History of the Royal College of General Practitioners — the first 40 years

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SUMMARY. A steering committee met in 1952 to plan for the formation of a new college of general practitioners. An analysis of the work of the Royal College of General Practitioners over its first 40 years suggests that the published aims of the steering committee were largely fulfilled and in some ways exceeded. The unifying theme of the College's development appears to have been the wish to establish general medical practice as a scientific discipline.

Keywords: history of the RCGP; history of GP.

Introduction

ON 19 November 1952, the College of General Practitioners was founded by a steering committee, chaired by Henry Willink, minister of health from 1943 to 1945. This followed memoranda presented by Fraser Rose and John Hunt to the General Practice Review Committee of the British Medical Association in 1951.[1]

It is not possible here to appraise all the achievements and failures of this new body or to assess its strengths and weaknesses. What is appropriate now, at the beginning of the fortieth anniversary year of the foundation of the College, is to re-examine the aims of the General Practice Steering Committee[2] and to comment on how they compare with the work of the College today. The main aims, expressed as 'functions' by the steering committee, were:

1. To provide a headquarters.
2. To give a lead to general practice.
3. To plan and follow an agreed policy about many matters concerning general practice.
4. To assist in the training of undergraduate medical students for general practice and promoting further experiment in this direction.
5. To help and promote the postgraduate teaching of general practitioners:
   (a) in training a qualified doctor for a career in general practice;
   (b) in continuing a practitioner's education throughout his career.
6. To pick out and encourage those [general] practitioners who are keen and able to do good original work on their own or in small teams ... Many ideas will arise from the problems of practitioners in their surgeries and in their patients' homes which will, perhaps, become the inspiration of important and widespread investigations. Later on College prizes may be given for outstanding work; research fellowships may become available, financed by gifts and endowments to the College.
7. To be a repository for the traditions of general practice.
8. To raise the status and enhance the prestige of the general practitioner among medical students, specialists and the public.
9. To improve the quality, the art, and the skill of general practice by setting a high standard and by encouraging and helping general practitioners to reach and maintain it in the same way that the royal colleges have raised and maintained the standard of specialized practice.

   To consider 'a diploma to be granted by the College' ... which 'will in no way interfere with the present qualifying examinations'... and 'will be in breadth rather than depth and only in those subjects which are of particular interest and importance to general practitioners in their daily work. It will always be only one of several portals of entry to the College ... it must be something of a hurdle, an emblem of quality worth striving for.'
10. Many other activities are sure to be explored by the College as it grows.

Providing a headquarters

Buildings

In 1952 there was no focal point for academic general practice anywhere in the British Isles. Establishing a headquarters for the new College was a priority and the first annual report described how 'a large and bright room has been acquired, at a reasonable rent, as the central office of the College at 54 Sloane Street, London SW1'.[1] This was the practice building of John Hunt the first honorary secretary of the College.

The College reached its present site, 14 Princes Gate, Hyde Park, London SW7 in 1968. Thus, the College is housed in a building of great history and beauty,[3] which accommodates about 80 staff and provides meeting rooms, offices, and accommodation for members in a setting which symbolizes the national standing of general practice. Comparable with the headquarters of the older royal colleges, and with an insurance value in 1991 of £7 130 000,[4] it provides a home for the council of the College.

Resources

The response from the profession to the foundation of a College was immediate — over 1000 joined within three weeks and over 2000 within six months.[1] Growth since then has led to a record membership in 1991 of over 16 000.[4] Since 1954 membership has risen by about five-fold, the subscription 65-fold, subscription income about 30-fold to £2 million a year, and assets about 500-fold.[4]

In step with this growth in membership has been a corresponding growth in the number of College staff to service it. The staff have become more professional over the years bringing a wide range of expertise to the College.

The faculties

The special strength of the College lies in its local faculty structure. Learning from the mistakes of the National Association of General Practitioners over 100 years earlier[1] the constitution and the membership of the council were arranged to ensure powerful local voices, which included active councils in Scotland and Wales.

