

THE DOCTOR'S VIEW

CLINICAL AND GOVERNMENTAL RATIONALITIES
IN TWENTIETH-CENTURY GENERAL MEDICAL PRACTICE

Thesis submitted for the degree of Doctor of Philosophy

by

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June 1991

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JUNE 1991

TITLE: 'The Doctor's View: Clinical and Governmental Rationalities in Twentieth Century General Medical Practice'
(Thesis submitted for the degree of Doctor of Philosophy.)

This thesis traces endeavours in the twentieth century to provide the 'intellectual' foundations for general medical practice as an independent, autonomous clinical discipline. The empirical focus of the study is upon the application of psychological and 'person-centred' approaches to general practice; above all, in the work of Michael Balint, and the Royal College of General Practitioners in the post-war period. The thesis is guided by two predominant theoretical concerns. First, to highlight the complex strategies and the wide range of means and resources that have been required to give substance to the claim that general practice is 'by nature' a person-centred endeavour. Second, to consider - and to question - certain influential approaches to medical power in general, and to the social consequences of 'emancipatory' - person-centred - forms of medicine in particular. Specifically, the 'power/knowledge' approach to medical sociology is contested both with regard to its empirical findings and in relation to its basis in the work of Michel Foucault (of whose writings on clinical medicine an alternative evaluation is offered).

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PREFACE

The study which follows is intended neither as a narrative history of general practice nor as a history of ideas about general practice. Its empirical concern is more specific than either of these. Focusing upon the twentieth century and above all the post-war period, it seeks to analyse some of the ways in which general practitioners have sought to autonomise their discipline by giving it an 'intellectual' basis. If the 'general practitioner' (or equivalent) has long existed as a professional label then nevertheless notions of what unifies the general practitioner's activities have undergone a degree of mutation.¹ It is these 'models' of general practice - physiological, epidemiological, psychological - which will be investigated here. As such, the purpose behind the study is partly of a 'methodological' order. The study seeks to show that what counts in evolving a coherent model of general practice is not just the provision of a 'representation' of the general practitioner's activities but a construction on several levels. One has to align, for example, the way the profession is organised with the way it produces knowledge; one has to address the question of the social 'telos' of the discipline itself. And these requirements impose limits upon what can and what cannot

be said in and about general practice. As we shall see, we are also concerned with 'limits' at a wider level. For general practice also appears in this study as a kind of 'social laboratory' for wider tendencies that characterise the nature of our 'present'. Most important here has been evidence of a mutation towards a mode of governance based less on anonymous rules and bureaucratic resources than one which is concerned to utilise the qualities of persons. In characterising general practice as being exemplary of modern 'technologies of subjectivity' we shall also have recourse to some of the works and insights of Michel Foucault and some of his followers.²

But this endeavour clearly involves some omissions which, in a narrative history of general practice, would clearly be important if not unforgivable. Little is said for example about the role of the general practitioner in the maternity service; certainly, a long-standing area of dispute. This is simply because this theme has not played an important role in the project of autonomising general practice as an independent intellectual discipline. Other themes are also omitted; there is little mention of medical 'politics' (cf. the discussions in Dobson 1971 and Forsyth 1966), nor of relations between general practitioners and the hospital service (Honigsbaum 1979; and, for a work, which focuses upon a similar theme of a 'split' in the medical profession, Horner 1922).

If the empirical focus of the study is a narrow one it is because the primary object of interest here is not the progression of a narrative but what might be termed the end-point of a series. Following some of the methodological stipulations of Georges Canguilhem, the study is analogous to a 'recursive' history which, so to speak, has its starting point and condition of possibility only with where the study itself ends (Canguilhem 1988: 1-23; Canguilhem 1968: 9-23). This 'recursive origin' is provided by 'person-centred' medicine; that form of discourse which seeks to promote an ever-greater sensitivity to the 'ideographic' dimensions of doctoring (cf. Armstrong 1979). In what follows the focus of investigation will be oriented towards the rules of formation of the medical vocabulary of the emancipation of the person in just one medical field, general practice; a discipline which has sought repeatedly over the past seventy years or so to take up the old mantle of the 'clinic' whilst consistently setting itself the task of treating the 'patient' - and, later, the 'person' - as opposed to the 'disease'; of treating the living individual rather than the inert corpse.³ The study performs this task on the basis of an 'inventory of differences'; an investigation of models of general practice that have existed prior to this 'person-centred' paradigm which today amounts to a kind of obligatory 'infrastructure' of thought in relation to medicine.

This 'recursive' interest was instrumental in determining the 'data-base' of the study. Aside from considerations of the influential work of James Mackenzie (Part 2) and of Michael Balint (Part 4) the empirical focus is upon the labours of the (Royal) College of General Practitioners (founded, 1952) to institute a patient-centred general practice. Parts 3 and 5 of this study are indeed effectively 'reviews of the literature' associated with this organisation. Yet we have not written the history of the College itself (for which, Fry et al. 1983). Rather, our interest was determined by the different ways in which the College has set itself the task of establishing general practice as an independent clinical discipline around the theme of the 'person-centred' dimensions of the general practitioner's tasks (Parry & Parry 1976: 217). The history of the College also afforded an exemplary site of investigation for a study which would be concerned with the ways in which intellectual endeavours depend upon a particular kind of organisational 'technology'. Epistemological statements - even in such a 'common sense' discipline as general practice - are always dependent upon an organisational infrastructure through which their emergence becomes possible.⁴

The main empirical 'body' of the study is prefaced in Part 1 by some considerations - relating above all to Michel Foucault's work Birth of the Clinic - which should serve to put the present study into a wide theoretical and methodological perspective.

PART ONE

METHODOLOGY AND CLINICAL MEDICINE

CHAPTER ONE

ON THE TASKS OF A 'HISTORY OF THE PRESENT'

1. The History of the Present and the Project of Recuperation

This study should be conceived as belonging to that order of investigation that Michel Foucault has called the 'history of the present'. This term should serve to draw attention to the particular kind of problem addressed by the study as well as to the approach employed in addressing this problem.

1.i. The notion that there could be such a thing as a 'history of the present' gained its specificity, claims Foucault, with Kant's essay Was Ist Aufkl rung of 1784 (Rabinow ed. 1986: 32-50; Foucault 1986: 88-96). Considering Kant's text, Foucault argues that the notion of Enlightenment (Aufkl rung) - that general project (more or less incarnated by the 'enthusiasm' for the French revolution) of the universal progress of reason in the service of human happiness, emancipation and freedom - should be understood as being inseparable from the

problematization and questioning of the phenomenon of the 'present' moment.

As Foucault notes, the question of 'enlightenment' (understood in a general sense) has been at the centre of philosophical and social reflection - especially in German thought - for some two centuries since the publication of Kant's essay. Here, typically, the central concern has been with the recuperation of enlightened reason from its own consequences, the tendency - apparently inherent to the project itself - for reason to turn 'despotic' (Gordon 1986c: 72). Numerous varieties of this theme of betrayal and recuperation could be invoked here: from Max Weber's well-known theses of 'intellectualisation' and 'disenchantment', a rationality of modernity having no 'regard for persons', to the claims made by Adorno and Horkheimer in their Dialectic of Enlightenment, which stated that the universal programme of reason had been turned against mankind; that the projects of the development of freedom and of reason had come into conflict with each other. Especially important for these authors was what they termed 'instrumental reason', that form of reason which took no regard for persons but which served only a blind scientific or technological interest (cf. on this whole theme, Sayer 1991; esp. chapter 4).

Writing very much in this vein, Jürgen Habermas has recently described how the autonomous development of the

objectivising forces of science and reason have served progressively to erase the forms of everyday subjectivity they were originally called into being to serve:

'The project of modernity formulated in the eighteenth century by the philosophers of the Enlightenment consisted in their efforts to develop objective science, universal morality and law and autonomous art according to their inner logic ... Enlightenment thinkers ... had the extravagant expectation that the arts and sciences would promote not only the control of natural forces but also understanding of the world and of the self, moral progress, the justice of institutions and even the happiness of human beings. The twentieth century has shattered this optimism. The differentiation of science, morality and art has come to mean the autonomy of the segments treated by the specialist and their separation from the hermeneutics of everyday communication' (Habermas 1985: 9-10).

Hence, for Habermas, the project of enlightenment is subject to a 'splitting' between the tendencies of emancipation and the estrangement brought about by an ever-narrowing 'culture of expertise'.

Now, Habermas claims that there are various strategies commonly put forward in response to the betrayal of enlightenment. The first which he rejects (and associates

with Foucault amongst others) is the attempt at a wholesale rejection of the 'culture of expertise' itself (ibid: 10). But, he argues, the problem will not so easily be made to go away. We must rather strive to recuperate the notion of enlightenment that is encapsulated in the project of a progressive modernity and force our scientific culture to serve emancipatory ends. For Habermas this 'project of recuperation' (as we shall call it) seems to take the form primarily of a philosophical endeavour; for example in the attempt to state the conditions of an 'ideal-speech situation' free from distorted communication.

This is indeed a valuable enterprise. Nevertheless, it can be argued that it has limitations. Prominent here is the fact that - in its rather utopian pretensions - this kind of analysis suffers from a certain blindness to the fact that the project of recuperation itself already exists. For this project has gained, especially in the twentieth century, a certain institutional momentum of its own that goes well beyond the philosophical, polemical or utopian specification of its 'ideal' conditions. This institutional project has sought to reverse the ascendancy of those elements of the Enlightenment that are conducive to reification and estrangement in favour of an emphasis upon the powers above all of subjectification; in short, to bring about a situation where reason is dictated to only by the demands of the freedom and emancipation of persons. But where are these institutional forms of

'actually existing' recuperation? One will get meagre results if one looks for this project in 'pure' form. Yet if one begins to conceive of the spirit of enlightenment itself as being not just one project of universal 'reason' but as entailing a multiplicity of diverse rationalities, then one can see evidence of the emergence also of a whole range of projects designed to 'rescue' the enlightenment spirit from the consequences of its own 'despotism'.

One can do no better than to turn to the work of Michel Foucault, and of those influenced by him, for evidence of the existence of these rationalities. Indeed the investigation of these forms of recuperation in the modern period can be described as the major preoccupation of Foucault's work. In his studies of madness (the 'liberation' of the insane), sickness (the 'free' clinical 'contract'), penal reform (the permanent 'critique' of the prison system) and sexuality (liberation from sexual 'repressions') Foucault demonstrated the congruence of enlightened discourses and repressive functions; the often simultaneous emergence of forms of reasoned 'despotism' together with the 'enlightened' rationalities for escape from this despotism.

In the twentieth century, the institutional forms of recuperation have received their impetus above all from the 'techne' of psychology (Rose 1985, Rose 1990). Two themes have been of particular importance. The first is that of an increasing attention towards promoting the

'subjectivity' of individuals. Although this attention has taken a variety of forms evidence from, for example, the penal system (Garland 1985), the medical domain (Armstrong 1983; Canguilhem 1978), war and labour (Miller 1986, Rose 1990), the education system (Hunter 1988), the welfare complex (Donzelot 1978; Burchell et al. 1991), and the domain of psychiatry (Castel et al. 1983) all point to an enhanced level of alignment between the promotion of subjectivity and the tasks of social regulation. The second theme is that everywhere this alignment has been accompanied by a demand for the services of 'expertise'. Everywhere subjects are incited to discover their identities by 'experts of subjectivity'; social workers, psychiatrists, criminologists, general practitioners. The promotion of subjectivity always seems to require the mediation of an expert 'other'. And expertise implies knowledge; typologies of subjectivity, and - perhaps more important - typologies of how subjectivity can go awry. Typically, this knowledge will be of an 'immature' sort. The sciences of subjectivity are never quite 'sciences'; they never exist within a pure laboratory world, but can only function within the context of their normative demands; to cure, to prevent, to promote, to rectify (Hacking 1979; also the conclusion to Rose 1985).

But it is not enough merely to describe the twentieth-century enhancement of subjective expertise in terms, for example, of the expanding 'interests' of a 'service class' (Lash and Urry 1986) or of the growth of a 'professional

society' (Perkin 1990). Rather one must seek first, to integrate with analysis of the 'social' functions of expert knowledge a detailed analysis of the actual - 'internal' - forms taken by knowledge in particular fields, and, second, to specify the variety of ways in which the 'subject' of this expertise, that is the model of the 'expert' him- or herself, has been fabricated within the co-ordinates of this knowledge.

1.ii. If Foucault's investigative approach has been exemplary here it is not because - as Habermas would have it - he has sought to reject outright the project of modernity and enlightenment. Rather he has sought in his work to align the notion of a 'history of the present' with a certain conception - differing from that of Habermas - of that project itself.

Foucault - through a reading of Kant's text of 1784 - proposes his own view of what the Enlightenment itself constitutes; and of what the 'spirit' of enlightenment confers upon criticism as a duty. As Colin Gordon puts it:

'Foucault distinguishes between an Enlightenment of sure identity, conviction and destiny, and an Enlightenment which is question and questioning, which is commitment to uncertainty' (Gordon 1986c: 74).

For Foucault, the question of enlightenment is synonymous with a permanent questioning of the 'present'. Kant, Foucault writes:

'defines Aufklärung in an almost entirely negative way, as an Ausgang, an "exit", a "way out" ... He is looking for difference: What difference does today introduce with respect to yesterday?' (Rabinow ed. 1986: 34).

It is this kind of investigation that characterises for Foucault the tasks of a 'history of the present';

'to separate out from the contingency that has made us what we are, the possibility of no longer being, doing or thinking what we are, or do, or think' (ibid: 45-6).

What are the critical or normative stakes here? The answer cannot be an easy one because Foucault's notion of enlightenment as a permanent questioning of ourselves does not imply any straightforward verdict upon reason or liberation. Foucault's project is not simply one of negation or 'refusal' anymore than it is one of affirmation or celebration. There is no intention to supply a 'critique' of anything, if by this is meant a denunciation of something - for example, as ideology or dissimulation - in order to establish the grounds for some pre-conceived or a priori alternative. Foucault's project is not to demonstrate how psychiatry has suppressed a better, more 'real' psychiatry or how clinical medicine has suppressed a better, more 'humane' medicine and so forth. 'Critique' in this sense always seeks closure, it draws up a dividing line of right and wrong - liberty and repression - and denounces the side of wrong from the side

of right. Critique legitimises its political alternatives by locating the constant repression of these alternatives in the past. But the logic of Foucault's work suggests that liberty is not characterised by closure but by inventiveness. The project of liberty - an 'impossible practice' - can never be completed; rather, liberty is the process of questioning itself. For Foucault the objective is not the romance of critique but the necessity of a permanent criticism a constant:

'work on our limits ... a patient labour giving form to our impatience for liberty' (Rabinow ed. 1986: 50).

A key theme here will be to attack those very points where questioning seems least possible; to undermine, for example, the 'obviousness' of all that seems to be most naturally in the interests of freedom, to illuminate the contingency that resides - often the product of a certain kind of 'blackmail' (ibid: 45) - within what is given to us as most necessary. Hence, if there is a normative intent behind Foucault's work it is:

'to discover to what extent the work of thinking its own history can free thought from what it silently thinks and allow it to think otherwise' (Foucault 1986b: 8-9).

Thus, thought must be freed in order to become inventive. One must attack precisely those points where inventiveness seems to be least possible. But the strategy here will not be that of critique and the alternatives that it offers but only that of detachment; thought must be

'allowed to think otherwise', it must be given a space in which further thought is possible, and this can only be done by detaching elements from each other; by drawing up, for example, what has been called an 'inventory of differences' in order to bring about a local reversal in the 'forgetfulness' that conditions all identities, all absolute convictions, all destinies. But this is not done in order to be able to 'remember' better but to provide the conditions for further invention, and the further practice of liberty. A corollary of this will actually be a certain modesty of analysis (albeit a modesty which will not be appreciated by those who wish to be lead by 'theory'), the necessary offshoot of a 'commitment to uncertainty'. No finite 'answers' are provided; the historian of the present does not always know what to do. His or her task is only to open up possibilities for the tasks of further invention.

2. A 'Sociology of Morality'?

Outlined in this manner, does not the 'history of the present' find itself at such a distance from contemporary sociology as to constitute merely an eccentric backwater of social thought?

2.i. Whatever the stylistic nature of some of Foucault's own writings and pronouncements this form of study does not exclude other forms. This is not merely because one

might wish to espouse a benign - and, possibly, insipid - theoretical pluralism. Rather, the history of the present is committed to its critical ambiguity - or, at least, its rejection of 'critique' - by the very nature of its preferred subject-matter. For most typically it takes as its object precisely claims to liberation or emancipation, that is, styles of thought that already take the form of critiques. What absolute 'epistemological' or 'ethical' ground is possible here? We would argue that a methodology that takes account of this difficulty indeed which makes it a condition of the analysis itself - 'permanent criticism' - is preferable to one that either straightforwardly and cynically rejects its objects of analysis as, for example, so many varieties of 'social control' or one which fails to see them altogether.

It can be argued that the methods appropriate to such a form of study can actually be related to some traditional concerns even of 'classical' sociology. One way of doing this is to refer back to Foucault's consideration of Kant's essay where he discusses the question of the 'present' situation. Criticising notions of modernity that see it only as an 'epoch' or a movement, Foucault prefers to envisage it as an 'attitude' by which he means:

'a mode of relating to contemporary reality ... a way, too, of acting and behaving that at one and the same time marks a relation of belonging and presents itself as a task. A bit, no doubt, like what the Greeks called an ethos' (Rabinow

ed. 1986: 39).

The proper manner, then, to search for the contingency of the 'present' might be through a kind of 'ethical' study; almost a sociology of 'attitudes'. But instead of doing surveys and so forth to find out what people 'actually feel' about this and that, we might imagine such a form of investigation as embodying the outlining of what might be called the 'supply-side' of our ethical ideals. This would entail, for example, a scrutiny of what have been called 'technologies of subjectivity' - systems of representation, evaluation, expertise and intervention that seek to promote certain types of orientation to the world, to others and to the self (Rose 1990: 8-11). In short, an investigation of those 'ethical systems' which mark out a realm of possibility - of, as it were, 'historical a priori' problematisation - through which subjects come to be governed and to govern themselves in the circumstances of the 'present'; technologies which, amongst other things, serve to mark out the;

'conditions in which the human being questions what he is, what he does, and the world in which he lives' (Canguilhem 1986: 37).

2.ii. The claim that Foucault's concerns can be characterised in relation to ethical systems or moral technologies might be reinforced by referring to Colin Gordon's remarks concerning the points of parallel between Foucault's work and those of Max Weber relating to the impact of collective powers upon Lebensstil and

Lebensführung (Gordon 1986: 84). As Hennis has shown, Weber's concerns, like those of Foucault, were focused upon the establishment of certain ethical values through the mediation of various kinds of social institution, such as the economic organisation of the classical oikos or - more prominently - various forms of religious belief (Hennis 1988). What else is religion for Weber if not a kind of 'ethical system' (see esp. Gerth and Mills 1967: 267-301)?

But if Weber's sociology of religion betrays similarities of intent with Foucault's project then perhaps an even more instructive parallel can be made with the work of that other great neo-Kantian sociologist, Emile Durkheim. Although there is some dispute as to whether Durkheim's concern with morality forms a running thread throughout his career (Hall 1987: esp. 3-12; 218-22) or whether the concern was merely a feature of the unfinished projects of his last years (culminating in the 'Introduction to Ethics' [1920]; Pickering ed. 1979: 77-96) what is interesting for our purposes is that when Durkheim does speak of what he calls the 'science of morality', he connects it - as does Foucault - to the social production of knowledge (Pickering 1979: 24ff.; Lukes 1973: 420). For Durkheim, morality is always entrenched in epistemology, a factor which stems, to be sure, from the way he defines 'morality' itself. Thus he distinguishes between 'morality' (morale) and mere morals, the former being something 'ideal' which exists 'in a region above the

realm of human actions' (Pickering ed. 1979: 92). For Durkheim, morality can be analysed sociologically, that is, through the investigation of the human institutions in which ideal forms of morality are generated. Durkheim writes:

'Every morality, no matter what it is, has its ideal. Therefore, the morality to which men subscribe at each moment of history has its ideal which is embodied in the institutions, traditions and precepts which generally govern behaviour' (ibid: 81).

Perhaps it is time to return the questions of ethics and morality to their once-important place within sociology. In this sense the history of the present is continuous with an attempt to re-activate the aspiration of a 'sociology of morality'. Although certainly conceived very differently from the norms of Durkheimian sociology, this thesis will be concerned with an investigation of the ideals of morality as they emerge in just one social institution of modernity; medicine.

CHAPTER TWO

'ANTI-MEDICINE'

1. The Project of Medical Recuperation: Anti-medicine

The term 'anti-medicine' will be used here to distinguish that mode of thought - or, rather, that 'ethos' - which regards the history of medical reason as a slow descent into 'despotism' (see e.g. on the 'scientisation' of medicine, Pelling's overview, 1983: esp. 379)¹. What unifies this ethos is the claim that the medicine of the past two centuries has been conducted increasingly 'without regard for persons' - hence, the frequent critiques and denunciations of 'hospital medicine', 'bio-medicine', 'doctor-centred' medicine, the 'medical model' and so forth (e.g. Jewson 1976; Engel 1981; Hart 1985).

1.i. A highly synoptic and synthesised ideal-type of the totality of forms typically invoked by anti-medicine can be organised around the themes of 'enclosure' and 'exclusion'. According to the anti-medical schema, medical space - typified by the modern hospital - is enclosed space. Confined within the hospital the 'sick man' becomes artificially cut off from the natural environment. In

parallel with this spatial enclosure, anti-medicine views medicine itself as enacting a corporeal enclosure upon the person of the patient, as the legitimate space of disease becomes confined - through the mediation of all kinds of instruments and de-humanising forms of technology - to the closed space of the body's interior. Here the aetiologies proper to the so-called 'medical model' reductively localise pathology, confining it to the impermeable plane of organs in isolation, invasive microbes, and disease 'entities'. At the same time these archetypes of enclosure are held to be reinforced by a parallel reduction on the level of social organisation and within knowledge itself. Thus the 'profession' monopolises knowledge in a closed domain - whilst a further gesture of exclusion takes place, within the profession itself, through the malign development of 'specialisation'. The profession designates and excludes those it sees as 'quacks' but above all it summarily excludes the patient from any say in his or her treatment. Moreover, the very form of the knowledge watched over by the profession is held to be of a closed order; the 'medical model' is a reductive, malignly objectifying and de-humanising schema instilled during education around the inert bulk of the corpse - indeed, a veritable metaphysics of death. Lastly, the medicine of enclosure could be said to have an 'extensive' logic whereby the interests of medicine expand further and further into the lifeworld, colonising ever-more marginal areas in a malign process of 'medicalisation'.

But on the other side of this coin is a peculiar kind of sociological eschatology. Struggling to be emancipated (and not just by medical sociologists, but - depending upon the 'setting' - by patients, after-dinner speakers, legislators, policy experts and so forth) is the symmetrical converse of the medicine of enclosure and exclusion. In its eschatological form this is simply the 'medicine of No', the logical converse of the medicine of enclosure and exclusion that seeks to be not confining, not enclosed, not occluded, not reductive, not exclusionary, not specialised, not death-laden, but open, dynamic, humanising, fecund, inclusionary, phenomenological, life-affirming.

1.ii. Reconstructed in such stark terms the connections between anti-medicine and the project of recuperation will be obvious. Medical reason has become despotic. It has turned upon its creators and become an instrument of domination rather than emancipation. This is where much medical sociology tends to stop; remaining satisfied with a description of the medicine of enclosure and exclusion with the addition of a few references to the need to 'return' to the 'sick man' (Figlio 1987). Yet, it is to the great merit of two recent works in medical sociology - Armstrong's Political Anatomy of the Body (1983), and Arney and Bergen's Medicine and the Management of Living (1984) - to have demonstrated that anti-medicine has long been more than just an eschatological theme, that this

'medicine of No' has actually had a substantial historical existence and an institutional form.

Both these works take as their subject-matter the emergence of what might be called 'institutional anti-medicine'. Thus both works focus upon general movements and trends away from 'technological' (scientized, objectivist) forms of medicine towards more humanising or 'subjectifying' approaches.

Arney and Bergen, surveying the medical field in North America, write of a 'great reversal' occurring in about 1950 away from a medicine which had its focus upon the hospital, disease, death, the body, and narrow forms of treatment towards one which focuses upon the community, (chronic) illness, life, the emotions and patient 'management' (ibid, cf. Arney and Neill 1982 for a more localised case-study). Armstrong, taking England as his focus, draws our attention to the growth of what he calls a 'community gaze' in modern medicine. Dating the transformation somewhat earlier than Arney and Bergen, he draws up an inventory of the progressive incursion of broadly 'psychological' forms of thought within British medicine. The 'shift' towards a subjectifying, psychological emphasis is located by Armstrong at the beginning of the twentieth century when the problem of mental functioning ceased to be 'madness' but became the less dramatic but more widely disseminated psychoneuroses (Armstrong 1983: chapter 3; & 25-7). Alongside this

development came the aspiration to track such minor neuroses and socio-medical problems in the community, especially as these were attached to high priority pathologies such as venereal disease, tuberculosis and child health (ibid: chapter 4: and 33). The apparatus developed for this work of 'integrated observation' in the community was, says Armstrong, the survey (chapter 6). Developed in the inter-war years, the survey allowed, on the one hand, for measurement of relational properties between people; an attribute which allowed for a novel conceptualisation of the relation between normality and pathology:

'In effect, the survey established the possibility of removing the abnormal/normal divide. The survey classified bodies on a continuum: there were no inherent distinctions between a body at one end and one at the other, their only differences were the spaces which separated them ... The survey was a synthesised gaze to relationships, to the gaps between people' (ibid: 51).

On the other hand the survey (especially as it developed in the war years) was a peculiarly 'subjective' apparatus:

'Illness was no longer the preserve of the medical profession but of the body's own perceptions; the body had to speak, not of some abstract pathological theory of illness, but of immediate feelings' (ibid: 52).

The survey in other words, although it was an apparently

'objective' instrument, actually served to incite a 'rising crescendo of individual expression' in the community (ibid: 52). To demonstrate the impact of these attributes of the survey Armstrong then goes on to discuss its application in four main areas; child health, psychiatry, general practice and geriatrics (chapters 6 to 9). In all of these fields there occurred a certain fabrication of 'subjective space around the object of the body' (ibid: 70). Finally, this 'subjectifying' progression culminates in, on the one hand, a 'community gaze' which - through above all the resurgent science of epidemiology (chapter 10) - focuses on the dynamics of morbidity in the community as opposed to the finite world of mere mortality; and, on the other hand, a model of pathology and patienthood that focuses upon the 'spaces between people' (bringing to the fore relationships and powers of communication). Hence, argues Armstrong, the concept of the 'patient' itself becomes problematic; from being something only just beyond a 'passive body' in the 1930s the patient becomes a matter of subjective 'identity' by the 1960s, a problematic 'whole person';

'a body constituted by its social relationships and relative mental functioning, a body, of necessity, of a subject rather than an object' (ibid: 102; chapter 11).

If Armstrong's account is impressive it is because it illuminates areas and themes of medical activity that are usually missed by those medical sociologists dominated by

the anti-medical theme. However, Armstrong seems less inclined to draw specific sociological conclusions from his work. He seems content to let the evidence speak for itself, rather than to spend time on an assessment of these forms of medical activity. For this kind of assessment we can turn to Arney and Bergen (cf. for a discussion of these authors, Silverman 1987: chapter 8).

1.iii. There is not space enough here to dwell upon the empirical specifics of Arney and Bergen's work. In a few minor respects their approach is different from that of Armstrong (being wider-ranging in historical terms and including, for example, illuminating discussions of contemporary trends such as sociobiology and the culture of 'spirituality'). But their over-all emphasis is the same. Thus, rather like Armstrong, they write of an increasing incursion of 'subjectifying' forms of medical endeavour in the twentieth century (and especially from 1950). They invoke, for example, the 'return of the experiencing person' (chapter 3) and the appearance of what they call 'medicine's subjective object' (chapter 4). However, whereas for Armstrong the increasingly 'social' and 'subjective' aspects of medicine actually seem largely to have made sociology and the human sciences possible (ibid: 113) - hence presumably obviating the possibility of a sociological analysis of these developments themselves - Arney and Bergen do seek to provide us with a kind of socio-cultural evaluation of these developments. They do not seek merely to criticize or denounce the new

subjectifying tendencies of what they felicitously call the 'tyranny of harmony' but to go;

'beyond [the] increasingly appealing and self-congratulatory image [of medical discourse] and examine whether [patients] might not be dreaming a variant of the old dreams that have always been dreamt about New Cities where nothing wild can exist to upset the order of things' (Arney and Bergen 1984: 7).

The burden of their discussion turns upon an implied opposition between medicine as a discipline centred on 'death' and as a 'social technology' concerned increasingly with the 'management of living'. In characteristically vivid terms, they write:

'We believe we are witnessing a great reversal in medicine. Once ... considerable work was devoted to the task of taming death. Death was the great beast that stalked in the darkness and threatened to attack unannounced at any moment. Now, in a Frankensteinian reversal, the great beast is no longer death but life. Life and living threaten, not death and dying. It is the lives of patients that present the most difficult medical issues today; their deaths are just special management problems' (ibid: 97).

Medicine, they claim, no longer operates according to a logic of 'exclusion', that is, on the other side of the borders of life and society. It is no longer concerned

merely with death and with the excluded worlds of the hospital and the dissecting room. Now medicine works through 'integration', 'inclusion'; it seeks to institute a 'joint adventure' between doctors and patients and to monitor and normalize at the level of the mundane problems of everyday life; teenage pregnancy, alcoholism, chronic illness. More and more, they argue, medicine seeks to impress itself into the very interstices of everyday living, to weave its way - using the seductive languages of 'harmony', 'partnership' and so forth - into the subjective world of the individual and his or her more or less mundane problems and micro-aspirations.

It is worth stressing at this point that Arney and Bergen achieve a genuine subtlety in their assessment of these developments. They eschew for example the conceptual language of 'social control' (as, incidentally, does Armstrong: e.g. 1983: 116-7; cf. also Armstrong 1986). Modern medical power, they argue, does not banish its 'object' to 'a darkened space beyond the limits of the accepted and the acceptable' (Arney and Bergen 1984: 126). Nor does it seem to embody an attempt at professional 'exclusion' of others from the medical domain; on the contrary, it genuinely seeks to include its 'subjective objects' - patients - in its endeavours (perhaps even to its cost in 'professional' terms; *ibid*: 170). In short, medical power has become productive and individualising, rather than reductive, 'repressive' and objectifying. Nevertheless, this development does seem to have certain

consequences which would serve to suggest that modern medical power with its incursion beyond death into the realm of the living is basically illegitimate or, at least, insidious. Thus, they claim, medical power - on the basis of its claims to scientificity - ceases to operate within more or less closely defined boundaries and begins to insinuate itself into ever further and narrower regions:

'The scientific discourse about the individual invents the individual as an object to be measured and managed in a social space that no longer has a boundary since it incorporates everything in the name of "scientific truth" (ibid; 126-7).

The burden of their argument thus seems to be that the 'subjects' that medicine creates only seem to be subjects, but are in fact objects; less free than they thought, since bound to the project of 'social order' entailed in the 'tyranny of harmony' (chapter 10). However, lest one should confuse the new medical object with the kind of (mechanistic) objects that were prominent in nineteenth century medicine, Arney and Bergen's preferred term is (to cite the title of their chapter 4) 'medicine's subjective object'.

2. Disciplinary Determinism and the Medicalisation of Life

This present thesis is heavily indebted to the work of Arney and Bergen, and especially Armstrong. Nevertheless, there are limitations to the kind of analysis that these authors provide. The problems arising from their accounts revolve around the question of medical power. And here a dimension of both studies must be introduced that has so far been suppressed - the fact that they are both expressly motivated by a 'power/knowledge' approach derived from the work of Michel Foucault (Armstrong 1983: 1-6; Arney and Bergen 1984: 3-6).

2.i. Armstrong's work is hindered by a form of functionalism - this can be called his 'disciplinary determinism' - that has a certain affinity with the anti-medical theme of 'enclosure' and which leads him into the inter-related traps of binarism, totalisation, and evolutionism.

Armstrong's methodology consists essentially of the adoption of a word - the 'gaze' - from Foucault's work The Birth of the Clinic (Foucault 1973) aligned with a 'disciplinary' perspective derived from Foucault's book on the modern prison, Discipline and Punish (Foucault 1979). The central idea that Armstrong takes up is that of the Panopticon, an ideal form of power held by Armstrong to be dominant above all in the nineteenth century. The Panopticon is conceived as an objectivising technology which fabricates its targets:

'a creative arrangement of power which

fabricated an individual body - that very body which was to be the point on which repression could be exercised and into which ideologies could be inscribed but, nonetheless, a body which had no existence prior to its crystallisation in the space delineated by a monitoring gaze' (Armstrong 1983: 5).

For Armstrong, medical knowledge in the nineteenth century can be analysed according to a model of 'panoptic surveillance' in direct parallel to analysis of the modern prison. Thus the science of pathological anatomy invented at the end of the eighteenth century 'by which diseases became localizable in the body of the patient' is, he argues, comparable to a contemporaneous change which occurred in the 'regime of criminal punishment' according to which 'the criminal became incarcerated and subjected to continuous surveillance behind the high walls of the prison' (ibid: 2-3). Here then, the doctor's 'gaze' is directly comparable that of surveillance whilst the targets of this form of power (prisoners, patients) are wholly objectivised, passive and 'docile':

'The prisoner in the Panopticon and the patient at the end of the stethoscope both remain silent as the techniques of surveillance sweep over them' (Armstrong 1987: 70).

But if, for Armstrong, the objectivising age of disciplinary power was eclipsed, in a 'substantive' sense, by the new rationality of the Dispensary and the community

gaze, then the type of power involved was still essentially - in Armstrong's view - of a 'disciplinary' order. Even when Armstrong describes the new medical gaze of the twentieth century (the main subject of his book) which seeks ultimately to construct patients not as 'docile bodies' but as active subjects then even here his methodological vocabulary remains that of surveillance and discipline. Thus disciplinary power is not effaced in the twentieth century; on the contrary, it is cynically enhanced. Even the Dispensary gaze - that twentieth century form of power that, in contrast to the Panopticon, radiates outwards in space instead of inwards - fixes its subjects in fast, frozen form, the mere ciphers of the regime of power that produces and embraces them. So if by the twentieth century the dominant carceral model of medical power has been replaced, then power remains in any case basically a carceral phenomenon. Indeed, for Armstrong, it is knowledge itself which encarcerates and disciplines by definition. In Armstrong's analysis the role of 'enclosure' and 'exclusion' is played by knowledge itself. Hence the power/knowledge relation is not discussed as a relation at all; rather the two terms are assimilated and the 'gaze' - a curious trait in a writer influenced by Foucault - is given 'sovereign' powers.

Leaving aside the question as to how far this approach has any real basis in Foucault's work, we can now address its substantive consequences in Armstrong's analysis. First, the matter of binarism. The new - substantive - regime

that Armstrong describes as emerging in the twentieth century is constructed necessarily in symmetrical opposition to this panoptic form. Hence Armstrong here opposes the term 'dispensary' - an outward ranging form of power rather than an enclosing one - to the panopticon (ibid: chapter 2; 'the new hygiene of the dispensary'). The transformation Armstrong describes is of exactly the same order as that 'Frankensteinian reversal' analysed by Arney and Bergen:

'In the twentieth century the diagram of power is rearranged. The medical gaze, which had for over a century analysed the microscopic detail of the individual body, began to move to the undifferentiated space between bodies and there proceeded to forge a new political anatomy' (ibid: 6).

The problem with this binarism is that it is difficult not to suspect that it is an artefact of Armstrong's methodology. The contrast between an 'objectivising' nineteenth century rationality and a 'subjectifying' twentieth century one seems to define in advance everything that Armstrong describes. A consequence of this is that Armstrong's account seems to take on the form of an evolutionism according to which medicine will become more and more subjectivising the further away it moves from the moment of 'reversal' itself. And this is in fact the case; Armstrong's book clearly sees the subjective powers of medicine as developing incrementally in the twentieth century.

This leads to a further consequence; that of totalisation. We mean this in two senses. First, one gets the impression that the forms of institutional anti-medicine described by Armstrong actually work, that is, they are wholly successful in constructing some finite kind of 'subject' out of their targets; in short, that 'real people' are more or less determined by forms of medical power. We shall contest this perspective in detail further below (and take up the matter again in the conclusion). In the second place, the implication of Armstrong's argument is that this newer form of the gaze is all-pervasive right across the medical field, that it is basically the same rationality wherever it resides (although cf. Armstrong's cursory observation that the Panoptic gaze still exists or, at least, 'has not disappeared'; Armstrong 1983: 111). This approach - which makes the subjective form of medicine appear as a veritable Weltanschauung - clearly has certain consequences. Above all, it leads Armstrong to a kind of 'stock-taking' orientation towards his evidence. Here, textual works of various kinds (predominantly medical textbooks) are listed cumulatively as 'expressions' of various themes and emergences (hence each text is basically considered as a unit). But what could be called the 'epistemological workings' of these texts - contradictions, inter-relations, conceptual linkages - are scarcely considered; rather, a mere listing of texts is sufficient to count as 'evidence'.

2.ii. Our main criticism of the theoretical approach of Arney and Bergen can also be related to the themes of binarism, evolutionism and totalisation. These authors seem to recognise the problem with a logic of binarism which would ultimately result in a periodisation of medical history as a kind of macro-alternation between subjective and objective forms. Thus, at the very beginning of their analysis Arney and Bergen introduce the notion of the 'pentimento'; 'the term used to describe those old paintings in which one image is so thin that the one under it still shows through' (Arney and Bergen 1984: 8). Using this image to some effect, they claim that modern medicine is like a pentimento with some old - objectivising - images still showing through beneath the new subjectivising veneer:

'In today's medicine different images of the doctor and patient are entangled, the new not absolutely clear, the old still discernible but no longer dominant' (ibid: 8).

The binarism does not disappear, however, since the pentimento image - insofar as it actually features at all in the main body of the book - merely serves to highlight the uneasy co-existence of two totalities rather than to articulate any degree of contingent inter-relation between them.

A slight difference from - or supplement to - Armstrong's account, in the matter of Arney and Bergen's evolutionism, can be isolated here (and represents a kind of

methodological complement to Armstrong's 'disciplinary determinism'). As noted earlier, Armstrong's account is far more closely honed upon the internal world of medicine itself. Medicine, for him, seems to be a kind of closed system which transforms itself endogenously. Arney and Bergen, however, provide a more 'extensive' analysis; they seek to argue not just that medicine is becoming more 'subjective' in its internal orientation but that it is seeping ever more finely into the minutiae of everyday life, taking up more and more concerns which were once not considered to be the province of medicine at all. Hence, their evolutionism seems to be, as it were, exogenous as well as endogenous. This tendency clearly bears comparison with the anti-medical theme of the 'medicalisation' of society. Whilst this is a matter for consideration in the conclusion to this thesis one immediate limitation of this perspective can immediately be pointed out. This is that the notion of 'medicalisation' seems to assume the pre-existence of a phenomenal realm of the 'social' confronted by a more or less fixed agent - the 'medical' - which seeks to colonise it. What such a perspective tends to miss is those ways in which the concept of the 'medical' itself undergoes transformation in the course of its development. Such transformations occur not so much as the result of an unproblematic extension of medicine's 'interests' as on the basis of a complex series of negotiations - and, commonly, arguments and squabbles - as to what properly 'medical' interests are in the first place. Hence, in a

manner that may be unwarranted, the notion of 'medicalisation' tends to pit the 'social' in opposition to the 'medical' - or, in the specific context of Arney and Bergen's account, 'life' against 'death' - rather than investigating how their inter-relations are negotiated (cf. on 'medicalisation', the introduction to Miller and Rose 1986).

In sum; the analysis of medical rationalities needs to be suspicious of what was termed 'disciplinary determinism' with its composite problems of binarism, totalisation and evolutionism, as well as of theories of 'medicalisation' in general. Let us now turn to give these hitherto rather negative methodological considerations more of a positive content.

CHAPTER THREE

MICHEL FOUCAULT AND CLINICAL MEDICINE

1. Michel Foucault's Birth of the Clinic

Michel Foucault's under-utilised work on clinical medicine can be used to illustrate a theoretical perspective on medical thought capable of bypassing some of the problems we have located in the work of the authors above.

First, an overview. Birth of the Clinic, claims Foucault, is intended to be a 'structural' study designed to uncover the rules of formation - the 'conditions of possibility' - of 'medical experience in modern times' (Foucault 1973: xix). Its object is 'clinical method' which Foucault sees as a kind of emblem of modern positivism:

'constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to the observing gaze without disturbing them with discourse' (ibid: xix).

Foucault seeks to replace the mere hagiography of clinical thought which tends to emphasise only 'old threadbare notions that had been medicine's basic tools as

far back as the Greeks' (ibid: xviii) with a methodology which focuses upon not thought itself but that 'un-thought' ('non-pensée') which 'systematises thought from the outset' (ibid: xix; cf. 1963: xv). It is important to stress, however, that the book is not in any sense a 'critique' of this ideal view, which typically stresses the:

'restraint of clinical discourse (its rejection of theory, its abandonment of systems, its lack of philosophy; all so proudly proclaimed by doctors)' (Foucault 1973: xix).

Birth of the Clinic is only a 'critique' in the sense that Foucault seeks to claim that clinical thought is not an age-old un-changing endeavour but has real - structural and historical - conditions of possibility. These conditions entailed a mutation at the end of the eighteenth century (largely around the impetus of new philosophies of language) in the articulation of the 'perceptible with the statable'; 'the common structure of what is seen and what is said' (ibid: xviii-xix). Perhaps the epistemological focus of this transformation can be isolated in what Foucault describes as 'a welding of the disease onto the organism' (ibid: xviii) whereby the nosological theory of the disease 'entity' (which really amounted to an 'ontology' of disease: cf. Kraupl-Taylor 1979: 5-16) was eclipsed by an orientation that situated the 'being of disease' in the 'three-dimensional space' of the body itself; a transformation that was accompanied by a new conception of the 'author' of medical statements -

the doctor - as a kind of 'subject of consciousness' able to trace the 'linear series of morbid events' according to a new 'grammar of signs' (ibid: xviii).

It should immediately be clear that there is some distance between Foucault's overview of the clinical 'edifice' of the nineteenth century and that characteristic of those anti-medical writers (Armstrong, and Arney and Bergen included) who regard this period as being dominated by an 'objectivising' medical rationality.

2. Space, Language and Death

In substantive terms we shall argue on three broad fronts, that is, in relation to the questions of the hospital (space), language, and death, that nineteenth century medicine was not - as both the anti-medical ethos, and Armstrong and Arney and Bergen would have it - basically a reductive or 'objectifying' totality of practices.

2.i. The initial focus will be the broad level of medical spatialisation. Here varieties of anti-medicine tend to focus upon one institution in particular; the hospital. Interpreters of Foucault's work as well as medical sociologists tend to have been united in their assessment of this institution. It is a reductive space which encloses its victims according to a certain logic - in Arney and Bergen's terms - of spatial 'exclusion'. Bryan

Turner's assessment of the hospital as an 'objectifying' institution is emblematic of this kind of viewpoint when he claims that medical surveillance brings about 'the disciplinary individuation of patients within the hospital bureaucracy' where:

'disciplinary methods subordinated the individuality of the patient under the routine of description, administration and control' (Turner 1987: 37-8).

While it is certainly the case that in Discipline and Punish Foucault has occasion to turn to the example of the hospital to illustrate the nature of discipline, we wish to argue in what follows that this is misleading in the context of Birth of the Clinic. For in Discipline and Punish medicine and the hospital serve as the surface of emergence or point of application for certain disciplinary technologies. 'Discipline', writes Foucault in that work:

'should be identified neither with an institution nor with an apparatus; it is a type of power, a modality for its exercise ... a technology'. As a technology it can be 'taken over' by institutions - schools, hospitals - 'as an essential instrument for a particular end' (Foucault 1979: 215).

So whilst this certainly implies that medicine is a key site for the operation of power it should not automatically lead us to a perspective that would force us

to see medicine entirely, or as a totality, in terms of surveillance or discipline.

This point can be reinforced by looking at what Foucault has to say in Birth of the Clinic and elsewhere about the constitution of the hospital as the site for the production of knowledge. We shall see, in fact, that according to Foucault's account the modern clinical hospital is actually predicated upon the demand precisely of evading such a description of itself as a reductive, exclusionary, enclosing, or 'objectifying' institution. In Foucault's account, the clinical hospital only made its appearance at the end of the eighteenth century in the context of a consideration of 'liberty': as a compromise between the demands of the 'free field' and those of pragmatism and pedagogy (Foucault 1973: 43 and 82ff.). The 'free field' is the term Foucault gives to the demand - as much politically motivated as medically required - for 'the suppression of every obstacle' (such as the old forms of the hospital) in medical space 'so that the natural needs of the species might emerge unblurred and without trace' (ibid: 38). Part of this project entailed the replacement of the old hospital structures with the provision of 'assistance' in the home, an emphasis one might say on the free and spontaneous space of the 'community'. If, however, the 'return of the hospitals' was to become an inevitability this was because of the demand that medical knowledge should itself be communicable in a free space, that is, according to the

pragmatic principles of the immediate communication of teaching within 'medical experience' itself (ibid: 68). This new rationality entailed, however, not a negation of what Foucault calls the 'medicine of liberty' but its reactivation, as it were, internally to medical knowledge itself:

'at the end of the Convention, the theme of an entirely new medicine, based upon the clinic, swept away the theme of a medicine restored to liberty that had been dominant right up to 1793 ... what occurred was the restructuring, in a precise historical context, of the theme of 'medicine in liberty': in a liberated domain, the necessity of the truth that communicated itself to the gaze was to define its own institutional and scientific structures' (ibid: 69).

In other words, the possibility of the clinical hospital depends - at least in thought or 'discourse' since nowhere does Foucault claim that the hospital was consequently a genuinely beneficent environment for the individual - on its being so far as possible not a hospital (in the pre-clinical sense of being a mere 'dumping ground for the sick') but a free space, appropriate to the idea of a 'medicine in liberty'; something of a compromise, in fact, between what Foucault calls the 'old clinic' of the eighteenth century, the old pre-clinical hospital itself, and university structures.¹

Foucault's well-known article 'The Politics of Health in the Eighteenth Century' (Gordon ed. 1980: 166-82) also bears out this contention that the modern hospital, from its very beginnings, is self-consciously not a 'carceral' type of institution as so commonly perceived by anti-medical writers. This is largely because the hospital that existed before its 'clinical' variant was itself perceived more or less along 'carceral' lines. Here

'the hospital appears in many respects to be an obsolete structure. A fragment of space closed in upon itself, a place of internment for men and diseases...' (ibid: 177).

Thus the reform of the hospitals - the reinvention of the hospital as a kind of clinical 'curing machine' - is bound up from the beginning with making the hospital less, as it were, of a hospital. Part of this endeavour entailed that the hospital should specifically not be an 'exclusionary' space - or, to invert Armstrong's language at this point, it should be even from the beginning more of a Dispensary than a Panopticon, radiating outwards, its staff moving out into the population and so forth (ibid: 178ff.) Indeed, tied to this moment is something not entirely dissimilar from Armstrong's 'community gaze' itself. For, as Foucault comments, the relation between the social sciences and medicine (and exemplified for Armstrong by the 'survey') can be dated further back in time than the early twentieth century (cf. Armstrong 1983: 113):

'Doctors at that time [the end of the eighteenth century] were among other things the specialists

of space ... the first managers of collective space ... concerned to think the space of habitations and towns. Countless people have sought the origins of sociology in Montesquieu and Comte. That is a very ignorant enterprise. Sociological knowledge is formed rather in practices like those of the doctors' (Gordon, ed. 1980: 151).

Foucault does not claim that the hospital is the opposite of 'carceral'. Matters are more complicated than this. The hospital is rather a compromise an uneasy alliance between what are basically 'political' positions. It could be said in this context that the hospital created the conditions for its own critique (see Gordon in *ibid*: 250). This is due to the fact that part of the significance of the clinical hospital is that it is a site of knowledge as well as of cure. Indeed, there is here a point of convergence with others of Foucault's analyses, which focus upon what Colin Gordon has aptly labelled 'institutional epistemologies' (Gordon 1990: 12). Part of the significance of the modern asylum, for example, is that it - like the clinical hospital - is a therapeutic instrument; a curative institution and a site for the production of knowledge rather than simply a 'carceral' domain. Similarly, one could say that the significance of the prison of the nineteenth century lies in that it ceased to be merely a 'carceral' domain, but sought to be a moral institution that reforms its inmates, and so on.

As Foucault shows, both these institutional forms contain, as it were, the conditions for their own critique, the functions of knowledge and institutionalisation existing in uneasy tension (see e.g. Foucault 1979: 266 & 268; cf. Garland 1985: 27-32).

If there is, then, something of an uneasy relationship between what can be called the 'liberating' and 'enclosing' functions of the clinical hospital then this can be further emphasised by considering the model of knowledge that is employed there. The anti-medical verdict upon this matter is quite clear (cf. Turner above); the hospital is a place of bureaucratic 'normalisation', a place where large numbers of patients can be gathered and a norm fixed. This does not always, of course, imply an anti-medical position. For example, Temkin has highlighted this numerical emphasis:

'Few things mark the chasm between ancient and modern medicine as impressively as does the different character of the hospitals. The ancient hospital, because it housed many patients, was looked down upon as neglecting individual sickness. The modern hospital, just because it houses many patients, was an institution where individual sickness can be described with some degree of precision' (Crombie, ed. 1966: 636; cf. Donnelly 1983; chapter 7).

Nevertheless such a 'numerical' emphasis would at least afford a useful purchase for an anti-medical stance. Yet Foucault conspicuously omits to take this opportunity (cf. Foucault 1963: 34). In fact, he takes some pains actually to contest the primacy of the 'quantitative' or 'objectivist' dimension of clinical knowledge. In the book's preface, for example, he contrasts the experimental approach of J.F. Meckel - who used 'the rational method of weighing equal volumes and comparing them' (Foucault 1973: xii; cf. the comments on this passage in Rousseau 1980) - with the far more 'qualitative' emphasis of the clinician, Bichat. The clinic, claims Foucault, owes far more to the latter approach than the former:

'the precise, but immeasurable gesture that opens up the plenitude of concrete things, combined with the delicate network of their properties to the gaze, has produced a more scientific objectivity for us than instrumental arbitrations of quantity' (ibid: xiii).

If the notion of normalisation by number is not an overriding theme of Birth of the Clinic it is because Foucault's argument is not that medical knowledge is somehow reductive of individuality (in the manner that a bureaucracy, for example, is typically held to be reductive of individuality). Indeed, normalisation and individualisation do not appear as opposed terms in Foucault's vocabulary at all. Rather, in his discussion of medical knowledge he is at pains to show how clinical knowledge is constitutive of individuality. There is,

however, once again something of a paradox here; for clinical knowledge, in a sense, seeks to be something of a contradiction in terms, for it lays claim to being a 'science of the individual', that is, a rational discourse that takes as its object the uniqueness of the individual fact: in short, a general science of singularity; a 'universal knowledge' of 'individual difference' (Donnelly 1983). This is indeed its main claim for significance, so far as Foucault is concerned:

'The individual is not the initial, most acute form in which life is presented. It was given at last to knowledge only at the end of a long movement of spatialisation whose decisive instruments were a certain use of language and a difficult conceptualisation of death ... The old Aristotelian law, which prohibited the application of scientific discourse to the individual was lifted when, in language, death found the locus of its concept: space then opened up to the gaze the differentiated form of the individual' (ibid: 170).

