What has the Royal College of Physicians ever done for us?

Richard Horton

Richard Horton FRCP FMedSci, Editor, *The Lancet*

A reply on behalf of the guests: Harveian Oration, 18 October 2006

Clin Med 2007;7:600–2

Until 1865, the Harveian Oration was delivered in Latin to prevent others from understanding the secret knowledge possessed by physicians. The Royal College of Physicians (RCP) developed an air of exclusivity, less out of a wish for privilege and more out of an urgent need for self-preservation but, by 1942, the College had reached a point where even its President, Lord Moran, likened it to 'an old world village from which the main traffic has been diverted by a bypass'.

The past 60 years have seen a remarkable renaissance of mission, energy and confidence. To the point where the Chief Medical Officer recommends in his report *Good doctors, safer patients* that 'a clear and unambiguous set of standards should be set for each area of specialist medical practice',[1] and that the RCP and related bodies, should set them.

The modern purpose of the RCP is to improve the health and wellbeing of individual citizens and the wider population. That bond between patient and physician, between the physician and the community, is indivisible. It is a tie of service and respect, compassion and commitment. It is a bond that is centuries old, renewed in every generation, and one that has outlasted popular fashion and even political trend.

Sir Michael Marmot (the 2006 Harveian Orator) described how social gradients in health disfigure our society.[2] Despite enormous economic and technological progress, notions of equity and justice remain at the heart of scientific and political debates about health and prosperity and, scaled up, those gradients and gaps have become a global predicament of unprecedented importance. This raises important issues of wider and pressing significance.

In 1665, the College faced a new and uncertain challenge and its challenger was a rather brilliant antagonist. The Royal Society had cleverly commandeered the College for its own meetings. Shockingly, it had been given equal rights to use the bodies of executed criminals for dissection. Physicians were understandably alarmed. Henry Stubbe, a pamphleteer-physician from Bath, wrote of how it 'grieved him to foresee a Rival Society treading so close upon the heels of the Aesculapians'. The great strength of the Royal Society was that it promoted the importance of reliable knowledge which was something of an anathema to many of the 50 or so contemporary Fellows of the RCP.

The two institutions became locked in a deadly battle to attract the blessing of Charles II. The Royal Society or the Royal College: which would be blessed first? Worryingly, the King had already indicated an early sympathy for the former (the Royal Society received its first Royal Charter in 1662). But on 15 April 1665, Charles II mysteriously appeared at an arcane anatomy lecture delivered by William Harvey's friend, George Ent. At the close of the lecture, the King stepped forward and promptly, to everyone's astonishment, knighted the orator. The Fellows of the College cheered and breathed a collective sigh of relief. But ever since then, the College has rarely left the honour of their lecturers to the chance presence of Kings or Queens.

The College learned at least three important lessons from its rivalry with the Royal Society. First was the importance of fostering a strong scientific culture in medicine, public policy, and non-medical opinion. Science remains an intense subject of contemporary debate and disagreement. The current curriculum is under fire from critics who claim that hands-on experiments are being replaced with classroom discussion. 'Soundbite science' was in the ascendance, suggested the Rector of Imperial College London. This was a complaint typical of the 'science elite', retorted others, including Sir Roland Jackson, Chief Executive of the British Association for the Advancement of Science, who has written that the existing model of science education has demonstrably not worked.

University chemistry and physics departments, disciplines that are critically important to medicine, are facing closure. This is a good thing, say some. Science should contract and 'claw back its nineteenth century glamour', according to the commentator Simon Jenkins. A public culture in which medical science is seen as a source of fear is described in Ishiguro's novel, *Never let me go*:

> *I saw a new world coming rapidly. More scientific, efficient, yes. More cures for the old sicknesses. Very good. But a harsh, cruel world. And I saw a little girl, her eyes tightly closed, holding to her breast the old kind world, one that she knew in her heart could not remain, and she was holding it and pleading, never to let her go.*[3]

Medical science, so this argument goes, brings tremendous benefits but tremendous losses too. Somehow one senses that this tarnished view of science is seeping into the public, maybe even the political, consciousness. Fortunately, the funding of the health and biomedical sciences in Britain has undergone a thorough overhaul. Sir David Cooksey's recommendations have strengthened the science base of the UK. His work provides a firm foundation for this College's continued influence.

The concern remains that society has come to take science for granted. It has failed to articulate its public value as a model for rational thinking. In truth, the effects of science on our lives are largely invisible and therefore easily forgotten. Yet scientific medicine, together with the universities and industries that sustain it, has developed a set of scholarly values that are concerned with generating and sharing reliable knowledge. Science invests in new ideas and new methods, in discovery and innovation. Scientific medicine is inextricably linked to society and social values, as emphasised by Sir Michael.

And so the rivalry between the RCP and the Royal Society is a story worth remembering. For the first lesson of this early rivalry is that the College has been strongest when it has paid most attention to the public good of science in the service of patient care and population health. During its long history, the RCP sometimes struggled to choose between the competing attractions of ceremony and science. When the College has chosen science, its influence and impact have been palpable. For the past half-century, science has been firmly at the heart of the College's work. Without it, this College would surely have withered. With it, and in an enhanced form, its future is as good as guaranteed.

