulam spoke about the aims of the course in 2019:

> 'Our passion for palliative care was borne out of the care given to our beloved son-in-law, Judge Khurshid Drabu in 2018. Khurshid was our nephew, son-in-law, but most of all my dearest and best friend. The UK is a world leader in palliative care and as we progress with the advances of medicine, maintaining human dignity at the end of life is a right for every individual and their family across the world. We hope that this small step that Ayesha and I are taking, with the help of the RCP, in setting up a palliative care course, will help to bring that right to the people in Kashmir, India and Pakistan.'

The Karachi course 2025

Dr Aisha Ambreen, assistant professor in palliative medicine at AKU, shares her reflections of delivering the training:

As the global need for palliative care surges, the disparities between demand and service utilisation are widening. This is particularly evident in low- and middle-income countries like Pakistan where access to palliative care services is limited despite a large, and growing, burden of life-limiting illnesses.

The goal of this course was not only to improve participants' understanding of palliative care principles, but to develop confidence in applying these principles in clinical settings. The aim was to move beyond palliative care being perceived as only end-of-life care and highlight its wider role in improving quality of life through management of common symptoms; supporting families while promoting compassionate communication through their journey of serious illnesses.

The 5-day programme brought together doctors and allied healthcare professionals who had exposure to palliative medicine, but wanted to strengthen their knowledge and practice further.

The teaching approach was deliberately kept interactive; combining short lectures, clinical discussions, case-based learning, group activities, role plays, reflective exercises and practical sessions.

The content covered key areas required for holistic palliative care practice. Participants explored the different approaches to palliative care delivery in a resource-limited set-up, with a unified aim to develop palliative care services within local contexts. Sessions focused on symptom management – including pain, non-pain and not commonly discussed symptoms.

A major focus of this course was on communication and understanding the patient as a whole person. Participants were encouraged to interact and contribute their experiences during the core lectures. Role play was incorporated to allow participants to experience challenging conversations, practise empathy and develop confidence in discussing sensitive topics. This was particularly valuable in a setting where conversations around serious illness, dying and prognosis can be complex and influenced by family dynamics, cultural expectations and beliefs.

One of the key insights gained from delivering this

course was the need to adapt the approach for a Pakistani audience compared to a UK audience. Although the core principles of palliative care remain universal, the delivery of palliative care needs to be tailored to local healthcare settings and available resources.

Discussions frequently explored practical questions; how to provide good palliative care when specialist services are limited; how to support families when home care resources are scarce; how to adapt recommendations to local availability of medications and services? This experience highlighted that an effective palliative care delivery cannot follow a one-size-fits-all model, but rather needs to be adapted contextually.

The role of family in decision making was another important discussion area. In Pakistan, families often play a central role in patient's care and healthcare decisions. Family autonomy often overrides personal autonomy. Rather than viewing this as a barrier, the course encouraged participants to consider making families partners in care while ensuring that patients' own desires and wishes remain central.

We touched base with participants 6 months after the course. The most encouraging outcome has been seeing the renewed confidence among participants, with a greater willingness to integrate palliative care approaches into everyday practice.

Feedback highlighted that the interactive nature helped participants move from a theoretical understanding towards practical application. Many participants valued the safe environment, discussing difficult clinical situations and sharing experiences from their workplaces. Some also suggested creating a dedicated core group to strengthen the development of palliative care in the region.

'Train the trainers' was another important component that aimed to develop local educators who spread palliative care knowledge within their institutions. Participants were supported to develop teaching skills, design sessions and deliver effective teaching to support continuous improvement. This approach recognised that long-term improvement in palliative care requires not only individual learning, but also the development of a local teaching network.

The future direction is to continue building on this foundation. Developing further courses led by trained local faculty will be essential to expanding palliative care education across Pakistan. The hope is that these programmes will contribute to a growing community of healthcare professionals who are confident advocates, influencing practice.

This collaboration has demonstrated the power of partnership, education and shared commitment. While there are significant challenges in developing palliative care services, building knowledge and confidence among healthcare professionals is an important step towards ensuring that patients living with serious illness receive compassionate, person-centred care – wherever they are.

Dr Humaira Jamal, a palliative care consultant in Central London Community Healthcare Trust and Rennie Grove Peace Hospice, writes:

From the first meeting with the RCP to inform me that the Jeelani Drabu Palliative Care Programme was going ahead, to the last day of the course, this journey has been the realisation of a long-held dream to promote and develop palliative care in the region.

My involvement as a course tutor with the Lahore course in 2019 was the first step in the journey. In 2025, I was invited to be the UK faculty lead.