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This is one of a series of articles celebrating the 40th anniversary of the Royal College of General Practitioners.

As more and more functions, especially education and local representation, became increasingly important, so did the role of the faculties and this was confirmed again at the beginning of the 1990s with the council paper 'The faculties — the future of the College'.[5] By 1991 the number of faculties had risen by about half to 32, usually by division into geographically smaller units, and 16 faculties had a membership of over 500 general practitioners.[4]

Leadership of general practice

The plaintive words of John Hunt in 1952 stated the problem: 'General practitioners had muddled along, and time and again had found themselves left behind, left out, edged out, and even pushed out ... many practitioners felt it was largely their own fault that they were in these difficulties. They had never organized themselves and they had no-one of the standing of the executive of the royal colleges when big decisions had to be made'.[1]

The steering committee offered an answer: 'The College will give a lead to general practice. This leadership must be both central and peripheral, and be supplied by men and women actively engaged in general practice. Above all things it must be truly national. The steering committee considers this leadership of practitioners by practitioners is something of great importance. Specialists can have little real understanding of general practice or first hand knowledge of its difficulties and problems. A college will be able to collect together family doctors of high ideals and strong personality, who will be ready to fill the many positions of trust and responsibility which the founding of a college will create'.[2]

So it has proved. The College is continually consulted by government and national organizations and has often given evidence of importance, notably to the royal commissions on medical education[6] and the National Health Service.[7] Large numbers of 'positions of trust and responsibility' have duly appeared. Notably the College has achieved direct representation on such bodies as the General Medical Council, the Conference of Medical Royal Colleges and Faculties in the United Kingdom, and the Clinical Standards Advisory Group. The council elects each year representatives on about 100 other national or regional bodies.[4]

In addition, College members have been invited to serve on many national bodies including two royal commissions,[8,9] several government committees, including the Gillie committee[10] (chaired by a College leader), the Harvard Davis committee[11] (chaired by a general practitioner), the Merrison committee,[12] and many professional committees and advisory posts both centrally and peripherally.

Leadership has always been a difficult issue in general practice. In the absence of a research tradition, which provides authority for leadership,[13] there has at times been suspicion, indeed anti-intellectualism. The College has created both leaders and leadership and the vigorous debates in the council have, as predicted, expressed 'both high ideals and strong personality'. Forty years on, College members can be confident that their subscriptions are making it possible for working family doctors to stop the voice of general practice being 'left out' or 'pushed out'.

College policies

The steering committee foresaw that their new college should 'plan and follow an agreed policy about many matters concerning general practice'.[3] They stated that the College would 'ensure that future development of general practice in Great Britain will take place along lines carefully considered by men and women with the right kind of experience'.

College policies have proved to be influential, and sometimes the dominant influence, in the development of general practice, not just in the UK, but also abroad.

In the 1960s and 1970s the College policy on the importance of introducing vocational training for general practice moved with speed. It was only 11 years from publication of the College's first report from general practice[14] to the 1976 NHS vocational training act and this was perhaps the most striking example of the College's policy-making role. In 1978, the College adopted a statement on the care of children[15] which integrated health surveillance with reactive care and this was introduced in the NHS in 1990.

Perhaps the most far-reaching issue was the series of College working parties on preventive medicine, led by John Horder. A series of reports from general practice redefined the discipline.[16,17] From then on general practice accepted that doctors in primary care had the responsibility and unique opportunity to provide personal preventive medical care in the course of ordinary day-to-day general practice.[18] Anticipatory care became part of general medical care and in relation to defined practice populations. In the 1980s, the emphasis moved on to quality and standards[19,20] with support for computerization and a vigorous defence of the registered list.[21]

Education in general practice

One of the main differences in the way in which the steering committee envisaged the future and the way the College actually chose to develop lay in education. The role of the College was seen as collating experience for those seeking a career in general practice and acting similarly for established principals. The College instead developed a two-pronged approach: vigorous activity within the College itself and a systematic campaign to gain entry for general practice to the universities. The College quickly tackled several aspects of education. Two of its five committees of the council were educational: the undergraduate education committee, and the postgraduate education and regional organization committee.[1]