Two key areas were, then, vital in the founding of clinical knowledge: language and death. A brief discussion of each, in the light of Foucault's comments, should serve to draw out further the sense of 'tension' that we have already noted as being at the heart of the clinic.

2.ii. Foucault argues that it was only through a certain usage of 'language' that it became possible to see things

in the body 'as they really are'. Indeed, it is only through language that the space of the disease itself could become mapped on to the real space of the body:

'The space of configuration of the disease and the space of localisation of the illness in the body have been superimposed, in medical experience only for a relatively short period of time - the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy' (ibid: 4).

Previously, argues Foucault, the disease had been conceived as a 'species' and the doctor's task had been to reach the species essence by 'subtracting' the circumstances of the individual who bore the disease itself. In other words, disease was a generality. Now, however, clinical thought superimposes the 'body of the disease and the body of the sick man' (ibid: 3) so that the disease always appears in its individual, particular form. What the doctor sees in the body henceforth becomes important: as Foucault says, this is the period that marks for the first time the importance of a certain kind of vision in medical thought; 'the period that marks the suzerainty of the gaze' (ibid: 4; we shall discuss the 'gaze' further below). But of key importance here was the conceptualisation of an alignment of what is seen in the body with what can be stated by the doctor (both for the purposes of knowledge - 'discovery' - and of instruction):

'It was ... necessary to open up language to a whole new domain: that of a perpetual and

objectively based correlation of the visible and the expressible' (ibid: 196).

Hence the emphasis upon the development of a form of language capable of describing the individual fact, a language sensitive to particularity, detail, density, tangibility; a kind of language - product of 'an arduous, delicate work' - able 'to encroach upon that sandy region that is still open to the clarity of perception but is already no longer so to everyday speech' (ibid; 169). And Foucault cites as exemplary of this a text by Laennec of 'extraordinary formal beauty':

'The liver ... slightly mammilated and emptied, was a yellowish grey in colour; when cut it seemed to be made up entirely of a mass of small seeds ... they were fawn or reddish-yellow in colour, verging in parts on the greenish; their fairly moist, opaque tissue was slack, rather than soft, to the touch ...' (quoted in ibid: 169-70).

The 'individual fact' here is hardly a 'reductive' one, flattened onto the homogeneous plane of numbers, experiments or reason. Rather, the plane of homogeneity that it inhabits is marked out by this kind of language - one sensitive, above all, to the 'coloured content of experience' - itself.

Again, there is a certain 'tension' here. Foucault claims that the form of clinical knowledge that he is describing is by nature 'positivist'. It privileges above all the

visible and the experiential in the construction of 'objective' knowledge. But, as Foucault makes clear right at the close of the book, this positivism also contains within itself that to which it is opposed; that is, what we might characterise as the more 'subjective' orientation 'that will be used later, and paradoxically used against it' (ibid: 199). In particular, claims Foucault, this form of positivism contains within itself all the elements with which it was to be opposed by phenomenology:

'the original powers of the perceived and its correlation with language in the original forms of experience, the organisation of objectivity on the basis of sign values, the secretly linguistic structure of the datum, the constitutive character of corporeal spatiality, the importance of finitude in the relation of man with truth ... all this was involved in the genesis of positivism' (ibid: 199).

Clearly to view the medical experience of the nineteenth century as being somehow reductive of individuality, as being of a resolutely objectivist nature would be misleading in the context of Birth of the Clinic; a consideration that has obvious consequences for those who would wish to locate the specificity of twentieth century medical activity in opposition to this objectivism. Rather that work tends everywhere to locate a certain tension between the varying impulses of the clinic.

2.iii. Anti-medical writings have often claimed that death is central to Western medicine, indeed that medicine is a kind of necromantic science, that it is preoccupied with the corpse at the expense of the living individual (Illich 1977; Figlio 1977; even a historian such as Richardson 1987: 30). In common with this tendency, we have seen how Arney and Bergen have characterised the opposition between the 'old' (nineteenth century) and the 'new' (twentieth century) medical rationalities as one pertaining between an emphasis on death and an emphasis on life. Yet, in spite of the vast centrality of death in Birth of the Clinic, the accent of Foucault's discussion is really quite different from this anti-medical theme.

Death is axiomatic to Foucault's discussion of how the clinic was born as a science of the individual fact. Death, for Foucault, is what places limits upon the new descriptive language of the clinic. The internal surfaces of the corpse - Bichat's tissues - form the essential and stable points of application for the mature clinical gaze of pathological anatomy, a fact which Foucault makes much of at a cultural level:

'Western man could constitute himself in his own eyes as an object of science, grasped himself in his language, and gave himself, in himself and by himself, a discursive existence, only in the opening created by his own elimination; from the integration of death into medical thought is born a medicine that is given as a science of

the individual' (ibid: 197).

If, however, Foucault's thesis that this medical event can be linked up more or less directly to philosophical factors of the 'birth of man' (in the Kantian question of the individual being both subject and object of his own knowledge) (ibid: 197) or to cultural factors such as the link between lyricism and individuality in Western thought (ibid: 198) will be to many rather far-fetched, his discussion of the discursive conditions of death certainly leaves no doubt that Foucault does not place a wholly negative interpretation upon this development. Certainly we would argue that a writer like Figlio is misguided when he argues, in a passage representative of the anti-medical perspective that, Foucault's discussion represents:

'a metaphysics of death of the sort Illich thought was so important to the establishment of modern medical thought' (Figlio 1977: 273).

On the contrary, Foucault claims that modern medicine is the first to dispense with the notion of death as being purely of a 'negative' order:

'For classical thought, finitude had no other content than the negation of the infinite, while the thought that was formed at the end of the eighteenth century gave it the powers of the positive ... [which] marked at the empirical level, the beginning of that fundamental relation that binds modern man to his original finitude' (ibid: 197).

An appreciation of how death becomes, for Foucault, a

discursive category of a positive order can be derived from a brief resume of Foucault's - certainly difficult, dense and occasionally obscure - discussion of the pathological anatomy of Bichat.

To begin with one might point out that Foucault is at this point attempting to be iconoclastic; he is assuming that his audience are attuned to the thesis - above all associated with Georges Canguilhem - that Bichat's work constitutes a kind of primary 'vitalism' (e.g. Canguilhem 1989: 61-3). Canguilhem associates disease with the specificity of life itself; above all, he claims that it is man's capacity to fall ill that makes him distinctive, a line of thought which he associates with Bichat's discussions of the specificity of 'organic life'. Canguilhem associates with the work of Bichat, then, that first alignment between the possibility of life and the capacity for disease. Foucault, however - whilst certainly not attempting to refute this viewpoint - claims that there is a 'third term' (aside from life and disease) which constitutes this specificity - and this third term is death. It was in the anatomy room that Bichat discovered that 'moving death' that formed the stable trajectory, away from the course of life, along which disease could be measured. For Bichat, death was not a negation but a positive, multiple, temporal phenomenon:

'Death is therefore multiple, and dispersed in time: it is not that absolute, privileged point at which time stops and moves back; like disease

itself, it has a teeming presence ... gradually, here and there, each of the knots breaks, until organic life ceases, at least in its major forms, since long after the death of the individual, miniscule, partial deaths continue to dissociate the islets of life that still subsist' (ibid: 142).

And from this epistemological construction of death the appropriation by a reasoned knowledge of the individual fact - and of all those forms of 'vitalism' that resist the reduction of organic life to the 'mechanical or the chemical' (ibid: 145) - was given its possibility: behind every form of vitalism (even that of somebody such as Illich in his resistance to the necromantic propensities of medicine) resides this genealogical origin of what Foucault calls 'mortalism' (ibid: 145): the very celebration of life (even in its most typical anti-medical forms) has as its condition this discursive appropriation of death.

Our discussion of Birth of the Clinic leads to one main proposition: that the bifurcation (exemplified in the work of Armstrong, and of Arney and Bergen) between the 'objective' - or the carceralising or mortalist - and the 'subjective' - or vitalist or libertarian - moments of medicine is in fact internal to clinical medicine itself; moreover, that the 'self-perception' of the clinic is firmly toward the libertarian rather than the carceral axis. This tension or oscillation that seems to have been

so central to medical thought since the end of the eighteenth century is of interest in relation to the wider question of 'enlightenment' that was posed at the beginning of our discussion.

2.iv. Foucault explicitly - if perhaps rather literally - associates the birth of clinical thought with the question of enlightenment. 'At the end of the eighteenth century' what mattered was above all the 'element of ideality' which, as it were, formed the 'infrastructure' ('anterior to every gaze') governing perception and its object; 'the unassignable place of origin where things were adequate to their essence' (ibid: xiii). Now, however, as Foucault explains, 'enlightenment' becomes, as it were, immanent to the gaze itself so that an active perception and a passive yet primary object can confront each other:

'seeing consists in leaving to experience its greatest corporal opacity; the solidity, the obscurity, the density of things closed in upon themselves, have powers of truth that they owe not to light, but to the slowness of the gaze that passes over them, around them, and gradually into them, bringing nothing more than its own light. The residence of truth in the dark centre of things is linked, paradoxically, to this sovereign power of the empirical gaze that turns their darkness into light' (ibid: xiv).

As has been argued, Foucault locates at the heart of the enlightenment project - and certainly within medicine itself - a certain tension or oscillation. No doubt this is reducible to the grounding project of the clinic itself - that it should be at once a science of the individual fact. A link can be drawn between this medical endeavour and that project relating to the 'sciences of man' that was Foucault's epistemological preoccupation in the 1960s (ibid: 197-8; Foucault 1974: 197 & 195-9). In The Order Of Things Foucault argues that the self-constitution of 'man' as at once an empirical and a transcendental entity has typically lead to a kind of double strategy of 'positivism' and 'eschatology' according to which logic man appears as a truth which is both 'reduced' and forever 'promised' (Foucault 1974: 321-2). This opposition is effectively given an institutional form in the medical world (cf. Foucault's comments concerning the relation between medicine and the human sciences; Foucault 1973: 198). For, in a sense, anti-medicine is itself dependent upon it; the critique of a reductive, objectivising medicine accompanied by a veritable eschatology of anti-positivist forms that would be more sensitive to the person. Birth of the Clinic effectively shows that one of the primary interests of medical thought lies in this axiomatic relation towards the question of enlightenment with all its tensions between scientisation and individuality, positivism and eschatology.

In short, the edifice of medicine may well be an exemplary site for the investigation of enlightenment rationalities - dialectics, betrayals, and attempts at recuperation. If so, it will be a privileged site not merely for some kind of 'medical sociology' motivated by the interests of the para-professions but for the tasks of a 'history of the present' in general.

CHAPTER FOUR

EPISTEMOLOGY, ORGANISATION, GOVERNMENT

1. An Analysis of Rationalities

Let us now turn to the question of the theoretical and methodological lessons that might be gleaned from Birth of the Clinic; and attempt to connect them to the present study.

1.i. It is worth making an obvious but perhaps neglected point; that Birth of the Clinic is not a 'social history' of medicine. Rather, it is a work oriented towards - if not actually occupying - the domain of the history of ideas. As Foucault himself comments, the work is:

'an attempt to apply a method in the confused, under-structured and ill-structured domain of the history of ideas' (Foucault 1973: 195).

But in a sense this is misleading. For Birth of the Clinic is not even a history of 'ideas' in any orthodox sense - that is, either a history of 'representations' relating to a natural 'object', and brought into existence through the midwifery of the powers of inspiration, 'discovery' or genius. Nor is it a history of 'behaviours', a

reconstruction of 'what really happened' in clinical hospitals at the end of the eighteenth century (and in relation to which the 'ideas' of those involved might serve as a yardstick) (cf. on the distinction between 'representations' and 'behaviours', the introduction to Foucault 1986b). Rather what Birth of the Clinic concerns might be described as medical 'rationalities'; styles of thought which typically entail the highlighting of particular 'questions' asked of reality; areas of visibility which become subject to particular conceptual problematisations and constructions.

In attempting to specify this level of analysis and its simultaneous distance from and proximity to the history of ideas, Foucault was no doubt influenced by the work in the history of the life sciences of Georges Canguilhem; and, above all, by Canguilhem's specification of the proper level of analysis in the writing of epistemological histories. What Canguilhem attempted to bring into focus in his works was - similarly - not the history of the referent (in writing the history of crystallography, he says, one does not write the history of crystals), nor the succession of theories that have come and gone in the sciences (Canguilhem 1968: 16; cf. Canguilhem 1988: introduction). Both approaches, adopting only a 'spontaneous' orientation towards their subject-matter, would involve, for Canguilhem, a confusion of the object of science with the object of the history of science. Rather, 'epistemological histories' should occupy that

position between phenomena and theories, where both have their original 'problematization' - that is, in the arena of concepts. A concept, for Canguilhem, is neither a mere 'word' nor a straightforward designation of a 'thing', but rather a kind of space of 'problematization'. Foucault's work is similarly oriented towards 'epistemological histories'; indeed, this is particularly evident in his late work where he talks specifically of a history of 'problematizations' (in Rabinow ed. 1986: esp. 388).

But if a history of problematisations or rationalities, is not quite the same as a history of ideas, then nor does it exactly occupy the domain of social history. This point can be underlined with reference to some of the work of Gaston Bachelard. Taking as his object of interest the mathematical and physical sciences Bachelard argued that scientific reason is heavily dependent for its workings upon what he called 'phenomeno-technics', that is the building up and construction of experience onto a stable and workable plane of analysis and intervention via the instrumental 'materialisation' of theories, or what he called the '"technical activity" of thought' (Bachelard 1984: 13). Hence, in looking at scientific theories it would be necessary to focus upon the material means by which such theories are operationalised. Foucault, working upon the albeit much more diffuse and epistemologically unstable domain of the human sciences, provides what might be seen as a variation of this theme in his concern with 'human technologies' - with all those material means of

rendering thought stable and 'outside ourselves' (Rabinow, ed. 1986: 388). Hence, the well-known emphasis in his work on what are often rather misleadingly called 'non-discursive' factors - political institutions, architectural inventions, welfare practices, and so forth. These should perhaps rather be seen as technologies for the rendering of experience into thought, and - conversely - of thought into experience; socio-material means for the rendition to exteriority, visibility, and stabilisation, of conceptual problematisation.

The point to be made here is that the inclusion of such 'non-discursive' factors in Foucault's works should not lead to the conclusion that these works occupy the domain more or less of an externalising 'social history'. Take for example, the notion of 'police' as it appears in Birth of the Clinic. In chapter 2 Foucault briefly discusses the collective investigations of the 'Société Royale de Medecine' which had been founded upon the principles of what Foucault calls a 'medicine of epidemics' (Foucault 1973: e.g. 25 & 28). Yet this collective - social - dimension of medical activity is not itself of great importance; or, rather, the 'police' aspect of the work of the 'Société' is only taken up in an 'epistemological' context. The intention seems not (cf. Rousseau 1980) to provide an 'externalist' history of medicine but to show that even apparently 'external' areas take part in and are part of the 'internal' constitution of medical thought. Far from being, as Rousseau labels him, the 'externalist's

externalist', Foucault is probably better understood as something like an 'expanded internalist' (cf. the discussion in Minson 1985: chapter 4). This is why, in Birth of the Clinic, Foucault is so selective about the evidence he adduces from areas that one might think would otherwise be excellent 'externalist' terrain. He goes into no great depth with the 'Societe Royale' (cf. Peter 1975), nor does he consider the French hygiene movement (Ackerknecht 1967: chapter 13, also La Berge 1984). But then, his purpose in Birth of the Clinic is not to write the history of all medicine and its ('external') 'determinants', but is, rather, with the institutional-epistemological relations constitutive of clinical thought alone¹.

1.ii. If this is granted, this 'epistemological' approach serves to re-open a gap, a sense of distance, that seems to become increasingly narrowed and uncertain in Foucault's work of the 1970s (and non-existent in the work of many of his followers and critics), between knowledge and power; between the elaboration of a rationality and the full actualisation of the tasks which it sets for itself (on this, O'Farrell 1988). Typical of this tendency is the supposition that the outlining of a rationality or style of thought has direct and immediate implications for the practices and modes of subjectivity of persons. In fact, there is no straightforward identity between the elaboration of a rationality and their actualisation in the 'real world'. As Colin Gordon has pointed out, there

are two fallacies to be avoided here:

'The misunderstanding here consists in a conflation of historical levels which reads into the text two massive illusions or paralogisms: an illusion of 'realisation' whereby it is supposed that programmes elaborated in certain discourses are integrally transposed to the domain of actual practices and techniques, and an illusion of 'effectivity' whereby certain technical methods of social domination are taken as being actually implemented and enforced upon the social body as a whole' (Gordon in Gordon, ed. 1980: 246; cf. Armstrong 1983: 133, note 50).

Of course, Foucault would no doubt have had a problem with any notion of a raw, spontaneous, foundational 'real world' at all since such an entity can presumably only be known through the basis of the problematisations of thought. However, this point should not be confused with the claim that Foucault reduces the subjectivity or behaviours of persons to their determination by the impact of thought or discourse. The historical epistemology of medical rationalities is not the same as a social history or medical sociology, according to which the real effects of medical activity are assessed in relation to the concrete behaviours or patterns of subjectivity that they induce. The investigations characteristic of Foucault's work centred upon the modes of formation of ideal forms of subjectivity as 'objectified' in thought, and in relation

to various objects and discourses in different periods. Thus he could be said to have been working upon the terrain of aspirations, of attitudes, of programmes, of ethical orientations towards the world. Such a conception of inquiry in fact requires that the notion of the 'subject' itself be left as all but an empty category for the purposes of analysis; even though, as Cousins and Hussain point out, this carries with it certain risks of its own since, as they argue:

'the human material on which techniques work is always already differentiated and hence resistances and failures may be related to the human material on which the techniques operate as well as other factors' (Cousins and Hussain 1984: 256).

Foucault, far from having an 'inadequate' theory of the subject, in fact does not have a theory of the subject at all. Certainly, in the light of this, the kind of analysis like that of Armstrong which attempts effectively to reduce subjects to forms of power (indeed, to one form of power - that of 'discipline') would seem to imply far too strong a claim for the powers of a 'human technology' such as medicine.

2. Reconstructing the Methodological Apparatus of Birth of the Clinic

In some respects it is a mistake to expect to be able to

summon up a coherent 'methodology' from Foucault's books. For Foucault's work is in general faithful to the principle that one tailors one's mode of analysis to the 'object' in hand. We might - adopting a rather 'naive' mode, perhaps - contrast here a 'toolbox' approach from a 'machine' approach. Thus, one takes a 'toolbox' to the evidence, one uses only those tools appropriate to the task in hand; the aim is not to allow the evidence itself to pass through some kind of pre-fabricated 'machine', capable of programming all the evidence in advance. Nevertheless, if one turns to Foucault's analyses themselves one can reconstruct certain themes, a 'way of doing things' that is characteristic. In doing this with Birth of the Clinic, we are concerned less to be resolutely faithful to that text in all respects than to use it so as to provide ourselves with tools for our own enterprise.

We shall 'read into' Foucault's book on -the clinic a threefold methodological schema whereby the birth of the clinic is accounted for along three analytic levels; those of epistemological articulation, organisational adequation and what we shall call 'governmental consciousness'. It should be emphasised that these are not Foucault's terms but are rather the methodological means that we shall be deploying in our own analysis. Nevertheless, Foucault's book can be read through the lens of this threefold typology, as can now be demonstrated.

2.i. The key epistemological term in Birth of the Clinic is the 'gaze'. This term should not, we would argue, be assimilated to the notion of 'surveillance' (a marked characteristic of Armstrong's approach), but should be allowed to retain its more or less 'substantive' function; that of describing the different forms of epistemological articulation proper to clinical perception, that is, the forms of association between that which is observed and the modes of 'seeing' that object and speaking of it. In short, the notion of the gaze in Birth of the Clinic seems to refer to modes of perceptual problematisation; the way that forms of knowledge, vision and enunciation are articulated together into a particular perceptual model; a kind of 'sensory economy' that articulates what the doctor can see, feel, say, teach, or know and which brings about more or less of an alignment between these functions.

One example of this epistemological articulation can be related to the discussion of language -and clinical perception in the early form of the clinic, before Bichat (Foucault 1973: chapters 6 and 7). Here, Foucault argues, one has not seen pathology until one has offered up a 'complete description' of it. Language in this sense, is not part of 'saying' but relates just as much to 'seeing' (ibid: 112-4); language is akin to vision, hence the image that Foucault uses of the 'speaking eye'. On the other hand, what Foucault calls the 'glance' is unlike the semio-clinical gaze in that it is sensory and direct; it strikes at the body at one point, as if one were touching

the surface of the body with one's eye (ibid: 122). So here, the gaze relates less to the seeable, or the sayable, than to the tangible; a matter of importance when one comes to consider the mature clinic of, above all, Laennec. For if the gaze is akin to the sensory immediacy of touching, then touching too, with Laennec, is effectively a form of 'seeing': so that even the use of the stethoscope remains for Foucault under the 'dominant sign of the visible' (ibid: 165).

Another example of epistemological articulation might also be invoked to indicate this time the way in which certain 'real' aspects of the world itself have to be 'mobilised' in a certain manner in order for particular forms of the gaze to be possible. In order for the 'real' space of the body to become the proper object of the medical gaze, properties of the body have to be conceived in a certain manner, and given privileges. Thus, the great achievement of Bichat was, for Foucault the discovery of 'a principle of deciphering corporal space that is at once intra-organic, inter-organic and trans-organic' (ibid: 127). This principle entailed a certain conceptualisation of corporeal space - 'a space ... concerned with order, successions, coincidences, and isomorphisms' - defined entirely by the differential thinness of tissues. Bichat's achievement was to conceptualise the body as a homogeneous, yet differentiated space of tissues (twenty-one types in all) which cross and intertwine around the organs; a surface upon which both the complexities of

pathological function and alteration and the gaze itself can be fixed:

'On the basis of tissues alone, nature works with extremely simple materials. They are the elements of the organs, but they traverse them, relate them together, and constitute vast 'systems' above them in which the human body finds the concrete forms of its unity ... Bichat imposes a diagonal reading of the body carried out according to expanses of anatomical resemblances that traverse the organs, envelop them, and, at the same time, bind them together ... ' (ibid: 129).

2.ii. The second analytical axis that might be considered is that of organisation (ibid: chapter 5). What are the forms of association that are implied by the form of epistemological adequation proper to the clinic? What sort of institutional structures would be required to promote these associational forms?

The first matter - that of forms of association - is taken up by Foucault in the context of Cabanis's report on medical administration in Year XI, which sought above all 'to provide a theory of the medical profession' (ibid: 78):

'The problem was to assign to it [the profession] a closed domain, reserved to it alone, without either resorting to the

corporative structures of the Ancien Regime or returning to forms of state control that might be reminiscent of the Convention period' (ibid: 79).

What was effected was a kind of compromise between the liberal demand ('patently inspired by Adam Smith') that there should be no authoritarian or exterior control over medical acts themselves and the demand that there should be no return to that internal - 'corporative' - control, that had opposed to the practiced gaze of the clinic the fixed axioms of the academy (ibid: 80). Instead, medicine was to be conceived as a 'secondary industry' - which does not produce wealth but which treats or measures it - whose practitioners would have to be subject to a rigorous system of examination in order precisely to protect the liberty of those that they targetted. But what was important here - and this is what actually characterises medicine as a 'profession' - was not so much the knowledge one possessed so much as the competence - the 'recognised probity' as Cabanis put it - or the 'set of possibilities' ('ensemble de virtualite') that characterised the person of the doctor (ibid: 80; cf. Foucault 1963: 81).

Thus, the birth of the clinic entailed a transformation in what might be called the substance of organisation. Instead of being directed at the object of knowledge, organisation was now directed at the 'knowing subject'. Hence the great importance that Birth of the Clinic attaches to clinical 'authority', to the 'subject' or

'author' of medical statements, the doctor. Central here is the form taken by the reproduction of clinical knowledge, that is, pedagogy; and the form of the institution in which pedagogy takes place, the hospital. The clinician is an authority who combines perfectly the act of seeing with the act of teaching; of 'disclosing' the forms of pathology. The hospital is a space in which the truth of pathology itself - removed from all the 'dogmatic language' of 'university speech' - is allowed to speak, albeit in a 'language without words':

'It is a question, in the absence of any previous structure, of a domain in which truth teaches itself, and, in exactly the same way, offers itself to the gaze of both the experienced observer and the naive apprentice; for both, there is only one language: the hospital, in which the series of patients examined is itself a school' (Foucault 1973: 68).

Thus the liberation of truth from dogmatism entailed a composite liberation on the terrain of the institution:

'in a liberated domain, the necessity of the truth that communicated itself to the gaze was to define its own institutional and scientific structures' (ibid: 69).

2.iii. The notion of a 'medicine in liberty' (ibid: 69) is also central to that level that we will call the 'governmental consciousness' of medical activity. Here

reference can be made to Foucault's later writings on 'governmentality', as well as to the work of other authors on 'rationalities' and 'technologies of government' (above all, Burchell et al. 1991, and Rose and Miller 1991). The clinic, as described in Foucault's work, displays evidence of a certain 'governmental consciousness', that is, a telos of epistemology and organisation that might have implications for wider - especially liberal - problematics of government. For on the one hand, as Foucault shows in the early chapters of Birth of the Clinic, clinical medicine concerns irrevocably the question of 'population' and the maximum of 'longevity' (see for example, the discussion of Turgot's writings, concerned to generalise the space of 'assistance' outside the hospitals into the homogeneous space of the population; Foucault 1973: 18ff.), and the delegation of powers of tutelage over its health and longevity to a closed yet free 'profession'. Yet, on the other hand, the form of the clinical encounter is itself a private one:

'a space with no other morphology than that of the resemblances perceived from one individual to another, and of the treatment administered by a private medicine to a private patient' (ibid: 19).

As such, then, clinical rationality could be said to be at once 'totalising' and 'individualising'; following a logic of, as Foucault puts it, 'omnes et singulatim' (Foucault 1981). And as he wrote in a text that is entirely in line with Birth of the Clinic on this matter:

'The emergence of a clinical medicine strongly centred on individual examination, diagnosis, and therapy, the explicitly moral and scientific - and secretly economic - exaltation of "private consultation", in short the progressive emplacement of what was to become the great medical edifice of the nineteenth century, cannot be divorced from the concurrent organisation of a politics of health, the consideration of disease as a political and economic problem for social collectivities which they must seek to resolve as a matter of overall policy' (Gordon ed. 1980: 166).

This level of 'governmental consciousness' concerns, then, the way in which the micro level of intervention is tied to the macro level of aspirations and programmes of longevity and security; the way in which clinical discourse fits itself into, and invokes, wider projects and rationales. And if there is what we might describe as a governmental 'telos' here - a form of subjectivity that the clinic typically seeks to invoke - it is that of the free citizen who engages in a kind of 'contract' with the clinic, one who retains his or her own interests whilst serving the interests of the wider collectivity by becoming an object of knowledge: a citizen who, whether rich or poor, is in fact only serving his or her own 'natural interests' by entering into the clinical contract. In fact, as Foucault argues, in its original form, this clinical 'contract' actually entailed a kind of

- more or less cynical - bargain between different social orders in the context of a strictly 'economic' rationale:

'And in accordance with a structure of reciprocity, there emerges for the rich man the utility of offering help to the hospitalised poor: by paying for them to be treated, he is, by the same token, making possible a greater knowledge of the illnesses with which he himself may be affected; what is benevolence to the poor is transformed into knowledge that is applicable to the rich' (Foucault 1973: 84).

3. On the Mechanics of Medical Rationalities

In the following analysis of general medical practice in the twentieth century a similar schema focusing upon the analytic levels of epistemology, organisation and governmental consciousness will be used. But, in accordance with the discussion of the first part of this chapter, it should be remembered that what are being described are successive rationalities within general practice. A major concern will also be with how rationalities are put together and held together; with what might be described as the 'mechanics' of the inter-relations of epistemology, organisation and government. In describing these processes some recourse will be had to a perspective that has been influential in recent sociology of science; that associated with the work of Bruno Latour and his colleagues. There is no space to do expository

justice to the full scope of this work here (Latour 1987, Callon 1986, Callon et al. 1986, Callon and Latour 1981 are all useful sources); and besides only selective usage is made of it to suit our particular purposes. Central to this mode of sociology is the proposition that both science and society (which are not viewed by these authors as opposite terms) are built up by chains of 'associations' (John Law, for example, has coined the term 'heterogeneous engineering' to describe this process). The most important concept here is that of 'translation' - be it of material 'actors' or human 'interests'. Translation describes that activity of bending the will of something or someone in accordance with one's own ends; of mobilising it or 'enrolling' it for one's own purposes until finally one ends up with a kind of 'network' of associations or 'alliances'. The purpose behind translation is always to make something stable and powerful - for example using a strategy of 'interessement' through which identities are imposed upon other actors (Callon 1986: 207-8) - to make a network hold through various 'trials of strength'. As Latour in particular has been concerned to demonstrate, one important means of doing this lies with the mobilisations of 'inscriptions', material traces that stabilise a field of investigation (Latour 1986); this theme will recur in subsequent chapters of this study.

In what follows, parts of this perspective derived from the sociology of science will be used to describe the

construction of medical rationalities. Such rationalities require a constant integration and association of elements (epistemological, organisational, governmental); but another requirement - as will be seen - is that what results should be as coherent and 'simple' as possible. The fabrication of a model or rationality of general practice always requires the simplification of reality, the reduction of elements in as mutually coherent a manner possible (on the notion of such 'coherence-conditions' in the service of a reduction of complexity, the most celebrated work is Hesse 1974). What follows is an examination of the way in which - not laboratory scientists - but general practitioners have sought to impose upon the heterogeneous reality which they confront such a sense of epistemological 'discipline'. What these general practitioners have in common is the task at once of making general practice a non-'despotic' clinical discipline (attentive to individuals, patients and - later - 'persons' as opposed to diseases) and of turning it into an autonomous and independent domain of endeavour and investigation in its own right.

PART TWO

JAMES MACKENZIE AND THE RE-INVENTION OF THE CLINIC

CHAPTER FIVE

MEDICAL INSTRUMENTS AND CLINICAL PRINCIPLES

1. Introductory

There are four reasons for entering the empirical side of our investigation of general practice with a consideration of the work of James Mackenzie (1853-1925).

1.i. First, the case of Mackenzie can show how for general practice to be tied to the project of anti-medicine a complex operation in thought was necessary. General practice has no 'natural right' to its attentiveness to the sick individual - or even if it does, in order for this aspiration to be realised a complex operation of conceptualisation, adequation and alignment was required. In short, it was James Mackenzie who first made out a case for general practice being exemplary of the ideals of an anti-medical - that is, non-'despotic' - clinical discipline. Second, Mackenzie was indeed the first to tie general practice to this anti-medical project then it does not follow that the project has remained the same since his formulations of it. This is an important point because Mackenzie is invariably mobilised today as the precursor

of modern forms of practice that seek to take an enlightened approach towards the sick individual; that is, the 'patient's view'. Third, we wish, to illustrate through a study of Mackenzie that anti-medical forms of practice invariably resort to an enhanced attentiveness to the characteristics, not so much of the patient, but of the doctor. Rather than the 'patient's view' coming into visibility, it is generally the 'doctor's view' which is highlighted; if anything, such forms enhance rather than diminish the doctor's specific claims to expertise. This is a tendency which will be referred to later as the generic 'doctorcentrism' of all forms of anti-medical medicine.

Lastly, the case of Mackenzie shows that - contrary to the instincts of the anti-medical impulse itself - the construction of those 'human' technologies which seek to be attentive to individuality, and to demonstrate their 'regard for persons' is necessarily of the same order (requiring similar strategies of 'interessement', translation and so forth) as that required in the construction of so-called 'material' technologies. The case of Mackenzie is a particularly apposite one with which to make this point; and the Latourian vocabulary of translation will be useful here. There are essentially two dimensions to his achievement; the first as the inventor of a 'machine', and the second as as the originator of certain clinical 'principles' designed to revolutionise

medicine whilst putting general practice onto an independent clinical footing.

1.ii. James Mackenzie (1853-1925) - one-time Harley Street heart specialist - was not a cardiologist but a general practitioner. It was during his twenty-eight years as a Burnley general practitioner that he carried out his initial research into the problems of failing circulation, heart failure, clinical semiology and the nature of pain. In 1885 he perfected an instrument - the *ink polygraph* - which could measure the activity of the ventricles and auricles of the heart; this led to important findings on the role of 'auricular fibrillation' in the onset of ventricular collapse. In 1906, at the age of 54, Mackenzie attempted to establish himself in London as a heart specialist; he later worked at the West End Hospital for Nervous Diseases, the Mount Vernon Hospital in Hampstead, the London Hospital and University College Hospital. In 1919, wanting to return to general practice, Mackenzie founded the James Mackenzie Institute of Clinical Research: here, with a group of co-workers, he intended to evolve a logic of clinical research -based exclusively on the skills of the general practitioner - which would focus specifically upon the early stages of disease where diagnosis was most imprecise. However, the project was not a success, and the Institute dissolved not long after Mackenzie's death in 1925.

Today Mackenzie is revered by general practitioners as the 'father' of those who sought to put general practice on the footing of an independent - and professionally autonomous - clinical discipline; the pinnacle of any modern general practitioner's career being to deliver the annual 'James Mackenzie Lecture' at the Royal College of General Practitioners.

2. The Invention of the Polygraph

Central to our treatment of Mackenzie's work - which we shall approach above all through his prescriptive text, The Future of Medicine (1919) - there resides a paradox that has often been commented upon. This concerns the specification of the grounds for Mackenzie's importance. Thus on the one hand, his renown relied especially upon his invention of a medical instrument - the clinical polygraph - whilst, on the other hand, his own claim to renown rested with his invention of a general clinical method and approach which took as its focus, ironically enough, the denigration of the use of instruments in medical practice (Reiser 1978: 182). As his Times obituarist summed up the matter:

'Those members of the profession who love a toy may remember him for his discovery of the venous pulse and his share in the evolution of the electrocardiograph. But deeper minds will recognize, as he himself recognized, that these were small matters compared to the great

principles which he elucidated and the impetus which he gave to a new study of medicine and a new outlook ... ' (The Times 1925: 8).

2.i. The focus of Mackenzie's work was - throughout his career - upon the problem of irregular heart action, and his invention, the ink polygraph, was designed to provide physical notation of such action in both auricles and ventricles (on Mackenzie and instrumentation; Reiser 1978: 103, cf. 174 & 182). This instrument consisted of several rubber tubes that connected to the various pulses on the surface of the body, which connected to a roll of paper on which 'traces' of the differential beating of the pulses were recorded. The significance of the polygraph was that it allowed an appreciation of the working of three of the heart's four chambers independently of each other. From this it could be seen that the chambers could fail independently of each other, such as in the case of 'auricular fibrillation' where the two upper chambers cease altogether, causing an irregular motion of the ventricle which eventually wears out leading to general 'heart failure'. The instrument worked by recording systolic activity from the jugular (neck) and radial (wrist) pulses and correlating them with the 'apex beat' (felt on the surface of the chest, measuring the left ventricle systolic impulse, Mackenzie 1908: 73) which served as the 'normal' rhythm. Thus the polygraph was an instrument which, as it were, mobilised the actions of the heart onto a flat, stable, homogeneous surface: or, to use

Latour's vocabulary, it was something of a 'translation device' transferring - and transforming - data from the complicated three-dimensional space of the body to the more manipulable and analysable two-dimensional space of what Mackenzie called his 'tracings'. The stability of its results, moreover, derived also from the mobility of the instrument and its ease of use:

'I got a very serviceable instrument which I could carry about in my pocket ... So easy was this after a little practice, that I could take a tracing of the radial and jugular pulse, or apex beat of a patient while the temperature was being taken, so that it was not time-robbing' (Mackenzie 1919: 86-7).

Thus under a wide diversity of conditions the polygraph served to enable equivalence and consistency to be maintained, and an entire corpus of graphic descriptions to be built up. This epistemological translation enabled Mackenzie to demonstrate that extra-systolic activity could be due to a premature beat of the ventricles (which did not necessarily imply a pessimistic prognosis) or more seriously to 'auricular fibrillation' which, Mackenzie showed, was not caused by an absence of auricular systole but by the irregular triggering by the auricle of the ventricle beat ('nodal-rhythm'; Mackenzie 1908: 160) - the simultaneity of which motion only giving the impression of an absence of auricular movement - such that eventual heart failure was caused by excessive movement of the

ventricle rather than the auricle itself (Mackenzie 1908: 64, 69, Mackenzie 1902, Mackenzie 1919: chapter 4).

2.ii. However, in order to succeed (that is, to be 'taken up' by others), Mackenzie's invention had to be - as his first, contemporary, and most insightful biographer demonstrates (MacNair Wilson 1926) - not just a 'material' technology (translating raw materials into graphic evidence) but also something of a 'social' technology. MacNair Wilson centres his account of Mackenzie's work largely around his professional struggle with the Royal College of Physicians - or the 'Giants' as MacNair Wilson calls them. Until 1907 the Royal College had been oblivious to the work of Mackenzie - then a lowly general practitioner in Burnley - and his results had been ignored. By 1906, however, as MacNair Wilson comments:

'The truth began to dawn on him that if his discoveries were to be made available to his professional brethren and to the world, he must himself carry them into the strongholds of the giants' (MacNair Wilson 1926: 178).

What made the Giants change their minds was not so much Mackenzie's move to London and Harley Street in 1907, that is into the physical 'stronghold of the giants' but the fact that his move into their social stronghold implied an acceptance of their conceptual values. Here, in fact, a social acceptance is disguised as a conceptual one: for what was 'taken up' were not so much Mackenzie's actual 'findings' as based upon his 'principles' (which we shall

consider below) but the 'social' status of his data such that his 'material' technology he offered was only of value because it was a 'social' technology as well. Thus as MacNair Wilson argues, in his aptly 'strategic' terminology, a translation of interests took place on the basis of Mackenzie's 'scientific' credentials as a man not of medical principles but of an interesting series of 'traces' (as exemplified in Mackenzie's Diseases of the Heart (1908) with its mass of scientific data):

'His polygraph was what it is the fashion to call an instrument of precision. The records he made with it were "scientific data", things which other men, similarly equipped, could make and examine ... These tracings could not be ignored; they were facts ... The Man of the Tracings, therefore was a force to be reckoned with' (MacNair Wilson 1926: 205-6).

However, if there was indeed a successful translation of interests here then it was a translation without complete mutual alignment. For whilst the Giants of the Royal College believed that Mackenzie had simply become one of their number, Mackenzie apparently believed that he had succeeded on the basis of his principles rather than his invention. Thus although, having given up general practice, success came very quickly for Mackenzie - Physician at the West London Hospital, Harley Street Consultant, member of the Royal College of Physicians - it was a success which was on both sides based on a kind of misrecognition:

'He accepted gratefully and gladly the honours that they offered him, because he thought that these honours were accorded to his principles. In fact they were accorded to his polygraph ... And thus a strange and most comic situation was brought about - a situation in which both parties believed firmly that they had conquered eachother' (MacNair Wilson 1926: 205 & 207).

Consideration can now be made of these 'principles' themselves.

3. Clinical Principles and the Future of Medicine

Mackenzie's project centred upon an attempt to shift the emphasis of his contemporary medicine from what he saw as its preoccupation with disease entities and the development of instruments to an emphasis on the patient's prognosis as interpreted on the basis of the doctor's 'unaided senses'. As such, Mackenzie's project can be seen as an 'anti-medical' reaction (in the sense of that term used here) to the impact of bacteriology with its apparant 'reification' of the notion of disease (interestingly enough, Mackenzie himself had been a pupil of Lister at Edinburgh; see Keele 1963: 104-5).

3.i. Although it can thus be described as a form of anti-medicine, Mackenzie's enterprise was in fact only a re-

affirmation of what he saw as already-instituted clinical principles. His work represents in some respects an attempt to 're-invent' the clinic. Thus Mackenzie expressly regretted what he saw as the recent disintegration of medicine into a series of insulated 'specialties' (especially those centred upon the laboratory and the corpse) (Mackenzie 1919: 44-5) and sought to relocate the 'leading edge' of the profession with the general practitioner, with his long-experience of first-hand relations with actual patients.

Mackenzie's starting point was a kind of nominalist reduction of the concept of disease. Diseases, he says, are but names, referring sometimes to the 'seat' of disease (as in peritonitis, galls stones), sometimes to symptoms (goitre, angina pectoris), sometimes to their discoverer (Bright's Disease), or to groups of symptoms and signs (rheumatism, neuralgia). All these forms of designation have the result that pathology is, as it were, 'reified' as having an existence independent of aetiological processes in the individual. This overemphasis upon disease has led to a similar overemphasis upon the specialisms, especially pathology which:

'is now so universally recognised, that everywhere facilities are given for its prosecution, so that it can be said that ample provision has been made for the study of the disease, after it has killed its victim' (ibid:

2).

In fact, Mackenzie argued, this conception of disease becomes only the tip of the morbid iceberg when disease is understood in its chronological context. He outlined four stages through which all disease must pass. Medicine, he claimed all but ignored the 'predisposing' and 'early' stages of disease (the domain of the general practitioner; where few signs or symptoms were present) and instead concentrated entirely upon the later 'advanced' stage ('... when the disease has progressed so far that it has caused destruction or modification of tissue and when its presence is revealed by a physical sign') and the 'final' stage (when the patient has died):

'Medicine has advanced so far that for the study of disease after the patient has died, we find institutions magnificently equipped, presided over by men of great experience and training' (ibid: 3; cf. Mackenzie 1909: 12-14).

Perhaps, then, for Mackenzie, medicine is indeed a kind of 'metaphysics of death' of the sort described by Illich. But his conception of the alternatives is no great distance from the clinical principles described by Foucault. Thus, Mackenzie's notion of pathology is one in which the 'being' of the disease has indeed disappeared, to be replaced by an emphasis upon the course of morbidity as it inheres within the very structures of the body. Yet, for Mackenzie, the site of the disease has retreated some way further beyond the range of the gaze: the lesion has lost some of its importance and disease has become a

rather uncertain phenomenon which cannot be known except through its 'manifestations' (symptoms and signs). Thus disease is something that has always to be inferred (rather than simply seen) from the evidence at hand: it is something that must be arrived at 'retroductively' from the evidence of its manifestations. Yet this viewpoint itself led Mackenzie at once to re-assert all the clinical principles of linguistic precision - to match the visible with the expressible through a close linguistic attentiveness (eschewing, for example, mere disease 'labels') - and to call for a certain humility in relation to disease:

'The recognition and due appreciation of our limits in respect of this imperfect nomenclature will warn us to make every endeavour to define our terms, and to make our use of names as precise as possible that like disease may be brought together from the unlike, and our classification be based no longer on superficial, and accidental resemblances but by deeper affinities' (Mackenzie 1909: 14).

Indeed this humility required only an enhanced visual attentiveness - we must, argued Mackenzie, re-learn what it is 'to see' - that had to be combined with the clinical emphasis upon allowing the trained senses to ignore the obstacles of prejudice and habit:

'The power of accurate observation and precise thinking is so seldom acquired because methods have become stereotyped, and many observers do

not realise that they are fettered in the bonds of tradition' (ibid: 2).

3.ii. It can be no surprise, in this context, that a nominalist appreciation of disease should be combined in Mackenzie's work with an emphasis upon the sensitive powers of the doctor - of which the model, for Mackenzie, was not the specialist but the experienced general practitioner. This is because the difficult understanding of pathology can only be achieved on the basis of a complex - 'aesthetic' - sense of judgement:

'Perhaps if we analyse it deeply enough, Mackenzie's service to medicine is chiefly "aesthetic". Although his methods were scientific, his real aims were artistic. He insisted upon personal impressions of the trained senses, and above all, the discoveries following from the use of these methods make him a healer in the great tradition, whose life will live on in many healed lives' (Williams 1946: 168-9).

Mackenzie, of course, made no claim to having invented this aesthetic, which, when applied to matters of prognosis, can seem like a 'sixth sense', a form almost of 'magic' (cf. on the 'clinical' foundations of this Foucault 1973: 121, and Jacob 1988: 34). Rather, he was reputed to have first seen it in action in Burnley, as employed by a colleague of his, Doctor Briggs:

'The mysterious power possessed by Doctor

Briggs, of knowing what was going to happen to his patients was neither more nor less than accumulated experience. Each time he looked at a new case he saw, in reality, hundreds of old cases, and remembered how they had fared' (MacNair Wilson 1926: 50).

However, Mackenzie did devote himself to anatomising this irrational or magical power in an attempt to find the principles behind it. The essence of this clinical experience lay in the doctor's use of the 'unaided senses': the eye, the ear and the percussed finger; factors;

'of importance in the perfecting of that necessary instrument to clinical medicine - the trained physician' (Mackenzie 1919: 185).

The doctor's approach, whether by eye, *finger* or ear, was always with Mackenzie contrasted with the use of medical instruments. Hence, Mackenzie - himself famous, as we have seen, for the invention of a 'machine' - wrote repeatedly of the need to expunge instruments from medical practice and research:

'The next thing the discoverer of a mechanical device must do after he has recognized its use in clinical medicine, is to get rid of it in practice' (ibid: 195).

The means with which this was to be done, the mobilisation of this 'sixth sense' of the doctor, and the over-all medical 'rationality' that resulted, can now be described.

CHAPTER SIX

MACKENZIE: EPISTEMOLOGY, ORGANISATION, GOVERNMENT

1. Epistemological Articulation

If Mackenzie was to be successful in his investigation of this 'sixth sense' of the doctor, it was less because of his recognition that this almost magical knowledge concerned 'familiarity derived from experience' in all the principles of morbid recognition - 'the eye has to be trained to see and the finger to feel, and this can only be brought about by long and patient education' (ibid: 185) - than from his epistemological elaboration of the conditions necessary for this experience to operate. For in order to make the doctor's aura calculable and capable of reproduction, as it were, Mackenzie had to posit a 'domain of evidence' - a privileged material surface (analogous perhaps to Bichat's internal surface of tissues) - that would be amenable to the doctor's gaze.

1.i. Part of this enterprise - it can be called the labour of epistemological articulation - can be seen through a discussion of Mackenzie's clinical 'semiology'. What is the difference between the 'symptom' and the 'sign' in

Mackenzie's work? Some have criticized him for making no distinction at all: 'Mackenzie had the irritating habit of using the terms signs and symptoms anonymously' (Mair 1973: 317). Certainly there is little emphasis on the symptom as being somehow 'subjective' compared to the 'objective' nature of the sign. Rather, both are objective in that both depend for their existence on the doctor to interpret their 'value' - requiring designation only if they possess some kind of significance. However, if there is a difference between them, it is that the symptom exist prior in time to the sign and thus may be derived from the evidence, not of the doctor's senses, but of the testimony of the patient.

The symptom always relates to the sensation of physical pain. But even pain is not a 'subjective' phenomenon; rather it possesses in Mackenzie's work a peculiarly 'material' status on the surfaces of the body. The notion that pain is a subjective phenomenon - was, argued Mackenzie, the corollary of the fallacious view that pain always relates to a particular organ. However, if we cease to be concerned with locating the organ in question but trouble to locate, as rigorously as possible, the pain itself, we will be lead to the discovery that the radiation of pain has, as it were, its own logic and can be mapped along the complex pathways of the nervous system:

'A recognition of the nature and meaning of this radiation revealed that the usual idea, that

pain is often so diffuse and vague as to be of little value as a symptom was wrong, for the production of pain is due to a stimulation of certain cells in the central nervous system, and the location of the pain is in a field definite and distinct in the peripheral distribution of nerves and these cells' (Mackenzie 1909: 67).

In order to track these material pathways of pain the doctor must internalise certain methods of analysis. There is, claimed Mackenzie, a 'law of association' on the basis of which we can map the complex of symptoms across the space of the body:

'in modifying the function of an organ or in impairing the health of the individual, [disease] produces a variety of phenomena, and the application of this law demands a search for the less prominent symptoms' (Mackenzie 1919: 127).

Perhaps more important, however, was what Mackenzie called the 'law of progression' since it is this that fixed the 'value' of the symptom. This law states that the discovery of the symptom should not be the end of the point of investigation; rather the symptom in question must be placed within the context of the mechanism which produced it and which will determine its future. The 'law of progression' thus has significance only within a kind of temporal economy according to which a symptom is only significant in relation to its origin, and more particularly, its outcome. Thus a symptom - or a sign -

can never be of importance in itself: its value lies not in its severity or triviality, but in its development (and association) alone, that is, its value in time:

'No physical sign should be valued by itself, its association with other symptoms has always to be considered ' (ibid: 166).

This semiology, according to which the doctor's experience and expertise is able to confer 'value' upon the heterogeneity of 'manifestations' that are 'signs and symptoms', was well illustrated by Mackenzie in the case of auricular fibrillation (Mackenzie 1902). Mackenzie's 'system of observation' revealed that this affection, occurring early in life or in middle age could, through over-exertion on the part of the individual, typically lead to full-blown heart failure (ventricular collapse) in later life. Hence this form of affection has a kind of 'value', the knowledge of which is distinct from the mere knowledge of the 'mechanism' which produced the affection itself:

'men who scientifically investigate the mechanism of phenomena, are quite content with a species of guesswork as to the value of phenomena' (ibid: 95).

On the other hand, in those cases of what he called the symptoms and signs of 'youthful irregularities' of the heart, Mackenzie concluded that these were of no 'value', that is, of no pessimistic prognostic significance:

'I watched those who showed this irregularity grow into manhood and womanhood ... They never

showed any signs of cardiac weakness even when engaged in hard manual labour' (ibid: 99).

1.ii. This evaluating gaze - so sensitive to the long passage of time and individual prognosis - could, of course, belong to nobody but the general practitioner, working like Mackenzie himself in the actual circumstances of daily practice. Nevertheless, for this gaze to work, Mackenzie had to posit various substantive characteristics as belonging to the body itself. Thus his work entailed a particular conception of the human body as possessing a series of attributes that make it naturally amenable to perception; the 'object' of analysis, the body, has to be made coherently visible, given a workable 'grid of perception'. In other words, both the body and the kind of perception which confronts it had to be given certain characteristics, certain forms, that would allow them to confront each other at all. In Mackenzie's work, this task was performed by what can be called a 'vocabulary of surfaces'.

First, there are the substantive surface forms that Mackenzie mentions which connect the inner world of the body to the doctor's perception. These forms have the specific task of being, as it were translatable from one organ to another. Take the phenomenon of 'pain'. This, as a generalised symptom is something that is common to all organic affections. Pain, for Mackenzie, follows specific, traceable pathways: the 'viscero-sensory reflex' and the

'viscero-motor complex'. The phenomenon of 'pain', as a material trace across these reflex pathways, forms a region of 'obligatory passage' common to all organic pathology. Moreover, as Mackenzie was concerned to show, the organs themselves are not susceptible to pain at all. But if pain rests upon a kind of area that is 'homogeneous' in the body (obviating the necessity, for example, of working out a separate form of knowledge relating to each organ) it also resides in areas that are peculiarly susceptible to the gaze of the physician. In particular, areas of 'non-striped' (non-striated) muscle are especially prominent sites for pain; that is, the surfaces of muscle wall that surround and project fragile organs (e.g. the bowel, gall-duct, the uterus). Mackenzie's work makes visible an entire vocabulary of such surfaces that traverse the body now and then coming to the surface, to be amenable to pressure on the skin (as in the case, for example, of those affections which produce 'cutaneous hyperalgesia') and thus to the direct scrutiny of the doctor. The vocabulary of surfaces not only unites the analysis of separate and diverse organs, but provides a kind of link between the inside and the outside of the body, a homogeneous grid of perception.