The course aimed to deliver high-quality palliative care education and sustainability by developing local educators – and to empower participants to put that knowledge into practice, disseminating and embedding palliative care within local organisations.

Planning the course to meet the requirements of palliative knowledge, practice and care delivery in a resource-limited country was my main focus throughout the many meetings we had over the year.

We had local faculty on board from the start. My first task was to find a collaborating organisation in Karachi, which led to meeting Dr Atif Waqar and Dr Aisha Ambreen of AKU. They provided invaluable insights into the local context; the role of the family in care, practice in a resource-limited environment and cultural nuances.

The 5-day course in Karachi was delivered in collaboration with AKU aimed to build on previous end-of-life care knowledge. The focus was on holistic care, symptom control, psychological care, ethical issues, advance care planning (ACP) and training the trainers.

The faculty included a senior palliative care nurse, Nadia Mulji, who had attended the Lahore course in 2019 and went on to lead the home care team at AKU hospital. She provided an important nursing perspective and ensured that the course remained relevant to the multidisciplinary team.

Assessments were built into the course – including a questionnaire at the course's beginning and end to assess changes in knowledge and confidence, as well as multiple-choice questions and feedback after every session and at the end of each day. There were 6- and a 12-month follow-ups planned to assess the long-term impact.

The collaboration with local senior palliative care clinicians ensured the success of the course. Their wholehearted commitment and enthusiasm were impressive. Success will be measured by any changes, any new services or educational events organised on return to their places of work.

Feedback from the participants

Dr Maryam Akbar, medical officer for palliative home care services, Shaukat Khanum Memorial Cancer Hospital, Lahore, said:

> 'The course significantly strengthened my clinical decision making in palliative care. From pain management and symptom control to recognising delirium, managing emergencies and complex end-of-life care scenarios, it covered all bases. Learning alongside colleagues across the country and mentors from both the UK and the region also highlighted how palliative care must adapt to different regional and cultural contexts. It was both practical and evidence based.'

Dr Noor e Sahar, consultant family physician at Liaquat National Hospital, Karachi, said:

> 'The palliative care course has been a highly rewarding professional development experience. It deepened my appreciation of comprehensive, patient-centred care and strengthened my competencies in symptom management, ACP and sensitive communication. More importantly, it reinforced the need to address the emotional, social and spiritual dimensions of illness alongside physical care. The knowledge and perspectives gained from this course continue to inform my practice, enabling me to provide compassionate, holistic and dignified care to patients and their families.'

Dr Maryam Abid, consultant medical oncologist at King Edward Medical University and Mayo Hospital, Lahore, stated:

> 'Attending the Jeelani Drabu Palliative Care Course was a truly enriching experience. As an advocate for integrated oncology and palliative care, it strengthened my communication skills and refreshed the knowledge I gained during my palliative care fellowship. The interactive learning and inspiring discussions by faculty reaffirmed my belief that compassionate, patient-centred care should be an integral part of every cancer journey.'

Strengthening future care

Following the residential courses, an online palliative care course for health professionals in the area will be provided. The online course will be accessible between 10 October 2026 and 10 January 2027, with an examination mid-January 2027.

Applications for this course are open until 31 August 2026. If you are interested in participating, please fill in the application form on the Jeelani Drabu webpage.

Thank you to all who have worked to make this programme a success.

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From RCP impact to women's global leadership: a journey of transformation

Dr Wajiha Rizwan, founding director of the Medical Women's Foundation Pakistan, shares her experience of the RCP's Global Women Leaders Programme in Pakistan and her ongoing work.

Growing up in Pakistan, I realised very early that the lives of many girls revolve around constraints imposed upon them, to the extent that sometimes even their birth is questioned rather than celebrated. Decisions about their education, career or marriage are made for them – not by them. In this process, many women lose their voice; some learn to be content with very little, but a rare few begin to challenge the norm. I did that.

The more I was denied a leadership role – from medical schools to professional boards – for being a woman with her own opinion and ability to disagree, the more I realised something deeper. Instead of adhering to the common saying, 'If they do not give you a seat at the table, then bring your own folding chair,' I began to wonder who was setting the table and why the world was making women adapt to places that were never built for them in the first place. I started asking why women in medicine couldn't have their own table? While resilience might help one woman earn a seat, mindsets that are unwilling to share decision-making power do not change overnight. This only happens when women unite to make places of their own.

A clear revelation emerged: Pakistan required an organisation for women health professionals. Despite constituting around 70% of medical college admissions, most women drop out of the field or are hardly seen at policy tables. This issue was not about merely personal preferences, but rather about systemic gaps.