Undergraduate medical students

'It [the College] could establish the principle that much more in general practice can be taught to students than is capable of being done at present and that general practitioners exist who are capable of doing it'.[2]

The College started by sending a questionnaire to all deans enquiring about general practice teaching in the undergraduate medical schools. The replies showed patchy arrangements, with only one school providing four weeks in the whole course and many providing a single day or no teaching at all.[1]

In 1954, the undergraduate education committee of the College published a report recommending that a general practitioner be coopted to the selection board when choosing medical students.[22] The following year the College's evidence to the General Medical Council included a recommendation that there should be an independent department of general practice in every medical school.[23]

In 1973, Pat Byrne's report on undergraduate teaching in the UK was published[24] and the campaign continued in the 1980s with two occasional papers, *Undergraduate medical education in general practice*[25] and *The contribution of academic general practice to undergraduate medical education.*[26]

After 40 years there is a department of general practice in every medical school, 20 chairs of general practice, and general practice has become the most popular branch of medical practice.[27]

Vocational training

In the early 1960s, the College took a strategic decision and chose to concentrate on the early years of post-registration training.

This was to prove the main focus of activity for about 20 years. The task of identifying the need for vocational training, defining it, planning it, and then persuading a reluctant profession to accept it is a story in itself.[28] From the early 1960s to the early 1980s this was the dominant educational theme and it was led by the education committee of the council, under the chairmanship of Bill Hylton, Pat Byrne and John Horder. Horder's evidence for the College to the Royal Commission on Medical Education was talked about years later and led to the College's report from general practice[6] effectively being accepted in the royal commission's report[8] in 1968.[29]

The annual William Pickles lecture traditionally has an educational theme and College lecturers in the past have used them to deploy the arguments with effect.[30-35]

The campaign was well-led and well-executed. It included a notable publication called *The future general practitioner.*[36] This College working party report set the educational agenda and couched its content for the first time in educational objectives. Teacher workshops were invented and started.[37] A remarkable course, funded by the Nuffield Provincial Hospitals Trust, was conceived by Ekke Kuenssberg and led by Paul Freeling and Suzie Barry.[38] In 1970 terms it was an example of teaching the teachers. In 1990 terms it was leadership training *par excellence.*[39]

Kuenssberg also identified the need for a new national structure and converted the College's vocational training committee into the Joint Committee on Postgraduate Training for General Practice, which started in 1975. This has proved to be an important partnership with the General Medical Services Committee with which the College is joint parent. The chairmanship is shared alternately and this body has had a big influence on standards in training practices.[40]

As late as 1981 it was possible for a general practitioner in the UK to become a principal, the highest grade of general practice in the NHS, without any specific training. It took until 1982 before the entire three-year training period after the preregistration year was implemented and longer still to raise standards, but the opportunity for 'a rigorous training programme' as defined by McWhinney[41] was at last available.

Higher professional education

When vocational training had been achieved and built into the professional system for medical education, the College turned its attention to the next phase. In a reinterpretation of its original five-year plan for vocational training, it called instead for a new set of opportunities for further education, identifying young principals as a priority group. Its current educational strategy calls for a wider range of opportunities for principals including the chance to learn research skills and methodology and to prepare, where desired, for higher university degrees.[42]

Continuing medical education

An early focus for continuing education came through the active practice organization committee, especially under the chairmanship of Ekke Kuenssberg and later Michael Drury, both of whom went on to become presidents of the College. It initiated a whole wave of activities: on premises, on staff, on systems of organization, and on equipment. It was effectively the beginning of the general practice team.[43,44]

The Graves Medical Audiovisual Library, which was first based on audiotapes, grew up as a part of the College through John and Valerie Graves, both active members of the College. It was a pioneering example of distance learning and an effective way of bringing good education into general practitioners' homes and practices. It later became the largest service of its kind in the world. The College has maintained its interest in distance learning through the continuing learning in practice project (CLIPP), which included the clinical assessment for systematic education (CASE) series. Both of these were initiated by Alastair Donald as faculty-based educational programmes and were supported by generous external grants.[45]

Particularly important has been the emergence of the regional branches of the College, the faculties, as educational providers. From the very beginning, faculty study days, symposia, and increasingly annual academic lectures have become events which both improve local education and bring College members together. It is now usual to have general practitioner speakers at study days and their teaching skills have grown substantially.