Second, we can say that this vocabulary of surfaces extends to the very exterior of the patient; the patient's 'aspect' and 'appearance' (see e.g. Mackenzie 1908: chapter 4). The state of this exterior surface provides a clue to those of the interior:

'When people past the middle age suddenly develop a pallor, the sign is one of grave significance, and may be the first clue to the beginning of some malignant affliction ...'
(Mackenzie 1909: 100).

In particular the doctor should look out, argued Mackenzie, for pallor, staring eyes, the appearance of fatigue, all of which can provide clues to the patient's condition. Mackenzie's vocabulary of surfaces is, then, a way of 'homogenizing' the body, a way of making it amenable to a coherent analysis from a single point; the view, in short, of the general practitioner. It is a means of giving the body a specific kind of visibility, whilst allowing the gaze that confronts it to be pre-eminently simple, governed by a limited number of widely applicable principles of perception.

1.iii. Mackenzie's epistemology represented a brilliant and coherent attempt to outline an approach - tied uniquely to the powers of the general practitioner - that would focus upon the 'patient' rather than the 'disease'. Yet it would be strictly anachronistic to read back into this the notion that Mackenzie was a practitioner - or precursor - of 'person-centred' medicine. For Mackenzie's patients are indeed just that - patients, and not 'persons' (cf. Abercrombie 1959: 18). If Mackenzie did indeed tie the enterprise of general practice more or less irreversibly to the fortunes of the patient, then this was not at all an attempt to 'include' the patient in medical

practice, to fathom a kind of consciousness, or to manipulate the 'soul' of the sick subject. Dr Annis Gillie, for example, is therefore quite wrong when she claims that Mackenzie's interest in pain was driven by 'compassion' (Gillie 1962: 10). Or, at least, this compassion played no part in Mackenzie interpretation of pain. Rather his purpose was to subject the notion of 'pain' to a rigorous localisation; for him, pain was a material not an 'emotional' concept. As he wrote:

'It is beside my purpose to enter into abstruse metaphysical considerations regarding the consciousness of pain and its mental affinities' (Mackenzie 1909: 22).

In fact all forms of 'psychologising' language were completely alien to Mackenzie's way of doing things, a factor that has lead his successors to correct this 'omission' for him. Thus Pinsent has noted the proponderance in Mackenzie's work at St. Andrews of a peculiar notion of 'exhaustion', when today 'we would probably think of anxiety states and psychoneuroses as fitting more closely [this] description' (Pinsent 1963: 11-12). In fact the patient's consciousness was, for Mackenzie, as much an obstacle to the gathering of information as a condition for it. So if it is indeed the case that 'Mackenzie demonstrated as few, if any, others have done the importance of listening to the patient, and evaluating the evidence that the patient can provide' (Gillie 1962: 19), then it is not the case that this entailed anything like empathy or an 'understanding' -

based for example, upon the doctor's own reflexive capacities - of the patient's emotions. If there is anything to be understood it is that the patient, as an indispensable source of knowledge, can be extremely difficult to handle. For example, the model of the clinical encounter in Mackenzie's work does not follow the logic of the confessional. Rather, it takes the form - to use Mackenzie's own term - of an 'interrogation':

'In all cases the patient's replies must be as direct and to the point as the question asked. The tendency to prolixity which some patients show must clearly be repressed; a clear reply should be obtained to each question and no question allowed to pass until the answer is obtained' (Mackenzie 1909: 102, cf. Mackenzie 1908: 20).

Mackenzie's system was, in short, an attempt to found a 'patient-centred' medicine, but not a 'person-centred' one. His work represents for perhaps the first time the possibility of a discourse that is able to speak simultaneously of the 'patient' and of 'knowledge'. Where it foundered, this was due, on the one hand, to the limits placed on generalising this form of knowledge (that is, on the level of 'organisation') and, on the other hand, to the limits of the conception of the 'patient' that it invoked (on the level of 'government').

2. Organisational Adequation

An emphasis upon simplification is absolutely central to Mackenzie's project (chapter 5 of The Future of Medicine, for example, bears the title; 'the simplification of medicine'), and can be seen as a vital aspiration in the context of organisational adequation; for the more coherent, the simpler a medical system, the easier it is to reproduce, that is both laterally (across the profession) and pedagogically.

2.i. The stipulation that the doctor should deploy only his 'unaided senses' in his work is no doubt part of this emphasis of simplification (Mackenzie 1919: 166); yet in fact Mackenzie's entire project is an attempt to stabilise the field of medicine, to make it workable in the simplest way possible. Thus we have seen how he outlined a particular conception of pain, a particular vocabulary of bodily surfaces, a certain conception of the doctor, a certain understanding of disease all of which, we might say, are enrolled in a kind of network of problematisations: this is Mackenzie's 'system'. This system has in particular a 'physiological' emphasis; it concerns especially organic functions. In his final years, at the St. Andrews Institute, Mackenzie attempted to formalise this physiological system even further, using as his central principle the notion of 'vital activity' (Mackenzie 1926). This later theory - centering on the notion of the 'reflex arc' as origin of disease and

introducing a 'law of fluctuation' to account for all organic activity (ibid: 67, 102) - classified symptoms according to either an 'Increased' or 'Decreased' (or 'Deranged') level of 'Activity'. Hence, a generically physiological theory of disease, in which:

'a symptom of disease is only an exaggeration of or an interference with a normal response' (MacNair Wilson 1926: 302).

Such physiological emphases have often in the course of medical history displayed the advantage of systemacity and relative simplicity. This is because they reduce the plane of analysis down essentially to one dimension; here, that of 'activity'. As Georges Cuvier wrote of a similar 'equilibrium' theory, that of John Brown:

'Brown's theory richly deserved ... success ... owing to its extreme simplicity and to certain beneficial changes in practice that it instituted. It seemed to reduce the medical art to a small number of formulas; that life is a kind of combat between the living organism and external agents; that vital force is dispensed in fixed quantities ... that attention should be focused on the intensity of vital action ...' (quoted in Canguilhem 1988: 42).

This demand for a simplicity of problematisation is, as we shall see, a key feature of all those programmes that seek to make general practice into an independent, autonomous discipline, even if a specifically physiological emphasis has not itself always been central to this demand. For

this emphasis itself possessed certain limitations, if seen from the perspective of the 'economy' and 'scope' that it conferred.

In fact, the kind of knowledge advocated by Mackenzie could scarcely lend itself to either reproduction or coherent organisation. For, to take the first of these, how can one teach what can only by definition be gleaned from - necessarily lengthy - experience? The very 'context-bounded' nature of general practice is exactly what gives it its archetypal status for Mackenzie; that the general practitioner, through long experience knows his patients so well. Thus, for Mackenzie, the doctor is only able to make his diagnosis on the basis of his personal knowledge of the patient over a period of years. The doctor's techniques cannot, then, be applied to any patient, rather 'knowing the patient before these changes occurred, the attention is arrested by the alteration' (Mackenzie 1919: 182). Thus it seems that the doctor's knowledge of his patients has to be personal and 'pastoral':

'To the untrained eye the members of a flock of sheep are so like one another that it seems impossible to recognise separate individuals, yet the intelligent shepherd knows the peculiarities of each individual, though he may not be able to give a comprehensive description of the features by which he differentiates them' (ibid: 200).

So one cannot just bring a 'template' to the patient; the gaze is not instantly workable on any material (although cf. the clinical examples given in *ibid*: 186-9). In other words, the very logic of the form of knowledge proper to the general practitioner actually precludes the reproduction of this knowledge in an economical form: rather, one has to become a general practitioner in order to do general practice, a form of expertise that cannot be taught. There is a contrast here with one of the defining characteristics of the clinic, as delineated by Foucault. The clinician, claims Foucault, was distinct from the mere 'officer of health' in that, for him, knowledge was 'free of all example' since, to adopt Foucault's rather obscure phrasing, 'the integration of experience occurred in a gaze that was at the same time knowledge, a gaze that exists, that was a master of its truth ...' (Foucault 1973: 81). Mackenzie's general practitioner, however, was more like an 'officer of health', employing a kind of 'controlled empiricism' - 'a question of knowing what to do after seeing' - and for whom the most important pedagogic element was 'his years of practice' (*ibid*: 81):

'Practice would be opened up to the officers of health, but the doctors would reserve the initiation into the clinic to themselves' (*ibid*: 82).

In other words, what Mackenzie's system lacked was a sense of exclusive insight as being proper to the general practitioner. We shall argue later that it was only with the turn to a 'psychotherapeutic' model of general

practice - and especially Balint's conceptualisation of the 'apostolic function' - that such a sense of natural insight could be claimed for the general practitioner.

2.ii. But Mackenzie's system was also deficient in the fact that it did not conceptualise adequately the site of organisation appropriate to general practice, nor the means of the codification of knowledge proper to it. The solitary practitioner might produce research of equal calibre as the practitioner bound up to a wider form of association; thus for Mackenzie there was no particular organisational form from which the general practitioner had to speak. Similarly, the question of forms of the codification of knowledge is of particular interest in the context of discussions of medical recording systems and techniques of inscription that will appear later in this study. Clearly the standardisation of such techniques would be a necessity should one wish to pass on knowledge to either colleagues or students. The tracings of the ink polygraph were themselves a good example of such standardisation in action. Yet beyond this - and in spite of his strong advocacy of record-keeping (see e.g. Mackenzie 1920) - Mackenzie did not provide a standardised system of notation capable of stabilising the forms of knowledge that were produced in general practice (a standardisation on a par, for example, with the kind of information possible to obtain within the consistent space of the hospital; see Foucault 1973: chapter 5). These factors have indeed been cited as being at the root of

the failure of Mackenzie's work at the St Andrew's Institute. Thus, in comparing the work of Mackenzie's Institute with that of the College of General Practitioners (founded in 1952), Pinsent notes that in spite of their common concern with record-keeping and with devising methods of research and education that would be unique to general practice as an autonomous discipline, there the similarity ends:

'for while the unit at St Andrews was the inspiration of one man, the College was the work of many' (Pinsent 1963: 15).

3. Governmental Consciousness

A similar - albeit far more productive - limitation of emphasis can be attached to what we are calling the 'governmental consciousness' implied by Mackenzie's work. What was the governmental 'telos' of Mackenzie's enterprise? What kinds of subjects did it construct as its targets of intervention? What, for example, is the model of 'health' or of 'cure' that is being invoked here?

3.i. To answer these questions we need to go back once more to the level of epistemological articulation. The epistemological network that Mackenzie built up was peculiarly dependent upon the exemplary properties of the heart. The beating of the heart - provided it is monitored over a lengthy period of time (such as thirty years) - is

something that can be measured; its irregularities provide a kind of index of individual destiny (Williams 1946: 130). The heart is also peculiarly indicative of individuality: partly because of its association with the emotions, but also because it both concerns the whole body - 'physiologically speaking the heart is the pump which sends blood to the whole body' (ibid: 130) - and its fluctuations can be used as an index of individual prognosis in general (the termination of the heart results in the termination of the individual). Building upon this 'exemplary' status of the heart Mackenzie worked out an entire theory of 'health'. For the heart's time is irreversible time; it is, like a 'reservoir', subject to depletion - and this property of the heart was translated by Mackenzie onto the wider level of general principles applicable to other organs, indeed to the organism itself. Thus for Mackenzie each individual has a store of 'efficiency' or what he called 'reserve strength' (Mackenzie 1919: 156). Using this notion, Mackenzie developed the procedure of getting his heart patients to exert themselves in order to observe when their 'reserve strength' should run out.

What he was measuring was the 'diminishing reserve force' (Williams 1946: 160) of the patient. But this physiological principle of cardiac efficiency was further translated by Mackenzie, on the one hand, from a principle relating to the organ's response to effort into one relating to the individual's response to the hardships of

life such as in particular, pregnancy, or more generally, work, labour, and on the other hand, into an even more generalised physiological theory relating to the very nature of 'health'. Health is itself conceived by Mackenzie as being a matter of 'reserve strength':

'There is a certain sense of "well-being" present in every healthy individual. Until the health is impaired one is barely conscious of its possession, and its impairment is the first sign conveyed to the individual that all is not well with him' (Mackenzie 1909: 15).

So from a certain notion of the heart's functioning in relation to effort we have moved to a conception of health in general as a kind of 'reserve force', in relation to which the doctor must monitor its physiological 'efficiency'. From the heart Mackenzie, as it were, moves outwards, to the functioning of the organs in general, through to the health of the individual. It is in short as if the individual has come to be 'represented' by the notion of the heart: this is how we can move from the centre of Mackenzie's epistemological enterprise outward to the wider level of 'governmental consciousness' of his enterprise.

3.ii. A model of what the patient must be in order to be a 'patient' can be derived from this physiological emphasis upon the heart. The most important factor is an emphasis upon prognosis. The patient is only a patient in relation to his or her future; as we have seen, some problems like

'youthful irregularity' are not enough to turn somebody into a patient, whereas cardiac irregularities in a pregnant woman will be since they can have a grave prognostic significance. It is, then, the patient's future and the future of the patient's affliction that is at stake. In this game of prediction the patient is conceived in relation to what he or she must be expected to withstand in the environment or in relation to the tasks with which he or she is confronted in daily life. In other words, patients are only patients if they are definable in relation to their life tasks; patienthood is tied to social obligation. Thus a labourer with a weak heart might have to give up certain tasks if a future ventricular collapse is to be avoided. Similarly, a heart symptom in a young woman will be of significance when one considers that this woman is likely to become pregnant and thus might, during labour, aggravate what might be otherwise an unimportant condition. This prognostic knowledge also works in a 'negative' way; thus, during the war, Mackenzie became especially interested in something called 'soldier's heart'. He was able to show, on the basis of his earlier work in general practice, that many symptoms - 'murmurs' - previously thought of as dangerous were in fact unlikely to have serious consequences, whatever the tasks and stresses facing the prospective soldier; thus Mackenzie no doubt contributed to a reduction of the numbers of recruits that would previously have been rejected as unfit.

3.iii. In short, Mackenzie's project was - if certainly limited by its epistemological conditions of possibility - tied beautifully to the three most important sites of the doctor's tasks pertaining before the introduction of the National Health Service. The general practitioner becomes a kind of mediator of the obligations of citizens in relation to the demands of war, labour and reproduction. The soldier, the pregnant woman and the adult male labourer can be designated as privileged objects of visibility for the general practitioner during the period of the 'panel' system. Here pathology only has significance in relation to the labours one has to perform. The doctor's role is to assess the physiological efficiency of his patients in relation to their social obligations. In fact it is possible to argue that the governmental logic internal to Mackenzie's programme was in certain ways congruent with then prevailing rationalities of government and welfare; specifically, with what Garland has called the 'programme of social security' in early twentieth-century Britain (Garland 1985: 130-142, cf. Rose 1980; also Luhmann's notion of the 'social' state, Luhmann 1990).¹

First, Mackenzie's theory of 'health' (as reconstructed here; cf. for his later theory based on the 'reflex arc', Mackenzie 1926: 39-49) can be aligned to certain features of this welfare programme. As the foregoing implies, the primary 'targets' are the same, namely those subjects that can be described as 'employees of society'; those with

social obligations such as workers and soldiers. Second, this entails an alignment in terms of vocabulary; especially in terms of the concern to promote 'efficiency' (on the imperative of aligning 'individual' and 'national efficiency', Garland 1985: 131). In Mackenzie's programme an unhealthy person can be described as one who is no longer physiologically 'efficient' or whose efficiency is retarded or threatened. Indeed, it becomes the doctor's task to decide whether the individual's efficiency is threatened or not. At this point, another feature of the programme of 'social security' can be mentioned; this is the requirement of making as rigid a demarcation as possible between 'security' for the able, disciplined and 'efficient', and segregation for the unfit. Garland quotes Beveridge from 1909:

'The line between independence and dependence, between the efficient and the unemployable has to become clearer and harder' (Garland 1985: 140).

Clearly this is a distinction between the possibility of employment and unemployability; so without overstating the congruence of this logic with the system of health care (for instance, by claiming that Mackenzie's programme amounts to a technology of 'segregation' of the unfit!) it can be observed how, similarly for Mackenzie, the doctor effectively becomes a kind of relay for distributing in the particular context of the health field, the patient between these destinies of efficiency and inefficiency. In short, Mackenzie's programme - whilst emphatically not

being a mere 'expression' of the rationality of social security - is in certain respects aligned with it. If so, this should not be taken to imply that the doctor's was a cynical enterprise. On the contrary, as Mackenzie noted, a mark on an insurance form, for example, could lose a patient the possibility of future income:

'I have known of so many instances in which gross injustice has been done to individuals, not only from a pecuniary aspect, but in having imposed upon them great expense, un-necessary treatment and mental disquiet, because the meaning and prognostic significance of some simple symptom had not been recognised' (Mackenzie 1907: 251).

Paradoxically enough, the coming of the National Health Service actually undermined the coherence of an enterprise like that of Mackenzie in its governmental aspects. For, whatever the degree of continuity existing between a governmental rationality of 'social security' and that of 'welfare' (as it emerged after the Second World War), the latter differs at least insofar as it implies a universal space of security, that is a rationality centred upon the entire population (on this distinction between the 'social' and the 'welfare' states, Luhmann 1990: 5-6). This called for new conceptualisations of the general practitioner's tasks, new conceptualisations of his primary objects of visibility, and hence a new epistemology for general practice. These tasks meant that

general practice could not simply 'return' to Mackenzie's principles, although they were to be nevertheless invoked often enough; rather new forms of epistemological, organisational, governmental consciousness had to be found.

PART THREE

THE TAXONOMICAL PROJECT

The College of General Practitioners in the 1950s

CHAPTER SEVEN

THE COLLEGE OF GENERAL PRACTITIONERS

1. Introductory

Would it be possible to organise general practice in such a way as to turn it into a 'discovering science'? Would it be possible to evolve a logic of practice that would have equal purchase in the narrow space of the surgery and across the 'free field' of the population? In short, would it be possible to combine in a single movement the aspirations of general practice to be both a form of knowledge and a form of practical intervention; to produce, in fact, via an arduous process of self-definition, a kind of intellectual 'culture' proper to general practice? What form of organisation would be necessary in order to combine these aspirations, what models of practice and intervention would be required, what kind of space of operations would need to be created, and what kind of doctor would move through this space?

1.i. The College of General Practitioners (founded in London in November 1952) attempted to answer such questions not with a manifesto or a general programme of intent (in the

manner of Mackenzie's Future of Medicine for example) but with a kind of philosophy of 'actual organisation', that sought to combine in practice and in thought a series of diverse elements; a concrete form of organization, a model relating to practice intervention itself, a model of research, and a model relating to the 'social vocation' of general practice as part of the post-war complex of welfare institutions. The epistemological focus of the College was to be, foremost, upon the macro terrain of morbidity studies and collective epidemiological investigation (here the function of the College was to monitor the collection of data by individuals on the 'periphery' and to integrate this data at the 'centre'). A secondary interest related to a micro domain of 'family studies' (here the focus was upon children and the mother). The model of knowledge here might be characterised as an un-motivated 'objectivism' of approach, whereby, as we shall see, what was at stake was a vast collective labour of definition. The domain to be investigated centred not upon the doctor's own persona (as was to occur later) but upon the space of the practice. Also important here was a certain ideal conception of the general practitioner himself; one centred upon the model of the 'country practitioner'. Organisationally, the College attempted to situate itself in what we shall call the 'free field' of general practice by setting up a kind of 'organic' relation to its environment; the College was not to be 'political' or legislative but immanent and permanently monitoring, achieving a kind of natural

integration of the free field. Lastly, on what we have termed the governmental level, there emerged in the 1950s an emphasis upon 'population' both in the sense that general practice was to be the discipline that would monitor patterns of morbidity across the totality of the population, and in the sense that the aspiration - grounded in a rationality that we shall label 'pronatalism' - was to promote the numerical (and 'qualitative') growth of population, that is to maximise population.

This chapter is not a history of the College in this period but an investigation of some of the heterogeneous elements, and the articulations between them, that were invested in the construction of this epistemological, organisational, and governmental network.

1.ii. The foundation of the College was a response to the state of 'crisis' in which general practice found itself in the years following the creation of the National Health Service in 1948 (Honigsbaum 1979, Armstrong 1983: 74, Stevens 1966). However, some care needs to be taken as to the manner in which we interpret the nature of this 'crisis' and the literature associated with it.

On the face of it matters were fairly simple. It was widely observed that the quality of general practice, and the morale of practitioners, was at a very low ebb. J.S. Collings's study of standards amongst one group of GPs

became a key reference point in the 'crisis' debate, with its denunciation of shoddy practice and dirty, decrepit premises, forms of organisation and conditions (Collings 1950). On the other hand, it is possible to see the very existence of a 'crisis' of general practice as evidence of its newfound 'visibility' as a form of medical endeavour in its own right. Thus, what was labelled a crisis was in fact equally a raising of the 'profile' of general practice. This coming into sight of general practice as a problematic discipline, was afforded by the very imputed causal factor in most contemporary 'denunciations' of general practice, namely the founding of the National Health Service (cf. Armstrong 1983: 100). With the coming of the new 'socialized' service, general practice became for the first time a homogeneous field of (potential) investigation, whilst becoming simultaneously, and as a result, something of a welfare discipline.

A homogeneous field of medical endeavour. With the advent of the National Health Service the practitioner, one could say, ceases to be a medical 'entrepreneur', vying with his competitors for patients, and gains instead a 'list', a segment of the population apportioned to his care. Moreover, only now do these patients themselves become a homogeneous group; for the first time, a GP's patients include unequivocally a community of 'citizens' (see on this, e.g. Ryle 1960: 314). No longer are his patients made up of discrete categories; the workers on the 'panel', the expectant mother, the private patient, etc.

Moreover, and no doubt in a more 'negative' sense, practitioners are forced into something like a potential 'common identity' merely by the harsh terms of the N.H.S. Act itself. Un-represented as a body at the negotiation of the Act, they had been 'excluded' from the hospitals, a 'contract' had been imposed upon them, and the pathway to consultant status had been blocked (Honigsbaum 1979 documents this split). General practice had become effectively a life sentence.

A welfare discipline. It would be bland to assert merely that, since Beveridge, medicine has been linked systematically to the provision of welfare - as we know, medicine has always been involved in this field (Foucault in Gordon ed. 1980: 150-1; BMA 1951: 33). The doctor (as in those famous comments of Virchow) has always demanded for himself something of a 'social vocation'. However, the National Health Service was not just the effect of a type of power (as Armstrong seems to suggest; Armstrong 1983: 100); it also consolidated, and re-forged various possibilities for social regulation. Central here was, on the one hand, the promotion of that general emphasis upon collectivism and solidarity that had grounded the birth of the NHS, and on the other hand, the notion of the 'family' as the target of expertise, advice and regulation. Building on what was no doubt something of a 'myth' - the ideal of the 'family doctor' (brilliantly documented in Loudon 1984: esp. 349) - the medical profession as a whole was able, in the context of the universalist space of

operations provided by the N.H.S, to stake out a claim to be the collective advisor to the nation in all matters relating to health, well-being and welfare. But, conversely, this 'universal' claim itself seemed to reinforce the potency of the concept of the 'family doctor', making it in turn, perhaps, something less of a myth. This was a kind of inverted logic that the British Medical Association's (BMA) Charter for Health (1946) brought out very clearly:

'The central idea is that national policy should be directed towards the satisfaction of human needs and the promotion of welfare ... Thus the doctor becomes the health advisor not only of his individual patients but of the nation as a whole. In this way the doctors collectively, without entering the sphere of party politics, can guide medico-sociological developments in the direction of the promotion of human welfare ... The collective function of the doctors is a recent development and it promises to become an increasingly valuable asset to the people' (BMA 1946: 5 & 23).

Thus one could say that the roles of the personal doctor and the doctors of the nation in this way became mutually re-inforcing; the space of the collectivity (the medical profession advises...) and the space of the individual citizen (the family doctor advises...) become aligned; medicine becomes, as it were, and at every level, a 'matter of state'. We might recall at this point

Foucault's comments upon the governmental rationale of 'omnes et singulatim' - the government of all and of each - and point out that general practice is here seeking (as we shall see in what follows) to align both the micro aspiration of individual tutelage and the macro aspiration of the regulation of populations (Foucault 1981).

But if this is indeed the case, this does not mean that medical activity can be reduced to a 'state function' in this (or any other) period. Medicine does not become the extended arm of the state, an instrument of repression, of discipline or even simply of 'surveillance' (cf. in this context Navarro 1978 and Armstrong 1984). Medical activity - being always dependent on particular and local problematizations, inherited models and borrowed analogies of functioning - is, no doubt, always too localized, too diffuse to be able to play such a role, even if an aspiration to such a role does indeed, as we have seen, have coherent conditions of possibility. In fact, if medicine as a whole was concerned to achieve anything in the post-war period it was that it should seek to situate itself in a new domain of operations; a domain we shall call the 'free field'.

1.iii. We borrow this term from Michel Foucault's analysis of pre-clinical medicine; in France around the 1790s (Foucault 1973: chapter 3). The notion of the free field is used to describe the domain, dreamed of in the 1790s, that would be entirely absent of all obstacles (medical

institutions such as hospitals, doctor's associations, university faculties and so on) to the passage of the pure medical gaze:

'[a] medical field, restored to its pristine truth, pervaded wholly by the gaze, without obstacle and without alteration ... a form homogeneous in each of its regions, constituting a set of equivalent items capable of maintaining constant relations with their entirety, a space of free communication in which the relationship of the whole was always transposable and reversible' (ibid: 38).

The College aspiration to produce a totalising 'natural history of disease' has, perhaps, something in common with Foucault's free field, that 'nosographical dream' in which 'the natural needs of the species might emerge unblurred and without trace' (ibid: 38). There is similarity too in that both are associated with the elimination of 'obstacles' to the free medical gaze. The free field that is our concern here is not opposed to fabricated and enclosed spaces of practice as such, but is, rather, concerned with linking them up into a homogeneous domain and with eliminating all obstacles within and between these spaces. Indeed; a 'space of free communication in which the relationship of the parts to the whole was always transposable and reversible'; a kind of network where equal force is exerted at all points. But if the field described by Foucault was constituted in relation to notions of liberty and enlightenment, then the free field

of the 1950s always entails additionally the evocation of the sick 'living individual' that moves through it. Tied to the notion of the free field - and existing in a degree of tension with it - was the discourse of the living individual, an area in which general practice (at least since Mackenzie) was accustomed to claim some level of authority.

The free field, then, was not a 'psychological' domain nor, on the other hand, was it posed in direct, binary opposition to the closed world of the hospital or laboratory. Rather, it was what we have already referred to as the 'homogenization' of the medical field that made the free field possible. For the first time all medical institutions were linked together - at least in 'theory' (the reality, as usual, was somewhat different, Webster 1988: esp. 12 & 34-5) - into a network of institutions, interlinked, monitoring the sick population that passed through it. Thus, it is possible to say that, in the post-war period, the hospital became something less than a hospital, and the laboratory less than a laboratory - since each should be 'clinical' and should now take account of the living individual. Take, for example, a document published by the Medical Research Council in 1953 entitled Clinical Research in Relation to the National Health Service (MRC 1953; CGP Archives; cf. on the later concept of the 'hospital' CHSC 1969). After noting the 'piecemeal' arrangements for the pursuit of medical knowledge in the pre-war period, the report went on to

elaborate a new organizational domain for research, and - effectively - a new object of research itself. A centralized Clinical Research Board was proposed. This would consist of a small group of 'advisory experts' from a variety of fields who would be responsible for the co-ordination of research throughout the country. But this elitism at the centre was aimed only at promoting a kind of diffusion at the periphery:

'We consider that there should be a measure of "decentralized" research... where there should be the greatest possible freedom from detailed supervision in promoting clinical research' (MRC 1953: 11).

A whole framework of action - a model of power itself - was, no doubt, presupposed by this institutional structure (not at all unlike that of the College of General Practitioners): one of empowerment and advice rather than force and constraint; of autonomy and decentralization rather than control and supervision. And along with this decentralization went an emphasis on the 'sick individual' (ibid: 3) as the object of research. Even the laboratory worker (with which the report was especially concerned) must return to the domain fo the sick:

'... the idea of research in medicine implies to many laboratory work with a severing of all clinical contacts. But that is not the concept of clinical research. In this, close constact with patients is essential ...' (ibid: 15).

What we have labelled the 'free field' was also a feature of an earlier document, published by the British Medical Association (B.M.A.), in 1948 on The Training of the Doctor (BMA 1948). This report, it is true, did not set out the domain in which medicine was or was not to operate; but it did argue self-consciously for a conception of disease that related more to the suffering, living individual than to the pathological 'disease entity' itself. Indeed, a medicine devoted to 'life' rather than death - in all fields:

'The living patient, and not the corpse, should be the central theme in the teaching of pathology'. (ibid: 139).

In sum, the report called for 'a different approach to both medical education and medical practice', one which stressed the reaction in the individual (the 'disturbance or disequilibrium in the structure and function of the organism') to the disease, rather than the disease itself. Future practice should be based 'on an understanding of the patient as a 'whole'', which implied:

'a search for the cause of the deviations in the normal in that particular patient, and... an understanding of the patient's history and environment, clinical observation, and the interpretation of the facts elicited.' (ibid: 52).

But, oddly enough, in spite of this advocacy of a focus on the sick individual, and the environment and history of

that individual, the report did not advocate general practice as the model for all medicine (as Mackenzie had claimed two decades earlier). This was not, however, due to oversight; general practice, claimed the committee, was, like other branches of medicine, a 'specialty' in its own right, but for that very reason it should not take pride of place (ibid: 9). If, on the other hand, general practice was later to claim the status (and with some degree of success) of being the discipline to take charge of the domain of the 'sick individual' this was due to a process of struggle, or at least of labour, on the part of general practitioners. This domain of the sick individual had to be defined (and, even more arduous, rendered operable) and an organizational space had to be constructed appropriate to the free field in which the sick individual was held to reside and move about. It was around these tasks that the College Of General Practitioners was brought into existence, and at which it was to labour in particular ways throughout the 1950s.

2. Labours of Definition

What were the functions of the College to be? Towards the end of 1951, several general practitioners - notably F.M. Rose and J.H. Hunt - began to circulate the idea of a college of general practitioners; not as a 'political' body but as an academic one (Rose 1951; Fry et al. 1983: chapter 2; Report 1952; Hunt 1952). The aim was to

emancipate general practice from the sense of repression and neglect under which it had so long laboured by founding an academically oriented institutional apparatus that would express the status of general practice as a specific 'clinical discipline' in its own right. The common starting point of all these writings was the question of whether general practice was or was not a 'specialty'. There was, however, no doubt about the answer to this question. After all, did not general practice have what could be described as a veritable 'ontology' (see for the use of this term Gaukroger 1978: 39) in the cluster of notions surrounding the figure of the patient; notions, for instance, relating to the continuity of the doctor's relationship with his patients; to the fact that the general practitioner is the first line of 'medical defense' seeing disease before it is given a name; seeing disease, as it were, in its natural state, beyond the walls of the hospital. Thus, for example, in a paper read at a meeting of the B.M.A.'s General Practice Review Committee in October 1951 (which had as its topic this very question), F.M. Rose attempted to define the proper 'ontology' of general practice:

'It is the doctor-patient relationship which is the first and dominant fact. The general practitioner is the doctor who sees disease in all its forms first' (Rose 1951: 174; cf. BMA 1951: 21; Hunt 1951 and Armstrong 1983: 80-81)

2.i. This 'ontological' emphasis had long been a familiar theme; we have seen a variant of it invoked in the work of James Mackenzie. Nevertheless, the notion of the practitioner as the first line of defense, the expert of the sick person and his environment (variously conceived) remained an empty statement, a polemical formulation and nothing more, until this notion itself could be made operable; until, in other words, a 'domain of evidence' (cf. Gaukroger 1978) could be linked systematically with this basic 'ontology', and until this domain itself could be made 'calculable', through an array of appropriate techniques, and stable, through the construction of appropriate institutional forms.

When a General Practice Steering Committee began to meet in February 1952, under the chairmanship of Henry Willink Q.C., in order to work out the particular form that a College of General practitioners might take, and to sift through testimony from a variety of countries as to what general practice actually consisted of, it was faced with what we might well call a 'paradox of organization' (see e.g. CGP Archives 1951). This paradox related to the fact that general practitioners, being hardy individualists to a man, were possibly incapable of organizing together as a kind of corporate body (the grounds for resistance to anything involving co-operation with local authorities serving as an example of this mentality). That the practitioner was generally held to be of sturdy independence of mind and action ('general practitioners,

thank God, tend to be individualists'; Symposium 1957: 139) was not some kind of accident simply due to common class origin or personal characteristic; rather it was considered to be fundamental to the very nature of his chosen occupation.

The Cohen Report of 1951 (BMA 1951; cf. MacFeat 1951) illustrates how the model of the doctor centred upon various characteristics in order that his persona should be appropriately fitted, in a kind of homological relation, to the individual. Thus following on from the 'ontological' statement that general practice entailed the underlying unity of medicine, and has as its goal the study of the 'whole man', the report proceeded to describe the 'desirable personal qualities' of the 'ideal general practitioner' (ibid: 25). Aside from being a man of 'independent' inclinations ('for those who value independence, a broad outlook, and a close personal contact with one's fellow man, there is no other branch of medicine which presents such a full and satisfying life'; ibid: 27), '[t]he general practitioner should be a man of culture as befits a member of a liberal profession'. He should cultivate interests outside the sick room - 'music, literature, sport, gardening, or another science' - all of which will be of value to his medical practice, since they will 'develop the whole man in him' and will give him, perhaps, a practical insight into the lives of the people with whom he deals:

'For example, a general practitioner who learns

to use his hands in some manual occupation will obtain a useful insight into the problems and difficulties experienced by a patient returning to similar work after illness or accident' (ibid:27).

All in all, the report claimed, 'in no other branch of practice is it so vital that the practitioner should be temperamentally and physically suited to his work' (ibid; 27).

But although this individualist persona was understood to be essential for the good conduct of general practice in the 1950s, we should note that this was a minimal condition for good practice rather than being actually a constitutive element of such practice. If the doctor was necessarily an 'individualist' then this was a condition of his objectivity as a doctor, and was not in contradiction to that objectivity. This point is important in that, later, for example in the work of Michael Balint, the theme of a 'philosophy of the physician' (as Temkin has it) will take on a renewed significance as it came to be realised that the doctor's very individuality worked against his objectivity as an observer; indeed the doctor's very 'perspectivism' came to be seen as constitutive of the nature of general practice knowledge. For now, however, let us observe that the problem consisted more of attempting to align this individualism to an appropriate form of organisation than of aligning it with particular kinds of knowledge.

This 'paradox of organisation' was inseparable from the question: how does one educate a doctor for service in the free field; how does one impose the rule of the institution on the autonomous individual? The answer, not surprisingly, had to be; in the most 'naturalistic' manner possible, that is, in the free field itself. Thus an educational role was proposed for the College which would entail a kind of universal system of apprenticeship (although cf. Westwood 1955 for hostility to the existing training system). As recognized by the steering committee:

'in the old days there was much good in the system of apprenticeship, with its impalpable influences of example and personal contact'
(Report 1952: 1323).

Hence, an undergraduate education committee would later be formed (January 1953) under the chairmanship of Geoffrey Barber, to exhort the educational authorities to let general practitioners train general practitioners both in universities and in the field itself. This policy was carried out only according to the logic of, as it were, 'spontaneous association' in the free field. There was to be no political campaigning:

'the young college believed that the most effective way of influencing undergraduate education was to encourage local faculties [of the college] to foster links with medical schools while, centrally, the college remained willing to respond to any requests from a medical school. It was deemed inappropriate to

initiate action from headquarters' (CGP 1953: 54).

The College was, however, prepared to influence this logic of apprenticeship in a more indirect, as it were, 'advisory' manner, through its role as a 'clearing house' of information. Thus, the Postgraduate Education Committee of the College was to set itself the task of making the - otherwise isolated - 'experience' of the general practitioner, as it were, calculable and capable of reproduction and dissemination:

'In many practices much useful experience and many good ideas, developed by trial and error over a number of years die when the practitioner himself passes away. What is wanted so badly is a storehouse and clearing house for all this information about general practice' (Report 1952, ii, 1321).

We shall look further at some of the work of the Postgraduate Education Committee below in connection with its labour of definition and standardization of practice premises. Let us only note for the moment how the notion of a possibly calculable, if still 'impalpable', 'experience' proper to general practice was enshrined even in the terms of College membership decided upon by the steering committee; either twenty years experience in general practice; five years experience plus a commitment to accept a certain amount of postgraduate training each year; or five years in practice plus a postgraduate

diploma (Fry et al. 1983: 78). We might characterise this pedagogic model of apprenticeship as being one in which training is subordinated to practice (in that all one needs to do to train is to practice). This is of interest for comparative reasons. For, interestingly, this is a model that will be in a sense reversed in the 1960s so that to practice will become subordinated to a particular - 'vocational' - model of training (in that practice itself will come to be seen, in ways which we shall examine, as a form of training).

2.ii. To this question of the form of organisation and the relation of the individual to it, we must add another with which all those who reflected on the nature of general practice as a 'specialty' were immediately confronted; the question of the 'range of service'. This problem concerned the fact that there was a lack of fit between, to revert to our previous terminology, the commonly ascribed 'ontology' of general practice and the '*domain of evidence*' with which it was confronted. For this domain was clearly far from stable. What did general practitioners actually do? Every paper in the 'crisis' literature found itself having to ask this question, and then answer it with a list of items that, typically, tended to read like a 'Chinese Encyclopaedia' of heterogeneous classification. F.M. Gray, for example, listed the field thus:

- '(a) diagnosis and treatment of all minor
- maladies (b) the preventive aspect of all

diseases (c) diet, clothing and individual hygiene generally, (d) ante-natal care and infant welfare (e) minor psychological conditions, including those found in patients with organic disease (f) certain other subjects not adequately covered in the undergraduate course. It would probably be wise to include here paediatrics and dermatology (g) methods of research in general practice' (Gray 1944: 121; cf. Rose 1951 for a similar list).

It would probably be true to say that this problem was never conclusively solved; in fact the heterogeneity problem at the level of the domain of evidence and investigation was only to get worse. For example, in 1955 a report of the College of General Practitioners 'Examination Committee' found itself making up a list of 'five hundred or more important diagnostic, prognostic, therapeutic, technical, medico-legal and administrative problems which play so large a part in the life and work of the family doctor' (CGP 1955: 33 & 33-7 for the Exam Committee Report). The problem of reducing this huge and diverse domain of evidence to more coherent and manageable propositions took a variety of forms, some of which will be considered below. What was always involved and at every step was a kind of labour of economy; above all, the aspiration was to reduce the field to its essentials using anything that will allow a coherent domain of evidence and investigation to appear through techniques that would

still allow access to the sick, living individual. As we shall see, in the 1950s this labour involved particular models of activity and investigation (that, for example, of the 'country practitioner') and particular metaphors of coherence (surrounding, for example, the technique of 'writing'). But, above all, what the matter of the 'range of service' required was further, possibly endless, investigation. The entire field of general practice must be defined and described in the most minute detail. This was the labour of definition.

Thus, the paradox of organization and the problem of the range of service were turned into positive advantages; each met in the imperative of research, the labour of definition. It was the category of research, the need to define everything about general practice, that united all the necessities of education, the person of the doctor, and the problems of organization into one moving paradigm of activity. To all problems the solution was - further investigation, further description.

2.iii. The organisational structure of the College was not designed to direct the labour of definition so much as to regulate and co-ordinate it. College headquarters was to be a kind of advisory centre regulating the free field of general practice. Thus, a faculty system was devised which would cover the entire country and provide local points of focus for educational activities and research; local faculties were expected to liase with their local medical

school (faculties were purposely sited in proximity to university medical departments in order to facilitate this) and to pass on and receive information from the central headquarters in London. At headquarters committees would meet to process information and re-distribute results back to the periphery in a kind of circular process of knowledge accumulation and standardization. The functions of the Research Committee of the College illustrate these principles of organization very well (ibid: 33). At the centre there was to be a Research Advisory Committee (composed of members from a whole variety of fields) whose task was to sift through proposals for research (typically concerning small individual projects and collective investigation alike - on the subjects of morbidity, epidemics, conditions of practice etc.), assess their feasibility and offer advice through what was known as the 'consolidated comment' system (Fry et al. 1983: 59-73; CGP Archives 1957 has a collection of these from the 1950s) as well as putting researchers in touch with relevant expert bodies should further advisory assistance be necessary. On the other hand, the Research Committee's task was also to liaise with outside bodies interested in the mapping of the free field (the Ministry of Health, statistical and research organisations and so forth) on advisory matters or in the organisation of larger scale research projects, and, if necessary, to activate the extended technology of the College's Research Register (a list of practitioners across the country who were prepared to take part in collective investigations) in collecting information in

the field:

'The college research organisation can work both centrally and peripherally. The central organisation will be equipped to cope with the consolidation of clinical records and material from practitioners and their study groups all over the country, and to advise with regard to techniques for the collection and analysis of this material and the necessary controls' (Report 1952: 1324).

The College's collective research technologies can be considered in due course; what concerns us now is this organisational morphology itself.

2.iv. The College's organisation was fitted perfectly to, and was homologous with, the free field itself. Thus on the one hand, according to this organisational schema, nothing is imposed upon the individual practitioner beyond his co-operation. He is not asked to change his ways but only to monitor his activities for the academic enlightenment of the collectivity. On the other hand, this freedom gives the College headquarters a purchase on the minutest limits of the free field itself. The tendrils of the College network extending with maximum sensitivity into the heart of the world of the sick individual, this knowledge is then fed back outwards to the periphery in the form of advice; thus standards are monitored and built up. In this sense the College network could be compared to

a kind of living organism, whose internal organization is linked with maximum sensitivity to the patterns of organization existing in the environment. The College is self-regulated, the periphery informs the centre, the centre informs the periphery. Moreover, the College network exists in a close - but 'free' and autonomous - articulation with other organizations that have the free field as their focus; the Ministry of Health, the statistics department of Birmingham University, the Medical Research Council, the General Register Office, the Public Health Laboratory Service, Medical Schools, etc. (for a list of these liasons in the first year of the College's foundation; CGP Archives 1953). Very quickly - and no doubt on the basis of a kind of generalised 'interessement' strategy - the College was to turn itself into a kind of 'obligatory passage point' for access to the free field. If general practice was to have a social - or 'governmental' - vocation, a relationship to the workings of 'power' it was to be within this space of operations. As an editorial in the second Research Newsletter issued by the College was to sum matters up:

'It is a curious quality of humanity that similar thoughts, ideas and beliefs may spring up at one time in the minds of several different people... The pendulum has started to swing away from the hopstial world, the world of departments, the world of the fragmented man... back to the study of the whole man as the varied stress factors of his life may affect him. It

may be that the next advances in medicine will come from a fuller understanding of the field in which 20.000 general practitioneres are daily at work and means must be found for exploring this field of clinical material' (Editorial 1953, 2: 3).

That there were sufficient practitioners interested enough to bring this field into the arena of collective visibility was indicated by the rapid early popularity of the College. Thus, within, three weeks of its foundation, 1.077 members had been enrolled. After six months this figure had reached 2.000 (1/10 of all GPs in the country at the time). Meanwhile, the numbers on the College's Research Register the 'ready to hand observer network' went from 380 in 1954 to 632 by 1958; the network was at least in place.

CHAPTER EIGHT

TECHNOLOGIES OF THE FREE FIELD

1. Research at the College of General Practitioners

In the 1950s the spotlight of College research was very much on the existing activities of the members of the College itself. To study the free field meant largely to study practitioners themselves (their premises and equipment) as well as - or, even, rather than - the supposed objects of their activities; sick individuals. An entire domain of investigation appeared relating to the various technical operations of general practice. The 'unit of analysis' of this discourse was the space of the practice, and the focus was upon the technical methods by which this space might be brought to a coherent level of visibility; organised and made known. Adopting a distinction used by the practitioners themselves, we shall divide these kinds of investigation into two; relating to technical (techniques of practice) and operational (concerning the space of the practice) forms of research. At the core of both - and functioning as a kind of metaphor of coherence - lies the necessity of writing.

1.i. In his study, published in 1954, Taylor asked himself what made up 'good general practice' (Taylor 1954). After sitting in on the surgeries of ninety-four 'good' general practitioners, Taylor came to the conclusion that a good general practitioner was only so good as the technological infrastructure of his practice allowed him to be: '[t]hese doctors have evolved a technique of good general practice'. Without actually giving this technique a specific name, he then proceeded to list all the logistical advances these practitioners had included in the operation of their practices; all these relate to the organization of the workload through systems ranging from group practice, rotas ('an ingenious device', the greatest innovation since the N.H.S.; Taylor 1954: 123), ancillary services, rationalization of equipment, clinical records and forms and paperwork of a great variety of kinds; all those matters, in short, which dominated all discussion about what is distinctive to general practice, what makes it a 'specialty' (inter alia, Walford 1955: 53; Watson 1957; Mallet 1955). What all these techniques of organization had in common was, no doubt, that they implied a certain written 'externalization' of the practice. All implied as a pre-condition a labour of representation of the components of the practice in, as it were, a one-dimensional space. There is a kind of generalised pragmatics of writing at work here; at every level it seems to be writing - or, more generally, forms of inscription - that, in the 1950s, provides the primary coherence conditions of general practice. But, this

technology of writing should not be seen as being a subtraction from the status of general practice as the domain of personal interaction between individual doctor and sick individual. On the contrary:

'Writing is a part of every profession ... Certainly it is a part of every profession with any claim to the title of 'learned'. Anyone, who supposes that any kind of medical practice can be properly conducted without the use of the pen (or the typewriter) is living in an unreal world. In general practice in particular it is by the pen that almost all positive action is initiated... By the pen the doctor extends his knowledge of the patient's illness by calling in the pathologist, the radiologist or the consultant. Above all, by the clinical records he keeps with the pen he greatly simplifies diagnosis, and daily saves himself hours of work' (R.J.F.H. Pinsent in Fry ed. 1954: 28).

At a number of levels writing is the constitutive medium of the free field. It is an activity proper to the work of that cultured individual, the professional doctor; but it also makes possible a certain relation - and hierarchy - between the aspirations of vigilance and logistics.

Vigilance: this inscriptional emphasis was held to permit a certain access in time to the 'ontological' domain of general practice - the patient. Above all, by the use of

clinical records the doctor gains access to the pathological 'life-course' of the patient; or, at least this is always conceived as a possibility. As most discussions are at pains to point out, clinical records are not a kind of instrument of surveillance for the doctor but rather an 'aide memoire' in treatment, markers to reactivate the doctor's memory and experience of the patient. Taylor, for example, describes clinical records as 'exercises in relevance' (compare Mackenzie's massive detailed histories, closer to the aspirations of Richard Bright than of Taylor and his colleagues) and as the 'key' to good general practice, providing 'the long-term chronic picture' against which any attack of acute disease must be judged' (Taylor 1954: 148). Similarly, an article in the College newsletter in 1955, discussed the relationship of the clinical record, and the episode of illness recorded there, with the life-course of the patient:

'Illnesses should be regarded as chapters in the life of the patient, and each chapter should be separated from the rest' (Walford 1955: 53).

However, this notion of putting people's lives into writing was to remain only at the level of aspiration. In fact, although the notion of biography (or, of what Armstrong has called an 'ideographic' medicine) was often attached to the usage of records, in fact no such usage was satisfactorily deployed. This was because of the impossibility of intermeshing the longitudinal or 'biographical' details of patients in a one-dimensional space of comparison (e.g. with the aid of statistical

analysis); a plane of consistency could not be found that could stabilize - on the basis of inscriptions - the sick, living individual. Or at least, this would have been impossible without compromising the logic of that field in other ways; for it was imperative that the keeping of records and the way they were kept should be left to the discretion of each individual doctor. There should be no rules, only 'guidelines':

'Methods that have tried and found helpful are described in the hope that others may find them equally useful or may adapt and modify them to their own personalities' (ibid: 53).

However, members of the College - as we shall discuss further later - always dreamed of designing the perfect 'continuous' record, the most perfect instrument of biographical technology (such as the so-called 'S' card, for example) that would have the capacity to fix the pathological life-course of the individual in a stable form, amenable to instant mental appropriation at the least glance of the practitioner's eye. For example, at a time when the emphasis on writing was perhaps losing favour as a means of access to the free field, in 1961 the Ministry of Health invited the College to give written evidence on the possibility of designing a card to be similar to the immunisation records then in use, which could serve the individual forever:

'The aim would be to try to train the public to carry this inside the Medical Card and its use would not cease with the end of the infant years

... This card would cover the individual permanently' (CGP Archives [n.d. 1950s]).

Nevertheless, if the emphasis on writing in general practice in the 1950s was another technology to get to the free field, indeed to provide a preliminary mapping of that field of the sick individual, then nevertheless, this sick individual itself actually seemed to elude this gaze, and to elude it constantly, whatever technological forms were put in place to capture it (a failure also noted by Armstrong in an interesting paper; Armstrong 1985: esp. 604).

Logistics: through writing, inscriptions and paperwork, and the 'externalizations' they allow, appointment systems emerged (Taylor 1954; Hadfield 1953: 701; Mallet 1955: 113) which order patients in the context of a calculated time, rotas (Taylor 1954: chapter 5) were set up (again, this was always more prominent in aspiration than reality in the 1950s) which allowed the entire space of the practice to be covered by a team of doctors day or night. It was through these techniques that the free field was covered, made homogeneous and continuous, in order that its constitutive elements - sick people - might pass through it with the minimum of obstacles and the maximum of visibility. In this dimension, a certain plane of consistency - the space of the practice - is aligned with the domain of evidence (all the activities of the doctor with the sick). As we shall see, this entire technological dimension was crucial to the carrying out of research

projects as well, via records, statistics, coding practices and so on. But it was also dependent upon them; research into the space of the practice (operational research; discussed below) is in fact vital to the appearance of all these logistical forms since an appointment system presupposes the existence of studies which will measure the length of the consultation; rotas require estimations of workload and so on.

The advent of the College - which was, in fact, only a wider space, in perfect homogeneity with these technologies of the free field (individual practices linked in a network) - saw a generalized cascade of inscriptions (as Latour might have put it). Thus as the official historians of the College noted, the very first task in setting up a College headquarters entailed the emplacement of a whole series of apparently trivial, mundane technologies of inscription:

'Arrangements were made for a great many papers to be printed - application forms for membership and associateship memorandum and articles of association and bye-laws, bankers order forms, receipt forms, writing paper and other items' (Fry et al. 1983: 34).

These, then, are far from incidental factors or trivial irrelevancies in relation to the real 'substance' of general practice. But what is it that the technologies of logistics and vigilance seek to achieve? Two functions are served; one of stabilization; and another relating to the

maximum reduction of distance. Stabilization: the space of the practice - when linked to the totality of other practices - becomes a kind of plane of consistency, that is, a space that is standardized and broadly comparable from practice to practice, and from centre to periphery and back again, as information is collected from the periphery and then returned to it in the form of advice (to raise standards, standards must first be found). The task, no doubt, is not to make all practices the same but to find a consistent way of speaking about all practices simultaneously; a vocabulary able to link different kinds of practice space (in rural, urban, market town, and industrial areas alike). Whatever the differentiations in practice conditions, whatever the personal inclinations, or individual interests, of doctors, the field will be aligned with itself on the level of techniques.

The systematic reduction of distance: Latour and others have shown in some detail how forms of inscription are used for purposes of 'action at a distance', to reduce the wide, ungovernable spaces of the world to one-dimensional, manageable planes of analysis (Latour 1986). However, here the reduction of distance means something more than this; it refers to all the efforts to remove obstacles and distractions between the practitioner and the object of his work. In short all these technologies are instruments to reduce and eliminate, so far as possible, all forms of interference or mediation between the free field and the gaze which appropriates it. As Taylor put it:

'The purpose is, after all, nothing more than to free oneself as much as possible from inessentials, so as to be able to concentrate on the essentials' (Taylor 1954: 174-5).