Initially, the idea of an organisation was just a thought experiment. As I shared it with others, there was very little positive feedback and huge criticism. Many dismissed it outright, while others blamed us for trying to create gender division in medicine. At one point, only five or six women were willing to support the cause; yet even they were unsure whether they were ready to pay the cost of challenging the status quo.

Then one opportunity changed the entire scenario!

I attended the RCP's Global Women Leaders Programme in Pakistan on the suggestion of Dr Somia Iqtadar, who knew that we were discussing creating a women health professionals' association.

This programme, held on 2–4 May 2023, became a turning point that gradually changed the narrative and opened up avenues that we thought were forever closed to us. For the very first time during this journey, which was quite draining at times, I was in a position to interact with intelligent and motivated women who understood where I was coming from – as a woman trying to create her own path in life – without having to explain my struggles.

This programme was geared towards empowering women leaders in the field of healthcare – through areas such as leadership and influencing skills, gender-based biases, teamwork, systemic change, time management and networking. The facilitators consisted of RCP faculty members Professor Mumtaz Patel, David Parry and Rebecca Selman; their skills were exemplary and they left an impact on us through personal stories and shared how success can never be smooth sailing. The leadership training also offered psychological safety for women to express themselves and reflect on their experiences and circumstances, which in turn helped attendees to overcome the unique challenges they faced and supported their personal growth.

Another major lesson that the programme imparted was the realisation that the leadership gap among women in the healthcare field is not only an issue in Pakistan, but a universal challenge. Women account for more than 70% of the health workforce globally, but constitute merely 25% of all leadership roles in high-income countries and less than 5% in low- and middle-income countries. Furthermore, women are largely underrepresented at senior academic ranks. Such discussions helped me realise that the challenges I had faced throughout my career were just the tip of the iceberg. According to the programme facilitators, the squandering of so many women's talents negatively affects the health system of the entire planet; the greater involvement of women in leadership would not only help female healthcare professionals, but benefit the whole community through the improvement of health agendas.

The vision of the Medical Women's Association of Pakistan (MWAP) became very clear in my mind: A healthcare community that enables women health professionals to thrive as leaders and positive agents of change.

Most people tend to laugh whenever they are presented with new ideas, but when I informed colleagues at the RCP of my vision to form an association of women health professionals, I received several encouraging words – especially from Mumtaz. This meant a lot to me at that time.

The programme also helped to develop valuable networks; eight of the 33 founding members of MWAP (Dr Mahwish Arooj, Dr Saima Chaudry, Dr Nazish Imran, Dr Nabila Talat, Dr Lubna Kamani, Dr Noor-i-Kiran, Dr Mehrin Farooq and myself) were part of this leadership development programme. The conversations that began among a few people now had the potential to spark a movement!

Once we knew that the challenges that women encounter in healthcare are universal, we went searching for associations of women health professionals across the world. In the process, we came across the Medical Women's International Association (MWIA), an association working since 1919, which has consultative status with both the World Health Organization and the United Nations.

We reached out to them with great optimism, but no expectations. To our great surprise and euphoria, we were accepted to form the Medical Women's Association of Pakistan (MWAP), the Pakistan chapter of the MWIA, on 26 October 2023, after a period of 6 months of continued efforts. We are especially grateful to Dr Beverly Johnson, social media chair, and Dr Eleanor Nawadinobi, then-president, for their continued support and encouragement.

We are now leading globally as Pakistan's national women's health professional association. I had the honour to represent Pakistan and MWAP as president at the Central Asia Congress in 2024 and the 33rd MWIA International Congress in 2025, with Dr Shamsa Humayun, our senior vice president.

MWAP is now actively contributing to building health professional capacity in Pakistan, raising awareness about workplace harassment, promoting women leadership development, and advocating for the rights and wellbeing of female health professionals – as well as women and children at national and international levels.

Looking back as an RCP Global Women Leaders Programme alumnus, all I can say is that while many courses build your CV, very few transform you into a leader who multiplies leadership in others and dares to challenge existing systems. For me, this programme truly accomplished both goals.

The journey continues, the path is challenging, but our determination is strong. At times, women's leadership is not given the attention or recognition that it deserves. In this context, we remain grateful to the RCP, which continues to be an important part of our journey as Global Women Leader Programme alumni.