The second lesson is embodied in its founding charter, which states that the College exists 'to curb the audacity of those wicked men who shall profess medicine more for the sake of their avarice than from the assurance of any good conscience'. This is a sound definition of medical professionalism which today is looking rather careworn.

The ways used to describe the state of medicine do little to indicate that professionalism is perceived as a valuable asset in our modern system of medical education and training. Professionalism may be observed, but it is hard to measure. A report on the state of our nation's health service published in October 2006 was not encouraging. According to the Healthcare Commission, 'patients' care will suffer' thanks both to weak financial management and to a variable quality of services in far too many NHS trusts.[4] The first annual health check of trusts found that they were not currently meeting standards of professionalism.

The Commission concluded that the NHS had to dramatically improve standards. In response, and not too defensively, one might say that the NHS is not merely an abstract collection of buildings, pathways, journeys, and systems. It is a collection of people, human beings interacting with other human beings; the public (patients) meeting health professionals. The annual health check is not a barometer of professionalism. It does not tell you how good the nurses, physicians, surgeons, and other health workers in the NHS really are. It does not measure the commitment of dedicated health service staff. Yet large swathes of the NHS are nevertheless branded 'weak'. To put it charitably, this seems an incomplete health check.

The fact is that the success of Britain's health system depends upon nurturing and celebrating the professionalism of health service staff to protect and augment the quality of patient care. The health service in each of the four countries of the UK has much to teach and learn from the others. Eroding that sense of professionalism, by exaggerating the alleged burden of weakness and mediocrity, is not an intelligent way to proceed. We will not regulate the NHS into success. But we can motivate health professionals to further success through respect, partnership, and by recognising the social virtue of the professions. It is that kind of professionalism that this College was founded to develop, and which it succeeds in building to this day.

A third lesson concerns the interface between science and medicine – namely, the value of both activities for the public good. And here there is a genuine dilemma that should be acknowledged. Much is said about a patient-led NHS and patient choice. That the patient must, correctly, be at the centre of professional concern was, indeed, embodied in the founding charter that this College of 'learned and grave men' would prevent the 'very many inconveniences [that] may ensue to the rude and credulous populace'.

We do not of course talk about the public being rude and credulous any more. But there is a paradox here concerning a very English notion of liberty. The advancement of society is, according to Isaiah Berlin, measured by 'the extent of a [person's], or a people's, liberty to choose to live as they desire'. We have now embraced this notion of liberty in the heart of our health policy. It is a brave idea. Yet it is an idea that sometimes seems at odds with the scientific and moral purpose of medicine, which is not to encourage the liberty to live as one desires, but to encourage healthy behaviour and healthy choices that are personally and mutually desirable. Is medicine, therefore, anti-liberty, anti-choice – in a word coercive?

It is this kind of logic that leads to charges of paternalism and the nanny state. Yet here, surely, is an area where civil society, medicine, and the state can forge a positive alliance. For medicine is, as Jeremy Bentham once argued, the most powerful means to maximise the welfare of society. Pure laissez-faire is not a healthy prescription for strengthened liberty. Unhealthy choices constrain liberty; they do not enhance it.

A patient-led NHS? Patient choice? The rhetoric is good. The reality may be rather different. To secure the freedom to make one kind of valued choice, perhaps sometime in the future, may mean having to forego the freedom of another kind of choice right now. Choice is not about the pure expression of liberty. In a democratic society, it must surely be about the informed expression of that liberty, a liberty perceived longitudinally and not instantaneously.

And this is what the wider endeavour of medicine – of this College, perhaps – should be about. To work to strengthen public reasoning as a central feature of our society; to find ways to upgrade the quality of public dialogue and exchange; to find the right language to discuss often complex technical issues; to recognise that silence is the enemy of health. In sum, to

maximise society's rationality, its health and scientific literacy.

I do not think you should pay too much attention to the words of professional writers, let alone editors. 'The writer is the engineer of the human soul'; I always rather warmed to that idea until I discovered it is attributed to Josef Stalin. Only reluctant writers, like William Harvey himself, should be trusted. But still, I believe that the RCP has never been more important to the future of patient care and public health than it is today.

Looking back at its history, this Royal College of Physicians has succeeded when it understood the value of strong scientific and clinical leadership; when it took public and policy engagement seriously; when it provided robust, reliable, and sometimes unpopular advice, independently, to government; when it succeeded in making wise alliances with civil society; when it was bold.

Thomas Sydenham, a Licentiate of this College, wrote in 1668 that a doctor's 'skill and science' should be directed to 'the welfare of his fellow-creatures', with the knowledge that the physician is not exempted 'from the common lot, but that he is bound by the same laws of mortality'. 'For these and like reasons', he continued, 'let him strive to render aid to the distressed with the greater care, with the kindlier spirit, and with the stronger fellow-feeling'. This is an admirable commitment for today.

References

1. Department of Health. *Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*. A report by the Chief Medical Officer. London: DH, 2006.
2. Marmot M. Health in an unequal world: social circumstances, biology and disease. *Clin Med* 2006;6:559–72.
3. Ishiguro K. *Never let me go*. London: Faber, 2005.
4. Healthcare Commission. *Results of the annual health check 2005/2006*. London: Healthcare Commission, 2006.