The greatest aspiration here is that of unimpeded visibility; communication without friction.

This aspiration - to clear the field of practice from all interference - explains why a principle of organization, such as that of 'group practice', which might otherwise seem to undermine the doctor's autonomy and individuality, could be adopted, or at least advocated, so widely; '... group practice can provide the conditions in which... doctors are set free for doctoring' (Ollerenshaw 1953: 620; cf. Watson 1958). While the 'group' principle became, from the mid-1960s a matter for the production of 'vigilance', at this time its emphasis is primarily logistical.

The group practice, with its array of ancillary services, secretaries, nurses and other workers allows a space to appear that is, in fact, medically 'purified' (which is why it is such a wholly different space from that of the health centre, which is, on the contrary and to its detriment, essentially a social space, that is, under local authority control):

'By relieving one of the burden of necessary but non-medical work the organization possible in a group leaves us free to meet our patients, not

only with more time at our disposal, but with minds undistracted by the 'mechanics' of general practice' (Ollerenshaw 1953: 620)

All these logistical and inscriptional techniques, then, are methods of displacement; methods that allow the sick person to appear in a pure space free of all reductive mechanisms. And hence the relation of hierarchy that logistics preserves over vigilance; for all these methods of stabilization and the reduction of distance certainly 'free' the sick individual for doctoring. Nevertheless, this space is not sufficient for a general knowledge of this sick individual to be established. Logistics did not deliver the 'sick man' into discourse, Indeed, in the 1950s it was not to be the patient, nor even the person of the doctor that was to be the unit of analysis of this discourse but the space of the practice itself.

1.ii. All these principles - writing, logistics, vigilance, stabilization, reduction of distance - can also be seen at work again in the second kind of research mentioned above; namely operational research. However, this form of research is concerned, not so much with the set of techniques proper to general practice, as with research into the actual space of practice itself. This kind of research was predominantly the concern of the Postgraduate Education Committee of the College. The task was to establish a stable, standardized space of the practice; not so that all practices would be the same but only that all might be at least comparable, amenable to

classification. Again, a labour of standardization was necessary, since it was hoped to advise young practitioners, lacking the benefit of long 'experience', on their 'needs' in practice; in terms of the architectural layout of the surgery, the equipment they would need and so on. Once more, research into how general practice functioned was linked with advice on how it ought to function; a circular process of research and standardization.

In 1956 the Postgraduate Education Committee reported to the *College Council* on the subject of 'the professional accommodation and equipment of family doctors and those intending to enter general practice':

'One of the functions of the College will be to act as a Centre of information for young practitioners on their needs in general practice on methods of record keeping, on new methods for diagnosis or treatment, and on the equipment needed for these' (quoted in Fry et al. 1983: 150-1)

Proposing the setting up of a Committee specifically to deal with the question of premises and equipment, they suggested that:

'such a committee would be concerned with (1) questions connected with general practitioners waiting rooms, dispensaries, consulting rooms, etc. (2) the administrative problems and record systems of family doctors, including details of

the charts (temperature, dietic, intake and output etc) and diet sheets, needed by family doctors to make sure that these were the best for their use, (3) the apparatus used by family doctors' (ibid: 150-1).

Investigations were soon underway. By May of 1957 a 'pilot scheme' relating to eight practices, divided into 'rural', 'country town', 'urban', and 'industrial' kinds of practice, was begun in order to establish a 'standard method of presentation' that could be used in order (in the apt phrase of a memorandum of July 1958) 'to put the practice into writing' (CGP Archives [n.d. 1950s]). This standardized procedure, as outlined by the Practice Equipment and Premises Committee involved details of practice organization, ancillary help, appointment systems, rotas, size of rooms, decoration, furnishings, lighting and temperature, ventilation, finances and costs, and the inclusion of architectural plans and photographs. Eventually, it was hoped, enough practice descriptions would be collected to form what would be an advisory dossier available from College headquarters on all aspects of the space of the practice. Additionally (in 1958) a 'Practice Equipment and Premises Room' was set up at College Headquarters (then in Cadogan Gardens, London) in order for an ideal practice room to be housed there for the edification of young practitioners (although by the end of October 1958 only one piece of equipment had thus

far been donated and that was considered too large for display).

The activity of putting one's practice into writing was far from being a marginal exercise in the 1950s, as a glance at successive editions of the journal The Practitioner (a journal with, at the time, close connections with the College) will bear out. The Practitioner was in the 1950s a journal of clinical medicine, taking for its quarterly topic a particular theme of medical research. In the 1950s the theme of general practice research did not relate to diagnostic innovations and so on but primarily to the study of the space of the practice premises; especially in a regular section of the journal called 'Equipping the Surgery'. A special edition on 'General Practice Today and Tomorrow', for example (Practitioner 1953, 170, 1020), contained as well as a series of photographs of exemplary practice premises, articles relating to 'The Doctor's Surgery', 'The General Practitioner's Premises', 'Organization of Group Practice' and so on. Meanwhile, in the following years, in an issue of the journal devoted to 'Advances in Treatment', the section on general practice (included as a section in its own right for the first time) passed quickly over the questions of advances in diagnosis and treatment (i.e. the two themes which dominated the other articles) and concentrated almost entirely on what was termed the 'way of life' of general practice, which are then laboriously described: 'It is here that the greatest

advances have taken place in general practice over the last two or three years' (Barber 1954: 468). After listing the latest advances in practice organisation the author declares that with these new techniques:

'G.P.s can happily face the greatly increased demands that are made on family doctors and much more efficient service can be given without losing the old personal family doctor relationship' (ibid: 469).

Here, however, it is the act of description itself - rather than the techniques - to which we wish to draw attention; for, what is clear is that the mere labour of description of the elements of this 'way of life' is itself an important form of 'research' proper to general practice.

2. Spatialisation in General Practice

What are the aspirations behind these labours of practice description? What kind of practice constitutes the ideal medical space? Above all, perhaps, what is sought is a well regulated internal environment, which includes a kind of 'atmosphere' (both physical and emotional), allowing for maximum visibility and freedom of movement; the absence of all obstacles that might divide the world of the sick from the gaze of the doctor. Anything that allows free flow of movement - albeit very carefully regulated (via appointment systems, electric buzzer calling devices,

receptionists and so on) - will be deployed, as long as a certain balance is maintained between the practice space as a 'scientific' domain, on the one hand, and as a 'homely' domain on the other (Robertson & Cusdin 1953: 581).

2.i. The importance of light in achieving the correct atmosphere is always emphasised; even insofar as a judicious form of lighting can be used to establish the correct (im)balance of reciprocity between doctor and patient:

'The doctor's desk is best placed so that from his chair the doctor can watch the patient as he comes into the room. If the doctor's chair is placed with its back to the window light his face will be in shadow and an anxious patient will be able to read his thoughts less easily. Conversely the patient will sit in a good light so that the expression can be clearly seen' (Pinsent in Fry ed. 1954: 23).

If the doctor has a kind of one-way visibility with regard to the patient, then the mind of the patient should be allowed to focus on the 'friendliness', the 'individuality', of the doctor. The consulting room, for example, should be an extension of the doctor's personality:

'The mantelpiece of one consulting room will be adorned by antique jade, of another by an array of cups denoting the doctor's prowess at golf,

or there may be photographs of large trout. Thus things will confirm in the patient's mind the feeling that he is visiting a friend rather than an impersonal medical official' (ibid: 22).

If there is any 'psychological' component to the consultation, then it derives more from the premises than from the person of the doctor. This effect can be enshrined even in the very decoration and layout of the surgery:

'A glass panel is let in the door to establish spiritual communion between the waiting-room and the rest of the building, and from the North Wall of the waiting room there projects a wall bracket on which is kept a bowl of flowers. The height of this bracket is such that to the patient in the hall, the bowl of flowers is framed in the glass panel of the waiting room door. Patients often remark that they feel better as soon as they enter the waiting room; complete cure, however, enabling them to dispense with the doctor's service has not been reported' (CGP Archives [n.d. 1950s]).

But how does the fabrication of this space of the practice give access to the 'free field' that naturalized space of the sick citizen? Is not the surgery by nature - even by intention ('contemporary in conception with traditional overtones') - a modern space and hence an artificial space? Can such a fabricated, ordered space be appropriate

for the 'family doctor', whose expertise lies by definition beyond anything resembling closed hospital structures? And is not one of the defining features of the general practitioner (we shall turn to it below) that he should treat patients in - and know the intimate details of - the home?

But we are forgetting that (to put it crudely) the 1950s represents an age of 'reconstruction'; an age, quite literally, where questions of building and architecture are of a peculiar salience, and are bound, with perhaps a new coherence, to questions of social utility and regulation (see e.g. Shaw 1985: 93; Donnison 1980: esp. 56-63). Even the home, of all places, is not exactly a 'natural' space in this context. Indeed, if one turns to writings from the same period - we will take as our example a text by Mackintosh (one quoted in medical writings) - relating this time to the 'ideal home' and its construction, one sees a degree of homology between this ideal space and that of the surgery (Mackintosh 1952; cf. on similar themes Riemer 1941). This level of homology had as its condition of possibility the fact that both home and surgery were, above all, 'medical' domains, having as their point of intersection the family:

'Housing takes a central place in the background of health because it is the material representation of home and the family' (Mackintosh 1952: 10).

Of paramount importance in the home is, in common with the

surgery, the need to maintain a carefully adjusted and monitored internal environment; a kind of physiology of the home in which the emphasis is on the functions - as opposed to the structure - of the home, and the family relations that architecture makes possible (see e.g. Arnold and Ware 1953). This theme of the internal environment of the home also shares with the surgery the fears surrounding overcrowding, and the lack of visibility this entails; the slogan 'one family, one dwelling' serving to remind us that the family home was itself more an aspiration of policy, something that needed bringing into existence, than an already mappable, wholly 'natural' space (Crowden 1952: 593-64). Tied to the fear of overcrowding in the family is a concern with minor morbidity (also mirroring that in general practice); great pains are taken with minute descriptions of systems of ventilation, fresh air supply, air temperature etc in order to ensure the least submission to the course of respiratory infections and to maintain the optimum 'atmosphere' (physical and emotional). But, above all, the desire for a systematic regulation of the interior space of the home demands attention, in parallel to the concerns in the surgery of logistics and vigilance, to the functions of rooms and the maintenance of constant visibility over offspring:

'The sliding panel between kitchen and dining-room might be glazed, so that the mother could keep an eye on her children playing in the sitting-room' (BMA 1946: 44).

The persona at the centre of familial regulation is, not un-naturally, the mother. She is the worker of the home which, in turn, is the specially designed workplace of the mother:

'Some families like to eat their meals in the kitchen. This habit ought not to be encouraged in the home of the future. The kitchen is the housewife's workplace and preparation room' (ibid: 44).

There is, then, something of a parallel or homology in the positions of mother and doctor in their respective domains; a homology that recalls Donzelot's notion of a kind of 'organic link' between mother and doctor (Donzelot 1979: 19). If there is anything novel in this link and the manner of its articulation in the 1950s then this relates more to the space in which it is embedded rather than the form of the link itself. The homology is a complex one. First, the surgery becomes continuous with the home; so that if the surgery is a fabricated space - that is both 'scientific' and 'affective' - then it is not, for all that, an artificial space; the surgery, like the home, will be an apt site for the observation of relations between mother and children. Secondly, this means that other sites - beyond home and surgery - become, at least from the doctors' view, inappropriate for family observation; hence the denigration of child guidance clinics and other 'alien' sites of intervention that we find in writings of this period:

'schools, clinics and other social services outside the family will have a large share in the national life, but they cannot take the place of the influence of the family environment' (ibid: 33).

Third, in spite of the homology that exists between home and surgery, in fact the home has priority; there can be no substitute for actual observation in the family space. And who is better qualified to observe this space than, as we shall see below, the family doctor himself who has such natural - moreover, such un-resented - access there? Fourth, just as there is an asymmetry of emphasis between the sites of observation, then also there exists an asymmetry of emphasis between the subjects of that observation; for the 'organic link' between mother and doctor is less an 'alliance' between these two personages interested in the welfare of children, than a problematisation of the figure of the mother herself. What is at stake, what is forever uncertain and under a perpetual suspicion, is always the competence of the mother herself, since she is the key to family functioning as a whole.

CHAPTER NINE

FAMILY STUDIES AND MINOR MORBIDITY

1. Governmental Consciousness

This narrow regulatory space of the family soon becomes one of the general practitioners's primary targets of expertise. To understand the ways in which this was so we need briefly to consider some of the prevailing rationalities of 'government' and social intervention targetting the family at the time, and - more particularly - at some of the ways in which some (but by no means all, for this was certainly a minority interest in terms of actual research) general practitioners attempted to link the domain of general practice into these prevailing rationalities which had as their aim the government of the internal space of the family.

1.i. The family itself had become a privileged object of scrutiny in the immediate post-war years as part, no doubt, of a wider 'governmental' problematic relating to the state of the 'population' as a whole. The experience of total war, the 'universal' provision of welfare, and the socio-political imperatives of mass liberal democracy

combined to make desirable if not straightforwardly practicable the life-conditions of the populace as the continuous object of investigation. The family represented the privileged focus of such regulatory scrutiny in that it was the 'training ground for the future citizen' as well as being the 'basic unit' of society itself (BMA 1946). Of course there was nothing especially novel (cf. the neo-hygiene movement of the inter-war years, for example; cf. Rose 1985: 147) about taking the family as the object of social regulation and as a target for a variety of types of expertise. What have changed (as we shall argue) are the technologies of access, the imperatives and emphases involved in this scrutiny, rather than the project of scrutiny itself. There was not, for example, much that was new, and not merely a re-invention of old aspirations, in that movement that Riley has labelled 'pronatalism' (Riley 1983: 157ff.); that broad problematic of social intervention that had as its founding scriptures the ongoing work of the Royal Commission on Population (1944; News Chronicle 1949 is a useful contemporary source).

The Commission had been established in 1944 in the context of 'national alarm' concerning the low birth rate (a context that provided the social rationale for the Family Allowance Act of 1945) and had as its primary prescriptive focus first, the encouragement of motherhood, and secondly, the reinforcement of a social necessity for technologies of what Riley calls 'corrective inspection'

in the home. The theoretical problematic around which these necessities of intervention clustered was found in that broad range of ideas known as 'Bowlbyism', characterized by 'an intense concentration on the married mother permanently in the home with the child' (ibid: 109). Let us single out only two implications of the pronatalist problematic that had Bowlby as its apotheosis; first, the central importance accorded to matters relating to 'affectivity' (the effect of 'separation', or of 'maternal deprivation' in general, is said to be the 'affectionless character') and the importance that is, therefore, attached to the emotional content of relationships in general, and the mother-child relationship in particular. Second, a certain 'anti-institutional' bias (creches, nurseries, hospitals etc are denigrated as being un-natural spaces) stressing the importance of the home; this bias also having a kind of methodological corollary in the emphasis laid, not so much upon 'training' the mother (in clinics, etc.), as upon the corrective 'observation' of the course of familial relationships as they evolve. These two points are stressed since it is, perhaps, above all around these themes that general practitioners sought to elaborate the elements of a broad paradigm of 'research' in the home that was, on the one hand, undertaken of necessity at a 'micro' level of investigation (by single practitioners etc) and, on the other, intended to be linked directly to the 'macro' aspirations of 'government' and pro-natalist strategies of welfare.

Affectivity and anti-institutionalism:

'In the domestic warmth of the kitchen, in the snug atmosphere of the surgery, there are so many more opportunities for this kind of instruction than in the cold comfort of the clinic; where, be the health visitor never so neat, the nurses never so charming, the voluntary helpers never so motherly, intimacy and the consequent will-to-learn are hard to generate' (Editorial 1957: 127).

The doctors - with their surgeries in a homologous relation with the family home - were in a position to designate as 'artificial' the space of the welfare clinic, and other institutions not considered part of the free field. The move away from 'closed' or 'artificial' sites of intervention - and the limited pathological forms they made visible - had already been given an 'historical' interpretation in the Charter for Health:

'Attention was then [i.e. at the turn of the century] directed in a variety of ways, such as clinics, health visitors, school inspection and so on, to the health of the individual, first to the mother, then to the infant and finally to the school child and the adult suffering from specific diseases such as tuberculosis and venereal disease... But the unit of society is the family and attention is now increasingly directed to the mass of preventable disease and death still occurring in the first few years of

life, to the psychological effects of bad homes and allied social factors and to the large number of preventable still-births and premature births' (BMA 1946: 28).

The paradigm of corrective inspection within this family environment (the general practitioners knew this field as 'family studies') was, as we have seen, the observation of relationships, especially as they involve the mother, rather than a centering simply upon the child as such. One doctor claimed, for example, that one could no longer speak of the 'deprived child' since deprivation was a phenomenon that related to the entire moral condition of the family (which was to be understood in 'ecological' terms) rather than to any single member of it (Craig 1956: 25). One must find a way, then, of observing the family and its pivotal relationships as a whole, and with a minimum of perceived, distorting interference. But what is one looking for? What is the character of this family space? It is 'psychological' certainly; first because what one is looking for in the 'general atmosphere' of the home are matters of temperament, patterns of affection and so on; secondly, because the solution is often a matter of psychotherapy, advice or management (of the mother). But this space is also 'sociological'; concerning 'problem families', 'deprivation' and so on; one must observe patterns of cleanliness, living conditions, the state of the garden and so forth. Lastly, the family space is 'medical'; the home is a kind of 'crucible' for minor morbidity, partly deriving from physical conditions

(especially relating to respiratory conditions) but also to the minor infections of infancy.

1.ii. Who better to cover this space than the general practitioner, with his experience and expertise in all these fields? The general practitioner stands at the boundaries of a variety of forms of knowledge, a position that enables him to arbitrate, in any particular case, between the claims of each form. His ability to distinguish between what is somatic and what is not is complemented by the ability to demarcate what is normal and what pathological even within the range of common afflictions. For example, minor morbidity is not always simply a somatic problem relating to the child alone:

'In children it is of vital importance to assess the home situation and the competence of the mother as a mother. The over-anxious and unsure mother is the one who will require management rather than the child who is suffering from abdominal pains, headaches, vomiting bouts or asthma' (Fry 1956: 561).

But as well as possessing this wide-ranging technical knowledge, the general practitioner also has conditions of work which enable family scrutiny to take place all but unheeded:

'as privileged persons with entry into all the houses in our practice we are better placed than many to observe and record other things about our patients than their ailments' (Editorial

1956: 4).

But, more than this, since the family suspects nothing from the family doctor except friendliness and advice, the doctor's corrective activities will pass all but unheeded and the liberty proper to the free field will have been upheld. For example:

'The education of the mother by the family doctor must be re-inforced by help from the health visitors and the district nurse. [But] He alone is able to walk freely into any part of the house; he is not an inspector; and advice and warnings perhaps carry more weight on that account' (Editorial 1958: 3).

Likewise, if the general practitioner is, in part, a psychiatrist, then he is so only to the extent that the patient is unaware that he is one:

'... a general practitioner may offend and lose a patient by suggesting an interview with a psychiatrist, neurotics not always being willing to admit that they need psychological help. It is, therefore, necessary for the general practitioner to understand psychiatry and to be able to practice it to some extent' (Burdon 1957: 28).

2. The Mother

However, if the rationale for the doctor's privilege as the all-seeing but unseen observer of the family space centred upon the family as a whole, the privileged point of intervention always remained the mother and the question of her 'competence' (see e.g. Thomas 1958: 364). In the person of the mother resided the intersection of all the important family relationships and problems; the mother was a kind of 'obligatory passage point' for all these, a kind of mobile representation of the internal space of family life (which was, no doubt, why the surgery, a place where the mother could be brought without, as it were, loss of information, could be conceived of as a potential extension of the 'affective' yet 'scientific' space of the family home.) Again, this question of the mother's competence could be a 'psychological' - or, rather, 'psychiatric' - matter, as in the case of the 'emotionally unstable mother':

'Much of this family's illness was due to the mother's temperament. The mother seems to spend her time trailing around the streets window-shopping or gossiping with her sisters or friends... There are frequent matrimonial quarrels and discipline is inconsistent and harsh' (Maclean 1956: 61-2).

But the great source of the doctor's power in such cases was not so much even access to the home as the ability - having a command of both fields - to distinguish between psychosomatic and somatic afflictions.

2.i. One exemplary form of pathology, where childhood morbidity was often referred to the person of the mother and the question of her competence, one which resided on the boundaries of the psychosomatic and somatic, the normal and pathological, was that relating to the 'catarrhal child'; a particularly common problem, since as the College journal's readership was informed, over 50% of childhood problems related to problems of the respiratory tract (Symposium 1958: 42-59). The 'catarrhal child' is in fact quite normal and merely going through a stage in life, part, in fact, of the normal 'process of development':

'All children pass through these phases, yet 50% are constant attenders at the general practitioner's surgery. There is a definite correlation between the frequency of attendances and the amount of anxiety expressed by the mother' (ibid: 51)

If the child is ill, badly behaved, anxious and so on, when it is in fact 'normal', then this is the fault of the mother:

'The child with an an anxiety-prone mother who attempts to mould him according to her own immature needs and complexes, must of necessity pass through more stormy passages than the child of a more mature adult' (ibid: 51).

The problem of the 'catarrhal child' can only be solved by the establishment of a good 'rapport' between mother and doctor, having as its pre-condition a strong sense of

trust on the part of the mother, a form of trust which must develop, as it were, in the free field, on the basis of past medical encounters and personal familiarity:

'As I have said proper management of the catarrhal child depends to a great extent on good rapport between mother and doctor, and takes time for this to develop and the time to get to know each other and to appreciate each others views, and the mother to believe in and have confidence in her own family doctor. How can this vital and essential relationship become established at a 'clinic' when the contacts are highly impersonal, and where the medical personnel do not attend the family during times of illness' (ibid: 46).

In addition, let us acknowledge that the resort to the person of the mother in problems relating to the 'catarrhal child' and to 'wheezy children' in general, was as much based on an 'epistemological' necessity, as well as one relating to the demands of social utility. For it was virtually impossible to develop satisfactory differential diagnoses relating to these conditions. Thus for instance, it was argued - in what may have been an extreme view - that, rather than merely relating catarrhal conditions to parental anxiety, they could themselves (making a kind of virtue of necessity) be defined by the presence of such anxiety:

'The utilization of the child's illnesses by the parents or the child must be the determining

factor in our classification of the case as a member of the catarrhal group. The catarrhal child as seen in practice has attached to it a parent with a free-floating anxiety, ostensibly related to the child's condition' (Nichols 1959: 44).

In one sense the catarrhal child is an inadequate example for us to take simply because it was the form of pathology where the aspirations of family studies were most successfully realised; thus, studies were undertaken at a 'micro' level of observation, re-inforced by more wide-ranging statistical information, and also tied to the 'macro' demands of social policy and pronatalism. More generally, the paradigm of family studies did not take off in general practice - except as a very general and rather ubiquitous aspiration - in such a coherent and effective manner. Let us attempt to cite some of the reasons for this relative failure.

2.ii. The 'low epistemological profile' of these forms of intervention can be noted. As already seen, the notion that it was the general practitioner's duty to be a kind of 'naturalist observer' of the family home was invoked often enough. However, on the whole, this remained merely a general aspiration, without specific epistemological conditions of coherence attached. In a sense, the general practitioner's claimed range of intervention here was too general; for instance, he was concerned not with, say,

'problem families' but, presumably, with all families. But as Riley points out the trend in this period amongst welfare agencies was to focus upon and isolate only particular kinds of family for intervention:

'a series of specialised agencies, such as the new psychiatric social work, "open up" only certain kinds of families to corrective inspection, like the revived category of the "problem family" ...' (Riley 1983: 170).

The general practitioners were hardly in a position to establish themselves as a specialised family 'agency' in this sense. Moreover, the doctor's power in this field was based, above all, on 'informal' knowledge of patients and the 'affective' powers of his influence. These powers of intervention were easy enough to invoke - especially in polemical opposition to other agencies of intervention - but, bearing only a weak 'epistemological profile', they were extremely difficult - bar a few exceptions such as in the case of the 'catarrhal child' - to place on a more systematic footing.

But if the breadth of the general practitioner's expertise was at once both the condition for his claims to intervene successfully in the family and the guarantee of the limitations of this claim, then, similarly, the consequence of this breadth of scrutiny was a kind of 'dilution' of powers; powers that others in narrower spheres found it easier to invoke. For instance, the doctor could perform statistical studies in relation to

childbearing, but others could do so more comprehensively (cf. Riley 1983: chapter 6). Similarly, the doctor's powers were based, above all, on the depths of his 'experience' and were thus intangible almost by definition. Yet, in relation to 'family studies', his technical resources were more or less the same as those of any 'psychiatrist'. Certainly, a 'psychological' approach that was unique to general practice was not at stake here: the doctor himself, for example, was not yet conceived as being himself a kind of 'psychological' subject, whilst the model of intervention remained strongly 'corrective' or judgemental (these two points are in contrast to later developments, analysed in the next chapter, where general practice becomes as it were wholly constituted by a psychotherapeutic rationality). Yet this very intangibility of the doctor's role was an advantage as well as a drawback; for, it enabled a link to be made with another form of 'micro' investigation; one, moreover, containing more possibilities for an alignment with wider 'macro' themes of government and policy; namely, that rationality - which was basically 'epidemiological' as opposed to 'psychological' - relating to the tracking and description of minor infections and epidemics in the free field. The basis of this link was derived from a particular conception of the person of the doctor; that is, the model of the 'country practitioner'.

CHAPTER TEN

COUNTRY PRACTICE AND COLLECTIVE INVESTIGATION

1. The Country Practitioner

The epidemiological model associated with the activities of the 'country doctor' was perhaps the most prominent paradigm of collective and individual investigation in the 1950s (Gibson 1973; Theokston 1957; Pickles 1948; Honigsbaum 1979: 211). In his ideal form - of which there was a living expression in the person of William Pickles - the country practitioner combined two related forms of knowledge; first, an intimate familiarity with the home lives and personal idiosyncracies of his patients; and second, a research orientation into the minor epidemics of the countryside.

1.i. The form taken by this intimate familiarity is 'pastoral' rather than properly psychological as such. In fact, psychological conditions - or at least, neuroses were supposed to be rare in the countryside; at any rate, the model did not allow the clear 'visibility' of such conditions. The country practitioner is the archetypal 'generalist', in two senses: First, he sees all kinds of

patients (not just those on the panel, etc.). Moreover, he knows these patients not just as patients but as members of the community of which he himself is a (privileged) part. And secondly because, being alone (cut off from hospitals, laboratories, midwives, social workers, even vicars) he does everything himself (minor surgery, dispensing, preventive medicine, friendly advice; Hughes 1958; 8). Moreover, in the country one's patients tend to be simple folk, with ways of their own which have to be (indulgently) understood; patients are in fact more or less equivalent to children in the countryside. And because the country practice is a close-knit community, the doctor himself will be a well-known character in the village, with powers of influence of his own. In short:

'The doctor in country practice cannot help taking a real personal interest in his patients; he enters into their joys and sorrows, and is well versed in all the small details which go to build up their relatively simple existence' (Pickles 1948: 201).

The country practitioner's personal knowledge is, then, based upon a kind of personal, 'pastoral' communion with what amounts to his 'flock'. He is by no means a psychiatrist, even if on occasion he does resort to the techniques of psychiatry which he knows just as he knows the basics of all the specialties of medicine; certainly, psychiatry bears no privileged relation to the form of knowledge particular to his endeavours. In fact, the true

object of research undertaken by the country practitioner, deploying all his personal knowledge, is minor morbidity, and epidemics in particular. William Pickles provided the model for this kind of investigation in his Epidemiology in a Country Practice (Pickles 1939; cf. Watson 1960 for an application of a similar 'country' model), a seminal work in general practice mythology: and Pickles duly became, later on, the first president of the College of General Practitioners. The particular circumstances of country practice, typified by a closely defined community with clearly defined boundaries and patterns of behaviour, are by no means only 'circumstantial' to the form taken by his research:

'There is something in country practice ... I believe it is the deep bonds of friendship which exist between doctor and patient - that breeds content and it would be unthinkable in most of us to change our habitat.'(ibid: 3)

This intimacy is important in that it makes it possible to trace the movements of the people in the area, to follow - in the case of infectious diseases at least - the 'natural history of disease', where it enters the community, who catches it from whom, where lies the focal point of the spread of the condition and so on. It is, then, only in the context of epidemics and patterns of infection that the doctor's knowledge of the 'relationships, friendships, and love affairs of all his patients' (ibid: 4) will come in useful for research.

1.ii. Pickles, a kind of Gilbert White of the free field - with more than a little assistance from his wife and daughter (and the Medical Research Council) - evolved an ingenious and simple technique for mapping the 'natural history of disease' in one-dimensional space. By the use of charts marking off in squares the days on which people in the practice contracted particular epidemics, a visual picture could be built up that revealed the time-intervals between contractions of the infection; hence allowing calculation of the typical incubation period of the disease, the period when it is at its most infectious, the length of its stay in the community, its juxtaposition with other infections and so on. In short, an entire, as it were, 'quantitative' mapping of the temporality of infections became possible. Moreover, using his personal knowledge of his patients, their relationships and their whereabouts, Pickles was able to provide a kind of 'qualitative' account of the course of the infection, where it came from and how it spread. This kind of investigation, then, depended for its efficacy upon the existence of a closed community of known individuals as the site of investigation. Indeed a kind of 'vital' epidemiology of the free field, a living experiment:

'Wensleydale in early days must have been as much a closed community as those herds of mice which experimental epidemiologists find so useful in studying the ways of epidemics' (ibid: 14).

In Pickles's work, the cause of an epidemic entering the

community will always be either some outside connection (gypsies, a visit by a villager to a large town) or a carnivalesque social occasion, with all its attendant dangers ('There are now cinemas, and there are, of course, concerts, whist-drives, and dances...'; *ibid*: 21). The most important crucible of infection is, however, the school, even though, fortunately, in the case of Pickles's Wensleydale; 'the headmaster is epidemiologically minded and alive to the dangers of the school helping an epidemic around the countryside' (*ibid*: 21).

Two facets of Pickles's research endeavour are of interest in the light of some of the collective activities of the College of General Practitioners. First, the fact that by his methods he was able to make real discoveries on the basis of a knowledge that only the general practitioner could possess. Take, for example, epidemic catarrhal jaundice (*ibid*: 65ff). This has a long incubation period (as it was Pickles's achievement to demonstrate) and individual contractions of the infection can seem so isolated in time and space that its nature as an infection at all was in some degree of doubt; indeed, it was thought to come from a common (sanitational) source such as the water-supply. But Pickles was able to show, by a combination of his time-chart analyses and his tracing of the movements of the individuals concerned, the 'person-to-person' nature (through droplet infection) of the epidemic and, hence, the long incubation period involved. Second, part of Pickles's achievement lay in his linking

of general practice to wider questions of social utility; not just for making the general practitioner more effective at preventive medicine than its own practitioners (Pickles himself was M.O.H. for his district), but for demonstrating, by example, that general practitioner knowledge can be important even for the 'macro' activities of the government of populations. One exemplary instance of this relates to October 1944 when Pickles himself gave evidence to the Royal Commission on Population, his evidence chiefly concerning the contraceptive habits of his patients, involuntary sterility, the utility of home helps and family allowances. The interest of Pickles's evidence as a witness to the Commission lay above all in its detail, his obvious intimacy with the minutiae of conditions of life in Wensleydale, whereas:

'... naturally much of the evidence we get, although also very valuable, is of a very general character and is the impression of witnesses in reference to the whole country' (Royal Commission on Population; Report of Evidence 1944: 1).

2. The Collective Investigation of Minor Morbidity

Would not the kind of intimate knowledge possessed by the likes of William Pickles be even more powerful, of even greater utility, if it could be related - on a systematic

basis - to the whole country? In spite of certain unavoidable departures from the model, the Epidemic Observation Unit of the newly founded College of General Practitioners represented an attempt to put the investigations of Pickles onto a nationwide basis; to establish the project of a natural history of disease as a collective endeavour.

2.i. A 'natural history' of disease: the disease takes a course in the community, the free field, which will have to be mapped, where previously it was invisible (in 1775, and in another 'free field', Fothergill had suggested the possibility of a natural history of influenza in this way). Previously, only notifiable infections (tuberculosis, syphilis) could be made visible; now, it was suggested, non-notifiable infections would come under medical scrutiny as well. These were the conditions rarely seen inside the walls of the hospital, conditions of which the full clinical picture or the typical course of infection remained unclear; epidemic winter vomiting, pyrexia of unknown origin (shere fever), influenza, measles, mesenteria, lymphadenitis, various respiratory conditions. Just as in the work of Pickles, the purpose of the Unit was to make visible, by use of technological forms (in this case, not an inscriptional cascade of 'time-charts', but through the collection of independent observations by individual doctors), an infection which, taken case by case, would have remained obscure; to describe both the 'picture' of the disease (characteristic

signs and symptoms) thus making diagnosis more reliable, and its natural course (incubation period, typical rate of spread and so on):

'... to locate a considerable outbreak of some undiagnosed illness and to define its clinical features' (Editorial 1954: 3).

Once the disease picture had been outlined, it would then be possible to begin pathological work (using the services of the Public Health Laboratory at Colindale) in order to find the offending organism; a kind of large-scale collective epidemiology of the free field becomes possible through an amalgam of smaller, localised epidemiologies. Let us note, parenthetically, how 'traditional', in terms of its methodological aspirations at least, this kind of research remains (describe the clinical features, isolate the microbe); all that is new is the scope of the research, its wide domain of investigation.

A collective endeavour: In order to make these forms of minor epidemic morbidity more visible a technology needed to be set up through which practitioners could alert one another of outbreaks and, in turn, report their findings. Once again, a kind of paradox of organisation is involved: morbidity in the free field must be allowed to emerge spontaneously, yet practitioners must be left free to follow only those research endeavours which interest them. Guided by the product of all these diverse interests a more or less stable plane of consistency should eventually appear, sensitive to all the fluctuations of

the minor morbidity in the free field. Thus, the technology consisted of an 'advisory' function at centre and periphery, and a 'warning' system, with the College's Research Newsletter (and, later, a publication called - enigmatically enough - Between Ourselves) serving as the means of communication between them. Advisory functions existed both at the centre (College headquarters) in the form of the Research Advisory Panel, and at the periphery:

'The appointment of a research member to the board of each of the Regional Faculties of the College will complete a general practitioner research network covering the British Isles' (CGP 1953: 21).

Membership of this network consisted of all those on the Research Register of the College (by 1954 there were 380 names on the register); these members, a kind of 'home guard' against epidemic invasion, could be alerted of outbreaks through the 'warning system' of the College. Thus, a practitioner who - on the basis perhaps of just a few cases - suspected that he had the dim outline of an epidemic appearing in his practice would notify the director of the Observation Unit at College headquarters. Next, a 'yellow warning' would be sent out to inform all those on the research register to be on the look out for similar cases and, should any appear, to inform the originator of the warning. Should the outbreak be of special interest a 'red warning' would be sent to all members of the Research Register. A 'purple warning', meanwhile, would inform those interested that a full

report of the outbreak would be published in the forthcoming Research Newsletter:

'For example, in December 1953, all members of the College in Hampshire and Dorset were notified within forty-eight hours of an unusual outbreak of 'pyrexia of unknown origin' occurring in Bexley, Hampshire. The distribution of the observers throughout the country is satisfactory, and in future it is unlikely that any epidemic of general interest will occur without soon being reported' (CGP 1954: 25).

Thus, by a kind of cumulative and circular process, from periphery to centre and back again, various 'pictures' of disease as it occurred in the natural domain of the free field were to be built up; it is the College organization, its associational form, linked by practices of inscription, that makes possible this new form of collective vigilance.

2.ii. The case of epidemic winter vomiting provides a good illustration both of the workings of the Observation Unit, and of what it was able to make visible. This condition is an example of an affliction rarely seen anywhere but in general practice; moreover its clinical picture is unclear, being a kind of vague concatenation of symptoms (mainly vomiting) with no physical signs present.

'What is known about this disease has largely come from localized outbreaks in closed communities such as schools, hospitals etc. One

aim was to study the disease as it appeared in general practice, with special reference to its seasonal incidence and its spread from one locality to another' (Symposium 1955: 90).

Over the winter of 1954 approximately 1,300 cases had been reported in 120 local outbreaks involving 120 general practitioners. As a result - and aside from being able to give a clearer 'picture' of the disease itself (its symptomatic form, period of incubation etc) - practitioners were able to differentiate the condition from others. Thus, a symposium on the condition held in 1955 was told:

'It was shown that during the autumn of 1954 the area of maximum prevalence and the direction spread of the winter vomiting disease were different from those of virus B influenza, giving support to the view that there are two distinct diseases' (CGP 1955: 28).

In addition the unpredictable nature of the course of the condition was confirmed as a clinical fact:

'We now know that this form of infectious vomiting may be either sporadic or epidemic; in epidemic form it may affect only one child in each of several houses or a whole family or school' (Symposium 1955: 94).

3. Assessing the Paradigm of Collective Investigation

What is the purpose behind this project of collective investigation? Is there, for example, an intimation of social utility lying behind it? How might it be linked to other, perhaps wider, aspirations and endeavours?

3.i. First, the paradigm of collective morbidity entails a rationality that could surely only have gained its initial problematisation in the context of warfare. This, to be sure, is not the warfare of large mobilisations, great battles, outsize heroism and generalised carnage. It is modelled more upon the fantasy of espionage: there exists in our society a secret army of epidemics, infections and undefined viruses, that need to be sought out so that one can mobilise one's defences against them. This model is compounded by a fantasy of totalising visibility: the notion that, given the right techniques and resources - and above all by mobilising a kind of army of the 'common man' (allusions to the 'Home Guard' are difficult to resist) - one can make this entire field of minor morbidity visible. What is interesting about this visibility is that its subject - the doctor, and the collectivity of doctors - is itself invisible; they exist in the pores of the collectivity and carry out their investigative tasks only in the course of their daily occupations.

What is no doubt important in a 'governmental' context here is the notion that danger lies in the minutiae, within the interstices of life; the threat is not

cataclysmic and finite but minor, and continuous. What is required therefore is a form of continuous monitoring; uniting the micro-world of the individual in the locality with the macro-world of the population. Nevertheless, this nosographical project as such was not in itself a new one (cf. Foucault 1973: chapter 2). For instance, as we have already noted, in aetiological or diagnostic terms nothing new was being sought here; no new typology of disease exclusive to general practice was forthcoming. Rather, all that is at stake is that a new apparatus is put in place for the detection of minor disease entities; a kind of 'naturalisation' of bacteriology - out of the confines of the laboratory and into the free field.

Second, there was naturally an intended economic utility; if the patterns of disease in its natural environment could be known, then, equally, these patterns could be predicted and prevention might become possible; hence, this research is 'economic' in the sense that it would cut down on involuntary inactivity in the population and would reduce - or so it was argued - the burden on expensive hospital care (since, in certain groups of the population, these minor afflictions can lead to more serious conditions) (CGP 1953: 7). However there was no sense in which it could be claimed that these forms of activity could replace hospital medicine and so forth through, for example, a kind of generalised prophylactics in the community; these activities were strictly incremental to already existing medical endeavours.

Third, and certainly more important, if more obscured, than this economic utility, was the link that epidemic research (as tied to the model of the country practitioner and the forms of knowledge he espoused) was able to make with the various problematics of pronatalism that took as their target the reconnaissance and maximization of the capacities of the child. For, above all, in all these cases of minor morbidity, albeit in a manner which is perhaps so fundamental, so obvious, that its acknowledgement barely appears, it is the child which is at stake. This child was not the same as that observed by the sort of 'family studies' discussed above, that is, according to a broadly 'psychiatric' model of intervention. However, what these two forms of investigation had in common (at the 'micro' level) was a similar orientation towards the link between the normal and the pathological. For the minor morbidities of childhood are, when derived from knowledge of their collective incidence, normal, natural events in the midst of the process of development. They are, then, events which the doctor can, if necessary, 'subtract' from the more serious, underlying pathologies that threaten the child, but they are also events which are, above all, precarious; for example, if they occur too frequently (a sure sign of pathology in the whole family), or lead to more serious conditions. Only the doctor, as we have seen, is able to arbitrate along this boundary of what is proper to normality and what is proper to pathology, of which he is the absolute master. It is not that the boundary

disappears altogether (as claimed in Armstrong 1983: 90), but that its uncertain outlines can only be resolved, brought into focus, by the expertise of the doctor at work in, and with knowledge of, the free field.

3.ii. However, it is not intended to suggest by this that epidemic observation was an extraordinarily powerful form of investigation; rather, the links that it was able to make with other demands, other forms of study were, at best, unsystematic. In fact, as a paradigm of the kinds of activity proper to general practice, the collective endeavour of epidemic observation did have several drawbacks. First of all, in what it had to discard from the paradigm of country practice as embodied in Pickles's work: the doctor's personal knowledge of his patients was no longer necessary in the collective context, in which the tracing of the movements and habits of patients to establish the point of entry of the epidemic could have had little meaning. All 'biographical' elements, those proper to the very 'ontology' of general practice, disappear:

'Much is to be hoped for from the marriage of the science of statistics to general practice though the reduction of such abstracts as emotion, fear, anxiety, and the components of mental illness to exact terms will be far from easy' (Pinsent 1958: 26).

Later we shall see how this epidemiological emphasis lead to charges of reductionism - an alienating movement from

the person of the patient to the reified figure of disease.

Second, the loss of this link between personal knowledge and epidemic observation entailed the widening of the gap between the 'micro' and the 'macro' levels of practice. In Pickles's work, the 'macro' knowledge of epidemics informed his 'micro' work in the home and, naturally; vice versa. On the collective level the intensity of this link was diminished in that a certain distance opened up between knowledge and intervention. Since knowledge becomes 'collective' it separates itself to a certain extent from the daily activities of the individual such that what was at stake at the micro and macro levels were in fact, in the end, different kinds of knowledge. Lastly, this linkage of everyday practice and epidemic knowledge was further compromised by the very choice of the targets of epidemiological study. Thus the circumstances of collective investigation meant that 'only a limited number of outbreaks can be located by the Epidemic Observation Unit at any one time' (CGP 1954: 76). The nature of the kinds of morbidity encountered by the Unit was somewhat at odds with the wider aspirations of the College to investigate 'minor morbidity' in general; by this term was meant common illnesses not generally seen in the hospital but nevertheless pervasive in the free field; in this way general practice might become the specialist discipline of minor morbidity. However, what actually became the object of study was not so much minor

- but common - morbidity in this sense, such as measles, as obscure morbidity (pyrexia, etc.); in other words, those illnesses that could not be made visible outside of the macro dimension afforded by collective investigation since they occurred too rarely in the locality to be of significance.

However, in spite of these limitations, the paradigm of collective epidemic observation was important, at least, in the manner in which it fitted in with, and was a part of, the general project of a mapping of morbidity in the free field; for in the 1950s this entire project was viewed, at least by the members of the College, as a novel endeavour of great significance in its own right.

CHAPTER ELEVEN

THE LIMITATIONS OF TAXONOMY

1. The National Morbidity Study

As writers in the College journal (and elsewhere) never tired of pointing out, the very fact that morbidity in the community was being made calculable at all was of great significance in its own right. Previously, medical statistics had been reliant on the classification of mortality alone; only the analyses of notifiable infectious disease had shown the way to what a general analysis of morbidity might look like, whilst the work of the Epidemic Observation Unit of the College had, since 1953, endeavoured to extend this kind of analysis into the realm of non-notifiable infectious disease. There was a kind of rationality of 'vitality' behind this aspiration; a kind of anti-medical rationale of clinical 'recuperation' designed to be in opposition to medicine's reliance on the grim evidence of death:

'To increase man's knowledge of himself he must study the circumstances of his life as well as those which cause his death' (Pinsent 1958: 26).

Meanwhile other organizations as well had, in the post-war

period, been investigating the extent of morbidity outside the space of the hospital (the Ministry of Pensions and National Insurance, for example); although none had attempted to do so across the entire free field of the nation itself.

1.i. This was a project the College was (from its inception, in fact) now planning. A College Records Unit was planned to supervize a constant monitoring of morbidity in the population:

'... to carry out a constant and continuous watch on the illnesses of the community through the eyes of an observer-group of perhaps a hundred practitioners. In many ways this watch will resemble that kept on the weather by the Meteorological Office, where reports from numerous field workers are co-ordinated and translated quickly into information valuable to us all ... It will be our task, with whatever help we may receive, to bring the sources of family illnesses to the surface, to measure their effects and to take steps to prevent spread or further recrudescence' (ibid: 334).

However, the Records Unit, when it finally did appear (in 1957), was actually to be far more concerned with the methods (or, the means of codeability) of data collection and typologies of morbid classification proper to general practice, than with extensive investigations of this kind.

But such an investigation (albeit not in continuous form) was, nevertheless, to be undertaken.

Like the College's epidemiological work, the National Morbidity Survey was intended as a contribution to a general project of the 'natural history of disease' (GRO 1958; 1960; 1962; cf. esp. Editorial 1953: 6-7). This conception, in fact, implied an entire historiography; an allusion to a period when disease had not been linked to the lesion or the microbe, the hospital or the laboratory, but had existed in a wholly natural space, amenable to systematic collection. This, then, was strictly a preparatory stage, a 'stage of taxonomy' in fact, when all the facts which are to make a science possible are gathered together 'and set in order so that all may understand them.' Indeed:

'This is the stage of taxonomy applied by Linnaeus to natural history, by such workers as Bentham and Hooker to botany when it became a separate study, and by Farr and others to man when his knowledge of the patterns of presentation of disease first made accurate definitions possible' (Research Committee 1959: 140).

And no one could doubt that the principles on which a natural history of disease would be founded would differ substantially from previous forms of medical classification. As Pickles declared in the first 'James Mackenzie Lecture' at the College:

'A nomenclature which is based on morbid anatomy or on the presence of infecting organisms finds little place in the daily records of general practice' (Pickles 1955: 4).

1.ii. How, then, was such a taxonomy to be created? What would be the necessary organisational forms and alliances that would be appropriate for its creation? What would be the techniques of data collection, analysis and presentation proper to such an endeavour? Above all, how might such techniques of data collection be put into operation without disturbing the contours of the free field itself?

Superficially, the answer to these questions was obvious and already in place. Did not the College itself 'represent' the free field? Surely, all that would be necessary was the collection of information across the organisational parameters of the College network:

'It may be that the next advance in medicine will come from a fuller understanding of the field in which 20,000 general practitioners are daily at work and means must be found for exploring this field of material' (Editorial 1953: 2).

But finding these means was not simply a question of collating at the centre the entirety of haphazard information collected around the periphery; for the domain of evidence and investigation of general practice was

simply too diffuse, simply too many forms of classification were possible.

This was a problem that had already been encountered by the Research Advisory Committee of the College when considering applications for research studies coming from the faculties. A 'consolidated comment' system was devised to monitor research strategies and to decide upon their viability (and to reject proposals which showed little likelihood of successful fruition); thus, members of the Committee would reply to the research proposals of local faculties with their comments on the research in question. Going through this material, one quickly perceives that the problem in the 1950s was less one of sub-standard research proposals but rather one of a lack of 'standards' altogether. Thus, although a host of individual practitioners had mapped the profile of morbidity in their practices all that had emerged was, far from a continuous picture of disease in the population, a mass of confusing, if impressive, heterogeneity.. For instance, we may quote from one of the Advisory Committee's 'consolidated comments' on a submitted proposal entitled 'A Year's Work in General Practice':

'I always wish that GPs who are interested in this kind of work would use the same classification so that their figures were comparable. Truly he will get something out of it himself but how much more could be obtained if his results could be compared with those of

other similar observers?' (CGP Archives 1957, no page numbers: Report on draft proposal of Hadfield-Jones, August 1957).

But how was a uniform system of classification to be devised when it was, precisely, a taxonomy of the 'free field' that was expected to be the outcome of such research? The research decisions taken in preparation for the National Morbidity Study, and some of the studies relating - under the broad shadow of the Morbidity Study - to questions of classification in general, show up this dilemma very clearly; a dilemma that can, in fact, be reduced to the question of the difficulties entailed in this strange marriage between the science of statistics and the art of the sick individual that general practice conceived itself to be.

1.iii. The Morbidity Study was intended to measure, first of all, the 'amount of sickness' encountered in the population:

'to provide data of value to the medical research worker, the sociologist, the administrator and, by no means least, to the general practitioner himself' (GRO 1958: 1).

This data was collected from the clinical records of 106 practices in England and Wales between May 1955 and April 1966, and was analyzed by statistical coders at the General Register Office. In fact, this data related to two dimensions; the general diagnosis and the diagnosis

recorded at each consultation: 'Upon these two items of information - consultation and diagnosis - are based all the tabulations in this study' (ibid: 17).

The problem was that the very dependence of general practice on the sick individual made the coding of diagnoses highly uncertain. Unlike the hospital case, where a diagnosis could be entered when the patient was discharged, in the case of general practice a diagnosis had to be entered at each encounter. This meant that, since diagnoses were liable to change and since patients were liable to attend the surgery more than once in a year, the unit of analysis could not be the patient. Thus, the morbidity survey could not relate to the sick individual at all; but related only to the 'period prevalence' of disease, i.e. the number of patients who would be consulting with a particular diagnosis over a particular period (which would thus be greater than the actual number of patients under study). Even a special means of codeability was devised to cope with the problem of diagnoses which changed over time; a diagnosis (e.g. dyspepsia) that was changed to another was placed, to borrow a phrase, 'under erasure' (that is, it was crossed out in relation to the patient concerned but still appeared legible as a statistic in the study) and another diagnosis (e.g. gastric ulcer) took its place on the record card (ibid: 10). As was pointed out at the time, this procedure eliminated from the analysis one of the elements most closely associated with the 'ontology' of

general practice, namely, the chronic patient with an underlying condition that manifested itself as a series of different conditions:

'The fundamental difficulty of recording the total 'morbid' picture of a patient may prove insuperable' (Howard 1959: 125)

What made matters worse was the sheer number of diagnoses that appeared in the survey itself, requiring to be coded into a manageable form; over 500,000 in fact (compare the mere 2,400 different diseases recorded in that previous record-breaker in the annals of medical nomenclature; Sauvages's Nosologia Methodica of 1763). This problem actually stemmed from a rather extraordinary concession that had been made to the demands of the free field; namely, each doctor being allowed to use the terminology that suited him best. The Records Unit of the College, when it came into existence at the end of the 1950s, found itself especially concerned with consideration of the question of diagnostic classification:

'Basic units of measurement had to be decided upon; whether the illness-experience of an individual, the doctor-patient contact, or the episode or 'spell' of illness, should be used' (Report 1958: 110).

However, a pilot study done under the auspices of the College Research Committee had already indicated the difficulties of applying strict diagnostic categories to conditions - usually vague 'symptom-complexes' rather than

clearly defined 'diseases' as such - encountered in general practice. Thus only 55% of diagnoses by the twelve doctors studied could be labelled as 'firm' (whilst only about 70% of these would later prove to be accurate); and 30% of diagnoses were found to be initially only tentative (Report 1958: 117).

Moreover, it was also recognized that the codings, which in the National Morbidity Study were worked up centrally by coders at the General Register Office, were themselves possibly arbitrary and of doubtful value. Take, for example, the largest diagnostic category in general practice; respiratory infections. Do these represent a real batch of diseases? This is a realm where aetiological details are almost unknown and clinical differentiations notoriously difficult:

'one causal agent may provide a whole variety of differing clinical conditions, and alternatively, one clinical condition may result from a whole variety of causes' (GRO 1962: 16).