We have now expanded our reach and are taking our work to the next level as an independent non-profit organisation, Medical Women's Foundation Pakistan (MWFP), registered in Pakistan and supported by thousands of volunteers nationwide – including several men. We remain committed to advancing women's leadership in healthcare and look forward to the RCP's continued support and collaborative capacity-building initiatives for women; including short observerships and future certification programmes, designed to strengthen skills, mentorship and professional growth.

And last but not least, let's change the narrative together: 'If they do not offer you a chair at the table, build your own and lead it like a queen, who makes space for others.'

Dr Saima Chaudry, director at MWFP, stated: 'Beyond the invaluable leadership skills, the RCP Global Women Leaders Programme provided a powerful ecosystem of change-makers. Connecting with the right people through this course is precisely what allowed us to get MWFP off the ground.

Dr Mahwish Arooj, vice president of MWAP, stated: 'This was the first formal leadership programme I have attended, and it exceeded all my expectations. In a world where leadership can often feel isolating, this programme created a lasting community of support, encouragement and empowerment.'

To find out more about the Global Women Leaders Programme, email global@rcp.ac.uk. UK-based physicians can read more about our Emerging Women Leaders Programme on the RCP website.

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

The Tuanku Nazrin travelling fellowship

The RCP and partners, the College of Physicians Malaysia (COPM) and the Malaysian Advanced Acute Internal Medicine and Ultrasound Society (MAAIMUS), provide the RCP-COPM Tuanku Nazrin travelling fellowship to our members.

In 2026, Dr Andrew Blanshard was successfully awarded the inaugural travelling fellowship following open competition. He travelled to Malaysia in May 2026 and recounts his experience to *Commentary*.

In May this year, I travelled to Malaysia as the inaugural Tuanku Nazrin travelling fellow.

I am currently an ST6 registrar in infectious diseases and medical microbiology at Manchester University NHS Foundation Trust, undertaking an out-of-programme experience with a focus on antimicrobial stewardship.

My interest in global infectious diseases has developed gradually over several years through studying parasitology, completing a diploma in tropical medicine, and later working as an infection specialist registrar. I have worked alongside Malaysian doctors visiting the UK, who bring welcome first-hand experience of conditions such as dengue and other tropical infections. The fellowship felt like a natural extension of this interest, and a chance to spend time learning in a different healthcare system with very different pressures; the sort of opportunity that was hard not to apply for.

The collaboration with local senior palliative care clinicians ensured the success of the course. Their wholehearted commitment and enthusiasm were impressive. Success will be measured by any changes, any new services or educational events organised on return to their places of work.

The fellowship is based in the state of Perak, one of the largest states in Peninsular Malaysia, stretching from the west coast up to the Thai border. It is geographically varied, with dense jungle, rural river communities and large urban centres. Perak is one of nine Malaysian states whose hereditary rulers rotate as King of Malaysia every 5 years. Sultan Nazrin Shah, the ruler of Perak and namesake of the fellowship, is someone who I would meet at both the start and end of the trip.

After arriving in Kuala Lumpur, I went straight from the airport to a ceremony at the College of Physicians Malaysia (COPM). I met the college president, Dr Paras Doshi, and was formally welcomed and presented with a certificate by Sultan Nazrin Shah as part of a wider event recognising exam successes and lifetime achievements, alongside a 3-day acute care conference. Later that evening, at the gala dinner, I found myself doing karaoke. Feeling that I should somehow represent Manchester, I attempted 'Wonderwall' by Oasis. It was not my best performance, but it did seem to go down well and was a memorable way to start the fellowship.

My journey through Perak began in the state capital, Ipoh, a city known for its white coffee, tin mining history and as the hometown of world-famous actress Michelle Yeoh. My first visit was to the state public health department, led by Dr Feisul. I received a very warm welcome and spent time hearing about their work and touring the department. The team spoke openly about the practical challenges they face, particularly in reaching remote and nomadic populations, and in managing seasonal patterns of communicable disease, such as predictable dengue surges around public holidays. Although the challenges differed from those we face in the UK, many familiar themes emerged – including vaccine hesitancy, public engagement and resource management.

Later that day, I moved into the clinical setting at Hospital Raja Permaisuri Bainun. The wards were busy, hot and largely open to the outside in the humid tropical environment. I saw patients with resistant bloodstream infections, complex disseminated bacterial infections, advanced HIV and a case of sporotrichosis following a cat bite. What stood out was the level of clinical judgement required, particularly where access to investigations, such as cross-sectional imaging, can be limited or delayed.