University departments of general practice

In 1966 McWhinney, one of England's leading general practitioner thinkers and later one of Canada's leading generalist professors, defined the four essential features of a discipline as: a unique field of action, a defined body of knowledge, an active research programme, and a rigorous training programme.[41] The work of the College for its first 40 years can be summed up as responding to that challenge and getting general practice into a position to fulfil those four criteria.

Entry for general practitioners to the universities was a target for the College from the start. The universities held the key to many research opportunities, to collaboration with academic colleagues, to better research facilities, to better funding for research, to access to medical students as a right and not as a favour, and to the provision of role models for medical students who were generalists not specialists. Departments and chairs of general practice would provide platforms for academic leadership, status, and representation which general practice had always missed so much. Since the aims of all academic bodies are the same — research and education — the colleges and universities should complement each other's work. This had always been true for specialist medicine: the question was how to make it happen for general practice. Universities and medical schools could only be reformed from within. Entry for general practitioners as university staff was required.

The College's success was remarkable. Within only 11 years the first chair in general practice in the world was established at the University of Edinburgh and Richard Scott, a member of the foundation council of the College, was appointed to it.

Regional advisers in general practice

The relative difficulty which the College had in getting university departments and professors of general practice was to some extent balanced by a rapid development of another kind of university general practitioner — the regional adviser in general practice. The regional advisers were appointed to lead the new educational system following a Department of Health and Social Security circular in April 1972,[46] and an adviser-led system of associate advisers and course organizers was established quickly in the mid-1970s. This system had no parallel in any other branch of medicine. It had been driven by need — the need to organize vocational training from a standing start, on a national scale, and on a regional basis.

In effect, the regional advisers had the responsibility for implementing vocational training and, supported by the course organizers and up to 2000 trainers, they did so quickly. Their links with the College were considerable and have continued. Between 1967 and 1990 six out of eight successive chairmen of the council of the College have been regional advisers. The College thus influenced and was influenced in turn by the standard-setting developments in training practices.

General practice research

College research

The research committee was one of the original committees of the Council and it was active within a few weeks, with letters in the *Lancet* and *British Medical Journal* by January 1953.[1] Individual general practitioners with a research skill or inclination were sought out, encouraged, nurtured and valued.

A classic early study was that proposed by Ian Watson at the very first meeting of the research committee in Bath in 1953[1] when he suggested using a number of practices to answer an important clinical question: whether penicillin, a new drug, helped in the treatment of measles, which was then still rampant. The results, published in 1956, showed that it did not.[47] The place of collective studies by the new College was established.

As early as 1958, the College researchers were fashioning the specific tools of general practice research. Even before the College *Journal,* Watts was recording in the old newsletter *Between ourselves* how to establish an age–sex register.[48] Eimerl, a chairman of the research committee, invented the E book, the first diagnostic register,[49] and opened the door to clinical review and later medical audit.

Later the College was to establish a number of research units, at Birmingham, Leigh, Dundee, Guildford, Manchester and Swansea, all built round general practitioner enthusiasts. The Manchester unit, established in 1967 under the direction of Clifford Kay, continued with the multi-practice tradition with the biggest study in the world on the contraceptive pill involving 46 000 women and their general practitioners.[50,51]

The Birmingham unit, formed in 1961, centred on the original research mind of Donald Crombie, in partnership with Robin Pinsent, a member of the original steering committee and of the foundation council. Pinsent was for many years research adviser to the College and gave advice to a whole generation of younger College members, many of whom made the pilgrimage to Birmingham and received not just advice but the stimulus and enthusiasm to carry out research in general practice. This, coupled with the personal and supportive style of the College librarian, Margaret Hammond, fired a whole generation of general practitioner researchers.