Diagnostic nomenclature was particularly insensitive in relation to respiratory infections; for example, are there not over 100 synonyms for infections of the lungs alone? Is it really a solution to break up the respiratory tract into two regions in order to produce two broad, perhaps wholly arbitrary groups, relating to the upper respiratory tract (colds, sore throat and so on) and the lower respiratory tract (bronchitis, pleurisy etc) (ibid: chapter 2: 32)? The problem lay, no doubt, in the

impossibility - that is, without breaking with established medical knowledge altogether - of forging a coherent set of diagnostic classifications proper to what we have called the 'vitality' of the free field; that is, a classification that would represent a break from that based on morbid anatomy, on the corpse. Thus, the basis of the coding operations was a modified version of the International Classification of Disease and Causes of Death, a classification that, as a College report on disease nomenclature acknowledged in 1959 '[was] not the most suitable classification for use in the continued observation of morbidity through its many changes' (Research Committee 1959: 140).

Finally, how useful was the Morbidity Study once it had been completed? Did it relate to clinical practice itself, could it be useful in aiding forms of intervention specific to general practice? Did it reveal anything specific to the 'natural history' of disease; or was it merely an impossible attempt - only of interest to the statistician and sociologist - at measuring disease in the community according to traditional criteria but in a new and highly unreliable space of operations? Volume III of the study, which was produced by the College itself, was concerned with translating the statistics derived from the observation of practitioners back into a recognizable general practice language, that is, in 'a clinical rather than a mathematical medium' (GRO 1962: v). In fact, as the introduction to the volume acknowledged, what was perhaps

most striking about the study was, less the information it gave concerning the prevalence and incidence of illness in the community¹⁰¹, than the way in which it revealed that statistical results were themselves largely dependent on the doctor concerned:

'It was found, for example, that there are a number of levels of diagnostic accuracy, and that each general practitioner uses by habit working diagnoses that may not fit accurately into categories designed by others' (ibid: 2).

2. Towards a 'Perspectivism' of the Doctor

In other words, towards the end of the 1950s, as doctors started to analyse the results and achievements of the 'stage of taxonomy', it slowly became clear that the appropriate plane of consistency where the elements of general practice could be seen and assessed was not the space of the practice alone, but the person of the doctor had to be taken account of as well.

2.i. In order to stabilize the domain of evidence in general practice the particular perspective of the individual doctor would clearly have to be included in that act of stabilization. This became all the more obvious once it was considered that disease appeared to be, as it were, 'socially constructed' by the doctor's own research interests and pre-occupations:

'Doctors who make a special study of a disease always find more cases in their subject than disinterested workers (GRO 1962: 36).

The 'occupational bias' of particular practitioners became evident:

'Bias of interest in a subject may make individual observation of the incidence of morbidity a practice of doubtful value' (Howard 1959: 129).

Simultaneously, towards the end of the 1950s, writers began increasingly to point out the lack of relevance of the statistical project as a whole to the aspirations of general practice knowledge, and its 'ontology' of the patient. Already, in 1955, one delegate to a Conference of Faculty Chairmen of the College had pointed out that:

'all the work written or discussed had concerned individual disease. Yet the particular role of the GP was to follow the same patient through many diseases. We should, in our researches, concern ourselves more with the patient' (Report 1955: 21).

Yet this was to remain an aspiration only, something always just over the horizon, an ever-residual problem to be ironed out. The College report on 'A Classification of Disease' commented, for example, on the problem in statistical surveys of:

'relating illness to the person who experiences it... It was hoped that any classification to be

brought into use by the Records Unit of the College be used in its relation to the patient, as well as in other ways' (Research Committee 1959: 157)

The interpolary nature of this aspiration is only underlined by its vague and ritual repetition:

'It is hoped to relate this information to the life and state of health of the patient who endures the illnesses, as well as to the doctor who observes and records as part of his daily work' (ibid: 157).

If the person of the doctor had been problematised by the obstacles encountered over diagnostic classification, then so too did the desire to 'return' to the person of the patient lead, as of necessity, to the medical persona. In fact, it is striking that whenever the patient is invoked then so are the personal attributes of the doctor:

'In this age of specialists the general practitioner is the specialist in domiciliary medicine, and, to my mind is the specialist in treating patients as human beings - and such a calling demands personal qualities besides medical qualifications' (Fleury 1957: 316).

It was recognised that if the patient was to be made, in some manner, calculable, then one had to turn to the doctor's persona to do it. An example from the 'consolidated comments' literature of the College will illustrate this, since it shows the nature of the

difficulties encountered by the paradigm of 'taxonomy' when confronted with the patient. In March 1959 a doctor submitted a research proposal relating to 'The Possibility of Predicting a Patient's Future Physical and Psychological Development and History by Clinical Methods and Observation, Examination and History Taking'. What could be more proper to the 'ontology' of the free field than that? The 'consolidated comments' by members of the Research Committee, in spite of being unanimously sympathetic to the ideals behind this kind of research, all reveal a similar logic; namely, that this was not a subject upon which they felt equipped to advise since it entailed matters of self-discipline, of 'self-surveillance', of education:

'It is perhaps a philosophy to be incorporated in medical teaching rather than a principle subject to objective general-practitioner research.'

And:

'This is surely not a project for research, but the suggestion of a method for personal self-discipline and the awareness-training of the prognostic facet of his art, to be carried out as a long-term personal plan by each G.P. individually' (CGP Archives 1959: 2)

2.ii. The concern with the patient - and hence with the person of the doctor - was also no doubt overdetermined by the impact of questions relating to psychological disorder

that gained in salience as the 1950s progressed (see e.g. Horder 1959; Kagan 1959; Fry 1960; Report 1958b; Hopkins 1956). On the one hand, the problems of nomenclature, discussed in brief above, faced a particular obstacle in relation to psychogenic illness. This was first of all because the psychoneurotics that everybody knew placed a great burden on the average practitioner failed to show up in statistical analyses, since - for the purposes of statistical study - everybody had to be given a more or less firm diagnosis:

'The troublesome neurotic is not revealed statistically' (GRO 1962: 41).

Second, because evidence of psychogenic afflictions themselves were notoriously uneven. A review by Philip Hopkins for example of 14 surveys relating to patients with psychic disorders in general practice revealed a variation from 6.5% to 70% depending no doubt partly on the area in question (the 'country practitioner' paradigm being notoriously ineffective in relation to psychic problems since these are so rare in the countryside) and partly on the system of classification used, and the personality of the individual doctor (Hopkins 1957).

However, if psychic questions represented an obstacle in this way, then they were also a kind of surface of emergence for the possibilities of practitioner research. This was partly because of 'institutional' reasons; the projected contents of the Mental Health Act (a 'Psychiatric Working Party' had been set up at the College

- on the prompting of the Ministry of Health - in 1956 in order to consider the possibilities of treatment in the community; Report 1958b) not surprisingly gave psychiatric questions a wide visibility in the closing years of the 1950s. But there had also been hints that a recourse to psychic functioning might be a way out of the problems of diagnostic classification encountered in research. Indeed Pickles himself had mooted this possibility in 1955. He had been impressed by the way that psychiatric nosology had made considerable strides in World War II by adopting a notion of health as a variation from the normal without the actual presence of disease, i.e. a functional classification capable of handling the 'dynamic' entity of the patient:

'By drawing on the major symptoms of the patient, and using terms denoting broad mental states and attitudes of mind, by adding thereto sufficient descriptive terms to give a word-picture of the sufferer, the problem was satisfactorily if clumsily solved... Might not general practitioners, also, accept the fact that health is a state in which variations from the normal or average may occur without disease being present' (Pickles 1955: 5).

Pickles, interestingly enough, was proposing a radical solution to the myriad diagnostic problems before they had even been fully encountered, in demanding 'a completely new approach to the nosology of the minor maladies met with in general practice' (ibid: 4-5). This call was,

indeed, to be taken up by others, albeit in different ways, throughout the decade in a variety of suggestions for alternative - invariably 'functionally' based theories of general practice diagnosis (cf. on Seyle's theories, for example, the special edition of Practitioner 1952, 172, 1027; or *ibid* 1959, 182, 1087; also Meillet 1955: 16).

But these alternatives were to reach their apotheosis in a way of thinking about general practice that bypassed problems of taxonomy altogether in favour of an approach that combined more directly the act of diagnosis with the act of intervention, therapy and cure - the clearest expression of which is to be found, as it were, crystallised, in the works of Michael Balint which shall be discussed in the next chapter.

3. The Taxonomic Project of the Free Field and its Failure

The discussion in this chapter was not intended as an account of the 1950s as a 'period', for example, as an uncovering of the 'world-view' of the sum of general practitioners at that time. What we have described was, on the one hand, a kind of 'rationality' amongst those general practitioners who wished to make their discipline 'autonomous' and, on the other hand, less a periodisation than the point of greatest intensity of this rationality; that is, the point at which various problematisations were

given their clearest expression. This rationality can be analysed epistemologically, organisationally and governmentally.

3.i. The epistemological focus was upon the project of a general labour of 'definition'; to draw up a 'taxonomy' of all the circumstances of practice. This entailed the project, on the one hand, of a 'natural history' of disease that would be built up from the sum of localised studies by individual doctors and, on the other hand, of all sorts of 'operational' investigations where practitioners would describe the techniques employed in their practices. Common to both these was the question of writings and inscriptions; the determination of the appropriate methods and means of codeability proper to morbidity studies, the drawing up of a rota, the writing of a prescription or a letter of referral, the operational task of 'putting the practice into writing' - everywhere the general practitioner was the one who has recourse to methods of inscription. The model of the doctor at stake here was derived from the image of the 'country doctor', the generalist in all things, naturalist of minor morbidity, intimate of his 'flock'.

The organisational focus was upon what we termed the 'free field', that world without obstacles where the sick, living individual would become fully visible. Although we saw that other areas of medicine similarly enjoined the need to get back to the 'clinical' emphasis upon the sick

individual, it was perhaps the general practitioners who claimed most forcefully to be the specialist discipline of this field. This was partly because the general practitioner was himself understood as being a kind of archetypal individual living and working in the 'natural' space of the population - thus perfectly 'adequated' to the circumstances of the free field. The model of organisation involved here might be described as one of free association; if the profession enjoyed a certain degree of integration then this was only insofar as all general practitioners were alike in being free, independent individuals. Thus the institutional organisation to which some of them chose to refer - the College of General Practitioners - did not exist over and above the body of general practitioners in the field, but was rather in a relation of immanence to the ecology of that field, serving merely to regulate and channel patterns of interaction and communication within its totality.

The governmental focus can be derived, first of all, from these organisational characteristics of immanence and totality themselves. The notion of a perfect un-hindered visibility of all and each - where the totality is in perfect equilibrium and alignment with the parts - is, no doubt, itself constitutive of the ideal of 'liberal' government where the population as a whole is fostered through the sum of micro-patterns of pastoralism and tutelage in a wholly 'naturalised' domain. Here the

apparatus of government itself is immanent to its targets, and invisible to them in the sense that its activities imply a minimum of distortion of the natural properties of the field itself. So, if in this - organisational - sense alone the network we have been describing possesses some characteristics proper to the themes of a liberal government, we might, secondly, add to these a prominent substantive theme that constituted what might be called the 'political consciousness' of general practice in the free field.

This theme cohered around the problematic of 'pronatalism' which took as its rationale of social intervention the fact of a declining birth-rate and the consequent aim to maximise the numbers of citizens through, above all, a regulation of the family. But the family was less the target of this problematic than the principal institution through which this problematic sought to work; the family was the 'training ground for the future citizen'. Through observation of the circumstances of the family environment, and especially through observation of the mother, the doctors sought to participate in the project of maximising the body of healthy citizens for the future. What we have here, then, is a problematic of social welfare; emphasising the nurturing of the totality of citizens of a population within an aspirational framework of solidarity (compare the more partial 'social security' problematic discussed earlier in the context of Mackenzie's work, which focused upon particular kinds of -

labouring - citizens). If there is an implicit model of citizenship being promoted by this welfarist rationality it might be characterised in minimal terms as being centred on the ideal of a collectivity of citizens; citizenship here is largely a question of integration, of the promotion of social cohesiveness. The collectivity of the doctors themselves was the archetype of this kind of cohesion; united - although free and individual - by bonds of common solidarity.

Nevertheless, because the sick individual - that 'ontological' foundation of general practice - effectively escaped the gaze of collective investigation, no content could be given to the kinds of subjectivities of citizenship that it was seeking to target and promote. This point can be made more clearly by recalling that what the paradigm of collective investigation failed to do was to integrate the format of knowledge proper to it to the matter of day-to-day activity and treatment. No guide for action in the surgery in relation to patients could be said to have derived from the form of knowledge proper to epidemiological investigation. Where the project succeeded in its focus upon sickness (morbidity in the free field) and vitality (the emphasis upon the living as opposed to the dead), it lost out in relation to the sick individual - which remained obscured. In this sense, the taxonomic project of the free field was a failure.

3.ii. By the end of the 1950s what the doctors had termed the 'stage of taxonomy' was drawing towards a kind of horizon. Under the pressure of certain difficulties - encountered with the means of codeability (forms of diagnostic classification); the appropriate plane of consistency and stabilisation (the doctor as well as the space of the practice); the domain of evidence and investigation (the massive, undercoherent, range of practice); and the projected 'ontology' of general practice (the patient) - 'psychological' issues (the term is used widely) gained, perhaps, a new kind of emphasis and problematic status. It became conceivable, at least, that such psychological issues might provide, at last, the foundations of coherence, the unifying thread of aetiology, classification, therapeutics and, possibly, even of the social vocation of general practice. Nevertheless it would be a mistake either to deny the impact of questions of psychic functioning on general practice before this time or to claim that the era of practice description, of the statistical mapping of the free field, came to an abrupt halt, or died an unceremonious death, by the end of the 1950s (far from it).

Questions of psychic functioning: that general practice had long possessed a certain relation to matters psychological and psychiatric is, no doubt, well established (cf. Armstrong 1983; chapter 8; also Armstrong 1979 and 1984). The 'ontology' of general practice, its

concern with the individual, with prognosis, had long been appreciated (just as had been the fact that confrontations with neurotics of various kinds was part of the grind of practice). But this did not mean that 'psychological' knowledge as such was to be deployed in any systematic way in relation to the patient. Similarly, that the practitioner had to be - in certain contexts - a kind of psychiatrist was also well-established, as we saw in relation to the minor discourse of 'family studies' which drew upon psychiatric models (see also the special issue of Practitioner 1951, 167, 998; Thorne 1958, or the works of C.A.H. Watts). But, then, he also had to be an obstetrician, a dermatologist, something of a surgeon, and so on. Thus, the question of psychic functioning certainly bore a relation to general practice, but it had never before been tied, as it was to be, above all, to the person of the doctor; that is, at the centre of problematisation of that discipline. No doubt, certain obstacles can be cited to account for this; the model of the country practitioner, the emphasis on the taxonomy of the space of the practice, the status of psychiatry itself; but also because other coherence conditions - we have cited, in particular, the paradigm of a general pragmatics of writing and inscriptions that served to unify various levels of investigation - existed already, and would have to be displaced. Thus, if a certain 'personalism' of the patient had long existed, before the end of the 1950s psychological knowledge had not been tied to the very identity of general practice as an

autonomous 'intellectual technology' in the form of a 'coherence-condition' (see, inter alia, Perth 1957; Model 1959: esp. 178 & 180; S.E. England Faculty 1959: 193; also Leigh 1953).

An unceremonious death? The project of taxonomy is still with us (Watson 1982 alone is testimony of this). It is not the demise of this form of knowledge that we have attempted to document here, but only the recognition of the inadequacy of this form in its claim to be the technology of the free field of pathology beyond the walls of the hospital; that is, to form the basis of general practice as an independent and autonomous clinical discipline. Today - as we will discuss further in chapter 4 - the work of the College of General Practitioners is still concerned largely with the issues that confronted it in the 1950s; the tracking of influenza epidemics, systems of diagnostic classification, advice on standards in practice and so on. Nevertheless, by the end of the 1950s a certain 'moment' had passed; a moment when, it was thought, that an independent discipline of general practice could be founded on the basis of a labour of taxonomy, a labour of definition alone; a moment when it was believed that, since the circumstances of 'good general practice' already existed, all that remained to do was, through the establishment of a particular kind of organizational form, to bring it into the light of day. In the 1950s it was felt that what was necessary was definition alone; even research took the form of a

mapping. Yet what appeared was a map of the free field; the occupant of that environment, the sick individual, did not appear; if anything, the person of the sick individual became more obscured even by the very process of taxonomy itself. Thus, after the stage of taxonomy, it was recognized, at least, that good general practice, especially if it was to get a grip on its proper 'ontology', would have to be, first of all, not discovered but invented.

Even so, one thing at least had been partly achieved; the status of general practice had been partially restored by the College's achievement in overcoming the paradox of organization proper to the very nature of general practice circumstances, and perhaps above all, the very existence of general practice had been demonstrated:

'General practice is no longer in the doldrums. The tide has turned and is flowing strongly'
(Watson 1957: 488).

PART FOUR

BALINTISM: A PSYCHOTHERAPEUTIC RATIONALITY

CHAPTER TWELVE

ANTI-MEDICINE AND PSYCHOANALYSIS

'One need be no talented prophet to foretell that one day numerous courses will compensate psychoanalysis for previous contempt.'

Sandor Ferenczi

1. Introductory: Balintism and Psychology

In the pages of The Doctor, His Patient, and the Illness (Balint 1957) - that classic work in the annals of general practice - Michael Balint first outlined a coherent role for the general practitioner as a kind of psychotherapist; it is difficult to conceive of a work situated at a further remove from collective investigations, taxonomies, and the activities of country practitioners. Balint's significance was not that he founded a 'school' of general practice but that he crystallised in his writings a general rationality, a way of conceiving what general practice was all about that went well beyond the specific teachings to be found in his works. This rationality will be given the name 'Balintism'.

1.i. Before giving some consideration to what is meant by this term, it should be said that we are not immediately concerned here with whether or not Balint personally caused the mutation that we are about to outline. The closing pages of the last chapter would certainly lead us to think that this was not the case; after all, matters psychological were coming to the foreground in general practice towards the end of the 1950s regardless of the intercedence of Balint's work. The question of Balint's 'influence' will be considered further at the beginning of the next Part; at this point it will be sufficient to draw up a kind of 'balance-sheet' of Balintism itself in order to emphasise at the outset how its various themes differ from those of the taxonomical projects of the 1950s.

On an epistemological level, Balintism replaces the emphasis upon the morbid space of the practice population with an emphasis upon stabilising the persona of the doctor himself. The doctor's personality becomes the plane of consistency, the perspectivist optic through which everything is visualised. Hence, a very noticeable feature of all those influenced by Balint is that they are obsessed with the doctor's reflexivity, his understanding of himself. And hence, a marked feature of Balintism is its replacement of the theme of surveying one's practice (using all the relevant inscriptive techniques) with the theme of surveying oneself; with 'self-surveillance'. Hence, too, the marked pedagogic emphasis of Balint's work; here 'knowledge' comes to consist less of surveying

a 'field' than of working upon the doctor's persona; pedagogy takes on an epistemological import. This transformation also heralds the end - or, at least, the re-location - of the obsession with inscriptions and writing. Now, what matters is less writing things down than listening to people's voices in the consultation or the seminar.

On an organisational level the model of association is one of interpersonal relations; the 'atmospheric' tensions and forces linking up members of the group practice, the 'team', the training seminar, or the family and the 'doctor-patient relationship'. Now the units of organisation centre upon the homogeneous field of 'persons'; a genuine personalism emerges. At the centre of this mode of organisation stands its most focused expression, the consultation, which becomes at once the paradigm of all relationships and the main 'object' of research and pedagogy. At the same time, on a governmental level, Balintism succeeds in gaining a certain purchase upon the mobilisation of forms of conduct. But it does not so not in order to judge the patient 'morally', but to get the patient to assess him or herself 'ethically'. Balintism can be described as a 'technology of subjectivity' that seeks to bring about a certain ethicalisation and autonomisation of the subject's relationship to self (cf. Rose 1990: 10). And - as will be argued - it provides a 'technical' basis for bringing this about, based upon a chain of 'identifications'.

These emphases can be reduced to four themes in particular. These form the 'substance' of Balintism. First, an emphasis upon the reflexive subjectivity of the doctor (sometimes this will be termed Balint's 'doctorcentrism'). Second, a reliance upon techniques associated with the uses of the group; a form of organisation that now takes on an aspect less of 'logistics' than of 'vigilance'. Third, an emphasis upon the narrow world of the consultation which becomes both a kind of 'affective' and 'scientific' space. Lastly, an important epistemological consequence of Balintism; a certain 'anti-scholastic' emphasis upon the values of 'practice' above those 'knowledge'. This is not to say that Balintism is 'against' forms of knowledge, rather it is against formal knowledge, abstract formulations, objectivist modes of analysis (such as taxonomies). Balintism favours, rather, an emphasis upon the 'workability' of a formulation; for example, upon immediate therapeutics rather than troublesome, formal diagnostics. This is the 'anti-scholastic' or 'interventionist' impulse of Balintism. This, it should be noted, is not a vulgar empiricism but an impulse which is grounded epistemologically in the substance of Balint's work itself.

1.ii. The governing force behind all of these problematisations is psychology, which now becomes actually constitutive of what it is to do general

practice; an epidemiological model is replaced by a psychotherapeutic one.

This, in fact, raises a prior question; the identity of 'psychology' itself. What exactly is psychology contributing to Balint's project? As we have seen, the association of general practice with problems of psychic functioning is, as Armstrong has demonstrated, a long-standing one. Yet Balint's work inaugurates a new departure within or beyond this old relation. So it needs to be specified exactly what psychology is doing for the general practitioners. And this question is inseparable from the wider matter of what psychology actually is: what is it, for example, about psychological forms of knowledge that has given them their tremendous 'parasitical' power, that power which enables them to graft onto other disciplines - social work, industry, warfare, advertising - and to transform them from within? And tied to these questions are the 'governmental' matters concerning; what kinds of subjects are presupposed by these incursions of psychology? - or, more specifically, how do projects such as Balint's seek to impose certain models of conduct upon their subjects? This, in short, is the question of the power of psychology.

There is, however, an even wider dimension to this question. This concerns the relation between psychology and the project of Enlightenment that was the subject of our opening remarks in the first chapter. For to raise the

question of the power of psychology is in some respects to go against the logic of 'psychologisation' itself. For does not psychology, in fact, always seek to be opposed to power? Is not the project of psychology and the therapies in which it is enmeshed all about the specification and recuperation of aspects of humanity and personhood from all those technological forms that otherwise reduce, suppress and repress them? Psychology is in fact the paradigm of a form of activity that would recuperate the Enlightenment project; by seeking to reconcile both rational knowledge and the emancipation of persons. What follows is, in this sense, a case-study of this project of psychology in one context, that of general practice.

2. An Outline of Balint's Project

The work of Michael Balint (1896-1971) is well-known and well-esteemed in the world of psychoanalysis (Khan 1969; Kohon 1986). A one-time pupil and colleague of Sandor Ferenczi, Balint had been director of the Budapest Psychoanalytic Institute from 1935 to 1939. After emigrating to Britain in 1939 he worked at the Tavistock Clinic in London (where he set up his first teaching seminars for general practitioners) from 1948 until 1961 (officially the year of his retirement) when he moved to a post at London University. At his death in 1971 he was President of the British Psychoanalytic Society.

2.i. Balint's analytic orientation tended - from his early writings of the 1930s (and especially under the influence of both his first wife, Alice, and Ferenczi himself) - toward an emphasis on research into analytic technique. Drawing upon, and extending, the 'object-relations' perspective Balint concentrated his attentions especially upon the phenomenon of the analyst's counter-transference; that is, more generally, upon the powers and reactions of the analyst himself in the particular setting of the analytic encounter (Balint 1952; 1968; Khan 1969). As an important recent assessment sums up the matter:

'The contribution made by the Balints in Ferenczi's footsteps is the introduction of the analyst as a subject of observation' (Haynal 1988: 77).

It is this emphasis upon technique and upon the analyst/doctor that characterises Balint's contribution to conceptions of general practice from the late 1950s onwards.

Indeed, if it is the case that Balint's name still commands a high reputation in psychoanalytic circles, if anything, that reputation is even higher amongst general practitioners. Balint's fundamental statement here is his classic study The Doctor, His Patient and the Illness (Balint 1957) which came out of research done in the context of a seminar Balint had set up for general practitioners at the Tavistock in 1950. The setting up of the 'Discussion Group Seminar on Psychological Problems in

General Practice' should be seen in the wider context of, first, Balint's background in Budapest psychoanalytic circles, and second, what has been called the 'Tavistock Programme' (Miller and Rose 1988). Common to both lies the aspiration to extend psychoanalysis and forms of psychotherapy generally beyond the question of psychoses and further into the more mundane problems of psychic functioning in the community; this aspiration lay behind the work of both the Budapest Out-Patients Clinic in the 1930s and the Tavistock Clinic after the Second World War (Dicks 1972; Gosling et al. 1967). General practitioners were, for Balint, excellent potential agents in this project since, as he argued, like it or not, the general practice consultation is characterised by psychic structurations similar to those found in psychoanalysis itself. Thus, very early on the research seminar at the Tavistock came to the conclusion that the doctor acted as a kind of 'drug' upon his patients; an influence that Balint ascribed to an 'apostolic function' that was deemed to be basic to the doctor's powers in the consultation (Balint 1957: chapter 1). In his book, Balint outlined his views relating to what he saw as the unique and hitherto underrated importance of the 'drug' doctor and its influence in - not just treatment itself - but in the very initial 'organisation' of symptoms by the patient in the first place. In a special way, then, via his responses to the patient's 'offers' (of symptoms, and complaints) the doctor is implicated in the very construction of the patient's problem; a fact which necessitated a close look

at the 'doctor-patient relationship' itself as an embattled site of potentially distorted communication. The doctor's task was - through the medium of, for example, a 'long interview' - to help the patient realise his or her psychic problem (of which the organic complaint was generally merely an expression) and to use the powers of the 'apostolic function' in its amelioration - for which special hard-won techniques, such as that of 'listening', would also be necessary.

Balint's ideas evolved in various ways in the years following The Doctor, His Patient and the Illness. Most notably he attempted in the late 1960s to increase the scope of therapy and make it applicable to more patients by introducing the so-called 'flash' technique. This utilised the spontaneous empathy between doctor and patient as a therapeutic tool, thus making a 'long interview' no longer a necessary stage of treatment. After Balint's death in 1971 this method was further developed by his followers, and perhaps represents something of a shift from the 'deeper' diagnosis of psychic malfunctioning originating in childhood to a more pragmatic approach concerned with the 'here-and-now interactions between people'. In any case, the basic component of the Balint technique remains; the emphasis on the psychic behaviour of both doctor and patient in the bringing about of an amelioration - not of organic pathology - but of the 'doctor-patient relationship' itself; if there is a central concern of Balintism it is,

then, the question of the intersubjectivity of doctor and patient.

2.ii. Balint's project - which bases its own reason for existence upon an assessment of what it sees as being wrong with existing medicine - is firmly in line with that general body of ideas we have labelled 'anti-medicine'. The tropes are familiar; the past one hundred and fifty years of medical specialisation have served to fragment the integrity of the person (Balint 1965). Against the 'traditional' form of diagnosis which merely sought to localise pathology, Balint would seek to promote the practice of an 'over-all' diagnosis of the patient's condition. This, however, would not entail merely adding the sum of the patient's 'components' together. Rather what Balint calls the 'whole person' is not just an amalgam of parts but a new entity. It is not merely the patient's 'illness' that is to be treated but what Balint calls the 'agreement' between the patient's 'offers' and the doctor's 'responses' in the consultation (cf. Balint 1957: 21-36). This entails treating the person of the patient as opposed to the actual symptoms he or she brings to the surgery. In short a potentially new object emerges for general practice.

This object - the 'person' of the patient - is only visible to the general practitioner. The specialist cannot see this figure; he deals with the mere mechanics of separate parts of the body. In fact it seems that for the

general practitioner to become a specialist of the whole person, it is necessary that the hospital consultant should remain something of a mechanic. In Balint's view, the hospital specialist should be deployed only as the general practitioner's 'expert assistant' (Balint 1957: 99-101), the technician to whom the general practitioner may occasionally refer his patients during certain brief 'episodes' of their basic underlying illness (ibid: 286). But this position of hierarchy over the consultant was not to be bought at the price of subservience to the psychiatrist or psychoanalyst. Balint was adamant that he was not simply 'applying' psychoanalysis to general practice. Rather, he intended to create a new autonomy for general practice as a psychotherapeutic discipline. A kind of 'interessement' strategy is at stake here. Balint has, as it were, positioned himself between psychoanalysis and medicine, mobilising both just as both felt that they were mobilising him. As Enid Balint put it:

'I do not think that he "applied" psychoanalytic theory and technique to medicine or vice versa, nor is it important which was his first love. Rather it was his way of thinking and the way he related to people which led him quite logically from one field to another - so that he allowed himself to be "used" in the two fields which most interested him' (Williams and Clare 1975: 139).

In short Balint's project faced in two directions. It aimed, on the one hand, at extending the principles of

interpersonal forms of therapy beyond the rarefied confines of established psychiatry and psychoanalysis, and on the other, at making general practice an autonomous discipline concerned not with diseases alone but with patients in their totality.

3. Patients and Doctors

At this point a problem emerges. How is one to mobilise this 'whole person'? How is a general knowledge of this most particular entity to be possible? Balint's answer is simple; forget the whole person, work only on the doctor's personality. As Pequignot succinctly puts it; 'Not being able to work with the totality of patients, Balint works with doctors' (preface to Sapir 1972: 10).

3.i. The technical necessity of ignoring the patient and working upon the doctor was acknowledged by Balint himself. Towards the close of his most important work on the application of psychotherapeutic techniques in medicine, Balint acknowledges that he has scarcely paid any attention to the person of the patient:

'we decided to centre our discussion on the doctor's technique and have hardly mentioned in this book the patient's psychotherapy or dynamics' (Balint and Balint 1961: 207).

But, he noted, bypassing this aspect seemed to be the very condition for making a 'whole person medicine' a workable proposition rather than an empty aspiration. Indeed, since

the figure of the patient is absent, the validity of the techniques could only be assessed in relation to the efficacy of those techniques themselves:

'we have not paid much attention to the aetiology of illnesses - but perhaps we may take the fact that our plan could be carried out and yielded some acceptable results as a proof that our view may have some validity' (ibid: 207).

So if we have here a whole-person medicine that ignores patients, we have, on the other hand, a whole-person medicine which works (or of which, at least, the conditions for its operationalisation can be stated). And it works because it is simple and economising; a radical reduction of complexity is achieved. But this reduction is not merely of a 'logistic' order (it being easier to gain access to the personalities of doctors than of patients); it is also of an epistemological order.

We have already mentioned that Balintism is an 'anti-scholastic', 'interventionist' rationality. What this entails is a kind of re-balancing of the relations existing between the terms knowledge-practice, diagnosis-treatment, and research-teaching. For Balintism, the principle is not to apply methods on the basis of what one already knows; rather knowledge follows upon whatever is workable in practice. For Balintism, the doctor does not first diagnose and then - subsequently - treat the patient; rather, diagnosis can only derive from treatment itself since the 'apostolic function' dictates that there

is never a moment when 'treatment' is not actually taking place, never a moment when the doctor is not helping the patient to 'settle' into one or other diagnosis. Lastly, for Balintism, even the production of truth - research - is itself dependent upon practice, or more specifically, upon education; which, to be sure, entails the consequence of a certain re-signification of the terms 'research' and 'education' themselves. Balintism shifts the main point of application of research towards the personality of the doctor himself so that to do research in general practice comes largely to signify research upon the deployment of one's self; 'research' will come to imply above all a process of the monitoring of knowledge, not upon an 'absolute' level of jurisdiction, but upon a reflexive level; that is, through 'self-surveillance' with the help of others. In other words; through education. But the notion of 'education' has itself, in this process, undergone a mutation in significance. Education comes to imply less the formal inculcation of knowledge than the permanent - 'vocational' - practice of self-surveillance. Hence, Balintism is not just a matter of an increased emphasis upon education; rather it places education at the centre of the epistemological status of general practice itself.

These are all emphases that shall be investigated in greater detail below. What is important to observe here is that - for an anti-medical rationality - Balintism possesses certain features in common with the most

'scientific' forms of reasoning. Psychotherapeutic rationalities are often held to be rather 'woolly' affairs. On the contrary, Balintism - as can now be investigated - is a veritable 'phenomen-technics'; it aspires effectively to produce the reality of which it speaks.

3.ii. We have said that Balintism ignores patients. This was perhaps misleading. In fact, Balintism as a technology seeks to mobilise 'whole persons' in their absence. By working upon the doctor's personality, Balint seeks the effect of 'acting-at-a-distance' upon the personality of the patient; he works on patients through the medium of doctors. What are Balint's grounds for making this a possibility?

To begin with, it is an important principle that the doctor only gets those patients he deserves. It is extraordinary, argues Balint, how the characteristics of a doctor's list of patients will tend to mirror the particular interests of the doctor himself (Balint 1957: 54; Balint 1961: x). Thus, each practice will tend to be automatically 'self-selecting':

'Even the people who constitute the practice seem to be characteristic of that particular doctor' (Balint 1961: 80).

But this all-important 'doctor-effect' does not simply stem from the fact that patients tend to register with doctors whom they find amenable. Rather, it is the product

of the inevitable 'apostolic function' of the doctor, that 'calling' (the religious terminology is endemic: Balint 1957: 226) which causes the doctor to seek to 'convert' his patients to his own particular way of thinking and acting in relation to illness:

'Apostolic mission or function means in the first place that every doctor has a vague but almost unshakeably firm idea of how a patient ought to behave when ill ... it was almost as if every doctor had revealed knowledge of what was right and what was wrong for the patients to expect and to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and un-believing among his patients' (Ibid 1957: 216).

The 'apostolic function' is an inevitable part of doctoring - especially in general practice where the doctor has a 'continuous' relationship with his patients. A doctor moulds his patients to his ways even before he has begun to treat them. This occurs, first of all, on the level of the isolated presenting illness. When the patient presents at the surgery the disease - and this is a distinctive aspect of general practice - is un-formed. The patient 'offers' various illnesses to the doctor which he must either accept or reject. The patient, argues Balint, will tend to keep presenting illnesses until doctor and patient can finally 'agree' to 'settle' the symptoms into an 'organised' illness (ibid: chapter 2). But, the 'apostolic function' also works on a broader level in that

- as it were, macroscopically - it determines what kind of patients there will be in the first place. So, if patients tend to come along complaining of organic illnesses this is because they have been (regrettably) trained to do so by the medical profession:

'By their apostolic function doctors train the population from childhood what to expect and what not to expect when they go to the doctor's. This training, though not very efficient, is not unalterable. We have taught our patients not to be unduly embarrassed when showing us their bodies; it should not be very difficult to teach them that often their psychological problems have to be shown too. The first step towards achieving this aim is, of course, to train the doctors' (ibid: 227: cf. 239).

Here, then, it is above all the doctor that determines everything; a kind of phenomeno-technical subject. The doctor determines what kind of patients there will be; the doctor determines what kind of illnesses these patients will have. The use of the term 'doctor-centrism' to describe this emphasis should not be taken as an implied criticism. On the contrary, is it not the case that any patient-centred approach will result in a valorisation of the doctor's technical powers? Rather, we should perhaps be impressed by the technical skill with which Balint has made a 'whole-person' medicine operable in practice. Moreover, he makes use of well-established grounds in the

elaboration of his 'phenomeno-technics' of the doctor, as can be seen from an analysis of the context of Balint's project within the field of psychoanalysis.

4. Psychoanalytic Writings and the Question of Technique

In fact, a brief review of some of the psychoanalytic themes that underlie Balint's work in general practice may help to clarify the specific contours of his general 'project' within general practice. For the mobilisation of one discourse in the service of another does not merely entail a straightforward task of 'application' of the one to the other; there is no clear entity called 'psychoanalysis' that is waiting, as it were 'ready-made' for 'application'. Rather, the particular characteristics of Balint's own project within psychoanalysis need to be specified.

4.i. Freud's work is not renowned for its emphasis upon technique; that is, in the way the analyst should actually conduct the analysis (see, for example, the comments of Enid Balint in Priest ed. 1982: 80). In fact, where Freud did consider the matter it tended to be in the context less of the 'day-to-day' methods of the analyst (where to sit, what to do with the cushion and so forth) than of the dual theme of the possibility of terminating therapy (i.e. of 'cure') and of the extension of psychoanalysis, that is, its expansion beyond the rarefied confines of

Hampstead or upper-middle class Vienna to confront general neuroses and problems in the community. Both these themes - which have their most famous conjunction in the work of Balint's teacher Sandor Ferenczi - were tackled by Freud in his famous 'Budapest Address' of 1918 (Freud: 1919). Here Freud gives cautious approval to the 'active' experiments of his colleague Ferenczi. These experiments were designed to overcome the 'deadlock' or lack of progression that occurred in many analyses through the use of a temporary 'role-playing' technique for the analyst (Freud 1919: 162: cf. the more hostile comments in Freud 1932: 153: also Ferenczi 1916: 39: and 1955: 198). Such 'activity' on the part of the analyst was designed ultimately to shorten the length of analysis itself. Once this possibility had been considered, in turn, it was felt (above all, by Ferenczi) that the 'extension' of analysis might itself become a possibility, since if methods could be laid down and analyses shortened then more and more people could undergo treatment. As to this second goal, however, Freud seems to have been generally sceptical, since the extension of analysis presupposed, for him, not only the possibility of shorter treatments but of defining successful treatment, that is, of concluding the analysis with a successful 'cure'. But as Freud was fond of pointing out he was far from being a 'therapeutic enthusiast' (Freud 1932: 151); psychoanalysis could help an individual to accomodate life's adversities but it was unlikely to be able completely to cure the individual. Rather, it seemed to him that any attempt to extend

psychoanalysis into a general 'psychotherapy for the people' (via, for example, the use of 'institutions or out-patient clinics') would end up being forced to alloy the 'pure gold' of psychoanalysis with the meagre 'copper of direct suggestion' (Freud 1919: 167-8: also quoted in Rose 1985: 218).

Part of the specificity of Balint's project can immediately be located in relation to this debate. For, as we have noted, Balint's project was endemically tied to the project of the extension of analysis (Haynal 1988: chapter 6). However, unlike Freud it appears that Balint did not believe that it would be necessary to solve definitively the question of the possibility of therapeutics and 'cure' for this to come about. Rather, by locating the possibility of an 'extension' of psychoanalysis outside the realm of psychoanalysis itself - in the world of general medical practice - Balint discarded the need for a therapeutic eudaemonism of approach. For the general practitioner is somebody who is stuck with his patients in any case; the 'doctor-patient relationship' is a fixed, ongoing 'project' which is not 'terminated' even when a specific disease 'episode' is cured. Here then was the perfect field for the project of extension.

4.ii. Another specificity of Balint's approach can be seen to emerge through a brief comparison with the work of Ferenczi. It is interesting to note that for Ferenczi -

above all, in his early work - there was an implicit opposition set up between the analyst's 'activity' (as advocated by Ferenczi in his 'experiments') and forms of analysis that were what might be called 'analysand-centred'. For Ferenczi's early experiments in active technique were strictly limited in scope. If, in these experiments, the analyst did indeed play an 'active' role then this was merely to be temporary and strictly catalytic. This active role, Ferenczi claims:

'is only a makeshift, a pedagogic supplement, to the real analysis whose place it must never pretend to take' (Ferenczi 1926: 208).

Indeed for both Freud and Ferenczi, the possibility of an 'active' form of therapy runs against what could be termed the otherwise desired 'patient-centredness' of the analytic encounter, that is the form of analysis where the 'free associations' of the patient have free reign. For Ferenczi, active therapy was only to be used when the analysis was in a stagnated state; after this:

'the expert will immediately resume the passively receptive attitude most favourable for the efficient co-operation of the doctor's unconscious' (ibid: 198).

For Freud, attention to the patient was only to be achieved through the maximum passivity of the doctor. In some famous passages Freud was to speak of the analyst's role as being like that of a 'receptive organ', geared to the patient's individuality, listening without judgement, adopting an 'evenly suspended attention' (Freud 1912:

112):

'He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone... The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him' (ibid: 117 & 118: cf. Haynal 1988: chapter 1).

Balint, however, reverses both this emphasis upon the 'temporary' nature of active forms of technique (as well, it might be noted, as the association of 'activity' with either 'role-playing' or 'denial' of the patients wishes) and the association of a 'passive' analyst with the maximisation of the subjectivity of the analysand.

For Balint, the 'subjectivity' of the doctor/analyst is something that can never be avoided in the course of analysis (cf. Ferenczi 1926: 198). Without rejecting the metaphor of the analyst as 'mirror' to the patient, Balint seeks, as it were, to radicalise its significance:

'Returning to Freud's metaphor, we see that the analyst must really become like a well-polished mirror - not, however, by behaving passively like an inanimate thing, but by reflecting without distortion the whole of his patient. The more clearly the patient can see himself in the reflection the better our technique; and if this has been achieved, it does not matter greatly

how much of the analyst's personality has been revealed by his activity or passivity, his severity or lenience, his methods of interpretation, etc.' (Balint 1952 [1939]: 207: cf. Kohon 1986: 58).

What has been introduced here, then, is not so much the periodic 'activity' of the analyst so much as an emphasis upon the continuous use of his 'subjectivity' in constructing the conditions necessary for analysis. What Balint foregrounds are the 'productive' aspects of the analyst's personality in creating a particular 'atmosphere' in which analysis can take place (cf. Haynal 1988: 77). This subjectivity on the part of the analyst does not, in Balint's work, have the effect of (temporarily) causing a diminution in patient-centred therapy, rather it is a condition of such therapy (cf. Ferenczi's later writings on how the analyst's 'tact' and 'elasticity' should serve to 'mould', as it were, the unconscious of the analyst to that of the analysand in a flexible relationship; Ferenczi 1955: chapter 8; cf. Balint 1952: 155-6). In short, for Balint, the emphasis upon doctor-centrism ('activity') is aligned with the demand for patient-centredness.

4.iii. What exactly does Balint mean by 'technique'? His usage of the term seems to differ from both Freud (who, as we have seen, did not give much thought to the matter outside certain particular contexts) and Ferenczi (who

uses the term 'instrumentally', that is, in relation to bringing about particular effects in the treatment). For Balint, 'technique' refers to the continuous activity of the analyst which, regardless of the intentionality behind it with regard to particular effects, contributes to the production of a particular 'atmosphere' during treatment. In short, techniques are productive of phenomena; they produce analytic reality. This understanding of 'technique' cannot be separated from two further themes; first, a parallel extension - some might say 'over-extension' (Kohon 1986: 54) - of the notion of 'counter-transference', that is, the totality of emotions (and behaviour) produced in the analyst by the analysand and especially by the analysand's own transference (Laplanche and Pontalis 1985: 92; Balint 1952 [1939]: 201-8); and secondly, and connected with this, something very much associated with Balint's own name in psychoanalysis (Laplanche and Pontalis 1985: 278; Balint 1952 [1949] 209-222) - the adoption of an 'object-relations' perspective.

Central to both these emphases is Balint's conviction that psychoanalysis must go beyond what, following Rickman, he calls a 'one-person' approach (that is, essentially, an 'objectivist' and 'individualist' perspective; Balint 1968: 21) in order to encapsulate the intersubjective world of person-to-person relationships. Now, this is not just a 'methodological' demand on Balint's part but also, for him, an assertion of one of the fundamental properties of psychic life in general (Balint 1952 [1937]:

74-90). Balint's great bugbear in the psychoanalytic world is the theory of 'primary-narcissism' which concerns an early state in which the child cathects its own self with the whole of its libido thus allowing no psychic energy for the 'outside world'. Balint's view on this matter, put crudely, is that 'primary narcissism' does not exist; rather object-relations are a more or less permanent feature of psychic life even at the earliest stages (Balint 1952: 86). Leaving all the relevant subtleties aside, we can state simply that what this boils down to is the assertion that all psychic life is characterised by inter-relationships; rendering the naive 'one-person' emphasis more or less redundant. If this demand does, indeed, become a 'methodological' one (relating to the requisite techniques in the analytic situation itself) it is not simply because the analytic situation is by definition also an 'interpersonal' one, that is one that involves - in the manner of all social life - a 'relationship' between active personae, but because there is an important homology between the earliest stages of object-love and the analytic situation itself; since, for Balint, the former is, via the transference of the analysand, effectively reproduced in the latter (see e.g. Balint 1952: 134). Thus, the analyst in the session corresponds with the object of the primary object-love of the analysand (Balint 1952: 131). Again leaving aside relevant subtleties we may note that this conception makes of the relationship in the analytic encounter not one

amongst others but a uniquely privileged kind of situation.

For Freud, it could be said, the actual analysis was connected by a relation of 'exteriority' to the life of the analysand; the patient comes to the analysis equipped with a whole (largely unconscious) domain of past experiences, fantasies and so forth. For Balint, the analytic situation - in general practice, the consultation - becomes the privileged point in which the key object-relations of that life are stabilized (since they are made homogeneous within the analytic situation) and confined. This, of course, makes of the encounter - and, hence, analogously, the general practice consultation - an enhanced technical instrument; the analytic situation (unlike the life of the patient) is a relatively 'stable' working environment - one can, for example, work with emotions within it, and apparently exclusive to it, without worrying too much about recourse to the actual past of the patient since the space of the analysis takes on its own 'autonomous' reality; it becomes a homogeneous working space. The analytic encounter - and its equivalent, the general practice consultation - has thus become analogous to a 'centre of calculation', a relay-centre which acts both as the point of convergence for sundry object-relations and the point of distribution for ameliorated affects.

What guarantees the 'stability' of the encounter, and which gives the data that emerges there its 'validity', is the analyst's counter-transference which, in Balint's extended usage of the concept, becomes homogeneous across the entire space of the encounter since everything is, as it were, measured through it, being the 'index' of the state of the relationship. If it can function as an index in this way, it is because the analyst actually produces the 'atmosphere' of the consultation himself. Between Freud and Balint, as Masud Khan has written:

'something has radically changed in the theory of analytic technique: both in its means and aims, and this difference lies very largely with provisions made by the analyst towards the creation of the analytic process and situation' (Khan 1969: 238).

But really we might say that what have changed are less the actual techniques themselves than the initial conception of 'technique'. A technique is no longer that which mediates between the 'theory' of psychoanalysis and its 'practice'; rather techniques (which, in Balint's work, refer overwhelmingly to the ways in which the doctor 'uses' or 'deploys' himself in the consultation) are now at the source of all psychoanalytic data; moreover they stabilise such data. The encounter (or, the consultation), which is the arena for the deployment of technique, becomes like the hospital described in Birth of the Clinic: a 'domain in which truth teaches itself'; a domain where all modifications are levelled out into an

equilibrium in that those modifications, as they derive from the doctor/analyst's personality, are at the - 'phenomenotechnical' - source of everything that occurs (cf. Foucault 1973: 109-110).

CHAPTER THIRTEEN

BALINTISM AND GENERAL PRACTICE

1. Michael Balint and General Practice

In drawing attention to the theme of 'technique' in Balint's work within psychoanalysis we do not wish to pretend that there is a complete continuity between this and Balint's work with general practitioners. Indeed, certain factors within the psychoanalytic oeuvre would seem to work against the possibility of any assimilation of themes. To begin with, the weighty emphasis upon the transference situation could be said to be mainly relevant to those patients who 'regress' during analysis; probably not a vast proportion of general practice patients! On the other hand, those forms of analysis - of which Ferenczi's 'active experiments' are only the extreme version - which privilege the analyst's powers tend also (aside from being particularly concerned with categories such as psychotics or children) to stress, as in no other area, both the importance of the analyst's own training analysis and the existence of long psychoanalytic experience; hardly propitious circumstances for transferring these techniques to general practice. Ferenczi commented, for example,

that:

'Beginners, or analysts of no great experience, do better generally to refrain from it as long as possible...' (Ferenczi 1926: 209).

These comments are not meant to show that Balint's usage of certain ideas from psychoanalysis is not legitimate. For, after all, Balint draws broad themes and emphases rather than conceptual specifics (with the partial exception of the notion of 'transference') from psychoanalysis. But there is another - this time methodological, or theoretical - intent behind our discussion of technique. That is, to show that Balint's project is, in fact, itself something like an intellectual 'technology', or a 'technology-in-thought'; to show, in short, that there can be such a thing as a human technology, one which takes human beings as its components. Let us attempt to anatomise - on the levels of epistemology and organisation - the workings of this technology itself, beginning with its central component that Balint specifically describes as a 'technical' instrument, the doctor.

1.i. Balint begins his most famous work on general practice by pointing out what he takes to be an obvious - but hardly ever observed, and never hitherto researched - fact; that is, that the doctor acts like a 'drug' upon his patients. It was quickly revealed in the Tavistock research seminar that:

'by far the most frequently used drug in general practice was the doctor himself' [but that] 'the paucity of information about this most frequently used drug is appalling and frightening, especially when one considers the wealth of information available about other medicaments, even those most recently introduced into practice. The most usual answer is that experience and common sense will help the doctor to acquire the necessary skill in prescribing himself. The shallowness of this self-reassuring advice becomes apparent when it is compared with the detailed instructions based on carefully controlled experiments with which every new drug is introduced into general practice' (Balint 1957: 1).

That the doctor is able to produce the atmosphere of the consultation is given further credence in Balint's account by the very un-evenness regarding the spread of neurotic problems in general practice. As he comments, although the number of neurotically implicated problems in general practice is generally put at about one-third of attending patients, this figure oscillates wildly - as the surveys of the 1950s found - between individual practitioners (ibid: 54). Balint's own accounts would seem to put the figure far higher than one-third. In a rough survey of two surgery sessions by doctors in the Tavistock seminar, out of a total of thirty-two cases only seven are not designated as either psycho-somatic or neurotic in some

fashion (ibid: 51-58). For Balint, the high figures of neuroses recorded in the practice populations of particular doctors is, however, a function, neither of over-zealous psychiatric forms of diagnosis nor of the existence necessarily of a massively neurotic population in general, but of the way of working of those doctors themselves:

'the doctor's personality and subjective interests may have a decisive influence on what he notices and records about his patients' (ibid: 53)

so that, on the one hand, he diagnoses a greater number of neurotic problems, and on the other, patients with these kinds of problems gravitate towards his practice.

This determination is achieved by the doctor's capacity to 'settle' the patient into the illness. At this stage of the argument, the link with the psychoanalytic literature is fairly direct. The illness, for Balint, is like an 'object' that the patient wishes to create out of him- or herself and, in the attempt, must go to the doctor for validation of the results. Thus the patient will 'offer' and the doctor will 'respond' and, under the auspices of the 'apostolic function' the patient will be allowed to settle into a diagnosis (ibid: chapter two). In this labour the doctor himself is the diagnostic instrument: what is required is that the doctor should be acutely aware of his own uses and effects. As Balint writes:

'I wish to state that the tool in psychotherapy

- the counterpart to the surgeon's knife, the physician's stethoscope or the radiologist's X-ray apparatus - is the doctor himself. That implies that he must constantly see to it that he is in good repair and in a serviceable condition [and that] he must learn to use himself as skillfully as the surgeon uses his knife, the physician his stethoscope and the radiologist his lamps' (ibid: 281).

In a direct parallel with the psychoanalytic literature, Balint declares that the doctor must have an 'elasticity' with regard to the patient, reflecting the patient's personality. Thus, on the one hand, the techniques actually recommended by Balint seem wholly passive. Balint's central technical demand is that the doctor should learn to 'listen' to the patient. Thus the interventionist techniques of the 'history' or the 'physical examination' are of little use with regard to the emotional traumas of general practice:

'Our experience has invariably been that, if the doctor asks questions in the manner of medical history-taking, he will always get answers - but hardly anything more' (ibid: 121).