I then travelled to Taiping, a smaller city set in the hills of Perak, with a sprawling lakeside garden and a slower, relaxed pace. The fellowship is intended as a two-way exchange, and here I delivered talks on antimicrobial stewardship, sharing some of our successes and challenges in Manchester, and a second talk about my department's approach to engaging people living with HIV in care. In return, I saw a wide range of infectious diseases that I would rarely encounter in the UK. These included advanced HIV with penicilliosis, Cryptococcus gattii meningitis, severe dengue requiring careful fluid management, and Plasmodium knowlesi malaria presenting with acute kidney injury. Plasmodium knowlesi malaria, a zoonotic infection transmitted from monkeys, was something I had never seen before. The severity of illness in some of these patients was striking.

In Taiping, I tried 'cendol' for the first time and immediately understood why it is so popular. It is a

refreshing dessert made with shaved ice, coconut milk, palm sugar and soft green rice flour noodles, and it was easily one of my favourite things that I ate there. It was the first of several times that I had cendol during my trip, with each place serving its own slightly different version.

From Taiping, I travelled to Gerik, a small town on the edge of the rainforest, about 2 hours away. Here, I joined the public health team working with remote Orang Asli communities deep in the jungle. Reaching these villages involved long drives followed by boat journeys across Tasik Temenggor, a vast reservoir created in the 1970s when the Temenggor Dam flooded the upper Perak River valley. Its creation transformed the landscape, submerging forests and old river routes, leaving countless tree trunks rising from the water in an unusually eerie fashion. At one point we had to stop because a family of elephants was bathing in the shallow river ahead of us; we waited patiently until they moved on, enjoying the rare sight.

In the villages, the focus was as much on building trust as it was on delivering healthcare. Public health interventions, such as insecticide spraying and bed net distribution, rely on careful engagement with communities. I had a go at spraying myself (using water rather than insecticide) and quickly realised how physically demanding it is in the heat and humidity. Alongside this, the team delivered simple but important health messages about recognising symptoms of malaria and dengue, and encouraging preventative measures. With no other access to the communities, the team often acted as a surrogate ambulance, bringing villagers into and out of the jungle when urgent medical care was needed.

Another visit to a rural clinic reinforced how closely clinical care and public health are linked. Getting there required a combination of road and river travel, but the clinic was well integrated into the community and able to manage some acute presentations. I met a young woman undergoing directly observed therapy for tuberculosis, with her care closely tied to her home environment and family. It was striking to see how much work the team had put into engaging her family in screening for TB, educating them about the signs and symptoms, alongside measures to prevent transmission.

My clinical placement concluded in the royal town of Kuala Kangsar, where I caught a distant glimpse of Perak's striking royal palace overlooking the landscape. In the evenings, I enjoyed exploring the town, wandering its quiet streets and browsing the local market. At the hospital, I received a warm welcome and gained further valuable clinical experience. One aspect that particularly stood out was the breadth of expertise expected of Malaysian physicians. With more limited access to specialists than I was accustomed to, they relied on strong generalist knowledge and clinical judgement to independently manage a diverse range of conditions.

Outside the clinical work, I was able to see more of Malaysia itself. On Penang Island, I explored its unique mix of culture and tourism. I also took a bike tour through the island's rural interior, including a visit to a durian farm, before enjoying the bustling streets of George Town and the ferry ride across from the mainland. Finishing my trip in Kuala Lumpur, I visited Chinatown, Merdeka Square, Jalan Alor, Batu caves and the Petronas Towers. Merdeka Square – where independence was declared in 1957 – had a strong sense of history, while Jalan Alor was busy late into the night with food stalls and crowds, as well as delicious food.

The fellowship concluded with a final meeting with Sultan Nazrin Shah, where I presented a summary of what I had seen and learned alongside physicians from the COPM, who discussed plans for strengthening physician training and workforce development in Malaysia with His Royal Highness.

Looking back, the most enduring lesson from the RCP-COPM Tuanku Nazrin travelling fellowship was how profoundly clinical practice is shaped by its environment and the people within it. Geography, resources and patient populations all have a visible impact on how care is delivered, and on how closely clinical medicine and public health need to work together.

On a personal level, it is not easy to neatly summarise the experience, with many wonderful experiences, new friends made and beautiful places visited. From singing 'Wonderwall' on the first night, to waiting for elephants at a river crossing, to travelling to remote clinics and meeting Sultan Nazrin, it was an extraordinary breadth of experiences packed into just a few weeks. It was a generous and varied experience, and I have made new friends and connections that will stay with me for a long time.

Find out more about the RCP-COPM Tuanku Nazrin travelling fellowship and the RCP's global work – and keep an eye out for future opportunities.

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