The Birmingham unit developed information systems such as the age–sex register[52] and later practice activity analyses.[53,54] It has also had a longstanding involvement with the national morbidity surveys, the first of which was being discussed with Logan in the research committee as early as 1953.[1] The surveys were then linked with the Birmingham Research Unit, the Registrar General and the Ministry of Health, and continue to this day in partnership with the Office of Population Censuses and Surveys and the Department of Health.[55,56]

Watson's epidemic observation unit at Guildford and Williams' unit at Swansea, established in 1975, made important contributions to understanding respiratory tract infection[57] and whooping cough.[58] Maurice Stone at the Leigh clinical unit, established in 1978, was one of the first to identify fibrinogen as a major risk factor for ischaemic heart disease, and started to show that multiple risk factor reduction in general practice was possible.[59]

The steering committee was prophetic when it said that College research fellowships 'may become available'. By setting up research and education foundation boards and later amalgamating them into the scientific foundation board, the College created a fund to support general practice research. In 1991 this had assets of £839 664. In addition the College can currently offer about six research training fellowships each year for general practitioners, and the first faculty-based research endowment started in 1990.

Discipline of general practice

The annual reports of the College describe in detail the work of the College. But what is the unifying theme? How has so much cohesion been achieved? What was it that drove such a small but effective band to start with the almost virgin field of education and research and why were the universities so crucial?

The College was trying to found a discipline. If there is one broad aim which encapsulates the overall strategy of the College, it is that, consciously or unconsciously, it acknowledged that general medical practice was not recognized as a separate discipline in 1952 and that this must be rectified as soon as possible.

So what is a discipline and why is it so important? The word is defined in the *Oxford English dictionary* as meaning 'a branch of instruction or learning'. It means a body of knowledge, and since learning implies a factual, objective basis, in effect it means a body of research. Since universities are designated organs of society for research and higher education, a discipline is a recognized university subject.

The issue is one of academic autonomy. Is the subject to be taught on the basis of its own research or on the basis of the research of others? In 1952 there was no scientific basis for the practice of general practice. Teaching was done mainly by others outside the field and on research done also outside the field, mainly by specialists. There were not enough studies from general practice to provide an objective basis for the discipline — general practice had not even been defined — therefore, it was not then a discipline.

The literature

In the development of any discipline, the literature is the key. It describes new knowledge and evidence for it, and often stands as the one permanent record of that research. The medium is the message; without a scientific literature there is no discipline. When the College was founded there was no single journal committed to publishing original work from general practice itself and the existing journals, such as *The Practitioner,* were essentially review journals.

The journal of record is a hallmark for a new scientific discipline and it came quickly. Pinsent, the first editor, and later McConaghey, turned a confidential news sheet, started in 1954, into the first general practice journal of record in the world to be recognized by the National Library of Medicine in the USA.[60]

The College followed this up by producing various series of academic publications, notably the reports from general practice, which began in 1965, and the occasional papers in 1976. Finally in 1982 the College started publishing books,[57,61] often republishing classic books from general practice including Pickles' *Epidemiology in country practice*[62] and Huygen's *Family medicine — the medical life history of families.*[63] No other generalist college or academy has published so much original material from general practice.

Denis Pereira Gray analysed the development of the literature of general practice[64] and suggested that the entry to *Index medicus* of the College's journal, coupled with the arrival of multiple books on the clinical aspects of general practice,[65,66] dates the establishment of general practice as a discipline to 1961, that is, only nine years after the foundation of the College.

Repository for the traditions of general practice

The College has certainly become the repository for the traditions of general practice as intended by the steering committee.

Its academic lectures, and their publication, preserve the thought and customs of each generation and the College has appointed an archivist and regularly mounts displays of papers, equipment and memorabilia. The library holds a collection of MD theses from general practice which is one of the largest in the world.