Thus, for example, in the 'long interview' the doctor must sit back and absorb - the parallel with 'free association' is obvious - whatever it is that the patient has to say. But, on the other hand, this 'listening' is not at all a privileging of the patient's subjectivity such that the patient in any way determines his or her own treatment. It

is not stretching matters too far to draw a parallel with this technique of listening and what Foucault calls the structure of 'visible invisibility'. This refers not just to the movement whereby the doctor 'sees' into the vast invisible depths of the body using the basis of prior anatomical findings, but also to the un-covering of the 'individuality', the hitherto invisible uniqueness of the pathological deviation, in the process (Foucault 1973: 168 & 170). But if what produces this 'individuality' in clinical thought is the 'incisive, patient, gnawing language' of a clinician like Laennec, in Balint's work this determination comes from the workings of the personality of the physician himself:

'While discovering in himself an ability to listen to things in his patient that are barely spoken because the patient himself is only dimly aware of them, the doctor will start listening to the same kind of language in himself' (Balint 1957: 121).

Thus, the 'domain of evidence', as it were, which allows diagnosis comes not so much directly from the statements of the patient but from the reflexivity of the doctor which reacts to them like an 'active' mirror. In this way the doctor will know - no doubt, in his heart rather than in his head - which matters to raise, which are of importance and which can be discarded, so as to reach the 'deeper diagnosis' beyond mere organic symptoms. The condition for such a reflexively conditioned diagnostic outlook is provided for the doctor by self-examination,

something which is as inevitable as it is useful:

'Somehow when we examine our patient, we cannot escape examining ourselves which is tantamount to disclosing our own ideas and wishes about what ought to be done in the particular situation' (ibid: 224; cf. the similar comments by Enid Balint in Priest ed. 1982: 80).

Two questions could be said to arise from this account. First, on what grounds does Balint assume that the doctor can trust to his own reactions in this way as a valid index to the individual pathology of the patient? Second, how is this apparant guarantee of validity 'technically' achieved?

The answer to the first question can be sought in the context of the 'consultationism' of Balint's approach: and the answer to the second in the context of the technology of the 'group'.

1.ii. If the doctor can trust to his emotions as the index of the 'deeper' pathology of the patient it is because both his own persona and the 'setting' in which he works are uniquely privileged. On the first point, Balint's assumption is that the equivalent of a transference relation exists between patient and doctor. If within psychoanalysis the state of the transference is largely dependent upon the state of the analysand at the time of the treatment, Balint assumes that, in the context of

general practice, it remains fairly constant; that is, that the patient constantly uses the doctor as an 'object' in the actualisation of more or less unconscious wishes. This is one of the most flattering concessions Balint makes to the general practitioners; even if he is only really making use of that long-standing trope to the effect that, due to the 'continuity' of the relationship between doctors and patients in the 'first line of defense', the patient has a peculiar dependency upon the doctor and the all but mystic power that he seems to wield.

But, as Laplanche and Pontalis point out, the notion of transference is generally associated, not with an on-going relationship, but specifically with the circumstances of the analytic situation; thus, transference tends to mean 'transference during treatment' (Laplanche and Pontalis 1985: 455). Similarly, in the general practice context, the consultation is a domain, sequestered from the rest of the world, where the patient's object-relations can be allowed to work themselves out upon the persona of the doctor:

'the doctor provides a setting for the work to be done, and for the [therapeutic] event to happen, and this setting thus acts like a boundary or a frame separating the whole occurrence from the rest of the world' (Balint 1961: 144-5).

So this domain has ceased to be a physical affair; a room,

a desk and chairs, an examining couch. The setting of the consultation now signifies a space saturated with the doctor's personality and the range of emotions that it produces:

'By setting we mean the sum total of the fairly constant relations created by the doctor's individual way of practicing medicine which the patient may make use of and must accept... In other words, it is the therapeutic atmosphere 'offered' to the patient to get on with his endeavour to obtain professional help' (ibid: 43).

Now, if the consultation is a privileged setting in this way it is, no doubt, only because it is, simultaneously, so representative of wider object-relations in the world. In the rarefied atmosphere of the consultation the patient 'uses' the persona of the doctor as, in Balint's terminology, the 'primary-love object' (typically exemplified by the roles of 'father' or 'mother': cf. Ferenczi 1952: 43) effectively in order to work through the relational and emotional problems that are at the root of the patient's 'flight into illness'. So the consultation, as a particular kind of 'setting', is only the concentrated terrain for the working out of relationships that could be said to pertain in the outside world and of which the famed 'doctor-patient relationship' is the corresponding expression. This term thus has rather a precise meaning for Balint; that is, less the on-going

series of encounters between a doctor and the patient that he knows well so much as the 'immediate' therapeutic 'atmosphere' of the consultation. Balint characterises this 'relation' as being one of 'mutuality' (he sometimes refers to his psychoanalytic work as entailing a principle of 'mutual analysis') wherein the patient comes along to the consultation in order, as it were, to recognise himself through the medium of the doctor's own powers of self-recognition. Thus the consultation is 'essentially an interaction between two people'. One of them, the therapist, creates and maintains by his professional skill an atmosphere in which the patient can reveal and recognise himself:

'Prompted by his symptoms and sufferings, and in response to the setting provided by the therapist, the patient becomes willing to let emerge to the light certain parts of his own personality, his character, his past history' (Balint 1961: 47).

Thus, what confers a sense of 'validity' upon what the patient 'offers' his doctor and upon what the doctor actually responds to in these 'offers' is the kind of push-and-pull effect provided by the merging of two subjective personae in the protected setting of the consultation.

The consultation is, literally, a kind of translation-device. All the tangled object-relations of the patient's world here become flattened out into a homogeneous space.

The consultation in Balint's hands becomes precisely a technology capable of capturing the relational world of the patient, as it were, in miniature; hence translating the reality of that world into a workable and more or less autonomous domain. Moreover, no aspect of the outside world eludes the space of the consultation. Thus, for example, in an article upon psychoanalytic technique dating from 1949, Balint comments that the orientation which he is proposing - which aims 'at understanding and interpreting every detail of the patient's transference in terms of object-relations' - is specifically intended to circumvent arguments by sociologists and anthropologists that psychoanalysis is only concerned with the isolated individual at the expense of social relations (Balint 1952: 211). Rather, these relations are themselves mobilised; that is, their effects are transferred into the circumscribed space of the encounter. Instead of making the domain of evidence for this 'social' investigation the totality of the patient's social relations in the 'real world', the domain of evidence becomes, conveniently and with admirable economy, the consultation itself (Balint 1961: 217).

Hence, no doubt, the extraordinary emotional saturation attributed to the consultation in Balint's work; a domain of complex ethical choices and 'sexual' counter-bargaining, an endless source and object of analysis and uncovering. Yet, the very hyper-emotional quality of the consultation also marks it out simultaneously as a

rigorous and even scientific domain. The very fact that the consultation is a kind of circumscribed world, governed by the homogeneous plane of emotions that make up the 'doctor-patient relationship', makes it a kind of laboratory, a world where emotions can be examined 'scientifically'. As Balint puts it:

'... the doctor's surgery, with its jealously guarded intimacies, has been turned by our methodological research into a scientific laboratory, in which properly observed psychological experiments can be carried out' (ibid 1961: 36).

A felicitous reconciliation this: a merging of the demand for 'scientificity' with the demand for 'affectivity' and attentiveness to the 'person' (the world of emotions and relationships). Might not, this 'consultationism' be said to represent - in a highly limited and specific form - one local solution to the demand, characteristic of both anti-medicine and the project of recuperation, that science and reason should be distanced from 'despotism' and begin to speak an ethical language, attentive to the qualitative properties of persons?

1.iii. However, since the consultation is by definition private - the option of directly invading its sacred boundaries for the purposes of research being wholly unthinkable for somebody like Balint - a parallel, organisational, space is required, one which exists in strict homology with the space of the consultation, where

the personality of the doctor can be scrutinised, analysed and stabilised. It has been pointed out elsewhere that the group is a (relatively recent) technical invention of superior importance in the maximisation of human resources (Rose 1990: x-xi). To see how the group functions as a technique in general, one can confront its workings on a local level, its point of insertion in regional technologies of which general practice is one.

Although Balint is far too 'practically'-oriented to provide us with anything like a 'theory' of the group (indeed the group emphasis is itself typical of this 'anti-scholastic' orientation), he is noted for the fact that as early as the 1940s he was advocating the development of group perspectives within the domain of psychoanalysis itself. The area of group relations, he wrote, was an 'extremely important field where both subject and object can be observed simultaneously; [where] some transference of emotions invariably takes place from member to member, i.e. object-relations develop before our eyes' (Balint 1961 [1949]: 219-20). Clearly the Balint research seminars were not designed as specifically 'therapeutic groups' in this sense, but then nor were they straightforward 'work groups' designed to solve specific problems (Bion 1974 [1959]: 129f). Rather, the point about Balint groups is that they combined several functions at once.

First, the group has an 'organisational' significance. In the context of the project of the 'extension' of psychoanalysis this should be clear enough: the group is the equivalent of the 'training analysis', that is, it is an economical form for stabilizing the doctor's personality as a particular kind of plane of visibility for use in the consultation. Logically, it could perhaps be argued, this form of self-analysis alongside one's peers should not be terminated so long as a doctor remains practicing; but Balint proposes that the group itself brings about an irreversible shift in the doctor's way of practicing (Balint et al. 1966); this is the 'limited though considerable change of personality' that group training is said to effect (Balint 1957: 303).

In the context of the demands of general practice itself, however, the group method has another significance. It could be said that the group is a peculiarly 'liberal' form of association as a training method, not only because the norms that are inculcated there derive as if spontaneously from the intersubjective 'agreement' of one's peers, but because in the course of this intersubjective activity the individuality of the doctor is not reproached and regulated but actively analysed and promoted. The group, in short, is a form of association that actually promotes individuality; a form of organisation that, whilst clearly exerting a degree of 'discipline' and 'normalisation', does not work against the freedom of individual autonomy. Once again, we have

here a perfect example of the demand - anti-medical, recuperative - that the values of universalism and reason should not compromise the value of the sanctity of the autonomy and individuality of persons.

Second, the group is, of course, a crucible of knowledge and research. What form does this take? The leader of the group - generally a psychiatrist - begins with the question 'who has a case?' - and somebody, anybody, begins. Working from memory, the doctor recounts a case with which he is having difficulty. Whether the case has any overtly apparant psychological content or not is not relevant; by the end of the ensuing discussion the case will be saturated with psychological speculation and interpretation (see, for example, the transcript of a seminar in Gosling et al. 1967: 114-143: cf. Sapir 1972: 99ff). What is it that is being 'researched' here? The answer relates neither directly to the pathology of the patient nor to the proper conduct of the doctor confronted with a particular situation. Certainly the question of what kinds of patients there are and how to deal with them does arise for Balint; just as does the question as to whether psychotherapeutic techniques are actually in general succesful (of which the criterion seems to be not the rate of 'cure' but of more or less accurate 'prognosis'; Balint 1957: 323-380). At any rate, the emphasis of the seminar is not upon curing the patient in question but upon analysing the reactions of the doctor. Certainly, the conduct of the doctor is endlessly

discussed, but the object of the research is not to devise - or even less to teach - an ideal course of conduct to be taken in difficult situations. Rather, knowledge here is a strictly individual affair; it concerns the effects of the doctor's own personality; it is research into the particular 'atmosphere' produced in the consultation by each individual doctor. So, we might say that on the level of 'knowledge' the project of the seminar is to gain general insight into the workings and 'side-effects' of the 'drug' doctor (ibid: 1), and, on the level of 'research' the seminar seeks to deliver up to the doctor self-knowledge regarding the effects of his own personality (that is, in psychoanalytic terms, the 'doctor's counter-transference to his patient': Balint 1957: 310), the particular 'atmosphere' that he typically engenders in the consultation.

The research seminar - and, as will be seen later, the group practice and the 'team' are similar forms of association - represents a space of analysis with unique access to the otherwise closed world of the consultation. A kind of translation of object-relations takes place from the one to the other, and back again. If one can indeed deduce, from evidence gained far away in the group, the particular 'atmosphere' generated in the private space of the consultation by the doctor this is because the group and the consultation are spaces which exist in a rigorous analogical relation to each other. Both are sites of relationships, emotions and, above all, of counter-

transference. The reporting doctor acts as an emissary from one to the other: he moves, carrying, as it were, his counter-transference within himself, lifting it out of one set of relationships into another. When one works upon the personality of the doctor who is reporting a case in the research seminar, one is simultaneously researching into the characteristics of that doctor's patients - the two, indeed, are inseparable. Thus, all of the doctor's feelings in the consultation emerge, in the group, as valid information about the patient:

'if any feelings or emotions are engendered in the doctor while treating the patient, these must be evaluated also as an important symptom of the patient's illness' (Balint 1961: 61).

Hence, a 'technology' of the whole person; whereby the patient is mobilised in the group through the agency of the doctor.

Third, the group is, of course, an instrument of training. It should be noted here, in this connection, that if the group context is the analogue of the consultation this can only be because the doctor is, as it were, the homologue of the patient; the doctor in the consultation has to be something of a patient himself in the group. The reporting process in the group is itself evidence of this homology. Thus, Balint notes that his group methods derived directly from the Hungarian psychoanalytic system of supervision where:

'the worker had to report freely about his or

her experiences with the client in a way reminiscent of "free association" (Balint 1957: 300).

Thus the report is itself the analogue of the patient's 'manifest dream-content'. Similarly what happens to the doctor in the group seminar can be compared with what happens to the patient in the consultation. The peers of the reporting doctor do not ask questions, rather they 'listen'; nor do they seek to direct (the psychiatrist or leader especially, is not a directive kind of 'teacher': Gosling et al. 1967). In the group seminar, the doctor is not 'cured' of a complaint; rather, through the collective ministrations of his colleagues a change is brought about - albeit obscurely and beneath the level of language or one's mere 'beliefs' about oneself (Balint 1957: 302) - in the self-knowledge of the doctor - that is, in his personality. Of course, if this change is to occur the group itself must have a therapeutic atmosphere so that the doctor is able to see the truth about himself frankly and without shame; a transformation that cannot occur through traditional, more 'scholastic' methods:

'Intellectual teaching, however good, has hardly any effect on this process of liberation and general easing up. What is needed is an emotionally free and friendly atmosphere in which it is possible to face the realization that one's actual behaviour is often entirely different from what it was intended to be, and from what one has always believed it to be... if

there is good cohesion between doctors in the group, the mistakes, blind-spots and limitations of any individual member can be brought into the open and partially accepted by him' (ibid: 303). Training in the group, then, like therapy in the consultation occurs according to a logic not of control but of self-recognition; the doctor comes to discipline himself only in the context of openness and freedom.

1.iv. So far our discussion of Balint's writings on general practice has centred around the question of how Balint provides the grounds for his 'phenomeno-technics'; that is, how the personality of the doctor produces information concerning the (absent) whole person. The principles behind what we called 'consultationism' and 'group' organisation served to provide a structure within which the statements of the doctor concerning the patient and himself can be regarded as 'true'. But if, as this suggests, Balintism can indeed be regarded as something like a 'regime of truth', it would be a mistake to suppose that the statements that it produces could be 'grounded' outside this regime itself. Nor would Balint presumably wish to ground his work in this way (for example, by recourse to some kind of universal and exterior 'standard'); for the doctor automatically validates everything he does merely by taking action.

As already noted briefly, Balint rejects what might be taken to be the usual priority of diagnosis over

treatment. The clinic described by Foucault was like this; first one diagnosed (for instance, by localising the site of the lesion) and then, subsequently, one took the appropriate action. In a sense, however, it could be said that there was a problem here in that, as Ackerknecht pointed out in his classic study, clinical medicine was very good as a form of knowledge but less so as a form of therapeutics (Ackerknecht 1957). But if it was the achievement of the clinic to have aligned the functions of research, knowledge, and training within a single movement (and, we might add, all within the context of what Foucault calls the 'medicine in liberty'), it was Balint's achievement to have aligned knowledge and research (into the doctor), training, and - at the same time - therapeutics.

As Balint writes, generally speaking in general practice, 'no diagnosis is possible without therapy' (Balint 1957: 67). To think otherwise would be to suppose that the doctor could impose a diagnostic 'verdict' upon the patient without taking the effects of his own personality on the patient into account. But the diagnosis does not concern the patient alone, it also relates to the doctor and his relationship with the patient:

'... the doctor's responses may and often do contribute considerably to the form of the illness to which the patient will settle down' (ibid: 20).

Nevertheless this reversal does not amount to a wholesale

rejection of 'theory' in relation to 'practice'. For example, in rejecting the priority of diagnosis over therapy, Balint does not dismiss the import of diagnosis altogether. Far from it; diagnosis is vitally important - but only once it is understood that diagnosis is, for the patient, actually part of the therapy itself (ibid: 25).

What is at stake here is not a straightforward rejection of knowledge in favour of action. For, of course, this very prioritisation of intervention is, for Balint, a 'theoretical' matter. What Balint is saying is that one does not have to wait around for 'knowledge' in order to embark upon practice. He would reject, in this sense, the notion of a 'stage of taxonomy' designed to conduct a preliminary mapping of the field (as we described in chapter 2); he is not concerned with theorising how general practice might be a speciality since for him it is so already. Rather, for Balint, the task is to research and develop techniques which already exist. The point, then, is not that theory or knowledge is unimportant but only that it is what takes place in practice that produces the kinds of theory or knowledge that are worth having. Thus, if Balint rejects what we have called 'scholastic' forms of knowledge - that is, abstractions or 'intellectualisations' (ibid: 31) - he does not belittle 'knowledge' per se. It is merely that now knowledge resides in different domains; its place concerns techniques and 'means' in relation to treatment not objects and 'ends' in relation to diagnosis.

2. What Is It That Balint Has 'Offered' General Practice?

We are now in a position to consider the question of the uses of Balintism for general practice? What grounds does Balint provide for general practice to establish its disciplinary autonomy?

2.i. Nothing could be more mistaken than to suppose that Balint has solved any long-standing aetiological difficulties within general practice; in particular, that concerning the relation between mind and body in the causation of disease.

For Balint, simply everything has a psychological component. Thus, although he occasionally quotes estimates in his works that put the number of 'neurotic' complaints at about one third, it is clear that Balint thinks that basically all problems, neurotic or not, have some kind of psychological component at their basis (see e.g. Balint 1957: chapter five). Thus he often tended to place his own contribution within the tradition of psychosomatic medicine of Ferenczi, Jelliffe and Groddeck for whom all organic illness basically originates in emotional conflict (Balint 1965b: *ibid* 1957: 254). Nevertheless, Balint was realistic enough not to expect general practitioners to treat all problems psychotherapeutically. Indeed, he specifically warned against this arguing that the great asset of the general practitioner's role was that he could turn off and on almost at will the kind of treatment he

delivered (Balint 1961: 144). So if it is the case that a cigar can indeed, on occasion, be just a cigar then sometimes too it is admissable - for the general practitioner - to treat a broken leg as simply a broken leg.

This sense of 'flexibility' (ibid: 144) in the practitioner's role is itself one of the assets provided by Balint for general practice. Indeed, the fact that Balint seems implicitly to believe that all organic problems are, in effect, emotionally based in no way commands those who have been influenced by him to accept it, let alone to try to prove it. For what matters is not so much that the patient's complaint is psychosomatic in origin but that, according to the logic of 'consultationism', the consultation itself - a highly charged emotional interaction between two people and a host of absent objects - confers upon the complaint an unavoidable psychological dimension. Whatever the nature of the patient's complaint he or she will be entering the world of object-relations in the consultation; such are the powers of the 'doctor-patient relationship'. And since everything has to pass through the consultation then everything can safely be said to be psychological.

2. ii. The demand for psychology also derives, secondarily, from a veritable 'symptomatology of civilisation' that here and there comes to the surface in Balint's work (above all in ibid: chapter 1). It might be

observed here how much Balintism is presupposed by urbanism and by those phenomena so often associated with it - loneliness, rootlessness, the breakdown of family ties and so forth (see esp. *ibid*: 2). Compare, in this context, the emphasis upon social relations in the countryside that seemed to be such a characteristic of our case-study of the College of General Practitioners in the 1950s. Indeed, one might speculate at this point that there is a contradiction in the logic of Balintism here. For on the one hand, we have the notion of the general practitioner as the expert of the 'doctor-patient relationship' in general. And on the other hand, we have the general practitioner as a specialist of minor neuroticisms, and particular psychological complaints derived from the debased circumstances of contemporary civilisation. Moreover, whilst not wishing to be ungenerous, does not the latter emphasis actually undermine the former in that lonely, rootless individuals will be less likely, by definition, to be involved in long-standing relationships with their doctor? Or is the doctor to be a kind of secular priest, a figure that any individual of the appropriate faith, and in whatever city, will be able to turn to?

In fact, Balint does frequently use terms characteristic of religion and 'confession'. Indeed, he writes of the doctor as a kind of 'father-confessor' (*ibid*: 227); a trusted friend to the individual in the face of the onset of social misery and decay. But the general practitioner

is not simply a vicar or a priest in medical garb; he is to be a 'professional' with a specific field of operations and expertise.

In Balint's view, the use of the 'everyday', or 'common sense' techniques of 'sympathy' or 'reassurance' are almost completely useless in the sensitive - yet, as we saw, 'scientific' - world of the consultation:

'The uses of empirical methods acquired from everyday life are as limited in professional psychotherapy as are carving-knife and screwdriver in surgery' (Balint 1957: 109; cf. Balint 1961).

For Balint it is only the discarding of such techniques - dismissively characterised by the term 'bedside manners' - and their replacement by the 'limited though considerable change in personality' that comes from group training that can raise general practice to a properly 'professional' level (Balint 1961: xi). 'Bedside' medicine for Balint is a mere 'private' relationship, not a 'professional' one, the latter being distinguished by 'the existence of a special and relevant kind of knowledge and skill in one of the two persons' (Balint 1961: 137-8). 'Professional' understanding, in fact, is characterised by a mixture of 'emotional' and 'intellectual' elements (ibid: 136), occupying a 'borderline position' between each and between which the doctor can oscillate as the circumstances demand.

So the general practitioner differs from the priest, even in his pastoral functions. In fact, his expertise is to relate to a specific sphere. At this points, Balint suggests a kind of strategy of professional 'enclosure' for the general practitioners around the mundane problems of everyday life. Thus again - and here we quote a passage which Arney and Bergen would surely enjoy - the mission of general practice is specified and thus enhanced:

'...may we claim for general practice and for proper psychotherapy, the other field that covers everyday life [that is, aside from hospital medicine which deals with the 'crises' of life] the many little or greater irritations of human existence, involving not so much life or death but what are perhaps equally important, contentment and human happiness?' (Balint 1961: 128).

Thus general practice is to be made the science of the mundane and the emotional; it is to get into the interstices of life. Here the opposition is less one of 'vitality' versus 'mortality' (or, a medicine of death as opposed to a medicine of life) than one of 'mundanity' versus 'crisis'; that is , a medicine of the everyday rather than a medicine of catastrophic injuries and heroic interventions. Social danger is now to be located in relation to everyday existence.

This fabrication of general practice as entailing a particularly specialised form of concern and intervention

is also paralleled in an 'organisational' context. As we argued earlier, Balint is very much concerned, like others before him, to reverse what he sees as the prioritisation of 'specialists' over generalists in medicine. Hence he puts forward an organisational model according to which the priority of 'responsibility' is reversed between general practitioners and consultants. This, as we noted earlier, is not entirely unlike previous renditions of this theme; that because the general practitioner knows his patients he should have over-all responsibility for them. Balint, however, gives this argument some force by coating it with a psychological gloss which meshes well with other themes in his work. This is done by positing the consultant-general practitioner relationship as homologous to the doctor-patient relationship itself. Thus, he claims that the consultant-practitioner 'relationship' itself is typically characterised by a pathological 'dependency' on the part of the general practitioner analogous to that much maligned phenomenon; the 'teacher-pupil' relationship (Balint 1957: chapters eight and nine). The general practitioners, in Balint's term, 'collude' in their own domination. Thus, equally, their liberation is up to them. The implication, then, more or less, is that general practitioners must seize 'responsibility' themselves both for their own conduct and for their patients and hence - eschewing the complications of 'medical politics' - bring about their own professional 'liberation'.

Lastly, still on this question of what it is that Balint actually contributes to the professional standing of the general practitioner, we have the question of research. The whole point about 'doctorcentrism' in this connection is that the only person who can research in the field is the doctor himself. After all, anybody can do a survey; but only the general practitioner can investigate the effects of his own personality:

'A real change for the better can be expected only as the result of long-term research into the pathology of the whole personality corresponding to what was described above as the deeper level of diagnosis. As the problems belonging to this field constitute the problem of general practice, no-one but the general practitioner can undertake this research' (ibid: 103).

2.iii. But Balint's contribution really goes beyond either the avoidance of knotty aetiological matters or professional 'flattery'. For Balintism also provides grounds for the coherence of the different elements of general practice.

First, this has entailed a certain simplification of the domain of general practice by 'problematizing' it in a certain way. On the level of the 'data-base' of general practice, as we have seen, particular aetiologies and so on are for all intents and purposes bracketted in favour

of a concentration upon the area of the consultation and upon the doctor's own emotional reactions to the patient. Similarly the actual evidential 'content' of general practice has been simplified to the homogeneous level of language and emotions: no special pieces of equipment are necessary for the working of Balint's system; no sphygmographs or surveys - all the instruments are present at hand, in the form of the practitioners themselves. This, indeed, is why one can describe Balint's system as a form of 'personalism': simply because the whole field has been problematised on the basis of the attributes of persons understood in terms of the object-relations they have with each other and the world.

Second, there is a dynamic element to Balint's problematisation of the parts of general practice; having problematised the field in this 'simplified' way he also provides means for the inter-connection of its parts, as well as the foundations of a general 'programme', a direction in which general practice will have to travel. A coherent system of organisation is worked out; a connection of different spheres of relations - thus we travel from the patient's personality (understood in relational terms; relations in childhood, with friends, parents, spouses etc.) to the site of the consultation (transference relations with the doctor) a space which is itself, as it were, stabilised by the group or seminar relations which support and stabilise the doctor's personality. It is as if, to borrow Latour's vocabulary

once more, the patient's personality has been made technically mobile by Balint through the agency of that of the doctor and the translation-device of the consultation. In short, what Balint has done is to have given the general practitioners a specific 'ontology' (that of the pathology of the 'whole person') combined with a specific domain of evidence and investigation (that of the emotional space of the consultation) and made this ontology and this domain capable of observation and supervision along a line of force which 'relays' the personality of the doctor through the self-enlightening and self-stabilising powers of the group.

Lastly, Balint's system is, as we have stressed, eminently workable. This is not just because it is a simple system allowing for the mobility of information through its parts but because, again as we have already pointed out, it is actually workeable before it is knoweable or made mobile. One way of putting this is, adopting a 'strategic' vocabulary, to say that Balint has achieved his strategy of 'interresment' by asserting that 'enrolment' (to his way of doing things) has already effectively taken place (cf. Callon 1986: 206 & 211). Balint's contention is that, whether the doctor adopts the techniques he is recommending or not, he will necessarily be practicing psychotherapy in any case: indeed this follows from the original contention that the doctor acts inevitably, like it or not, as a 'drug' on his patients. Above all, this emphasis allows for the achievement of a what might be

described as a long-held 'ambition' of all clinical forms of knowledge: that is, to combine in one movement a form of aetiological-diagnostic knowledge with a therapeutic rationality. Even the Parisian physicians of the late Eighteenth Century failed to provide any coherent therapeutic models to complement their achievements in the field of clinical knowledge. Balint has done so by actually deriving the form of knowledge from the form of therapy and connecting them both in the persona of the doctor. The possibility of both knowledge and therapy are now, as it were, relayed through the medical persona.

3. The Power of Psychology

If Balint's enterprise is indeed a 'psychological' one, then, we are now entitled to ask, what role is psychology actually playing here?

3.i. Psychology has, above all, an epistemological function. Proceeding very schematically, we contend that what we term loosely the 'psychological' orientation has peculiar efficacy within the intellectual programmes of other disciplines because it combines two functions that have generally been opposed to each other. The first is the capacity to make visible a domain, to confer homogeneity upon heterogeneity. Psychology does this, on the one hand, by making everything in that field flat and homogeneous; the world is composed of persons and their emotions,

entities to which everything else can ultimately be reduced. On the other hand, this domain is not conceived as being fixed and static but fluid and composed of nothing but relations. This has the effect of tying the domain together; every entity seems related to all the others, a magnificent coherence is achieved. In the case of Balint, we have seen how this works in the context of the roles of the persons involved themselves. Thus, we have seen how the patient in the consultation bears a relation to the doctor in the group. But also there is an inter-relationship achieved between the functions of the activities in question as well. Thus, we have seen how in Balint's 'system' a relation is set up between the functions of research and training, and between training and therapy; to perform any one of these functions is simultaneously to perform the others. A curious, 'formal' quality is thus achieved.

Second, in contrast to this 'formalising' aspect, there emerges another that, one might think, would normally be in opposition to it. Thus one might normally imagine that the greater the internal 'coherence' of a discipline the less would it be the extent of 'correspondence' achieved with the world. Yet, as we have seen, although Balintism is able to achieve a 'formalising' effect in relation to its subject-matter it is also able to privilege the powers of intervention and therapeutic 'aggressiveness' - according, perhaps, to the logic of what we have termed its logic of interventionism. Thus just as Balintism

imposes order upon the world it sets up the conditions for intervention within it.

3.ii. The considerations relating to what was called the project of recuperation with which this study began will lead us to some obvious conclusions at this point. 'Psychology' - if our case-study of Balint can be accepted as evidence - is a powerful kind of perspective from the standpoint of this project. For it combines at once a rigorous, 'scientific' standpoint - a kind of Spinozism where there is only one substance, relationships, undergoing a multiplicity of modifications and affections - with a veritable 'human touch', since these relationships are themselves properly 'human' values. At last; the possibility of a 'scientific' rationality (since, it occurs in the controlled atmosphere of the consultation) attentive to persons?

It is to be hoped that we have succeeded in conveying what we think is most remarkable about Balint's enterprise. A certain amount of iconoclasm has been involved here. We have claimed that, far from being simply a tender-hearted therapeutic eudaemonism, Balintism is better distinguished by the rigours of its construction as a kind of 'technology'; a kind of machine composed of moving parts that mesh together, and implicate each other at every step. So far, however, we have concentrated upon matters of epistemological articulation (upon the doctor, the evidence in the consultation) and of organisational

adequation (the group) and discussed how these matters are tied together by Balint. However, there is obviously another dimension to the notion of 'technology'; that is, that this notion implies a 'telos' - targets and effects that are sought out, material to be worked upon. Balint's network is indeed a 'human technology' in this sense. It has, has can now be investigated, 'governmental' implications.

CHAPTER FOURTEEN

THE GOVERNMENTAL CONSCIOUSNESS OF BALINTISM

1. Patients: On the Therapeutic Tasks of Balintism

Every rationality that takes human subjectivity as the object of its contemplation and intervention must project for itself a world in which intervention is required and, equally, in relation to which the rationality in question is uniquely equipped to intervene (see on this, Colin Gordon in Gordon, ed. 1980: 248). What, then, is the state of the world projected by the logic of Balintism, and what is the space of intervention that it sets out and reserves for itself? One can gain some provisional insight as to the specificity of Balint's contribution here by reference back to the problematic of social intervention that prevailed in the 1950s.

1.i. Under the aegis of a prevailing governmental rationality of a welfarist 'pronatalism', 'enlightened' general practice took as its social task, above all in the 1950s, the observation of the economy of family relations in the material space of the home. Here, the model of the practitioner - working preferably in the home itself or in

the 'homelike' space of the surgery - was that of the all-seeing but unseen observer of relationships, taking as the privileged object of observation the mother whilst, it could be said, the privileged object of actual 'interest' was the child.

Balintism is, as one might expect, both fairly close to and yet at a certain remove from this rationality. If one takes the domain of 'family studies' in the 1950s, for example, there is, on the one hand, a sense in which both this domain and that of Balintism presuppose something of a 'psychological' orientation: both, for example, see the family space as being one criss-crossed with precarious emotional involvements which the doctor must, above all, seek to 'understand'. In certain respects it is possible to claim a similarity of prevailing concerns governing the two rationalities: thus, if we were correct in ascribing to the logic of 'pronatalism' an affinity with the thinking of John Bowlby it can be argued, for example, that both are concerned with the question of 'attachment behaviour' in the family domain (see on this the article by Pedder in Kohon 1986: 295-308; esp. 296). On the other hand, in the manner in which this relational domain is problematised and, above all, in the actual logic of organisation presupposed by each, the two rationalities could be said to differ greatly.

If they could be said to have in common the presupposition that the domains with which they deal are, if not exactly

'natural' domains but ones which can be conceived as being immanent, autonomous and self-governing then the first important difference between them could be said to lie in the fact that, within the logic of Balintism, the doctor is actually himself part of the domain which he 'confronts'. In the 1950s, it could be said, the general practitioner, for all his involvement, was an 'outsider', a privileged 'observer'. Now, however, that domain 'addressed' by the ideal practitioner, as we have seen, also includes his own self. This, of course, is only a reflection of the fact that the very domain addressed by Balintism is, in a sense, far more 'rarefied' - and, additionally, more therapeutically oriented. The domain of evidence moves out of the material space of the family and surgery and into the 'emotional' space of the consultation. The effect of this, not surprisingly, is to privilege the relationship between the doctor and the patient so that on the one hand, the visibility of specific inter-familial relationships declines - the privileged emphasis upon the mother-child relationship, in particular, recedes; Balint has all but nothing to say about children - and, on the other hand, the 'immediate' situation of the family loses importance and makes way for an emphasis upon previous relationships in the patient's life (important figures from which coming to 'correspond', as we have seen, with the person of the doctor himself).

1.ii. In this sense, Balintism is far more individualistic in implication than was the problematic of the 1950s.

Thus, Balintism, it can be argued, envisages a world where the predominant forms of social pathology derive not from the breakdown of familial 'attachments' but from the breakdown of relations between the individual and the environment (composed of other individuals). But this individual is, as it were, 'universal'; it can be anybody. Balintism does not focus upon, for example, the child but upon people in general; adults in their relations with themselves and with others.

Nevertheless, if Balint hardly ever actually talks about the actual patient, how is it possible that the governmental 'telos' of his work is directed towards the promotion and regulation of this 'universal' individuality? First, we can look at his theory of pathology. As will be seen, this entails a conception of pathology as being at once constitutive of individuality, and - when it reaches the form of an 'illness' - threatening to it. Second, we can follow the logic of doctorcentrism itself; we can scrutinise doctor in order to find the implied model of the patient.

1.iii. What happens when the 'whole person' falls ill? For Balint, every illness is but the expression of the patient's personality. Thus he writes that the illness:

'is a kind of child, in this case a bad damaged child which instead of bringing pleasure brings pain and disaster to its creator' (Balint 1957: 253-4).

Illness can, of course, bring gratification as well; either through what Balint calls 'direct gratification' or 'secondary gain' (ibid: 261). Moreover, for Balint, the illness is not only an 'expression' of individuality - being 'as much a characteristic of the patient as the shape of his head, his height or the colour of his eyes'; it is also actually constitutive of individuality. Thus Balint asks:

'Which is the primary, a chronic organic illness or a certain kind of personality? Are the two of them independent of each other, interdependent, or is one the cause and the other the effect; and if so which?' (ibid: 255; Balint 1968 is an extended elaboration of this theme).

Balint effectively answers this question concerning the relation between disease and personality by resorting, as it were, retroductively, to a common source that will account for both. This is the theory of the 'basic fault'; an example of a concept which, in his general practice writings, Balint takes over directly from his psychoanalytic work (Balint 1957: 255-8 & 360-2: cf. Balint 1968: 18-23: cf. Kahn 1969: 244).

Rejecting the 'accident' theory of illness (wherein, as with medicine in the hospital, each illness episode has no 'meaning' at all: Balint 1961: 125) Balint contends that each episode stems from a basic lack of fit - 'in the biological structure of the individual involving in varying degrees both his mind and his body' (Balint 1957:

255) - between the individual and his or her (personal) environment. This lack of fit both is and stems from the 'basic fault', that 'love-deficiency condition' experienced by the child in his early years. But what is 'basic' about this condition is that it is more or less inevitable for all people since it derives ultimately from the split between a world before birth where the individual and the environment are un-differentiated, in a state of 'one-ness', and the world after birth where objects necessarily intrude themselves:

'Birth is a trauma that upsets this equilibrium by changing the environment radically and enforces - under a real threat of death - a new form of adaptation' (Balint 1968: 67 and chapter twelve: cf. Freud 1955: e.g. 62).

Hence Balint's notion is that, not merely does illness confer individuality upon a person, but that illness - when referred back to the 'basic fault' - actually is this individuality:

'Although an individual may achieve a good, or even a very good adjustment, the vestiges of his early experiences remain and contribute to what is called his constitution, his individuality or his character make-up, both in the psychological and in the biological sense' (Balint 1957: 255-6).

Balintism would be, then, a technology designed to bring about enhanced ego-functioning in relation to the 'basic

fault' which resides in all of us and which is the source of individuality. Individuality is, then, both in a sense 'pathological' and inherently 'normal' in that it is to be the objective of therapy and cure. Illness becomes constitutive of the self.

What the doctor must seek to strengthen in relation to this 'basic fault' is character. Character is not in opposition to individuality, but it must exist alongside it if it is not to become a liability for 'government'. 'Character' is a notion that seems to be defined for Balint according to the extent of either the 'volatility' or the 'stability' of the individual's emotions or object-attachments. The volatile character would be a threat to society; the stable but individual character (presumably) an asset. In fact, this notion of character itself seems to be at the root of Balint's pre-occupation with the 'extension' of psychoanalysis in the first place. For, as he wrote: the man with 'a weak character' is an 'everlasting danger' for society (Balint 1952: 162). Character is what controls 'the relation of man to the object of his love and hate', indeed character is a particular way of loving and hating (ibid: 160):

'A man with a strong character is a gain for society, a man with a weak character an everlasting worry, an everlasting danger' (ibid: 162).

The social imperative of Balintism, it could be said, lies less with the need to promote 'solidarity', the alignment

of the roles of individuals with other roles, other individuals, so much as individuality itself - 'strong character' - with maturity and 'solidity' alongside this.

This emphasis upon strengthening character was re-inforced by the turn towards so-called 'focal therapy' in the late 1960s. But the method through which this was to be done was not to entail the promotion of 'regression' in the patient. In fact, Balintism is actually distinguished by its emphasis away from the recovery of past influences upon the patient's present problem. If general practice, for Balint, was a question of delving into past experiences, relations to the father and to the mother then, surely, the project of the 'extension' of psychoanalysis would not have got very far. Rather the whole point is that, through transference and counter-transference in the consultation, these matters can be dealt with, as it were, 'on the spot'. Balint and his successors were increasingly pre-occupied with defining how this effect of 'immediacy' was to be achieved: hence, the development of notions such as the 'here-and-now' technique (Gosling et al. 1967) or so-called 'focal therapy' or 'flash technique' (Balint and Norell 1973: esp. chapter two). The purpose behind these techniques was to develop a quicker form of therapy than the so-called 'detective method' that used a 'long interview' to get at the patient's problem (ibid: 7). Instead, the doctor is to hone in upon a single focal area of the patient's problem by seeking for a 'flash' effect; a sudden moment of

'intimacy' between doctor and patient, a spontaneous mutual awareness between them of something that is important to the patient. This form of therapy was designed for incorporation into the average six-minute consultation; a literal 'quick fix', for the therapy was to make no attempt to get beyond the patient's defenses, nor to return to key episodes in childhood, but instead - on the basis of the uses that the patient can derive from this sudden 'intimacy' with the doctor - the task was to enhance the patient's ego-functioning. The purposes of technique are then to strengthen the autonomy of the ego, strengthen the patient's character, promote the patient's autonomy.

Whilst these notions of the 'basic fault' as pathology and the promotion of 'character' as the 'telos' of general practice intervention do figure in Balint's work, they do not occupy centre-stage. This is because, as we have argued, Balint does not really trouble himself too much with the question of the patient at all. But we can turn his doctorcentrism to our own account here; for there resides within Balint's writings on the doctor an implicit model of what the patient should become.

2. Doctors: Balint's Ethicalisation of General Practice

What are the doctor's tasks? The answer to this looks easy at first. For would it not be possible at this point to succumb to a wholesale critique of Balintism; to declare,

for example, that its emphasis upon the 'basic fault' in all patients leads it to a logic of 'medicalisation' whereby everybody is designated as being sick?

2.i. However, as the very logic of doctorcentrism implies, the class of those who are pathological (which is indeed coterminous with the class of all persons) is not actually the same as the class of patients. For Balint, the pathology, the 'problem', only really becomes an 'illness' once the patient has decided to go to the doctor: thus, he writes, the consultation only occurs when patients 'have converted the struggle with their problem into an illness' (Balint 1957: 257). Moreover, the presenting complaint can only be settled into a proper 'illness' with, in any case, the doctor's 'co-operation'. Before this occurs it is quite possible that people will be coping with the inherent miseries of human existence more or less adequately. But, more than this, the emphasis on the 'immediacy' of the situation in the consultation (the 'here-and-now' situation as it is sometimes expressed by Balint's followers), actually dictates that delving into the fundamental conditions of the patient's life is not actually the doctor's business. The task, for the general practitioner, is not actually to uncover the 'underlying conflict' (ibid: 273). This may indeed be the business of the psychoanalyst (Balint 1968: 22), but, as Balint never tires of pointing out, the general practitioner is not just a second-rate psychiatrist or psychoanalyst (which is why one will find very little actual psychoanalytic

vocabulary in the work of even Balint's immediate and closest followers). Rather he has his own field of concerns that derives from but can not be reduced to the model of 'patienthood' that has as its basis the notion of the 'basic fault'.

2.ii. However, in a sense, this is to evade the matter. For is not Balintism a form of 'medicalisation' in the way in which it seeks to exert a kind of 'moral' influence upon the patient? Could not Balint's work be analysed under the rubric of 'social control'; for example, by arguing as do Arney and Bergen that medicine is becoming concerned with more and more areas of life with which it was not previously interested. In fact, as will be argued more extensively in the conclusion, Balintism is perhaps better understood not in terms of 'moral' regulation but in terms of 'ethical' regulation. What Balint achieves - and one could extend this verdict to all those who take the 'psy' disciplines as their model for general practice - is an 'ethicalisation' of medical practice and endeavour.

Clearly, prior to Balint medicine had been concerned with 'ethics', that is, with quandaries concerning action to be taken, with the moral implications of medical interventions and so on. But Balint goes further than this in that he makes general practice, as it were, productive of ethical situations. If general practice has become what can be called an 'ethical technology' this is not because

it embraces, for example, a species of 'victim-blaming' on the basis of the modification of lifestyles, nor because it is concerned with explicitly 'moral' direction or the 'normalisation' of its targets, but because it exhorts its targets - patients - to problematise themselves in an ethical manner.

How does Balint's intellectual technology seek to do this? After all, there is actually very little in Balint's work that deals directly with the aims of treatment, with what effects one is generally trying to achieve with the patient. But these aims can, we argue, be reconstructed on the basis of our analysis of Balintism as a particular kind of rationality. For the patient in the consultation is only an analogue of the doctor in the group seminar. In both settings an 'atmosphere' of self-surveillance is set up through which one can come to self-knowledge and 'maturity' on the basis of a working-through of one's relations with others and with oneself. In the consultation, the doctor 'uses himself' upon the patient in order to effect a 'change of personality' analogous to the one experienced in the group seminar by the doctor himself. The doctor does not instruct the patient how to live - this would be a form of moral judgement or normalisation from the standpoint of, for example, a transcendent value - but rather becomes, more generally, a kind of model reflexive being, who, considering himself in relation to others, finds what he must be in order to become himself. If the doctor is, for Balint, a kind of

'teacher' then this is not because the aim of therapy is to instruct the patient but to:

'enable the patient to understand himself, find a better solution for the problem facing him, and thus achieve the integration which has not yet developed, or has broken down because of a diminished relationship between him and his environment' (Balint 1957: 127-8; cf. Balint and Balint 1961: chapter 8).

The goal, then, for both doctor and patient is a certain 'maturity' (a favourite term of Balint's) in which the demands of individual autonomy and environmental integration are reconciled. So rather than promoting a definitive 'guide for living' Balint's work could be said to promote a generalised ethical problematization of modes of living, exhorting the patient to come to reflect upon what he or she may be in order to come to a fuller sense of self-possession. Balintism is a technology for the problematization, surveillance and affirmation of the self.

2.ii. In spite of these considerations, Balint does in fact use the word 'teacher' to describe the function of the doctor (Balint 1961: chapter eight: 'The Doctor's Responsibility'). But he emphatically does not mean by this that the doctor must teach the patient how to live in order to attain the minimum of misery out of life. The doctor is not a 'teacher' because there is anything specific to be taught; on the contrary, the whole point is

that there is nothing definitive to be taught:

'We have to accept the fact that the world, including theology, philosophy, ethics and science, does not offer the doctor unequivocal advice about the crucial decision of what to teach' (ibid: 114).

What necessitates teaching on the doctor's part is fate itself; one teaches because one must. Training is, in a sense, part of the discovery of the nature of one's own particular, personal fate as a doctor. Thus, Balint effectively advises the doctors; 'become what you are!':

'... the therapist must always have the courage to be himself and be willing to accept as much of his own peculiarities, weaknesses, and strengths, skills or limitations as he is able. He must not try to 'put on an act' for his patient' (ibid: 158).

This is because, when he is before the patient, the doctor is already beginning to teach regardless of any of these limitations and so on which he may possess. The doctor teaches because it is part of the 'apostolic function' that he should do so; it is merely one of the 'pharmacological' effects of his personality:

'It is a painful responsibility to realise that teach we must - our only choice is what to teach' ... it does not matter whatsoever whether the doctor shuts his eyes and refuses to see what he is doing or accepts his role and chooses consciously what he teaches - teach he must'

(ibid: 110, 'italics' in original: & 114).

So, if this teaching has no pre-given 'content', what does it involve? Certainly not anything as crude as, for example, a 'proper, free and satisfactory sexual life'. Rather it will depend upon the doctor: each one must make a choice of what ethics to teach, whether explicitly or implicitly - and these ethics must derive only from one's own responsibility to oneself. If one merely becomes what one must become then good teaching practices will automatically follow; the doctor teaches with his personality; he teaches the practice of 'self-understanding' which itself (regardless of its content) is the benchmark of 'maturity'. And in the on-going relationship he has with his patients he becomes for them not, note, a 'super-ego' but rather 'a kind of additional or subsidiary ego' (ibid: 146). It is more as if the doctor is a teacher, then, 'by example'; he is a model of exemplary conduct.

The doctor therefore teaches not with codes and rules but, as it were, with his very 'being'. Such teaching may indeed take a long time:

'If a gardener consistently prunes a tree in the same way, the effect of his conscientious work will show up more and more impressively as the years pass by' (ibid: 115).

But what is it that is exemplary about this figure? In what way is the doctor a 'model' for his patients if he does not preach a philosophy or deliver instructions from

a manual? Partly the influence resides in the persona of the doctor himself - the 'apostolic function' is expected to mould the patient to the interests of the doctor - and this would presumably extend even to the factor of 'advice' on the part of the doctor as to sexual and emotional matters and so on. In this sense the patient is expected to be actually like the doctor - since after all, the patient has chosen to go to that particular doctor.

But beyond this, the doctor's influence is both more general and more 'personal'. This exemplarity surely consists simply in what we could call the doctor's 'practice of freedom', his coming to self-knowledge and maturity on the basis of a kind of working through of his relations with others and the constant labour of self-surveillance this implies. The doctor becomes a model reflexive being, who, considering himself with the help of others, finds what he must become in order only to be himself. At its minimum this 'teaching' will entail, presumably, the promotion of the principle of self-surveillance, self-awareness, self-understanding itself. It is the fact that one must monitor oneself that is to be taught; for this self-monitoring (which the doctor enables the patient temporarily to do) will enable the patient 'to feel more and more a part of, and more related to other people' (Balint 1961: 143). Illness is presumably an excellent opportunity for this teaching to take place since it is a time when one's 'individuality' is most evident (since in illness, as we know, the 'basic fault'

has come to the fore) yet when one's 'character', one's maturity, one's autonomy has been lost (which is why one goes to the doctor - for 'support'). Hence, sickness is, presumably, when one is most vulnerable to change and self-transformation - an irreplaceable opportunity for the 'teacher' to do his work.

Finally let us note what is implied 'politically' by what we have termed this 'practice of freedom'. Once again the values that are implied are perfectly those of a liberated reason proper to what was termed the project of recuperation. Nobody is coerced in this schema, everyone is merely guided by the ministrations of others to become themselves; autonomous, mature, responsible characters. Balintism: a perfect (re-)incarnation of the 'medicine in liberty'?

Coda: Exemplary Personae of Modernity

In 1913 Max Scheler - doyen of characterology and 'personalist philosophy' - wrote an essay entitled 'Exemplars of Person and Leaders' (Scheler 1987: 125-198: cf. Schnadelbach 1984: 186-191; also chapter eight). Here he argued forcibly that the role played in what we might call the constitution of subjectivity by 'personal exemplars' had been neglected in favour of more obvious models in the guidance of conduct:

'While it is true that we can find an immense

literature on the problem of leadership, there are only a few who have seen the significance, formation, and effectiveness - the power of the moulding of our souls - that exemplary persons have exercised' (ibid: 129).

Scheler's claims as to the actual primacy of the personal exemplar in the formation of conduct of 'ruling minorities' would no doubt (and not unlike his political views) seem a little overstretched to us today (ibid: 136). Nevertheless, the general emphasis is surely both praiseworthy and illuminating:

'What has a forming and grafting effect on our souls is not an abstract universal moral rule but always, and only, a clear and intuitive grasp of the exemplarity of the person' (ibid: 134).

Scheler went on to outline four basic differences separating the concept of the 'leader' from that of the 'personal exemplar': first, he argued, it is characteristic of the personal exemplar that, unlike the leader, he does not know that he is a personal exemplar; second, the personal exemplar is, unlike the leader, independent of time and space (he may be a God, a demon or an historical figure); third, the personal exemplar is, unlike the leader as if by definition, morally worthy; and fourthly, whereas the leader demands and inspires 'action', the personal exemplar demands 'our being and the cast [gestalt] of our souls' (Scheler 1987: 135).

If one were now to resurrect Scheler's long-forgotten project for an outline of the course of the 'personal exemplar' in history the work of Michael Balint and his colleagues might surely provide some interesting material. For the Balint doctor is not a 'leader' with access to transcendental values, rather he is an 'exemplar'; he is like the patient, only an expert in self-understanding and maturity. We might, however, wish to modify some of the distinctions made by Scheler between the personal exemplar and the leader in the light of this evidence: and perhaps it is not surprising that such modifications should be made - after all, it is not supposed to be characteristic of 'liberal' societies to devote too much favour to the rhetorical sway of 'leaders', especially morally corrupt ones! If one were to suggest that the doctor of the whole person constituted something of a personal exemplar then we would have to argue that there has been something of a 'reversal of visibility' with regard to this concept in recent times. So, for example, if it is true that the personal exemplar should indeed be morally worthy and that his effects relate, less to heroic action than to our very 'being', we should have to point to the curious 'concretisation' of the personal exemplar in other respects. Thus, now it is constitutive of the personal exemplar (at least in the form of the whole person doctor) that he is broadly aware of his effects; indeed, he seeks to exploit them in order to influence the government of the conduct of life amongst the populace; in fact, he becomes an instrument for the promotion of such

conduct. Similarly, his 'exemplarity' ceases to be independent of time and space: the exemplary person becomes a very 'concrete' figure, and he has his base of operations in every high street. A veritable 'technology' of the personal exemplar is formed (cf. Horobin 1986).

