

The art of medicine

The Royal College of Physicians at 500 years: changing roles and challenges

The Royal College of Physicians (RCP) celebrates its 500th anniversary on Sept 23, 2018. Few organisations have been in continual existence for longer in the field of medicine and to be able to celebrate a quincentenary is a remarkable achievement. Over 500 years, the RCP has assumed different priorities and functions as a consequence of the many changes in British sociopolitical history and British medicine. Here, we reflect on these changing roles and current challenges. .

On Sept 23, 1518, Henry VIII, at the behest of his personal physician Thomas Linacre, issued a royal charter that established the College of Physicians. Linacre observed that medicine in Britain lay largely in the hands of “monks and empiricks” and perceived the need “not only create a good understanding and unanimity amongst his own Profession, which itself was an excellent thought, but to make them more useful to the publick; and he imagin’d that by separating them from the vulgar Empiricks and setting upon such a reputable foot of distinction, there wou’d always arise a spirit of emulation among men liberally educated which wou’d animate them in pursuing their inquiries into the Nature of Diseases and the Methods of Cure, for the benefit of mankind” (cited by Towers).

Henry’s royal charter set in place “a perpetual College of Learned and Grave men” that would be able “to withstand in good time the audacity of those wicked men who shall profess medicine more for the sake of their own avarice than from the assurance of any good conscience, whereby very many inconveniences may ensue to the rude and credulous populace”. These sentiments remain central to its ethos, and from its foundation, the RCP has focused on regulation and licensing, and on education and scholarship.

The Royal Charter introduced a new system of regulation that placed, for the first time, the powers of licensing the practice of medicine in the hands of men educated in medicine. The College was given the powers to restrict practice in the City of London and surrounding 7 miles to its own fellows, and also to elect these fellows. This regulatory and licensing role remained the chief function of the College for more than 300 years. Outside London, doctors were usually

licensed by the local clergy, but in London the royal charter removed the church's influence, much to its disapproval. London was also important because it was where medical practice was most lucrative. In 1518, as the King had noted, the London public were at the mercy of largely unregulated quacks and charlatans, nurses and midwives, surgeons and apothecaries. It was into this melée that the College entered with the licensing role as its most powerful weapon.

Over time, the fellows of the RCP began to dominate the British medical landscape, and by the 17th century the physicians (the fellows of the College) were, in the hierarchy of practitioners, the "first class of medical practitioner in rank and legal pre-eminence" (a phrase *from Willcock*). Their success was partly due to their learning and to the academic nature of the College, and the educated and fashionable physicians were consulted by the wealthy. The pickings in London were great, and in the 17th and 18th centuries, many of the fellows amassed great fortunes. Below them, in the medical hierarchy, were the surgeons who were generally considered by physicians to be essentially craftsman, and below them were the apothecaries, as mere purveyors of drugs.

The licensing and regulatory authority was underpinned by royal prerogative and it was from this that the College's legitimacy and power stemmed. The Royal Charter had stipulated that the number of fellows of the College should not exceed 40 at any one time, and this limitation remained in place for 300 years, rendering fellowship a valuable and exclusive commodity. As time passed, however, the fellows were seen increasingly as self-interested and avaricious, a view reinforced during the 17th century by a series of unedifying disputes over the rights of practice with the apothecaries over whom the College had been given supervisory powers. Fellowship, furthermore, was restricted to those with doctorates awarded to or incorporated by the universities of Oxford and Cambridge, the only two English universities then granting medical degrees, and was prohibited to foreigners, Roman Catholics, dissenters, non-conformists, non-Christians, and anyone who practised surgery or midwifery. Some of those thus excluded were, accorded the title of licentiate, an "inferior" category of doctor, who were licensed by the College

to practise medicine in London (and extra-licentiates outside London), but without the other privileges of the fellows.

During the 18th century, schools of medicine grew up in Scotland and across Europe and adopted the science of the Enlightenment to a greater extent than the backward-looking Oxbridge colleges, entrenched as they were in classical learning. Inevitably, the restrictive criteria for fellowship increasingly rankled. This became another source of discontent. By 1763, there were more licentiates (73) than fellows (46) and as a body the licentiates began to protest.