Improving the status of general practice

It is clear from the steering committee's report that the status of the general practitioner in 1952 was a matter of great concern.[2] Most of the opening page of the report is devoted to status and the idea recurs throughout. Indeed the problem of status was several hundred years old[67,68] and was an important factor in the move to found a college of general practitioners in 1845.[69,70]

General practitioners achieved their aim of entry to the medical profession and separation from the 'quacks' through the medical act of 1858, but only at the price of becoming the lowest members of the medical hierarchy. Moreover, within 30 years, control of general practice passed to specialists with the introduction of the MRCS/LRCP diploma in 1884.[71] In this way general practitioners became symbolically the children of two parent specialist royal colleges.

In 1952, general practitioners in the UK were, as now, the oldest and largest branch of the medical profession.[1] Yet they did little research, published few papers, rarely taught medical students, had limited opportunities for apprentice-type training, no university department of general practice, and no professor of general practice anywhere in the world. The low regard in which they were held was epitomized by Moran who referred to general practitioners as 'falling off the ladder'.[72] Moreover the publication of the Collings report[73] revealed major deficiencies in general practice and there was no body to undertake research on its behalf. The very existence of general practice was threatened and devalued by Arthur Thompson in his lecture 'Is general practice outmoded?' (paper presented at the Royal Society of Health, 70th health congress, 1963).

Medical students were taught that research and professional development occurred only in the specialties. Specialist medicine was confident, relatively well resourced and the hospital appeared as the dominant centrepoint of medicine. Few students chose general practice and many of those who did came from medical families where the clinical interest and confidence of a parent acted as a counterweight to the pull of the specialist system. Phrases of the day reflected the public view: 'ending up in general practice' and, even more strikingly, 'just a GP'.[74]

Since general practice had low status, it was usually unrepresented in the corridors of power. Indeed outside the medico-political arena of the British Medical Association and the Conference of Local Medical Committees it had few leaders and none with an academic or scientific base. When the idea of a new National Health Service was being discussed in 1946–48, the three specialist colleges were consulted and expressed their views with force[75] but general practice had no voice. The absence of such a voice was noted and was one of the driving forces in the establishment of the new College of General Practitioners.[76]

So hostile to the idea of a generalist college were the then three medical royal colleges that the College of General Practitioners had to be founded in secret. Hunt describes how the very idea of a college of general practitioners was ridiculed. Russell Brain, then president of the Royal College of Physicians, wrote in 1952 that the three royal colleges had 'just settled the point that there would not be a college of general practitioners'.[76]

Thus, it took over 100 years after the previous attempt before general practitioners were to achieve their professional independence: the independence of the medical generalist from the medical specialist. Once founded, the College of General Practitioners sought to raise the status not just of general practitioners, but also of their patients. In contrast to the dominating territory of the teaching hospital bed,[77] the general practitioner's beds in the home were devalued. In contrast to medical school teaching on the 'interesting case', the general practitioner's patients were all too often described as 'blocking beds' or 'crumble'.

General practitioners needed articulate people who could present the case for the 'doctor for the people'.[71] Doctors who work in homes with families[63] have a different perspective and can value the common and incurable problems which patients face daily. They have put issues like continuity of care,[78] doctor–patient relationships,[79] poverty,[80] communication,[81] the home[63] and the environment,[17] on the research and teaching agendas of institutional medicine.

Given the longstanding problem of status, the issue of recognition for general practitioners and their College was greatly eased when the royal charter was conferred by Her Majesty the Queen in 1967, and presented to the College by its royal patron, His Royal Highness Prince Philip, after he had been elected first an honorary fellow and then president in 1972. More recently, the College has been honoured by HRH Prince Charles taking office as president of the College in November 1991 for its 40th year.

Quality of general practice and standards of care

If the steering committee in 1952 was not able to envisage quite how radical the College's academic strategy would be, nor how great its achievement in terms of status as a discipline, the reverse is true for quality and standards. Here it had a wider vision — it took the College over 31 years before it used the words of the steering committee, 'quality of general practice', for its quality initiative[19,82] and 38 years before it defined some minimum standards of clinical care in practices.[20]

Standards of care

All royal colleges exist to benefit patients; this is the justification for their charters and charitable status. The Royal College of General Practitioners has produced innumerable guidelines and advice in publications, such as the reports from general practice on personal preventive medicine, the organizational folders introduced by Robin Ridsdill-Smith and clinical folders introduced by Colin Waine. All these tackled common problems of general practice and offered practical advice and support to general practitioners in their daily work.