Of course, as Scheler stresses, a particular social formation will only get the personal exemplars that it deserves or desires. The Balint doctor holds up a mirror to some of our values; a practical self-monitoring sort of fellow combining all the advantages of scientific knowledge with practical know-how and personal and sexual wisdom. Balintism is a kind of technology designed for the production of such values. In fact, Scheler himself even mentions the category of the 'physician' in his discussion. This figure is, in his account, amongst those categorised as 'the leading minds of civilisation' along with 'scientists and technologists', that is, those whose value 'does not lie in disclosing his self-value' but in 'actions and accomplishments'.

Now, this assessment would have to be reversed; the doctor's value lies precisely in his self-value. The Balintised general practitioner is not a heroic figure - a brain surgeon or a flying doctor - but a disciple of everyday life. The general practitioner's 'heroism' lies in his humility, his responsibility, his maturity and perhaps in his capacity as, in Scheler's terms, to be a 'master of being' (Scheler 1987: 196-7).

PART FIVE

THE REGIME OF SELF-SURVEILLANCE

**A Balintist Rationality at the (Royal) College
of General Practitioners**

CHAPTER FIFTEEN

FROM TAXONOMY TO PEDAGOGY

1. Balintism and the End of the Taxonomical Project

All the themes of this chapter seek essentially to draw attention to the same basic transformation that will be the focus here, and which has guided the selection of material in what follows. This transformation is simply the shift towards the problematisation of the person of the doctor as the primary epistemological resource within general practice. All the material in the following pages - running from the early 1960s to the early 1980s - will be adduced as evidence of this shift. Thus the chapter should serve simply to give this transformation a certain visibility. But in doing this it is also intended that the breadth of this regime be made visible. A Balintist rationality? Not, certainly, in the sense that all members of the College were committed followers of Balint or quasi-psychotherapists or psychoanalysts. But Balintist in terms of a certain emphasis of themes already located within Balint's work itself; the doctor's perspectival powers of reasoning, his thaumaturgic powers of treatment, his reflexivity, the focus upon the consultation, a

commitment to group organisation, a reversal of the old link between treatment and diagnosis - these are what the two discursive regimes have in common. A kind of vernacular Balintism, then; or a generalised 'regime of self-surveillance'.

1.i. Around the start of the 1960s the project of taxonomy was displaced by a new rationality. Taking the work of those associated with the College of General Practitioners as a 'data-base' (and the College journal in particular) a certain displacement of old themes becomes evident. In the 1950s the concerns of the College centred around the question of discovery and research. The task of the College was, above all, to draw up a taxonomy of the 'free field' of general practice; to draw up morbidity profiles of practices, to investigate the complex pathways of minor epidemics in the community and to develop diagnostic practices and aetiological schemas proper to general practice as an independent discipline. The image of the doctor was modelled above all on the 'country doctor'; personal friend, amateur scientist, local personage and practical generalist. The model of collegiate organisation was that of a kind of organic collectivism; the College was conceived as an information-gathering centre whose purpose was to reflect the natural equilibrium of the 'free field', and to circulate information across the homogeneous network of general practice.

But by the early 1960s these collegiate emphases shifted to the issue of training (Editorial 1964: 303); from objectivising the 'free field' to working upon and conceptualising the persona of the doctor. This transformation was as much a rearticulation of the old themes as a wholesale reversal away from them. In fact all the main themes from the previous decade remained; those of research, of education, of 'logistics' and 'statistics', of the status of the doctor and so on. But these themes were ordered according to a new economy. The transformation was not a move away from the project of founding a general practice attentive to the living patient rather than the corpse; rather, this project was re-sited around the issue of training itself. Two areas evidence this continuity.

First, the question of the 'patient' or what was termed above the projected 'ontology' of general practice. This ontology remained stable insofar as general practice remained linked as an independent endeavour to the 'anti-medical' concern with patienthood, that is, with treating the patient and not the corpse or the disease. But if this was the long-term clinical ideal behind much thinking about general practice, it remained difficult - as has been shown - to operationalise on the level of knowledge and research.

In fact during the 1960s the ideal form of this patient-centred ontology itself underwent transformation. In the

1950s the aspiration for a patient-centred medicine revolved around the question of the 'sick individual' moving through the grid of time. It would be anachronistic to read back into this conception of the individual any will to capture a 'biographical' or 'holistic' patient - for example, using the tools of psychology. In the 1950s to be a 'generalist' implied that one performed, as a doctor, many functions. It was only in the 1960s that the 'generality' of the practitioner's tasks came to refer to properties of the patient as opposed to those of the practitioner himself; that is, it is only now that the patient becomes a 'general' phenomenon with all the demands that this implies by way of 'wholism', biography and subjectivity. But - as this chapter will show - an entire - 'technological' - infrastructure was necessary for the actual appearance of this figure.

Second, consideration can be made of the status of psychology. It is not only at this point that medicine in general and general practice in particular became concerned with the domain of the 'psychological'. David Armstrong has convincingly outlined the long genealogy of the impact of psychological ideas - especially grouped around the problem of the minor neuroses - in twentieth century medicine (Armstrong 1983). Further psychology has long had a special status in the history of anti-medicine itself; the work of J.L. Halliday in the 1930s, for example, is testimony to this (Halliday 1948; Figlio 1987; Armstrong 1983). Psychology in these cases possessed

primarily an aetiological function in that it was recognised that there was a psychological dimension to many illnesses. In the 1960s, however, the status of psychology was transformed from this rather narrow aetiological function to become central to the very constitution of general practice as an autonomous discipline. As such it began to traverse the whole space of general practice; it became, as it were, residual everywhere; a factor in diagnostics, therapeutics, pedagogy, professional identity and even in the question of medical organisation. At the same time, this diffusion of psychology at, as it were, all levels lead to a generalised personalism; all levels of general practice became constituted by the subjectivity of persons; general practice became - not just a 'patient'-centred discipline - but person-centred. This sense of an ubiquitous personalism and of psychology as constitutive of the field of general practice at all levels has already been illustrated in the case of Balint; indeed, his work is a kind of blueprint of it. But what was the extent of Balint's actual influence on this transformation itself?

1.ii. By the 1980s doctors and others, surveying the field, felt it to be evident that Balint had had a major impact on the discipline (e.g. Freeling in Pendleton and Hasler 1983: 161- 175; Stimson 1978). What was the nature of this impact?

In some senses, the influence was more or less direct. In particular, it is worth singling out a very important, if certainly controversial, training publication sponsored by the RCGP (discussed further below) that was more or less explicitly derived from Balint's insights; The Future General Practitioner, Learning and Teaching (RCGP 1972). However, if one assesses 'direct' influences such as Balint's training seminars in numerical terms, the results are scarcely impressive (see e.g. Marinker 1970). The comparative figures given by Sapir for the early 1970s reveal the relative success of Balint-style groups in Germany (the seminars around H. Stolze drawing some 1,000 practitioners each year) and France (where some 10% of the doctor population had participated in Balint groups); whereas in Britain only 1% had been involved in such groups by 1974 (Sapir 1972: 185-8; Honigsbaum 1979: 310-311). Similarly, if one looks for a specifically 'Balintist' legacy in British general practice one will be disappointed; we will not have reason to examine, for example, the Journal of the Balint Society here since it remained a strictly marginal publication. It can be pointed out, however, that those doctors who did take part in seminars under Balint's tuition have had a disproportionate influence upon general practice. Honigsbaum comments that those who had attended Balint-style seminars - people like J.P. Horder, M.L. Marinker, P. Hopkins, and P. Freeling - 'exerted an influence far out of proportion to their numbers' (ibid: 311); notably, in fact, in relation to the training policy of the Royal

College of General Practitioners. Yet even these writers were not 'Balintist' in the sense of seeking dogmatically to defend and extend the legacy of the 'master'; one will find few concepts in their work explicitly derived from Balint's writings, nor even do these authors make much use of psychoanalytic concepts in general. So even here the influence is less of a 'direct' nature, than a general one of orientation; perhaps, a certain 'style of thought'.

This is no doubt why writers on general practice are unanimous in stating that Balint's work has been greatly influential whilst at the same time finding it difficult to pin down the nature of that influence to anything more than the most general terms. Sowerby, in a critique of Balint's ideas, acknowledged in 1977 that Balint's work 'has probably had more influence than any other on the development of general practice over the past twenty years' (Sowerby 1977: 583) whilst seven years earlier an editorial in the College journal noted, but was unable to specify, its general influence and intrinsic 'greatness' (Editorial 1968: 408). An editorial in the same journal in 1973 declared of Balint's work that it:

'marked a watershed in the development of general practice. Even now ... it can be claimed that this [The Doctor, His Patient and the Illness] is the most important book on general practice to have been published this century' (Editorial 1973: 133).

The editorial continued by observing that, although Balint

himself probably only personally dealt with a few hundred general practitioners (of whom, it noted, 'many were of Jewish origin and many were outstandingly able'), his influence was both vaguer and yet more generalised and far-reaching than a merely numerical survey could suggest:

'It may be that ... in time his greatest achievement will be seen to be his effect on those doctors who never met him ... He who in his seminars elucidated the role of the father figure has become a father himself ... we believe that what Freud has become for psychiatry, Balint will become for general practice' (ibid: 135).

More recently Christian Heath has praised Balint:

'who more than anyone else brought to the profession's attention the importance of communication in the consultation. This is not to suggest that many general practitioners formed or participated in 'Balint groups' or were directly influenced by his work. Rather his powerful demonstrations of unexplored illness and the criticalness of communication to diagnosis and treatment permeated the profession and gave support to the growing arguments for postgraduate training and research in general practice' (Heath 1986: 2).

Balint's influence might be described, then, as being 'catalytic'; at best his work made possible a heightening

of visibility of certain themes (those of the doctor's reflexivity, communication, etc.). Yet to acknowledge this influence is not the same as to suggest that Balint's work operated in a straightforwardly causal manner in transforming general practice away from the taxonomic project. Rather, his work exists within and is part of the same intellectual 'atmosphere' of the newer themes and trends that began to be consolidated in the early 1960s, and which formed the basis of what is now often labelled the modern 'renaissance' in general practice. Indeed, as Balint himself pointed out there is a sense in which a 'Great Man' - or 'causal' - view of his work is precluded by the very nature of that work itself. After all, the only 'method' of the research seminar is to let surface only what must necessarily surface, as dictated only by the nature of the preoccupations of the present times:

'Our seminars are based on a spontaneous participation without any prepared agenda ... one soon becomes aware of a sort of inherent system which reflects the spirit of the time... that is, which grows naturally out of research work and has not been imposed on it from outside' (Balint 1969: 203).

However, we must attempt to state the 'causal' status of Balint's work a little more closely than this if certain misunderstandings and 'over-interpretations' of the evidence are to be avoided. The first point to be made concerns the definition of Balintism itself. What emerged

from the previous chapter was less a coherent, instrumental set of 'doctrines' (tied to a specifically psychoanalytic vocabulary) so much as a collection of inter-related themes; Balint's emphasis upon the reflexive subjectivity of the doctor, upon the 'ethical-scientific' space of the consultation, an appreciation for group relationships and person-to-person dynamics more generally, and lastly the 'anti-scholastic' bias that afforded a certain privileging of practice before knowledge, treatment before diagnosis, education before research. And these themes - rather than specific doctrine or a specifically psychoanalytic vocabulary - summed up what was meant by Balintism.

What we will be looking for in this chapter, then, will be evidence of a congruity with these themes rather than evidence of specific 'adherence' to Balint's teachings. As such, the analysis presented here actually precludes causal considerations. Rather, what will be at stake are not dogmatic affiliations but, as it were, lines of force which link the themes of Balintism to wider, institutional themes in general practice. In short, Balint's own work and the wider, 'Balintist', rationality in general practice that we are about to describe are in a relationship of juxtaposition; a relation of 'adjacency' rather than 'causality'. Moreover, in the process of translation from one - more or less narrow - context to another - far wider, more diffuse - field, the themes and emphases in question will clearly undergo a certain

transformation, a loosening of conceptual intensity, which should not be evaded. And this means, that the themes in question will themselves be subject to a diffusion, a heightening of ambiguity. No doubt there are many lines of force that one might trace linking Balint's work to wider rationalities in general practice and elsewhere; the signification of his work is neither uni-directional nor pre-determined. In this study we will be concerned with three such line of forces in particular. First, with outlining the connections, alignments and re-alignments pertaining between Balintism and the general epistemological theme of self-surveillance. Second, with the way in which these emphases come together to form a veritable organisational 'technology' of general practice, based upon a 'chain of identifications' linking trainer, trainee and - lastly - the 'whole person'. Third, with the genealogy that links a person-centred psychotherapeutic approach in general practice - perhaps rather unexpectedly - with a neo-liberal 'governmental' emphasis upon the 'responsibilisation' and autonomisation of subjectivity.

2. Surfaces of Emergence

What were the surfaces of emergence of this general 'spirit of the time' to which Balint refers in the above quotation? Certain more or less contingent themes and perspectives can be isolated as conditions of emergence of the themes both of Balint's own work and of the

rationality of 'self-surveillance' considered in this chapter. Some of these have already been considered; for example, it was shown in the last chapter how matters 'psychological' became increasingly visible and simultaneously problematic (since so apparently 'doctor-dependent') in the results of the surveys themselves (see e.g. Playfair 1961: 419-442). Similarly, a mutation in the notion of 'madness' received institutional recognition in a manner relevant to general practice during this period. Thus the 1959 Mental Health Act proposed a new, general category of 'mental illness' (itself placed at the most generalised region of a kind of continuum marked by 'severe abnormality', 'subnormality' and 'psychopathic disorder') to replace the more restricted and 'negative' terms of 'unsound mind' and 'mental defect' (Royal Commission on Mental Illness 1958; for the general practitioner's views on this; Editorial 1960; also B.M.A. 1960). The Act also, of course, made minor 'madness' everybody's concern - and especially the general practitioner's (Curnow 1962: esp. 23) - in an immediate 'community' context as well as in a conceptual one.

2.i. A similar and related mutation occurred in the context of what can be called the pharmacological problematic. This influence was marked on several levels which can be linked broadly to the impact of psychological or 'behavioural' perspectives. First drugs - especially librium and valium - objectively enhanced the social visibility of minor depressions, emotional upsets and so

on simply because of the rise in prescriptions that resulted from their introduction (Jeffreys and Sachs 1983: 54). Here, the reaction (excessive prescriptions) to an apparent onrush of psychological and behavioural problems was deemed as being as pathological and dangerous as the problems themselves (Lane 1969: 101; cf. Grant 1957: 16). As an Editorial put it in the College journal in 1979:

'it was a pharmacological revolution which exposed this deficiency... [and] drew the attention of government, public and profession to a reality which had previously been underestimated' (Editorial: 1979: 325).

Second, drugs themselves were recognised to have psychological effects (Handfield-Jones 1962). To study the problem of drugs was to study the psychological aspects of therapeutics (Balint et al. 1966 classically addressed this question). Indeed, as with Balint's therapeutics of the doctor the pharmacological problematic is one that seems to emphasize the priority of therapeutics above knowledge: one prescribes a drug because one knows it will have effects rather than because one has fitted the cure to the aetiology of the disease. This is no doubt why Balint deployed the pharmacological problematic in his conceptualisation of the doctor as a kind of powerful, dangerous 'drug' requiring a constant labour of monitoring and assessment (Balint 1957:1). The drugs problem also met up with this necessity of self-surveillance by the doctor in the question of 'prescribing habits' which were known to differ individually from doctor to doctor: in other

words, drugs were a psychological matter in relation to the doctor as much as to the patient (Eimerl 1962: and the findings of the Hinchcliffe Committee of 1959).

Third, the pharmacological question related to a sense of urgency and crisis in the present, indeed to a new theme of 'present-centredness' that contrasted with the objectivizing aspirations of general practice in the 1950s. The emphasis moved from a concern with identifying the (morbid, organisational) properties central to general practice as an independent field, to a vigilant concern with identifying the emergent problem, the contingent trend or event and the tasks necessary for dealing with these; a theme that can be described as the 'problem-centred' focus of general practice emerging at this time. In relation to the terminology of an earlier chapter, it can be said that here vigilance has taken precedence over logistics; or, at least, that the latter is now to serve the purposes of the former. What is interesting about this theme is that it was mirrored on other levels of general practice; most notably on that of diagnosis and clinical rationality itself where - as will be seen later - the identification of problems and tasks became central to treatment.

Connected with this concern for the contingency of the present was the emergence of a new link between 'prevention' and 'urbanism' which can be usefully contrasted with the problem of infectious disease in the

Nineteenth Century. As de Swaan notes the very idea of the 'urban' was tied both to infection and a 'police' network of prevention:

'Nearly all urban concern for order, decency and cleanliness could be collapsed in the paradigm of infectious disease and at the same time this notion hinted at a programme of prevention' (de Swaan 1990: 124).

For the general practitioners of the 1960s - emerging from a paradigm largely centred upon 'country practice' - the problem of the urban present was, schematically, not one of hygiene (whether posed in terms of filth, sanitation or even 'mental' health) but of isolation, solitude, depression. This theme was given paradigmatic expression in Balint's work:

'Particularly as a result of urbanization, a great number of people have lost their roots and connections, large families with their complicated and intimate interrelations tend to disappear and the individual becomes more solitary, even lonely' (Balint 1957: 2; for similar expressions of this theme, inter alia, Watts 1972: 233; and esp. R.C.G.P. 1977: 205-6).

What was at stake in the 'present' was, above all, the breakdown of old - especially familial - ties of interdependency which as a corollary made the supportive functions of the doctor ever more important (e.g. Browne and Freeling 1967: 32 & 38). The field confronted by the general practitioner came to be conceived less in terms of

families and their disruptions than in terms of the potential breakdown of family life altogether. But if the isolated individual was conceived as a 'threat' to social stability, what had to be promoted was not the opposite of isolation - collectivism, solidarity - but autonomy, self-reliance, self-responsibility, individual maturity, the ability to live with oneself without dependencies.

2.ii. One particular consequence of this trend of problematising present contingencies was a certain denigration of the powers of 'theory' or formal knowledge. This can be connected to the comments already made about psychology. In general practice one confronts contingent problems in practice itself, not through a priori judgements or preliminary 'taxonomies'. Without doubt, the import of a 'psychological' orientation resides largely in that it is the incarnation of this 'retreat from theory'. Thus it is a commonly-held characteristic of 'psychological' approaches that they should be interventionist, dynamic, and open rather than closed, artificial, theoretical. In fact, in a rather paradoxical way, psychology represented the attempt to conceptualise this retreat from objectivisation and theory in general practice. Now, what is at stake here is specifically a 'psychological' perspective as opposed to a 'psychiatric' one. Psychiatry is a discipline that can indeed be 'applied' to general practice (e.g. see the work of the General Practice Research Unit at the Institute of Psychiatry, collected in Shepherd et al. 1981, 2nd ed.;

also Williams and Clare 1979). But what now takes on a certain provenance is not psychiatry as a mere 'aspect' or 'branch' of general practice, but psychology as pervading it. This distinction is one that emerged very clearly from the College's own report into psychology published in 1967 (RCGP 1967). After a certain amount of agonising over definitions, psychology emerged as that form of activity that deals with 'human relations' (known as "'non-specialist psychiatry" [which] the members found difficult to define') an activity concerned - in contrast to the rarefied concerns of both 'formal psychology' and psychiatry - with 'the basic problems of everyday personal and family medicine' (ibid: 1, 15). Thus psychology represented that tendency to get away from the "'objective" view of disease, which obscures the essential unity of the human being' (ibid: 13). This explains the hostility to psychiatry found amongst many person-centred practitioners (e.g. RCGP 1972: 19), the frequently-stated indifference to precise calculations of the exact component of psychiatric problems in general practice (e.g. Byrne and Long 1976: 14-15). What was at stake was not particularly the assessment of psychiatric pathology but a more generalised focus upon, above all, the emotional relationships (e.g. Mitchell 1971: 2); interpersonal relations at work within the individual, in the family, in society and in the consultation. This status of psychology actually explains why one finds very little conceptualisation of 'psychic' matters in the general practice field. Here, psychology designates a

general emphasis, a general ordering of the field rather than any commitment to specific dogmas. Cline sums this up:

'In its widest aspects psychological medicine is the science of understanding human emotions, personalities and relationships in the medical field' (Cline 1961: 243).

3. The Emergence of the Imperative of Vocational Training

Psychological ideas, as in the case of Balint's own work, were also important in providing an intellectual basis for training doctors. It is to a brief descriptive overview of the entrenchment of this pedagogical rationality both in the College and in general practice as a whole that we now turn. (Pereira Gray 1982; Hasler in Pendleton and Hasler 1983, and Horder and Swift 1979: 24-32 are main sources on the history of vocational training.)

2.i. The College, and other bodies, had of course been interested in the question of training and education before the mid-1960s. As Pereira Gray comments the Cohen Report (BMA 1948) in declaring general practice to be a specialty thereby implied the need for a specialist form of training in the discipline (Pereira Gray 1982: 1-17; although cf. Editorial 1964: 303 which describes training as a new emphasis). Indeed, in 1948 the government had agreed to set up an assistant trainee scheme whereby post-

registration students could be attached to practitioners who would receive government remuneration for their services (Fry 1988: 62-3). The ethical notion of 'vocationalism' ('continuing education' throughout a doctor's entire career), however, was not yet tied to this demand: what was required was merely a respectable gap between registration and entry into independent general practice. During this period the trainee would be an 'assistant' to a principal practitioner but the latter was not required to possess any specific educational skills, let alone an exemplary 'persona' with which the trainee should identify. During this period the trainee would merely gain experience and be inculcated with the skills specific to practice. By the late 1950s, in any case, the assistant trainee scheme was agreed to be in a state of collapse (Evans 1967 reviews the failure of the scheme). On the one hand, the numbers applying for traineeships was declining and those in traineeships were complaining of being used as cheap assistants, learning little, at government expense; a problem which reached its peak in 1965-6 (Pereira Gray 1982: 4, 7). On the other, the purposes and content of training appeared to lack any coherent ideological rationale or underpinning, let alone commonly agreed standards to be achieved; standards which the research-orientation of the College had done little to illuminate.

Calls for a more comprehensive provision of post-registration training received an ideological boost from

the 1961 Christchurch Conference on Postgraduate Education (Fry 1988: 65) which called for local postgraduate centres to be set up as permanent regional facilities for continuous education, and an institutional one from the acceptance by the Ministry of Health in 1964 of the principle that postgraduate education was the responsibility of NHS exchequer funds (Pereira Gray 1982: 7). Nevertheless, the problem still remained as to what this education should consist of: what should be the 'ends' of training, what sort of doctor should it produce?

2.ii. It was to these questions that the College of General Practitioners was to give special attention from the early 1960s, turning its resources from the matter of research to that of postgraduate education and training, with an influential series of reports and documents on the content and organisation of training (e.g. RCGP 1967 & 1969) ¹. These immediately register the shift of emphasis from the concern to illuminate the characteristics of the 'free field' towards the delineation of the ideal properties of the general practice doctor:

'The need in the community is for a doctor with a very broad training. His essential task is the assessment of problems which are presented by patients and families in his care. Such assessments demand an understanding of psychological, social and economic factors which influence health and disease as well as an understanding of physical pathology' (CGP 1965:

1).

In their submission of evidence to the Todd Commission (1968) the College working party on vocational training recommended a post-registration period of five years, two of which were to be spent working in general practice and the rest in hospital posts (preferably in the fields of obstetrics, paediatrics and psychological medicine); a period reduced by the BMA and the Department of Health to three years (RCGP 1969). In 1967 the General Medical Council of the BMA accepted the recommendation that all doctors should undergo vocational training, a recommendation also echoed in the Royal Commission on Medical Education 1968; cf. also JCPTGP 1982). But what matters for the purposes of this discussion is less the apparatus of vocational training than the ideals it implied. For its significance lies less in the fact that it gave rise to a longer period of qualification for doctors than the fact that it made training into a kind of permanent ethic of practice (e.g. Horder 1969: 9). Vocational training prepares the general practitioner for practice; it makes him a minimally competent (that is, not 'dangerous') practitioner; a 'safe' practitioner but not a composite practitioner (cf. the comments of Fry et al. 1983: 78; cf. Horder 1969). This latter status can only come about, not through qualifications but through ever-continuing education; an understanding of the general practitioner's entire career as being a never-ending learning-process.

If on a 'political' level the institutional implementation of vocational training was beset by delays and failures - largely due to hold-ups at the Conference of Local Medical Committess over the question of payments to trainees - then it is nevertheless true to say that the aspiration itself remained at the heart of general practice discourse across the 1960s and 1970s. No doubt the very tardiness of the implementation of vocational training was contributory to this discursive persistence (in 1968 there were only ten centres in the United Kingdom offering vocational training schemes, and one hundred and two by the end of 1973; Hasler 1974: 614). Thus, it was not until 1975, under the auspices of the RCGP and the General Medical Services Council of the BMA, that a Joint Committee on Postgraduate Training for General Practice was set up to devise guidelines for training and to handle the logistical matters of finding hospital posts, trainers and trainee practices for trainees. Whilst the big breakthrough in legislative terms came with the NHS Vocational Training Act of 1976 (see for details: Parliamentary Papers 1975/6) the actual recommendations deriving from this were only to be implemented over a relatively long time-scale. Thus the Act stipulated that it would not not be possible after February 1981 to become a principal in general practice without having completed a (vocational) training year or having earned a certificate of equivalent experience, and that by August 1982 it would no longer to be possible to enter general practice as principal without having completed a three year programme

of vocational training, including at least twelve months in an approved training practice. But in effect, the mere emphasis upon training achieved what the taxonomical project of the free field had failed to do; to turn general practice (albeit by fiat rather than 'discovery') into, in Pereira Gray's words, an 'independent clinical discipline'. Thus, the 1976 Act might indeed be compared in its significance with the 1858 Medical Act (Pereira Gray 1982: 17; Editorial 1976).

Of course, the College was not uniquely responsible for the emphasis upon vocational training that was to be such a feature of the two decades after 1965. The Platt Report (1961), for example, had already emphasized the principle within the hospital service itself by arguing that all non-consultant grades should have training status. But the College (especially through its programme of 'training the trainers') was to give this general movement an 'academic' or 'intellectual' substance, and - in the process - sought for the general practitioner an 'exemplary' status (indeed, as the archetypal 'clinician') within medicine as a whole. In this way the College was able to raise its own profile within general practice. It was by no means the obvious vocation of the College to take upon itself the role of researching into, and setting, training aims and standards. In 1964 Kenneth Robinson, then Minister of Health had suggested the founding of a new institution to counter the declining rate of recruitment of general practitioners:

'Surely general practice must in future require special postgraduate training. A desirable development is the idea which is being canvassed for setting up an Institute of General Practice which would have the job of carrying out research and education and establishing standards' (quoted in Hunt 1965: 79).

The College had to transform itself in intellectual and organisational terms in order to take on this role. It was to do so not merely by exerting an intellectual 'influence' on training schemes and so on, but - on a more concrete level - by turning itself into a kind of 'obligatory passage point' for those who wished to demonstrate high standards in general practice.

2.iii. By the early 1960s it had come to be recognised that the impact of the College on education in general had been minimal. As John Hunt, one of the founders of the College, put it:

'After eleven years of the College's work all this is disappointing; ... the main impact of our College on training for general practice itself can never be in the undergraduate phase' (Hunt 1964: 139; cf. Editorial 1964: 303).

With recruitment to the College on the decline, he proposed - in a perfect example of the logic of 'interessement' - to link the fortunes of vocational training to the very identity of the College itself; specifically by making vocational training effectively a

compulsory condition of eligibility for membership (including a commitment to continuing education) so that 'students will take much more interest in our College's work than they do at present' (ibid: 143).

By July 1968 the College had introduced - in a reversal of its founding principles - an examination requirement for entry; the 'MRCGP' (see on the retrospective rationale behind this e.g. RCGP 1974, College's evidence to the Merrison Commission). A three-year period of vocational training - provided it was on a scheme specifically approved by the College - would qualify the candidate to sit the exam for College entry. The adoption by the College of an entry-examination had effects that were relevant both to the internal structure of the College and to its place within the wider field of general practice. In fact the whole question of the exam had been almost coterminous with the foundation of the College itself; an 'examination committee' had already reported on the subject in 1955 (CGP 1955: 33-7). However, successive Annual General Meetings of the College were to reject the idea as not complying with the ideals of general practice where, in the absence of a formal ladder of advancement, seniority was necessarily predicated upon long-earned experience rather than evidence of the attainment of formal knowledge. But with the adoption of the idea of the exam the role of the College underwent a subtle shift (cf. 'College News' 1960 and Cookson 1960). From being above all a research organisation it was now to become

simultaneously a 'professional' and 'educational' organisation regulated by specific entry standards. Entry to the College guaranteed a certain competence but above all a particular orientation to general practice; in short, to the 'patient-centred' orientation espoused by the College itself. But if in this way, with the adoption of the exam, the College effectively entered into the field of 'professional politics' this was concealed by the strictly 'academic' nature of the College's concerns. For the exam itself was primarily an academic matter:

'The mere exercise of defining the scope of the exam will itself give a guide to those whose duty it is to teach undergraduates and organise postgraduate courses; and general practitioners themselves will gain a clearer idea of the range of the work' (Editorial 1962:3).

More widely, what was significant here was that, since completion of a vocational training scheme carried with it no formal qualification, the MRCP - which could be taken only after completion of those training schemes specifically approved by the College - soon came to fulfill this role; with the effect that possession of the MRCP itself came to signify qualification for the status of principal in general practice. An exemplary 'interessement' strategy was involved here according to which general practitioners, in being tied to the professional necessity of vocational training, were simultaneously to be tied to the ideals of the College. On

the one hand, if students wished to gain an academic qualification in general practice then they would have to take the College's MRCGP exam. On the other hand, passing this exam meant that they would be members of the College itself, and hence tied to its principles; person-centred medicine, continuing education. So, without actually making College membership compulsory for aspirant principals, by instituting an exam for entry which was simultaneously a certificate of completion of vocational training the College was placing itself strategically in a position, as it were, between the personal aspirations of younger practitioners and the wider - 'professional' - vocation of general practice as a particular kind of discipline. Thus the College was able effectively to align the personal ambitions of practitioners and the values which the College was seeking to disseminate within general practice.

The effectiveness of this strategy was reflected in recruitment to membership of the College. In 1960 only about one-fifth of all general practitioners in the United Kingdom were College members (Fry 1960: 390; cf. Fry 1988); by 1988 over half of existing principals in general practice were members (a figure which includes those who had been principals before 1981 and therefore had no vocational 'need' to join the College).

CHAPTER SIXTEEN

COLLEGIATE PATTERNS OF ORGANISATION AND RESEARCH

1. The Group Environment

The organisational transformation that occurred at this point can be characterised as entailing a movement away from a 'free field' conception to a 'group'-centred one. What was at stake was the 'material' of organisation itself; in place of an emphasis upon the space of the practice, its 'population' and morbidity profile the organisational domain confronted by the College came to be seen as being composed wholly of the relationships between persons.

1.i. During the 1960s the concept of the 'group' - though not always the word itself - came to signify the organisational principle towards which general practice naturally tended. For writers associated with the College of General Practitioners, the 'field' of general practice ceased to be, as it were, 'free', bounded only by the region or the locality, but became defined by a micro-institutional network of group relations. Clearly, a certain degree of 'reciprocal causality' was at stake

here. On the one hand, the idea of the 'group' itself, largely under the aegis of broadly 'Balintist' educational prescriptions (as put forward in both the initiatives of the College and the recommendations of official discourse, for instance those of the Todd Report of 1968) exerted a certain influence, whilst, on the other hand, organisational and financial constraint made something of a necessity of ideology here. This dimension of constraint is illustrated by the crisis that hit the profession in the mid-1960s which centred around the questions of underfunding, declining remuneration, low standards and lack of manpower (Klein 1983: 84-8, Gibson 1981: 95-7). In the BMA's 'Doctor's Charter' (BMA 1966) the notion of the 'group practice' emerged as part of the solution to these problems in that group methods of organisation facilitated the granting of funds for resources that would otherwise be denied the individual practitioner, whilst simultaneously retaining the 'personal' emphasis of doctoring alongside the autonomy of doctors that might have been threatened under the alternative organisational conceptions founded on the control of local authorities. Group organisation had, of course, long been advocated although, for the Cohen Report its definition seemed to be unclear (MOH 1954: 17). Now, the notion emerges effectively as a compromise between the independent, personal doctor and the collectivist, salaried implications of local authority provision.

1.ii. It is of interest to note in this context how the concept of the (long-advocated, little implemented) 'health centre' could also, with certain modifications, be brought under the umbrella of the group principle (see Harvard Davis Report on group practice, DHSS 1971; Sluglett 1961; Forman 1962: esp. 376). Thus, the Todd Report proposed both large group practices (even in the countryside; a proposal that would effectively obliterate the country doctor) and health centres so long as the doctors acted as a 'group' (Royal Commission 1968: 33-4; cf. the discussion of general practice organisation in Armstrong 1983: 82-4).

The group notion was useful precisely because of its applicability to a number of different levels of organisation (as pointed out by e.g. Dermott Grene 1966: 119). Thus, aside from its obvious - and paradigmatic - training uses (enshrined, for example, in Section 63 of the Health Services Act of 1968 with its provision for the setting up of Postgraduate Education Centres) the group principle has what might be termed a 'horizontal' significance relating to the 'peer' group (the group seminar, the group practice) and a 'vertical' significance (particularly applicable in the health centre) which concerns the doctor's relations with other medical and ancillary workers. Amongst doctors themselves the group principle was indispensable; the doctor could achieve 'wholeness' as a professional through the inducement to reflexivity and self-awareness guaranteed by his peer

group; the medical professionals with whom he worked (see e.g. Freeling 1976: 180-197; Courteney 1981: 57-65). As regards non-'medical' colleagues, it should be noted that the 'team' concept was itself only taken up within the context of a 'group' problematic. In fact, from the beginning of the 1960s the College had wedded itself to the principle of 'attachment' according to which health visitors, nurses, secretarial staff and midwives would join practices (see esp. Report 1961; cf. Baker 1964). Far more contentious was the role of the attached social worker; partly since social workers brought with them dreaded nuances of local authority control (Council 1968: e.g. 314) and partly because of claims, for example by Margot Jeffreys, that social workers should actually be the leaders of the team (on which matter, Editorial 1968; and - for some extremely forthright opinions - the letters pages of the BMJ and Lancet throughout the 1960s). Ancillary workers in general, however, were seen as being consistent with personalist and wholist rationalities in general practice (see e.g. Jeffreys and Sachs 1983); partly, as the phrase went, because they 'freed the doctor for doctoring' by performing otherwise dreary or administrative tasks (Wallace and Harvard Davis 1970; 168); partly because the very interaction of health professionals was a spur to attempts to define the field proper to general practice itself (Marinker 1970: 79); partly because it was widely felt that the keeping of paramedical staff under the noses of the general practitioners would also keep them under general

practitioners' substantive control (e.g. Lord 1965: 251); and lastly in that the very fact that the Team could pose a threat to the 'whole person' (a diversity of experts dividing up the patient) also served as a spur to the constant programmatic re-iteration of that project itself (Cartwright and Anderson 1981: chapter 5; Marsh and Kaim-Caudle 1976: 13-23). Of course, all this was only acceptable - and the whole person could only be protected from fragmentation - provided the general practitioner himself remained in ultimate charge, as himself the most 'responsible' member of the team with ultimate 'responsibility' for the patient (Central Health Services Council 1963: 38; Mackichan 1976).

2. Changing Imperatives of Collegiate Association

This 'group' or 'person-to-person' conception of the basic organisational field of general practice was tied to a shift in the way in which the College viewed its own relation to that field. This can be represented broadly as a movement from an 'ecological' model, whereby the College was seen as being, so to speak, part of the 'environment' of general practice which it served to regulate, to an 'instrumental' and more 'executive' model, whereby the College was to take a more distanced and strategic stance from the world of general practice; a 'mutation' that can be traced in the pages of the Annual Reports of the College in the 1960s (cf. Fry et al. 1983).

2.i. This mutation is evidenced above all in the realm of the organisation of research, the original raison d'etre of College organisation. It has already been seen how in the 1950s the organisational axis of the College lay with its research activities at two levels: research intended to make visible the extent of community pathology and that related to the workings of practices themselves ('operational' research). Both kinds of research were essentially 'descriptive': knowledge of the 'free field' was built up through a dialectical process of observations on the periphery and collection at, and re-distribution from, the centre. Thus, the role of the centre was primarily 'informational': it did not exist, so to speak, 'above' the 'free field' but was immanent within it. Now, in relation to research, the centre loses this relation of organisational immanence. This transformation was due, no doubt, to the relative epistemological failure of general practice research (CGP 1958: 40ff). The numerical proliferation of projects was coupled with the recognition of the lack of commensurability amongst those projects themselves. As discussed earlier, it soon became clear that no totalizing and objective knowledge of the 'free field' was ever going to emerge along a single and manageable dimension. By 1965 it had become clear, at least, that general practice research could never exist in an analogous relation to parallel forms of 'specialist' research and discovery:

'The direction in which research in general practice will develop is becoming easier to

discern. There will always be something to offer the medical specialties but general-practitioner research will never compete with them in their own research fields... He must relate his observations to those of the biologist, the social anthropologist, and the geographer rather than to the pathologist, the radiologist or the clinician' (CGP 1965, 13: 37).

2.ii. But what occurred was not the wholesale eclipse of research as an important dimension of general practice but the recognition that 'better' general practice would depend not so much upon the the discovery of objective knowledge as upon the better education of practitioners themselves. A corollary of this was the demand that general practice should imitate the specialities in terms of their hierarchical composition (rather than in terms of the specialist aspiration to extend knowledge): 'The 'Chief' in general practice as well as in hospital, needs his housemen and registrars' (ibid: 38). Central here was the turning away from a paradigm of benign 'amateurism' (the almost 'botanical' Gilbert White-inspired model of natural investigation which had been a defining feature of the 'free field') towards one of a more resolute and specialist 'professionalism'¹.

The early 1960s was a period of stock-taking and review - largely undertaken on the grounds of financial considerations - within the College. Whilst the basic

structure of a centre existing in relation to a multiplicity of provincial faculties remained intact, the nature of the centre itself was transformed. Within the domain of research organisation itself, the foundation of the Records and Statistical Unit under the directorship of D.L. Crombie in 1961 signalled the beginning of this trend. This marked a movement away from, first, the central emphasis, accorded within research to 'epidemiological observation' and, second, from the organisational tenet that all co-ordinating activities be - if situated at the centre - 'immanent' to the periphery, to a paradigm where research arrangements would become situated at a certain distance or remove from both the everyday, clinical activities of College members on the periphery as well as from central College concerns themselves. Hence, the Unit, financed by a grant from the Nuffield Foundation, was established in Birmingham away from the College centre, and with a degree of autonomy from College Council and the Research Committee itself; the College maintaining merely an 'advisory' role with regard to research through the auspices of an enlarged Research Advisory Unit, also situated in Birmingham (CGP 1962: 32-4; CGP 1963: 32; Pereira Gray 1982: 13).

3. Transformations Within Conceptions of Research

Within the domain of morbidity research itself there were some epistemological corollaries to these organisational

transformations.

3.i. There emerged in the 1960s something of a reaction to the 'scientific' pretensions of the epidemiological model that had been at the heart of the College's activities in the 1950s. By the time of his Mackenzie Lecture of 1972 D.L. Crombie could note how, in the past, general practice had not lived up to the aspirations expressed by the College motto, 'Cum Scientia Caritas':

'... we have lamentably fallen short of the sentiment expressed by this phrase. Medicine is a vocation and not primarily a science. This is a fundamental fact that we forget at our peril' (Crombie 1972: 7).

Part of this relative disillusion with 'taxonomic' forms of research stemmed from the fact that epidemiological investigation could be done by other kinds of professional worker: it was not specific to general practice (see e.g. Kalton 1968: 81-95). The implicit hostilities to what was viewed as 'incursion' emerged in an editorial in the College journal from 1971 which, reviewing a book by a team of academic epidemiologists - sneeringly described as 'a group of colleagues well known to one another' - could declare that:

'Epidemiology is a subject in which there is no immediate and obvious benefit. This is in contrast to patient care where, if all goes

well, there is a visible end-product in the recovered individual' (Editorial 1971b: 313-4).

Nevertheless, what occurred was not a wholesale rejection of epidemiology but a shift in its perceived use-value (the work of G.I. Watson was testimony to the enduring appeal of the epidemiological paradigm; Watson 1982). The numbers on the College research register increased progressively across the 1960s and 1970s. Moreover, individual studies were often successful; for example, the research concerning the 1957 epidemic of Asian influenza - heavily indebted in its investigative atmosphere to the work of Pickles - which had disproved the thesis that teenagers with the illness were less infectious than young children (Eimerl et al. 1969; Watson 1960: 44-79). But what had become clear was that epidemiology could not become the basis of a governing rationality of general practice at all levels. What was the nature of this relative eclipse of the role of epidemiology?

3.ii. Large-scale investigations of morbidity became a more specialised activity not perceived as central to the daily endeavours of the typical College member. This was partly the result of the fact that - in spite of the individual successes - as many as one-tenth of the projects undertaken under the auspices of the Research Committee in the 1960s failed to get off the ground (Editorial 1961: 345-8). Moreover, the lack of comparability of individual studies had certainly dampened

their over-all research significance by the mid-1960s. Thus, one survey of some thirty-seven individual research projects concluded with:

'a plea to workers in this field to publish future findings in a form which lends itself readily to general comparison. Our own survey demonstrates beyond any doubt the serious difficulties that confront anyone who tries to shape general hypotheses from the mass of material that has accumulated since 1945 and to which additions are continuously made' (Lees and Cooper 1963: 435).

The recognition that research was an enterprise requiring both sophisticated methods and a certain amount of financial expense contributed to the idea of setting up a separate Research Foundation in the early 1960s and shifting the leading-edge of research thinking away from the central organisation of the College to the academic GPs at Birmingham University (ibid: 346). This body was primarily responsible for conducting, along with the Department of Health, the second national morbidity survey in 1970-1 (OPCS 1974; RCGP 1976; Crombie et al. 1975: 874-879).

3.iii. On the other hand, research did remain an important aspiration for the individual practitioner but, paradoxically, not primarily as research. Thus in the preface to the second edition of Eimerl and Laidlaw's Handbook for Research in General Practice (the central

work on this topic in the 1960s) the purposes of research are located principally in the domain of the doctor's 'understanding of self' and the knock-on effects this was seen to have in relation to treatment:

'All these experiences lead to the conclusion that the family doctor who undertakes this self-imposed discipline is enabled as a result to offer a better standard of care to his patients' (Eimerl and Laidlaw 1969 [1962]: viii; cf. Howie 1979).

In other words, the fact that the individual study is an individual study is now at the very centre of its importance: there is less expectation that these individual studies might be possible to put together to describe one homogeneous field. Research becomes an aspect of self-education, transforming the doctor's now all-important conception of self:

'The survey has led me to ponder over things more deeply than is normal in general practice and it has enabled me to understand my practice the better' (Ryde 1964: 294-7).

Similarly in two much-quoted articles T.S. Eimerl praised the aspiration of 'curiosity' for its own sake above (although not in opposition to) any objective ends it might serve. After specifically criticizing the ideal of the large-scale uniform investigation using a mechanical punch-card system, conceived in abstraction from the practice of investigation itself, Eimerl went on to argue that the best kind of research in general practice was the

kind which contributed to the doctor's self-understanding:

'All this effort enables the participating doctor to better himself, to educate himself in matters primarily unknown to him, to become a more knowledgeable person and, it is hoped, to offer a better service to his patients' (Eimerl 1961: 636; Neale 1961: 43).

A perspective like that of Eimerl was clearly not in opposition to epidemiology as such. Rather, epidemiology had to be adjusted to the specific, situational perspective of general practice. What such an adjustment had to consider, above all, was that it provided 'the necessary freedom to the recorder' since, in an important sense, it was the recorder who was the object of investigation.

Moreover, this project of adjustment also had to take into account the fact that epidemiology, at least in the context of general practice, was a broader field than had previously been imagined. Thus, a way would have to found of problematising the emotional content of general practice within this epidemiological problematic. After all, were not current epidemics primarily mental in any case?

'If the amount of bodily disease in the world reached the same proportions of the many existing, social ills with mental and emotional causes... an epidemic state of emergency would

be declared and strong measures would have to be taken to combat the menace' (Eimerl 1961: 43).

This project spawned a series of attempts to devise new micro-technologies of recording data that would serve the purposes of monitoring individual patient biographies, illuminating emotional relationships and contributing to the doctors self-understanding as a vocationally unique individual with emotional effects on his patients.

3.iv. One of the first devices to be promoted was an invention of Eimerl himself, the 'E' Book or 'loose-leaf ledger' (Eimerl 1960). This system was intended to reconcile the problem of correcting the lack of commensurability of individual studies with that of maintaining the very individuality of the doctor. The actual objective was for the individual practitioner simply to record everyday diagnoses in his practice in such a form as to facilitate both quick recording and ease of transfer onto punch cards for analysis by the Records Unit. No actual discoveries were expected from this method: the knowledge revealed by the analysis of 'E' Book data would serve to illuminate particularities of individual practices and their practitioners rather than yield information about general practice as a whole. Thus, analysis showed the usual predominance of problems such as the common cold, acute tonsillitis and acute bronchitis: actual discoveries are, rather, made within this generally unsurprising horizon of morbidity, about particular

characteristics of individual doctors:

'The effect of individual professional attitudes is shown clearly for acute tonsillitis where Dr W. records at least twice as much of this as his colleagues... These aspects of the assessment of the case-load of general practice are puzzling yet not unexpected; they add materially to the problem of what happens in general practice...'
(Eimerl and Laidlaw 1969: 54).

The 'doctor effect' that became such a visible aspect of all studies of general practice morbidity also troubled the work of the Records and Statistical Unit. Part of the problem, they found, actually related less to the doctors themselves than to the disease labels they habitually employed. A study of whether disease labels commonly in use actually fitted 'the aetiology, pathology, and morphology of the disease process actually described by the label' concluded that there could be 'no great confidence in the accuracy with which the labels imply aetiology or pathology', especially in relation to personality disorders and mental and emotional illnesses (Symposium 1963: 204). The reaction to this kind of classificatory problem in their modified College 'Classification of Disease' was to place diseases relating to more or less vague symptoms and complexes into a category of their own (ibid: 204-16). Nevertheless, the dream of a classificatory system, perfectly fitted to general practice conditions had now disappeared².

Instead, attempts were made to develop means of measuring individual morbidity across time, but in a manner that would make comparison of results possible. Hopes centred particularly upon the summary 'S' Card (named after Dr. Richard Scott), designed to be both stable and flexible, usable with minimum interference to the doctor's daily tasks yet capable of central analysis (Records and Statistical Unit 1966: 34-40). The cards were designed to 'allow a picture of the sickness experience of an individual to accumulate over the years and be made readily available'. Information entered would include details of matrimonial status and social class as well as purely 'medical' data (ibid: 38). However, in spite of the durability of the programme of instituting biographical methods amenable to inscription the practice itself remained strictly a marginal one. This was, no doubt, due to the basic incompatibility of biographical and statistical approaches. For the paradigm of central analysis here remained 'epidemiological' in that it concerned analysis by disease label rather than of the 'biography' of the individual as such (see the follow-up study in the Birchfield Research practice; Research Unit 1973). The domain of investigation here - although certainly representing an attempt to get away from some of the more 'disease-centred' aspects of epidemiology in that it sought 'to demonstrate patterns in the sequence of illness' in individuals (Research Unit 1972: 380) - related to such aspects as whether a child who gets measles before chickenpox would be more likely to get

rheumatoid arthritis than one who has had chickenpox first. In other words, this form of analysis related to 'longitudinal' disease patterns rather than 'patient-centred' biographical data as such (ibid: 380).³

4. Rationalities of Self-Surveillance

It could be said that all such 'inscriptional' models of research were still tied to a kind of 'totalising' rationality; to the idea that one might be able to write down the entirety of an individual's history, family relationships and so on. There now emerges another research rationality that - to revert to the vocabulary of a previous chapter - actually puts 'vigilance' before 'logistics'; a rationality that concerns not totalities but rather contingent problem-areas and the isolation of particular tasks. This rationality is contingent, present-centred, evaluative, even political; but, above all, reflexive. It can be accounted for on both a micro and a macro level.

4.i. On the 'micro' level of investigation - and in a clear parallel with some of the concerns of Balint - there emerged a concern that was concerned with investigating the doctor's own powers of reasoning; and in particular with the 'constitutive' powers of diagnosis. This had an obvious relation to the demands of education; and was also to be instrumental in promoting an interest in methods of

'audit' in general. Crombie, in an Appendix to the College's evidence to the Todd Commission (1968), used such an analysis - of the doctor's habits of diagnostic pattern-recognition - to demonstrate how general practice differed from hospital medicine (Crombie 1966). In particular, it was found that in 65% of cases there was no need for an examination but that diagnosis could be achieved on the basis of the history alone, and especially on the doctor's experience of the patient (ibid: 28). The signification of diagnosis here takes on both an enhanced importance and an augmented uncertainty. Important because the diagnosis has itself an instrumental value in relation to treatment of the patient (that is, diagnosis is part of, and subordinate to, treatment; see e.g. Report 1961: 135). Yet uncertain because - for this very reason - the actual accuracy of the diagnosis may be in doubt. Diagnosis thus came to be in effect a self-validating process, since the diagnosis itself was understood to possess a kind of force of its own. Browne and Freeling, for example, noted how the circumstances of the consultation themselves modified the diagnosis: 'any interview involves interaction between doctor and patient which begins to modify the situation being presented' (Browne and Freeling 1967: 1). Hence the accuracy of diagnosis was given less emphasis than the doctor's intuition concerning what course it would be necessary to take:

'This system of starting treatment before there can be any certainty that it is essential is

based on the system of probabilities that cannot be measured accurately' (Crombie 1966: 29; cf. Drury and Hull 1979: 176ff. for a similarly 'probabilistic' emphasis; although cf. Castel's comments on risk in his article in Burchell et al. 1991).

The model of the doctor's reasoning here, although classically 'intuitive' according to the best 'clinical' traditions (Atkinson 1981; cf. Atkinson 1983b: 237-9), is nevertheless now considered understood as deductive as opposed to inductive: the doctor typically measures probabilities amongst a variety of alternative diagnoses and treatments; the doctor's reasoning powers are generically 'economic' in that they serve to select amongst alternatives. Thus a rational appreciation of the thaumaturgic process of diagnosis soon became conceivable:

'Traditionally the process of diagnosis was left undefined, a natural art, or explained as a process of intuition' (Gale and Marsden 1983: 8; cf. the pioneering work of Elstein in the USA, Elstein et al. 1978).

Now, however, it can be seen that diagnosis actually functions according to the best Popperian principles: the doctor generates hypotheses on the basis of 'broad psychological processes' (ibid: 131) which he then tests. The uses of intuition here are not opposed to the use of logic or reason:

'Intuitive methods, of course, are merely the

use of pathways which have been mapped out in the thought processes of the brain by laborious and continuous use and to this extent are based on logical or scientific method' (Crombie 1964: 588).

Interestingly enough, such a rationalised - even probabilistic - perspective actually allowed for a reconciliation with the 'aesthetic' - even self-consciously 'Hippocratic' - conception of diagnosis:

'If we believe that perception is a creative process and the perceiver selects a few of the mass of stimuli presented to him and uses his imagination to create a picture, then we can say the same about clinical diagnosis. For diagnosis is but an extended form of perception and we even use the expression "clinical picture" as if we were artists rather than doctors' (Elliott-Binns 1978: 116-7).