In September, 1767, resentment boiled over into a small riot, known as the Siege of Warwick Lane, in which the College Comitia (its ruling council) was disrupted by an invasion of licentiates which ended in physical violence. As the then College President, Thomas Lawrence, put it “With inhuman violence they broke into this very senate, like swimming sea monsters in our medical ocean”. The events had a chastening effect and very slowly the College began to modernise.

Reforms gathered pace in the early 19th century. The Apothecaries Act of 1815 gave the Society for Apothecaries licensing powers, and then the Medical Act of 1858 was passed into law which, with its amendments, created the General Medical Council (GMC). This body took over the licensing and regulation of all doctors nationwide and, at a stroke, removed what had been the major function of the College, and the source of its power and influence, for the previous 300 years.

Examinations had always been part of the regulatory process and increasingly became the focus of the reforms as the College’s role changed in the 19th century. The examination had taken the form of an oral test conducted in Latin by the censors, and was open to abuse and privilege. After the 1858 Medical Act, procedures had to be changed. Formal written papers were introduced, leading to the foundation, in 1859, of the Membership of the Royal College of Physicians (MRCP) examination, which has endured since although with continuous modification. Women were only allowed to take the examination from 1908, Latin and Greek translation papers and then modern languages were dropped as a requirement in 1936 and 1963, respectively. In 1968, the RCP joined forces with the Colleges in Edinburgh and Glasgow to create a joint membership examination, the MRCP(UK). This examination is now the RCP’s

most important activity and is a national and international success story. It is now held in 24 countries and requires a high level of knowledge over a wide range of medical specialties. In Britain, passing the MRCP(UK) has come to assume a quasi-licensing function as a mandatory requirement for all UK trained consultant physician appointments. If this were to change in the future, the RCP would lose one of its major functions, and the nature of British medicine would also change – and with the current shortage of doctors in the UK in some disciplines, the rise in specialty examinations, and the increasing cost of the MRCP(UK) examination, this has become a possibility.

Until the early 19th century the number of fellows was small—always less than 60, and usually less than 40—but with the 19th-century reforms, the numbers grew, exceeding 100 for the first time in 1828. After 1858, the lower category of licentiate (and later extra-licentiate) was replaced by a new category of member, awarded to all those who passed the newly established MRCP examination. By 1948, there were 747 fellows and 3000 members. Members paid no further fee, and the RCP's income in those years derived largely from the fellow's annual subscription. Financial pressures mounted, and in 1960 it was decided that at least 200 fellows should be elected each year. This was a watershed in the RCP's history and since then the criteria for fellowship have been progressively eased, to the present position in which all physicians are actively considered for fellowship after only 3 years in a consultant post. The award of fellowship, once a sign of exclusive distinction, has become more routine and less elite. Furthermore, recent changes have led the RCP to open fellowship to some categories of non-physician. In 1969, a new category of Collegiate Membership was introduced, open to existing members who paid an annual subscription for the privilege of being more involved in RCP activities. Recently, other paying categories have been created, some of which do not require the MRCP(UK) or even a medical degree, and the RCP now uses the term member to refer to all these paying categories as well as its fellows. There are now more than 18 000 fellows, and over 17 000 members, and neither fellowship nor membership signifies the degree of academic distinction that was the case in the past.

Since its origins the RCP functioned much as a “gentleman’s club”, but this too has changed. The RCP was slow to admit women, and it was only in 1909 that the bylaws were changed to allow women to take the membership examination and the first female fellow was admitted as a member that year. In 1934, paediatrician Helen Mackay became the first woman to be elected fellow, and the clinical haematologist Janet Vaughan was the first woman elected to the College Council in 1943. Dame Margaret Turner-Warwick was elected the first women president of the RCP in 1969. Arguably, the RCP could have done more to support women in medicine to a far greater extent. In the past few decades, however, progress has been made with women regularly holding many of the senior college positions.