In 1985 a major statement of policy was produced, *Quality in general practice.*[19] This set the scene for the 1980s and was followed by the College's most recent advance, namely the new system of awarding fellowship of the College on the basis of a rigorous practice-based assessment which it introduced in 1989.[20]

MRCGP examination

The history of the MRCGP examination, discussed by the steering committee in 1952, has been interesting.[83] Step by step and in parallel with the educational campaign for vocational training, the College introduced in 1965 an examination in general practice and it was soon made the only normal route to membership. It started with only five candidates, but built up to over 2000 a year in 1986.[4] The MRCGP examination became the only national endpoint examination for vocational training. The examination was recognized by the General Medical Council in 1967 and became an additional registrable qualification. In 1979 the Royal Commission on the NHS suggested that passing this

examination should become the normal prerequisite for entry to the grade of principal in the NHS.[9]

To celebrate 25 years of the MRCGP examination the College published an occasional paper, *Examination for membership of the Royal College of General Practitioners (MRCGP).*[84]

Other activities

The steering committee realized that the College would become involved with many other academic activities, as indeed it has. These are too numerous to list, but notably include the construction of the first general practice thesaurus and the provision to all members and associates of an enquiry service and a computerized on-line search service for references. This, with a faculty computerized database and the increasing trend to provide professional staff based in faculties, set the scene for much more local activity in the College in the future.

One aspect of the College's work that was not foreseen in 1952 was its international involvement. However, having started the first scientific journal of general practice the College has continued to play a part in the worldwide renaissance of primary care,[85] which it does through an active international committee.[4] Many of its former faculties have developed into independent colleges, and its support of the World Organization of Family Doctors (WONCA) led to Stuart Carne[86] becoming president of WONCA and John Lawson and Douglas Garvie becoming chairmen of WONCA council. In addition, Lotte Newman became president of SIMG, the European organization for general practice.[87]

Cum scientia caritas

After its first 40 years perhaps the main conclusion about the College of General Practitioners is that it proved to be the mechanism for releasing a vast amount of intellectual and emotional energy in the largest branch of the medical profession. It has been a liberating movement on a grand scale.

The College was a solution to a longstanding problem faced by general practitioners the world over — professional isolation. By constructing a framework for communication it disseminated good ideas rapidly and, most important of all, allowed cross fertilization of ideas to begin.

The College is not just a beautiful building, nor solely a national academic institution, but a group of people committed to improving general practice. To understand the College, it is not enough to delineate the dates, the documents, and the decisions, although these are the data of history. The College is essentially a group of human beings, thousands of doctors and about 100 staff working together for a common cause.

A new national academic body needed to identify and communicate its subject. When this was later defined as having both a scientific and a personal relationship component, the masterly motto of the first chairman of council, George Abercrombie, came into its own. *Cum scientia caritas,* science with compassion, encapsulates and communicates the essence of good general practice.[88]

The human contacts, the help, the support, the encouragement and sometimes inspiration are the unseen and often unrecorded cement which holds together the academic bricks. There are few active College members who have not at times been helped through personal contact with another member to tackle the difficult and demanding job of being a modern general practitioner.

As in all other organizations, people get out of the College what they put in, transformed in ways that they do not always expect or understand at the time. The College is powered by people, few of whom work alone. The stimulation, the enthusiasm, and the personal support are freely given by colleagues who are first and foremost personal doctors. The College is built on friendships: in the faculties, in the committees, and in council.

Conclusion

The General Practice Steering Committee of 1952 was a remarkable body. It met only eight times between February and November,[2] overcame substantial legal and medico-political hurdles, and formed the College. Its subsequent report is of historic importance and revealed a vision which the evidence suggests has been largely fulfilled.

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