In parallel to the changes in licensing and membership, the RCP’s educational and advocacy roles have also evolved. In the 19th century there were, apart from the endowed lectures, few formal educational events, but now the RCP offers a large range of lectures, courses, meetings, publications, and electronic resources. In earlier years, political engagement with the monarchy and with Parliament, focused on its licensing role, and was essential for its survival. However, by the late 19th century the RCP was acting independently giving advice to politicians primarily related to public health, health hazards, such as alcohol, and housing. In the 20th century, its most impressive political achievement was the work of its President, Lord Moran (Charles McMoran Wilson), assisting and supporting the UK Government, in the face of opposition from the British Medical Association, in establishing the UK’s National Health Service (NHS) in 1948. From the 1950s onwards, the RCP’s advisory role has become more prominent with regular meetings with politicians and significant contributions to the debate around smoking, notably in its seminal 1962 report *Smoking and Health* (1962), and more recent interventions on alcohol, air quality, sustainability, and the health impact of climate change.

The influence the RCP can exert depends on its prestige, reputation, and scholarship, and is underpinned not only by the distinction of its fellows but also by its responsibility as a repository of medical history. This role has been an enduring achievement, with the historical library and archive at its centre. Linacre donated his own books and in 1654 a library was opened with William Harvey’s bequest and books and subsequently others made large gifts of books.

Catastrophe occurred in 1666 when the Great Fire of London destroyed the library, which was then endowed in grand style with the bequest in 1680 by the Marquis of Dorchester of his entire library of 3400 books. The library has subsequently and consistently expanded to become a leading medical historical collection and its archive contains many important documents relating to medicine and the RCP affairs, together with a notable collection of prints and art works, silverware, and objects. Regular exhibitions are held centred around its collections to raise public interest in medicine. Another valuable historical resource is Munk's Roll, a near-complete collection of biographies (obituaries) of almost all its past fellows over 500 years. As the number of fellows is rapidly increasing, gaps are sadly appearing, but Munk's Roll is an extraordinary achievement and is a rich source of information for medical historians.

The RCP has thus evolved greatly over the years. It is now an organisation primarily focused on maintaining high standards of medicine by education and advocacy. In 2018, its recently revised mission statement shows how much has changed: "The RCP's core mission is to drive improvements in health and healthcare through advocacy, education and research. We are an independent patient centred and clinically led organisation, that drives improvement in the diagnosis of disease, the care of individual patients and the health of the whole population both in the UK and across the globe". Despite of its manifold achievements, though, there are challenges ahead, not least the effects of the growth of medical specialism, the RCP's struggle to retain professional and political influence, and the financial risks of a burgeoning bureaucracy.

A dramatic change in hospital medicine in the past 50 years has been the rise of the medical specialties. Powerful specialist societies and associations have developed in all major specialties and subspecialties and many hospital doctors now feel primarily identified with their specialist societies rather than with the RCP. Maintaining a strong sense of belonging to and of ownership of the RCP are becoming increasing challenges, and are compounded by the perception among some physicians that the RCP largely promotes general medical training at the expense of specialty training. Similarly, in the field of education, national and international specialty societies hold conferences that dwarf the RCP's own and most postgraduate education is now conducted through these societies. As a result, the RCP's own courses have become increasingly focused

on generic topics, such as leadership and audit, which may threaten its reputation for scholarship. These developments reflect profound changes in the profession and the practise of medicine. If such trends continue the RCP, at least in its current form, may become less relevant.

In advocacy, just as in education, the RCP exists in an increasingly crowded market place. It has been seen by many doctors in recent years not to have had a decisive influence, or even taken a strong position, on some of the major concerns of the profession, for instance, on medical training and service provision. The RCP has considered it better to take a behind-the-scenes and softly-softly approach that is not self-interested or too political, and this has rightly or wrongly led to a perception that its voice is muted. Thus, there have been major changes in both the NHS and the practice of hospital medicine, together with an erosion of professionalism, that have dismayed many physicians. Financially too there are risks in the future. The RCP has widened its range of work, perhaps too diffusely, and has developed a growing bureaucracy. Now more than 420 people are employed by the organisation and, together with estate developments, have resulted in rising costs resulting deficit budgets for the first time. Care will also be needed to ensure the financial viability of the RCP's second, recently opened, centre in Liverpool

These are complex challenges, and a strong vision and a clear sense of priority are required to navigate through the turbulent waters ahead. Yet current challenges about its role, priorities, and finances should not detract from the important and valuable contribution the RCP has made and continues to make, and it deserves the support of the medical community. For most of its 500 years, it has been a vital force in the British medical landscape, and it must remain so in the rapidly changing world of medicine, for the good of hospital practice and for maintaining the high clinical standards of medicine.

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Further reading

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