Again, we have here, then, a kind of 'phenomeno-technical' understanding of the doctor's powers. The general practitioner thus becomes the most 'creative' of all practitioners for whom 'history and examination is for confirmation only, as it were framing the picture rather than painting it' (ibid: 117).

Clearly for such diagnostic principles to be properly instilled the doctor needs to learn how to monitor his own

powers of reasoning; after all, this is the only way to test the validity of his otherwise largely self-validating powers. The task, then, became for the doctor to monitor his own powers of reasoning in order to gauge their effectiveness. The principle of medical audit (Mourin 1976), for example, was about 'self-criticism' (the analogies with Balint's work will be obvious): 'it is by reflection on experience that one learns' (Williamson 1973: 698):

'The main aim of audit is to analyse critically the methods used to define the patient's problem and the action taken to resolve it... so that the service offered to the patient can be improved' (ibid: 697; cf. Duncan 1965; also Hodgkin 1973: esp. 767; and on how 'self-evaluation' actually differs from audit, Birmingham Research Unit 1977: 266).

But it was also about knowledge - not about the totality of the 'free field' but about establishing the 'normal' standards to be expected from doctors; that is, with 'in its broadest sense, defining the 'normal value' upon which all medical practice is based' (Williamson 1973: 706). The question of 'audit' in the context of specifically educational research. Now, in the context of our general discussion of devices of inscription, let us only note an influential import from America embodying a similarly reflexive and evaluative rationality; the 'problem-centred medical record' (POMR). This, as a Journal editorial noted, entailed a change of emphasis from worrying about

the exact accuracy of diagnostic categories to 'problems presented by the patient or perceived by the doctor' (Editorial 1973: 301; Tait and Stevens 1973). This form of record was designed to highlight various problems and to monitor the doctor's progress in handling them (Weed 1963). What the POMR highlighted was not so much the biography, or even the cure, of the patient as an assessment of the powers of the doctor:

'The effect of this kind of record is also to shift the focus of attention away from the results and more towards the doctor's intention' (Editorial 1973; 301; cf. Clarke 1974: 771).

4.ii. This general shift towards an evaluative and reflexive, problem-centred rationality - here manifested at the level of the doctor's own self-surveillance - can also be seen at work on a more 'macro' level, that is on the level of, as it were, the self-surveillance of the profession as a whole. At the widest level, there emerged in the 1960s a concern, less to know and map the health field objectively, as to predict problems and tasks strategically. This development corresponds well to what Rudolf Klein has called the 'politics of technocratic change' of the 1960s (Klein 1983: chapter 3) which saw a general governmental emphasis upon accounting techniques of cost-benefit analysis, P.A.R. (Programme Analysis Review), efficiency studies and so forth (ibid: 64-5). Within the health service itself, there emerged the 'forward planning' emphasis of the Hospital Plan and the

'Health and Welfare' programme for community care (Ministry of Health 1963). Like the 1962 Hospital Plan, the latter programme outlined a long-term (ten years) planning initiative for the local authority health field (ibid: 1-2), devising rationales and setting monitorable targets. Again there is a kind of 'audit' mentality of self-surveillance at work here:

'Forward planning ... fulfills a number of important purposes. In the first place it provides the opportunity ... to review past performance, ... present needs and future expectations' (ibid, revision to 1975-6 [Cmnd 3022]: 1).

Within general practice itself the Gillie Report (Central Health Services Council 1963) was also part of this literature of macro self-surveillance, its task to specify, plan and predict:

'To advise on the field of work which it would be reasonable to expect a family doctor to undertake in the foreseeable future, having regard to the probable developments during the next fifteen years' (ibid: 5).

One problem, however, was a dearth of studies - 'objective data' - outlining what it was that general practitioners actually did (ibid: 55). The literature produced by the College concerning 'Present State and Future Needs' in general practice was designed to fill exactly this kind of gap. Begun in 1965, these reports attempted to meet the

need not for a total mapping of the free field but for 'critical analysis and evaluation of our work as an essential pre-requisite for the best and most effective use of our resources' (RCGP 1970: Preface). These reports supplied a variety of infrastructural information for general practice giving details of workload, manpower, content of general practice, ancillary trends and services and so on. But these analyses were intended not just as descriptions but as tools for evaluation, instruments for acting upon the present. Central to this concern was also the practice of prediction, the consideration of 'future needs' (Pridham 1962); for each evaluation could only be temporary in relation to an uncertain future, when, in turn, further re-evaluations would have to be made.

This rationality had, in turn, a corollary on the level of the practice itself; in the form of the setting up of 'diagnostic indexes' and 'age/sex registers' (and, later, screening facilities) of practice populations, intended to provide constantly re-evaluated pictures of the diagnostic state of the practice (Editorial 1971a: 59-60; cf. Drury and Hull 1979; Jameson 1970). Of course, the importance of such devices at the level of the practice had been recognised in the 1950s. But now these ceased to be factors primarily for research but became essential prerequisites for the daily, clinical conduct of general practice itself. What was required was less a logistics to bring the circumstances of practice to visibility; rather these logistical devices serve the purposes of a constant

institutional vigilance. A re-evaluation of the relation between information and temporality was clearly at stake here. Very schematically this might be characterised simply as a problematizing of temporality; one has to establish temporalities, what the future holds, the exact specifics of the present!⁴ Time has ceased, for the general practitioners to be a 'medium'; it has become something problematic, and an 'input' or a 'resource' for general practice (cf. the comments in Armstrong 1985); a consideration that may be clarified by a brief discussion of the uses - conversely - of 'space' in this context.

4.iii. For a transformation was also taking place in relation to how the space of the surgery itself was conceived. Earlier, we saw how architectural writings on general practice in the 1950s stressed that the surgery should be a 'homely' place - even if the home itself was, to an extent, itself partly conceived as a 'scientific' domain. Now, it could be said, the link between home and surgery is sundered. With the emphasis on the specifics of the doctor-patient relationship in the consultation - to which we turn below - the epistemological necessity that the home should be linked 'homologically' to the surgery was displaced. The ideal surgery became a much more 'artificial' space with standard furniture, lighting and so on; indeed its primary attribute came to be that it should induce efficiency rather than conducive of cure (M.O.H. 1967; cf. Richard 1962). This is because the atmosphere derives now not from the space of the surgery

but from the person of the doctor. So in a certain limited sense, from the 1960s on, the earlier force of the linkage between architecture and therapeutics was diminished. Since 'each consulting room is stamped with the personality of the doctor who uses it' (Jones et al. 1978: 100) the nature of the actual space of the consultation is less of an integral part of the therapeutic process. Of course, this is not to say that architecture loses its significance for general practice. One important consideration, for example, remained that of freedom of access to the doctor and amongst colleagues; a problem compounded by large group practice or health centre buildings. In addition it became seen as increasingly necessary to separate out functions in the surgery, and, in particular to free the realm of interpersonal verbal communication from that of other - lesser - functions. Hence one can still read off discursive priorities from architectural principles; functions became separated through the architecture of the building so that treatment routines, 'scientific investigations', bodily examination, and history-taking and private interview could occur in different spaces; the central being that of the private interview (Adams 1962; M.O.H. 1967; 25-31).

Overall, however, it can be argued that, in terms of therapeutics, the functions of space have lost their importance in relation to a temporal perspective of self-surveillance and vigilance according to which the

particular characteristics of the present are assessed and monitored in the light of the past and with a view to future development. The strong link between a personalist and a temporal perspective should not be surprising, but it is interesting to note that general practitioners themselves sought to characterise general practice as being, somehow, a uniquely 'temporal' discipline (e.g. Editorial 1973: 749). Thus, one very influential work attempted 'to demonstrate that [the general practitioner's] understanding and use of the time scale is peculiar to general practice' (RCGP 1972: 6ff.) and observed that time was at once a diagnostic tool ('we must understand the fragmentary, yet continuous, nature of consultations in general practice which may form an evolving process lasting days, weeks, or even years'; *ibid*: 6), a therapeutic tool and an organisational tool.

It was as if time had ceased to be an empty category for the practitioners, a framework for events, but had itself become a conditioned variable, and a resource to be used and understood. Perhaps the most important area where this was so was that of the consultation - around which, by the mid-1970s, a very large literature had built up - and the concern to map in minute detail the gestures and strategies of its successive segments and phases.

CHAPTER SEVENTEEN

OPERATIONALISING THE REGIME OF SELF-SURVEILLANCE

1. Communication and Consultation

It was around, above all, the specificity and sanctity of the consultation that general practice's claim to be an independent clinical discipline was to be laid from the 1960s on. This area was one in which Balint's own work had a more or less direct influence, although, as Armstrong has demonstrated, the discourse of the 'doctor-patient relationship' and its offshoots has a genealogy that stretches prior to and laterally beyond Balint (Armstrong 1982; Heath 1986: 2). However, this discourse, in fact, only became central in general practice when connected to the renewed interest in training. In an introduction to an important collection on language and the consultation in general practice, Tanner noted that the emphasis upon the consultation had been largely due to:

'the recent efforts, mostly sponsored by the Royal College of General Practitioners, to set up postgraduate training programmes for practitioners, both practicing and in training' (Tanner 1976; 1).

In Balint's own work, as we have seen, this link is specifically made; the doctor must train himself to receive the patient's full communication in the context of the consultation.

1.i. A subtle transformation was at stake here; one which marks the transition to a 'consultationism' similar to that found in Balint's work. For from the 1960s the 'doctor-patient relationship' ceased, in effect, to refer solely to an ongoing relationship between the doctor and the patient that he knows well, marked by trust, confidence and so on. This aspect does not disappear but it is overshadowed by a more important emphasis, one that stresses the process of communication almost exclusively within the narrow confines of the consultation itself. Thus, the consultation becomes a closely circumscribed domain where a unique kind of situational logic applies. Increasingly, studies in the 1960s, 1970s, and 1980s were to focus upon describing this unique logic and its variations; and the aim of postgraduate training became above all to inculcate the special skills of communication in the consultation.

The theme of communication draws attention to two emphases. Transformation: communication is intimately connected to the philosophy of vocational training and the demands of therapy. Communication, training and therapy are intrinsically transformative endeavours:

'The purpose of communication is not just to

deliver a message but to effect a change in the recipient in respect of his knowledge, his attitude or eventually his behaviour... good communication is difficult. Few can master it without special tuition and constant attention to its effectiveness' (Bennett 1976: 4).

Individuality: the practice of communication always entails an enhanced emphasis on uniqueness, singularity:

'... Communication must be matched to the knowledge, social background, interest, purposes, and needs of the recipient. It requires empathy, which is the power of projecting one's personality into and so fully understanding, the object of contemplation ... (ibid: 4).

Part of this individualistic emphasis linked up, of course, with the question of relationships and self-surveillance:

'Communication forms relationships; without communication there can be no relationship ... The doctor needs more than most to monitor his own behaviour. This is termed 'knowledge of self' ... but it is difficult because it resembles an emotional striptease' (Recordon 1972: 818).

The vocabulary of communication, then, was found to be ably fitted to the task of linking together otherwise disparate aspects of general practice; it works in the

literature like a kind of 'operator' moving across the field and translating all activities into its own language. For example, the notion was able to link the prerogatives of diagnostics (Drury and Hull 1979: 92ff.); the patient has to communicate his or her problem to the doctor: treatment; the doctor's job being to understand the patient's communication and then to communicate the meaning and purpose of the treatment back to the patient (Fitton and Acheson 1979: 84; Browne and Freeling 1967: 44; Stimson and Webb 1975): cure; since merely by communicating a level of self-understanding to the patient the patient's condition may be improved (a great theme of Balint's work): prevention; health education being a form of communication, for example, on matters of lifestyle (Fletcher 1973: part 2): professional organisation; governing relations between consultants and the GP and the GP and his group colleagues and the team (ibid: chapter 3): training itself; training is 'communicative' in that it induces 'a change in the recipient', or of perspective in the trainee (e.g. Fitton and Acheson 1979: 6). Moreover, the notion of communication was a peculiarly 'doctor-centrist' one. For, as Bennett commented, communication per se never fails; only the communicator - in this case the doctor - is subject to failure (Bennett 1976: 127). Hence, one of the first emphases of this literature was with the transformation of the persona of the doctor as communicating-device.

1.ii. It goes without saying that the communication paradigm fed directly into the emphasis upon the consultation, the paradigmatic person-to-person encounter. This was, after all, where consultation was both at its most problematic and its potentially most powerful. Browne and Freeling's The Doctor-Patient Relationship (1967) was one of the most important early contributions - besides those of their mentor, Balint himself - to this field (although Shorten 1966 is perhaps the first 'micro-study' of the consultation). The doctor in the consultation, they claimed, possessed a very special skill:

'There is a sixth sense to provide information about the patient; the emotional experience evoked in the examining doctor by the attitude and bearing of the patient' (Browne and Freeling 1967: 1; cf. Berne 1961: 84-90).

The consultation was not merely the place where this sixth sense was deployed, but was also a variable in itself. It was not where one simply diagnosed a pathology that existed prior to the consultation 'because any interview involves interaction between doctor and patient which begins to modify the situation being presented' (ibid: 1). Therapeutics, then, is going on all the time in the consultation; something which has key epistemological import. For, just as in Balint's work, the primary focus was directed not towards 'scholastic' theories of communication but directly towards training in skills of consultation. To gain 'knowledge' in general practice came increasingly to signify a mastery of this 'sixth sense' -

and no epidemiologist or even sociologist could provide this information. Hence on the basis of, as it were, an epistemological 'enclosure', general practice knowledge was to be increasingly confined in its signification to the acquired learning of general practitioners themselves. This knowledge had to be earned not simply taught:

'The transaction between doctor and patient is an interaction. It cannot be demonstrated by teacher to student or carried out under direct supervision' (ibid: 63-4).

Rather, what is at stake is a form of knowledge that eludes codification or strict rules of application by its very nature:

'The consulting room is as confidential as the confessional, but the doctor has no rigid data of religion either to turn to or to beset him' (ibid: 73).

In fact, this 'consultationist' emphasis represents the precondition of that whole secondary emphasis upon the 'doctor-patient relationship' which has been so very visible in the literature since the 1960s. The consultation became a kind of enclosed space that was 'scientific' in that it was a space closed off from the world and its complexities, a domain with a finite number of homogeneous variables (emotions passing between doctor and patient), a pure space of communication. The consultation:

'That most curious and fascinating of micro-

social systems, where, under a burning glass the symbolic interaction between patient and physician can be examined' (Stevens 1974: 6).

But this emphasis also had the effect of obscuring other domains. In particular the priority of the 'home visit' has now declined in significance; as indeed it had in actual - statistical - importance (by 1978 home visits represented only 0.1% of consultations: Pereira Gray 1978: 14). It was as if the home had become too inconsistent a domain in comparison to the consultation where one's emotions could be mobilised repetitively, visit after visit, alongside the stable personality of the doctor. Although, in fact, this may have been an epistemological rationalisation; a change of emphasis due to 'political exigency' as much as anything else. For, particularly after the Seebohm Report, the domain of the home became linked above all with the person of the social worker or the health visitor, rather than the doctor (on this question; Hasler and Stewart 1968: 33; Editorial 1968)

1.iii. It was not surprising that this 'scientific' aspect of the consultation should give rise to forms of study that attempted to treat the consultation as the equivalent of a laboratory (Editorial 1975). One expression of this was the interest in language and behaviour within the consultation; a form of analysis that combined the paradigm of communication - and the generation of

knowledge about forms of communication - with the more immediate demands of training.

Byrne and Long's study of 'verbal behaviour' in the consultation in their Doctors Talking to Patients (1976) is a good example of this, a work which could not be further away from the epidemiological emphases of the project of taxonomy (Byrne and Long: 14-15). Conducting a micro-verbal analysis of consultations Byrne and Long criticised the prevalence of what they termed 'doctor-centred behaviour' amongst general-practitioners, opposing to this, of course, a 'patient-centred' model according to which the doctor would be sufficiently self-aware as to be 'elastic' in relation to the particular needs of the individual patient:

'What we are offering here is a sort of camera with which one may take a picture of one aspect of a doctor's performance, even a self-portrait. Given such a picture, the doctor concerned is then left to decide whether or not he is satisfied with what he sees. Any doctor who wishes to do so, trainee or principal, may learn to analyse his own behaviours ... and monitor his progress in the use of new behaviours' (Byrne in Tanner, ed. 1976: 70)

Vocational training, they claimed, was the only means of instituting this model persona as the norm. However, other studies tended to be less obviously prescriptive as this whilst being more overtly 'academic', even multi-

disciplinary in orientation. Tanner's volume for example - sponsored by the College - included contributions from linguists, psychologists and educationalists as well as from general practitioners.

Yet what is one to make of this literature? For whom is the central discovery that 'medicine is more concerned with language than any other profession with the possible exception of law' significant (Tanner 1976: 11)? What practical or theoretical interests is this literature designed to serve?

Certainly it seems fair to assume that the interest in the field of consultation analysis went way beyond its immediate use-value to practitioners themselves. David Crystal commented, for example, in his contribution that:

'All a linguist can do is analyse interactions and see whether one's intentions of success or failure can be supported by pointing to specific features of the language use' (ibid: 50).

He did not himself, however, attempt such an analysis in his article but was more interested in the formal properties of language in the consultation. It is not surprising, then, that by 1983 Pendleton could note that whilst there had been a huge upsurge in studies into the linguistic features of doctor-patient interaction, this had contributed little of substance to assessing the actual effectiveness of consultations (Pendleton and Hasler 1983, 5-53: 46). Moreover, whilst communication

studies were an essential input into training, it should be remembered that this input occurred less upon the level of formal knowledge (that is, the theoretical elaboration of what to train) than upon the question of how the doctor should act within the consultation; a preoccupation, for example, of the influential 'social skills' approach to consultation training evolved at Oxford (see Wakeford in Pendleton and Halser 1983: 233-247; also Hasler 1978: 352-4). Nevertheless, this latter theme - the notion of skills specific to the consultation - inevitably came to be overlaid upon the former theme concerning the matter of 'what was going on' in the consultation. In any case; the 'method' of consultation, rather than its more traditionally 'clinical' dimensions, came itself to be largely constitutive of what was meant by 'knowledge' in general practice and consultation studies took on an almost exclusively pedagogical import.

1.iv. But in fact, what is most interesting about this work is less its supposedly practical uses but precisely the way in which the consultation - and the general practice consultation in particular - had carved out for itself such a central position for those elsewhere who wished to analyse human interaction. This can be seen on two levels; first in the domain of the social sciences and secondly, in that of medicine itself.

It would be difficult to ascribe priority to either the social sciences or medicine with regard to the

introduction of interest in the consultation. Armstrong is surely correct to place a major emphasis upon the works of Parsons in the 1950s (although he also looks to earlier works such as those of Brackenbury in the 1930s, and Parsons himself largely took over the theme from his mentor L.J. Henderson; Gerhardt 1990: 2; cf. Armstrong 1982). It would be difficult to imagine the theme having anything like the resonance it did, however, without the influence of psychoanalysis which took the meeting between analyst and analysand as its very object. It was no doubt in part this context that gave consultation studies such visibility from outside. Thus from a large number of perspectives, the general practice consultation became a kind of model space of interaction; a natural setting for the study of person-to-person interaction in general. Although, much of this writing carried, and carries, prescriptive elements, the interest in general practice is not merely instrumental in relation to that discipline. For Parsons, of course, the consultation was a model for the 'social system' in general (Gerhardt 1990; 29, Parsons 1951) and those who have followed him into the field have necessarily had to modify (and, arguably, trivialize) his emphasis, as Gerhardt has demonstrated, in order to bring socio-critical elements into the perspective. Our interest here, however, does not concern the virtue of all those studies that have taken the general practice consultation as their research object but rather it concerns the very fact itself of the visibility these studies have conferred upon general practice in general, a branch of medicine

that seriously seemed as if it might wither away at the beginning of the 1950s. Under this increasingly scientific - that is, analytical, objectivising - gaze, the general practice consultation has become an intense ethical site in the sense that every smallest gesture, tiniest move, most insignificant statement is subject to an obsessive dissection. 'Ethical' because this literature shows that at each step in the consultation order can be maintained, a satisfactory solution achieved, only on the basis of choices - of which the general practitioner must be a master - which, though apparently insignificant, maintain the interaction at its fragile equilibrium. Moreover, the justificatory infrastructure of all these detailed micro-analyses was that, to be able to make these choices both in an 'elastic' manner and as part of routine day-to-day performance an entire 'regime' of self-surveillance is required.

This is because an attention to ethical choices always presupposes a sphere of freedom, that is, an area where a multiplicity of choices are possible. How is the doctor to do the right thing given all these options? Given this ethicalisation of the consultation it was inevitable that consideration should be made more and more of the kind of person the general practitioner should be so as to be able to make these choices spontaneously. The focus should not be upon the body of knowledge at his disposal so much as upon his own disposition in relation to the body of knowledge that he wields. The ethicalisation of the

consultation has thus made possible the birth of the general practitioner as a particular kind of person; and hence of a particular kind of professional being. The so-called 'renaissance' of general practice is then inseparable from this ethicalisation, which allowed general practice to perform an act of 'enclosure' around its activities.

For the enhanced profile of general practice also depended upon the fact that general practice was able to claim an exemplary status within medicine itself in relation to the characteristics of the consultation. This act of 'enclosure' was achieved, of course, only by vaunting the sanctity and uniqueness of the 'the central medical act, the consultation' (RCGP 1972: xii, also chapters 2 & 3). This was largely due to that emphasis - already referred to - into the diagnostic pathways employed by the doctor. Under the impact of writers like Karl Popper (and, later, Americans like Elstein), it came to be noted that doctors typically deployed a kind of problem-solving deductive intuitionism in their practices. An important RCGP publication from 1972, for example, stated that the notion of innocent - i.e. inductive - observation was, in fact, a myth:

'In reality, of course, no such innocent observation is possible ... it is the process of recognition and testing which is the basis for clinical problem-solving' (RCGP 1972; 22, 44).

This general interest clearly privileged the domain of

general practice since it was the area where initial diagnostic choices were at their widest. Soon, textbooks upon clinical method in general tended to take general practice as their model, so that it came to be argued - usually, in the context of training - that a period in general practice was essential for all doctors who wished to learn good habits of clinical method (ibid: 22; cf. Wright and MacAdam 1979; Fraser 1987: esp. 82-3; also Wright 1975: 721; Marinker 1978: 203). It is interesting that one side of this work was a clear challenge to the 'charismatic' approach to the question of diagnosis apparently favoured by hospital consultants. Thus in contrast to the 'traditional' approach according to which 'the process of diagnosis was left undefined, a natural art, or explained as a process of intuition' it was recognized that although diagnosis came after long experience to be a matter of intuition it nevertheless followed wholly rational principles of hypothesis generation and testing (Gale and Marsden 1983).

What is important here is the notion that general practice was the optimal place - in the context of all medicine - to teach the situational logic of clinical method. And of course, the proviso went with this that training should take place not in an abstract manner - for instance, in the lecture theatre - but in situ, or as it was termed, in a situation of 'hot learning' (RCGP 1972: 9). Hence, it was characteristic of discussions of training to emphasise practical forms of the inculcation of knowledge. After

all, the process of learning is not the mere inculcation of knowledge but - in a clear parallel with the communication literature - involved actual changes in behaviour:

'All learning results in a change in the learner's behaviour. Teaching is therefore the attempt to modify his behaviour in a given direction' (RCGP 1972; 1).

Indeed, a distinction can be made between 'training' which is the inculcation of task-orientation and specific skills, and mere 'education' which entails more of a fixed content and more formal methods (Cormack et al. 1987: 34-5). As for methods of training these would have to avoid all formal forms such as lectures, and instead focus upon small group work (task-centred or process-centred). For general practice is, after all, primarily about relationships:

'He will usually work in a group with other general practitioners ... with the help of paramedical colleagues ... Even if he is in single-handed practice, he will work in a team and delegate when necessary' (RCGP 1972; 1).

Group work is good for the students in that 'it challenges their beliefs and attitudes and abilities to work with one another in order to explore developing relationships' (Cormack et al. 1981: 65). Thus all learning in the context of postgraduate education is self-learning, self-discovery; but also discovery of self. But in order to institute such a regime of self-learning, an entire

'infrastructure' was required; a whole set of linkages which would allow a particular kind of doctor to appear, without the mediation of formal, 'scholastic', knowledge. What was the nature of this infrastructure to be?

The form that teaching employed entailed a homology between patient and doctor and trainer and trainee, very similar to those we have found within Balint's work:

'Just as the patient goes to the doctor seeking help with health, so the trainee goes to the trainer seeking help with his education. Just as the doctor has experience of patient's problems, special skills in helping them and a wish to do so, so the trainer has special experience of trainee's problems, special skills in training, and a wish to help' (Pereira Gray 1982: 133; cf. Freeling and Barry 1982; 11).

A 'line of force' was thus created running from the patient at one end to the skills of the trainer at the other. But where there is homology so there is economy; simplification. A similar strategy to that of Balint's 'doctor-centrism' is at stake here. Just as Balint economised by not working with patients directly but with doctors instead, so the College turned the burden of its attentions to the question of the trainer and his relations with the trainee. It was to be, above all, to the 'training of the trainers' that the main efforts of the College - especially from the mid-1970s - were

destined to turn (e.g. Freeman and Byrne 1976 [2nd ed.]; Freeling and Barry 1982, an account of the Nuffield Project set up in 1973 involving the RCGP and the Tavistock Clinic; also Editorial 1972 and for an earlier emphasis, Report 1965: 74)). After all, if one gets the right trainers, the rest of the equation will take care of itself. A chain of identifications is created: trainees identify with the attributes of trainers; trainees become doctors, and patients identify with doctors. To institute the regime of self-surveillance as it ultimately effects the patient it is, in fact, to the trainers that one must begin.

But if the trainer is the key personage at the end of this chain of identifications, it is the trainee who is, as it were, the pivot that links the trainer on the one hand, and the whole person of the patient on the other. The patient will be the subject of the next chapter. For now, however, we are in a position to begin with this personage at the centre of this chain of identifications; the trainee.

4. Trainees: Individuality, Ethics and Ideals

Those sitting the MRCGP and those undertaking vocational training can be considered together since the former was designed specifically to 'map' the latter; thus, the MRCGP

was effectively conceived as a certificate of vocational training. What is it that this exam is designed to assess?

4.i. The MRCGP examination was designed to test 'the knowledge, skills and attitudes of the candidate in 'whole person' medicine' (Moulds et al. 1978; 3). Thus, the destiny both of the College MRCGP and, through it, vocational training in general are aligned specifically to the project of 'whole-person medicine'. Taking a publication from the middle of our period as an index (Moulds et al. 1978; cf. Hall 1983), the exam has five components; an essay-paper which examines diagnostic ability and clinical management on the basis of 'gobbets' of case-records. The gobbets appear as parts of a long 'narrative' of a single case-history (taken in stages, with the candidate not allowed to look ahead at the outcome of each stage) in order for the 'longitudinal' and contingent dimensions of general practice to be tested. Second, a traditional essay paper dealing with subjects clinical, administrative, psychological and so on. 'Correct' answers are arrived at by peer consensus on the part of the examiners. Third, a very wide-ranging multiple choice paper. Fourth, an oral based on the candidates 'log diary' of his experience in the training practice and centred primarily on organisational and administrative matters. This oral:

'brings candidate and examiners into direct contact, thus affording the former a chance to express his personality, expertise and

compassion and the latter the opportunity to assess these attributes (within the limits of their own skills in the matter)' (Moulds et al.: 22).

Lastly, a 'problem-solving' oral based on clinical material.

4.ii. What sort of doctor is the ideal here? First of all, the practitioner must be 'reflexive' and person-centred. We are struck by the huge range of subjects that the general practitioner has to know. In another work, largely concerned with the content of vocational training, Freeman and Byrne (1973) outlined six major areas, each divided into a multiplicity of subsections, in which the doctor should be competent; clinical knowledge, society and medicine, the practice, research, continuing education and attitudes. Just as in the 1950s, so now the domain of evidence of general practice is very wide.

Yet the accomplished trainee is not expected to be the unequivocal master of all things. And nor is an attempt made to hone down all the varieties of practice circumstances to some underlying principle. What is required is not omniscience but evidence of a certain level of 'competence', an ability to deal with the everyday uncertainty and heterogeneity of practice (ibid: 86). A related point was to be voiced by Marinker:

'The so-called facts of clinical medicine and the theoretical frameworks which underpin them

will change considerably through the professional lifetime of the students and trainees whom we teach. What will not change are the criteria by which they judge the quality of their own thinking and that of their colleagues' (Cormack et al., eds. 1981: 122, 107).

Above all, what is required is a 'reflexive' kind of rationality able to derive an orientation towards future action on the basis of past knowledge and experience. Now competence is indexed by personality; indices of good trainees tend to focus not upon actual 'results' so much as upon general factors of personality. Important amongst these might be the attribute of 'flexibility' (see the critique of 'rigidity' in Byrne and Long 1976: e.g. 112) in the face of events or 'elasticity' in relation to the individuality of patients (Fletcher 1973). Study of the non-'medical' sciences can help here in that they raise the trainee's sensitivity to individual, personal factors; thus contributing to the development of 'maturity' (an important term) in the trainee; that is, they have as much of an ethical as an epistemological import. Thus, for example, the Gillie Report stated that:

'There is evidence that appreciation of human environmental problems adds to the students' own maturity and counteracts the sectional and mechanistic outlook that can result from intensive academic training in matters of scientific exactitude and specialised technique' (Central Health Services Council 1963: 49).

Similarly, the best trainees, in Freeman and Byrne's account were those who showed a good 'all-round balance' on the 'personal' index of variables of intelligence, aptitude and ability, personality and attitude (ibid: 7). An important attribute here is that of 'confidence'; not just in the sense of self-belief so much as self-knowledge, and the ability to act as a 'support' for patients:

'The doctor should be willing to take his patients into his confidence and to explain his proposals in terms appropriate to the individual patient. He should give patients confidence, give them his full co-operation and relieve their anxiety' (ibid; 15).

Thus, what is at stake here is less an omniscient scientist than explicitly a 'person-centred' practitioner - 'kind, courteous, honest and humble' (ibid: 24) - with 'the capacity to define a patient's problems, to undertake management and therapy and to relate with patients and colleagues' (ibid: 11).

Second, the heterogeneity of information at his disposal, means that the (trainee) doctor should be sensitive, above all, to individuality, to the unique event. This uniqueness is manifested, first of all, in the person of the patient. The whole person is the amalgam of a variety of perspectives. As Armstrong has described:

'This "whole person" is the product of a series of smaller discourses (on compliance,

communication, etc.) which, though intertwined with one another, have contributed several elements to the final perception of the patient; a "subject" imbued with personal meanings, constructs, feeling, subjectivity, etc. The whole person is a multi-dimensional rather than a unitary being' (Armstrong 1982; 119).

These dimensions meet up, as it were, in the doctor's own intuition; the doctor, as Marinker is to put it, must 'compose all of his diagnoses simultaneously in physical, psychological and social terms', the relative weight of which will determine the individuality of each case (Cormack et al 1981; 125). But, secondly, this quasi-intuitive process itself requires self-surveillance on the part of the doctor:

'the doctor has to learn how to cope with this information, and how to take decisions about priorities and appropriateness. In this the study of the patient begins to encompass a study of the doctor himself' (ibid: 128).

We find here once more what we earlier termed a doctor-centrist emphasis proper to forms of 'person-centred' medicine. The advocacy of person-centred medicine always begins with the self-cultivation of the doctor.

To sum up: the examiners seem to be searching for evidence of an 'ethical' vocation in the candidate. This is less a matter of 'what must I do?' in a set of given situations but 'what must I be?' in general terms in order to

accommodate, through the necessary situational logic, a variety of circumstances, typical and unforeseen; in other words, the doctor must be a persona able to cope with uncertainty. A certain sense of balance is a requirement here. The doctor must have a level of humility in the face of his generic lack of knowledge, yet should be strong enough to give support for those more in need, more uncertain even than he:

'... however laudable it may be for a general practitioner to display a proper sense of humility at all times, it must be pointed out that many experienced examiners hold strongly to the idea that a doctor who has not yet learned that a patient wants his doctor to be confident, wholly absorbed by his disease and yet deeply compassionate and objective, all at the same time, is not yet suitable for membership of the Royal College of General Practitioners ... you should display to your examiners that although you are a reasonably confident and safe doctor you are at the same time deeply aware of your own limitations in coping with all the trials and tribulations to which humankind is prone' (ibid: 23).

Again, there is evidence here that general practice has become largely an 'ethical' matter; a domain where what matters is the particular quality of the human being in question.

4.iii. That it is above all the personality - or, at least, the doctor's personal competence - that is at stake in vocational training can further be seen from Freeman and Byrne's assessment of the aims and effects of training. That there should be any doubt about the aims which training sought to achieve may seem slightly surprising. Yet, in fact, early writings on this matter were rather vague. The Todd Report, for example, seemed to place the reasons for the setting up of vocational training squarely in the realms of the promotion of professional satisfaction:

'doctors are dissatisfied with the absence of information about the prospects offered by alternative careers, the lack of clearly defined paths towards them and the inadequate or uncoordinated provision of appropriate training' (Royal Commission 1968: 41).

However, it was only in 1976 (2nd ed.) that Freeman and Byrne were able to report that:

'there does appear to be good reason for the implementation of vocational training. It is the first time that systematic and objective evidence has been produced on this widely assumed point' (Freeman and Byrne 1976: 11).

Freeman and Byrne claim that those schemes judged by them as being of high quality were most effective at changing the personality of the doctor, entailing a movement away from:

'the characteristics of rigidity,

authoritarianism and cynicism towards a doctor committed to patient-centred medicine, that is, a form of medicine that seeks to interpret the wishes of the patient and to respect the patients autonomy' (ibid: 1976; 11).

Reviewing these findings Pereira Gray wrote that:

'Many trainers think there are major aspects of personality which may affect attitudes to practice and patient care ... (if) training courses have the ability to alter these variables it is a finding of immense significance' (Pereira Gray 1982: 215).

So, just as for Balint - and Freeman and Byrne have a similar liking for group methods (since weaker trainees gain when in groups with better trainees) - the aim is to produce something like a 'limited but fundamental' change in the doctor's personality. Again, what is at stake, what is being mobilised here, is the ethical quality of the doctor. This has ceased to be merely a necessary condition for good doctoring; it has now become constitutive of it.

4.iv. But this 'ethical' ideal of the doctor's persona seems actually to be formed upon the recognition of two, perhaps not entirely complementary, principles. First, that stressing the importance of (diagnostic) pattern-recognition and, second, that stressing the (more mystical) apostolic function of the doctor. Now, what can be described as the traditional ideal of 'clinical experience' located a 'charismatic' element in both. The

'clinical mentality', as Freidson termed it, was as much a matter of 'tacit' as it was of 'technical' knowledge (Freidson 1970; cf. for the distinction between 'tacit' and 'technical', Jamous and Peloille 1970; also the fascinating piece by Roche, 1984). The doctor's skill at diagnosis was seen here as entailing more or less 'thaumaturgic' powers; hence the ability to diagnose was an element of the doctor's charisma (cf. Foucault 1973: 81). For the general medical practice of the 1970s, however, the two become separated. Diagnostic skills, though they become intuitive through experience, are basically rational and do not derive from the 'charisma of illumination' (to adopt Max Weber's apt term). On the contrary, they locate the basis of the doctor's powers in the highly 'rational' - if subconscious - fabrication of diagnostic 'schemas'. Hence, the possibility of a technological extension of such schemas - for example, through methods of computer modelling that explain or reproduce artificially diagnostic processes (RCGP 1985a) - has not at all been posed in opposition to whole-person medicine; presumably since both are dependent upon the doctorcentrist foregrounding of the doctor's own reasoning powers.

Nevertheless, a curiously 'irrational' component seems also necessarily to inhere within this very 'rationality'. For whole-person medicine itself dictates that the doctor must be conceived as being essentially 'supportive', and must have a link to the patient, based on the emotional

'rapport' of the 'doctor-patient relationship'. This sense of rapport, or sympathy, is an important mechanism of individualisation:

'The sense of welcome, of interest in this person as a person distinct from the one before and the one after, and of readiness to listen to whatever problem this person chooses to present - these things can go far to determine the success or failure of the consultation' (RCGP 1972: 44).

A 'structural' problem seems to arise here in that the debunking of the doctor's charismatic powers may serve to undermine the grounds for the success of his powers of reasoning (a topic which aroused some anxiety amongst general practitioners at a recent conference of the MSD Foundation; 1989). If the doctor's skills are simply those of 'pattern-recognition', for example, what grounds can there be for seeking to promote and maintain the personal and 'irrational' - yet therapeutic - rapport with the patient? Of course, these are, in fact, two strands of the same doctor-centrist logic whereby what is at stake is always the doctor's power (rational or irrational) to define everything that happens in the consultation. The different lineages of these two sides of the doctor's competence - 'rational' and 'irrational' - will appear later in our discussion of the 'governmental consciousness' of the regime of self-surveillance; now we turn to the trainers.

5. Trainers: Operationalising the Regime of Self-Surveillance

Through the figure of the trainer were to pass all the problematisations of what an ideal practitioner was. The trainer is, so to speak, the end-term of the regime of self-surveillance.

5.i. Trainers obviously had an exemplary status:

'future teachers should be drawn from those doctors who are known not only as able and thorough clinicians, but who also have training in teaching skills and techniques ... [The College] proposes to assume responsibility for advising on standards in teaching practices, and for reviewing them periodically. It intends to continue its policy of approving vocational training schemes for general practice, for the purpose of its membership examination' (Report 1972: 79, 83).

The College was to take as its task how, as it were, to 'operationalise' the required qualities; and it was to do this especially through the device of monitoring training schemes themselves by designating that any graduates from an approved scheme should be eligible automatically to sit the MRCGP exam. What, in fact, the College sought was restrictions upon practice such that only those practitioners that it had approved could be responsible

for the training of others. Thus, by the time it had come to greet the 1976 NHS Bill, the College was fully committed to a strategy of professionalisation through, as it were, self-discipline:

'The Bill will create a precedent in British medicine since it formally places a constraint upon a doctor's right to practice in the NHS which goes beyond the traditional requirement of being a fully registered medical practitioner' (Editorial 1976: 631; cf. the comments of Pereira Gray 1982: chapter 17, esp. 189).

Of course, it would be naive to view this strategy of discipline as in some manner working against the interests of the profession itself. On the contrary; 'professional control has in fact been completely retained by the medical profession' (Pereira Gray 1982: 189). What was at stake was, rather, the profession's right to discipline itself, and, in so doing, to define its territory and tasks. The College's strategy hence became that of disciplining the rest of the general practice profession in the name of the 'person-centred' philosophy that it espoused.

5.ii. What were these values to be? One of the first of the courses to consider the question of trainers was the Nuffield Project that the College set up in collaboration with the Tavistock Clinic in 1973 in order:

'to disseminate widely among GPs expertise in identifying the core content of general medical

practice and in designing and operating curricula appropriate to teach it' (Freeling and Barry 1982: xi).

The authors sought to construct 'above all a curriculum which includes a good deal of self-directed learning [to] foster self-awareness, personal flexibility, and skills and critical review' (ibid: 8). The authors delineated a 'double-motive' to their research; to institute a person-centred medicine and a learner-centred education (ibid: 11). On the basis of small-group training methods the courses would seek to instill in the trainers the values of a good recall of factual knowledge, of the performance of manual skills, of interpersonal skills and of self-understanding (ibid: 13). The most valued skills were the making of clinical judgements and problem-solving in addition to communication skills, the gathering of information, and relating to colleagues (lowest of all in the hierarchy were surgical skills) (ibid: 115). In other words, we have a set of emphases here which are exactly analogous to those referring to the trainees; loosely, the import of autonomy, self-reliance, self-reflection, critical judgement, sensitivity to individuality, pragmatism, discretion and so forth. What was actually at stake was, in fact, less the vaunting of an extreme ethic of humanisation but a balance to be achieved between extremes of behaviour, in order to produce a well-rounded, well-adjusted doctor, a composite personality. In short, a personality well fitted to the project of recuperation; reasoned but sensitive to the modulations of the realm of

personal qualities. Thus, for example, the authors sought to use a form of personality measurement derived from the work of Jung, and Eysenck, which sought to operationalise and idealise the median point between the values of 'tough-minded / tender-minded', 'conservative / radical', 'extraversion / introversion', 'sensing / intuition', 'thinking / feeling' and 'judgement / perception' (ibid: 29); the good practitioner being the one who best reconciled these extremes of desirable conduct.

5.iii. If there was a problem with this kind of evaluative method it lay in the fact that it sought to assess trainers outside the context in which they themselves worked; that is, their own practices. Its premises were viewed as being too abstract. A document from the very end of our period serves to illustrate the problems that arose when this deficiency was addressed and to show how considerations of the nature (or the 'core content' as the doctors liked to put it) of general practice tended to resort to considerations of the persona of the doctor himself. This report is useful in that it sought to focus not (as in the earlier vocational training literature) upon the doctor's potential but upon actual competence.

In 1980 the College set up two working parties to devise a method of 'assessing the performance of established general practitioners in the setting of their own practices' (RCGP 1985b: 1). The context of these investigations was really two-fold; first, that of the

trainers literature (a practice that was well-assessed would qualify as a training practice) and secondly, as part of the increasingly burgeoning literature on 'audit' (especially self-audit) and 'quality'. It is striking how the person-centred influence was still very much a feature of the working parties:

'between them the seven members brought a long experience of family medicine, work in Balint groups, involvement in medical education at all levels, intimate knowledge of the MRCGP examination, and active participation in trainer selection procedures' (ibid: 1).

Yet, they took what was conceived as a novel form of practice-assessment (although the emphasis as such was hardly novel):

'The working party decided to tackle the problem in a totally different way, going back to first principles and focusing primarily on the general practitioner rather than on general practice. What were the attributes that really mattered? Which qualities would he or she need to possess in order to discharge adequately the diverse and formidable obligations of a general practitioner in today's society?' (ibid: 1-2).

In fact, as will become evident, the findings of the working parties represent a useful crystallisation of long-standing themes rather than any novel conceptual innovations.

The working parties decided that the ideal doctor should have four desirable attributes in particular. First, clinical competence. The doctor should use a personal but logical, observant and unrushed approach to clinical matters:

'he carefully follows up his patient and actively seeks to learn the consequences of his action or inaction ... He employs opportunistic health education and constantly re-inforces advice on lifestyles; and by giving relevant information freely to patients tries to encourage them to share responsibility for their own health care' (ibid: 2).

Second, accessibility. Above all, the patient - as well as the doctor's own colleagues - should have more or less free access to the doctor. Third, the ability to communicate. The doctor should be attuned to the 'wavelength' of his patients and colleagues. This also involves a 'transformative' element:

'He shares information and decision-making with the patient as much as possible; the patient feels supported and encouraged by the doctor, and better informed than before, and so feels more capable of handling future episodes of similar illness' (ibid: 2).

Fourth - and probably most importantly - there is 'professional values'; that is, above all:

'the doctor's perception of his relation to individual patients and to the practice

community; his ideals and sense of priorities; the spirit which motivates and guides him in the general evolution of practice' (ibid: 2).

Professional values relates to patients as well as his colleagues:

'He sees that part of his professional role is to bring about a measure of independence; he encourages self-help and keeps in bounds his own need to be needed' (ibid: 2).

This document may be said to lie at the apotheosis of the discursive logic of 'person-centred' medicine in general practice. That discipline is now conceived, not as a body of thought with its own proper object, but as fundamentally a kind of ethic. What has become important, above all, is the mobilisation of professional values, that is the virtuous qualities of persons. Indeed it is this ethical context of general practice that is now held to provide in the first place the grounds for its disciplinary specificity and, hence, autonomy. General practice has become simply that form of activity practiced by a specific kind of persona invested with a requisite number of 'values', the general practitioner. It has become a technology for the instillation of particular modes of personhood.

It is not surprising, in this context, that it was soon discovered that the personality of the trainer has a direct bearing upon that of the trainee. Trainers are not

merely 'exemplary' in relation to trainees; rather the former have a direct influence on the educational outcomes of the latter. A study in 1982, for example, found that the knowledge and skills of the trainer - his 'personal interests and attitudes' - were more important variables in education than the actual methods used in training. Thus the results of a survey to sample the influence of trainers on trainees showed that:

'the teachers clinical knowledge and problem-solving skills in patient management are major determinants in the trainees learning and performance, irrespective of the trainees scores on entry, and that compatibility of cognitive style and personality between teacher and trainee helps the learning process' (RCGP 1982).

In short, the trainer acts upon the trainee in a manner analogous to the way in which the doctor is held to act upon the patient; the latter in each case comes to identify with the former. Thus the trainer is a kind of relay point directed ultimately at a certain kind of patient.

CHAPTER EIGHTEEN

THE GOVERNMENTAL CONSCIOUSNESS OF THE REGIME
OF SELF-SURVEILLANCE

1. Autonomy, Maturity, Responsibility

In what follows, some 'lines of force' will be analysed which link the logic of Balintism to a wider 'neo-liberal' problematic of government. It should be made clear at the outset, however, that what is to be detailed here will be just one mode in which Balintism has been mobilised by the practitioners associated with the College. We seek to show how the logic of Balintism has been 'taken up' in a particular ethico-political context; and how this has no doubt entailed something of a translation of some of Balint's own original teachings into a more or less novel context.

1.i. Earlier we linked general practice in the 1950s to a wider - 'welfarist' - rationality of pronatalism. This had several elements: in particular an emphasis upon the large space of the population, an emphasis upon the status of the child - which lead to a problematisation of the role of the mother - and a normative aspiration towards the

promotion of 'solidarity'. The person-centred perspective that we have seen in this chapter being grounded in the notion of training since the early-1960s, however, became amenable by the end of the 1970s to what can be described as a 'neo-liberal' logic of governmentality. This term is intended, however, in a rather limited sense. Perhaps this is best expressed by saying that person-centred general practice - existing as it does necessarily within a predominantly welfarist institutional network, the National Health Service - has found itself aligned with certain typically non-welfarist but rather neo-liberal themes (for which; Rose and Miller 1991).

The governmental rationality of neo-liberalism can best be described in relation to what it opposes. One might describe its programmatic trajectory as a 'de-governmentalisation of the state'; the removal of the varied regulatory apparatuses of life-conduct away from the purview of the state:

'Neo-liberal political rhetoric breaks with the assumptions, explanations and vocabularies of the field of political discourse mapped out by welfare. Against the assumption that the ills of social and economic life are to be addressed by the government, it deploys theories of government overreach and overload' (Rose and Miller 1991: 48-9).

One particular target here is the so-called 'culture of dependency' (ibid: 49) whereby citizens are held to become

morally (if not also economically) dependent upon the state apparatus, towards which they have a relation of passivity and reactivity, Thus a neo-liberal logic of government would seek to replace this regime of dependency with a citizenship model based upon:

'active entrepreneurship ... to replace the passivity and dependency of responsible solidarity as individuals are encouraged to strive to optimise their own quality of life and that of their families' (ibid: 49).

The economic vocabulary is endemic here. Both in the literal sense that the individual is to become a kind of 'entrepreneur' maximising his or her own resources in the market place - regardless of the regressive norm of solidarity and collectivity - and because economic calculation is held up as a desirable metaphor for social behaviour in general; goal-directed, rational, always striving for the maximisation of resources:

'Economic entrepreneurship is to replace regulation, as active agents seeking to maximise their own advantage are both the the legitimate locus of decisions about their own affairs and the most effective in calculating actions and outcomes' (ibid: 49).

Now, it will be argued in what follows that there are certain very striking features of the project of self-surveillance and training that have certain points of alignment with this general neo-liberal project - at least

at the 'programmatic' level (for 'ideologically', differences have frequently been all too obvious). This is not to argue that general practice has become straightforwardly neo-liberal; rather that much of its defining philosophy has lent itself to wider neo-liberal trends¹. Thus, our argument is not that general practice embodies a governmental rationality of neo-liberalism but that its own 'governmental consciousness' is, in certain respects, consonant with that project.

In the 1960s, programmatic writings about general practice changed the burden of their emphases away from an implicitly 'welfarist' governmental consciousness towards a programmatic emphasis upon the inculcation of autonomy and individuality. Thus, for example, the 'population' emphasis (exemplified by epidemiology) was transferred firmly towards a focus upon precisely what is particular or unique about the individual. The emphasis upon family relationships in the home moved decisively towards the homogeneous space of individual - adult - persons in general. Of course, the home and the family remained important (after all, the label of general practice as 'family' practice stems from the 1960s) but they certainly lose their centrality of emphasis in relation to the vaunting of persons and their relationships in general; family relationships become important only in the context of their particular emotional mobilisation within the consultation.

One consequence of this movement was that general practice now lacked an explicit sphere of specificity beyond the generality of attendees at the surgery. Thus, certain exemplary targets, specific categories of person such as the child and the mother, lose their high profile in the literature. What came to replace these targets was only a homogeneous field of relationships; anybody who turned up at the surgery became, in this sense, an exemplary kind of target. Nevertheless, it is of course possible to argue that this generalisation of the concerns of practice was itself predicated on an implicit privileging of certain targets; and a scrutiny of these might be expected to yield insight into the nature of general practice as a particular mode of tutelage, a particular technology confronting a particular kind of subject.

1.ii. The most obvious candidate here would be the depressed or anxious woman. This troubled personage might act as a kind of yardstick for the ethical imperatives at stake in the age of training, a personage who - although rarely singled out on a theoretical level - appears again and again in case-histories and accounts of general practice.

Take, for example, the case of Mrs Gale reported in Pendleton and Hasler (1983) in the context of a chapter devoted to 'the doctor as the equivalent of a laboratory investigation' (166-174; cf. RCGP 1972: 4-8 for similar cases; Recordon 1972: esp. 819-821; also Balint 1957

passim for this kind of case-study). Mrs Gale consulted her doctor with two exemplary disorders of this period; anxiety and depression (ibid: 171-3). What is at stake in the doctor's attempt to treat this condition? The doctor's actual role is to give support to the patient through the use of 'empathy' (ibid: 166). By observing his own reactions (that is, by making a 'laboratory investigation' of himself) the doctor should be able to isolate what is most dangerous - contradictions in the identity of the patient:

'the doctor should identify any incongruities between components of his observations, including his empathic ones, and seek to explain them and make predictions to test his observations' (ibid: 166).

The therapeutic ideal at stake here is that of 'consistency' in the patient. But what defines 'consistency' here? Not, to be sure, any ideal norm posited by the doctor. On the contrary, the patient should be consistent only in relation to herself. Closely tied to the notion of consistency is that of 'maturity'. A mature person is somebody who is able to retain consistency in the face of the unforeseen variety of life-situations; in other words - and an analogy with the ethical stance of the doctor can be drawn here - the patient should be able to remain flexible in the face of uncertainty:

'Maturity is seen as the ability to integrate new experiences in such a way as to produce the optimum response' (ibid: 173; cf. Browne and

Freeling).

The doctor's role, given this situation, is to act as a kind of 'prop' for the patient during the period of low maturity - 'to help patients avoid maladaptive responses and achieve optimum development as individuals' (ibid: 74) - and thus, during this period, give the patient the shelter to develop her personal autonomy anew. In this process, the doctor may use his charismatic 'authority' selectively and put himself forward - 'offer' himself in Balint's terms - as the 'model' with which the patient can identify:

'therapeutic activities included acting as a confidant with whom the failure of situations to develop could be shared, and acting as a model for new coping behaviour ... allowing the patient to work through stressful life-events in the safe house of a secure doctor-patient relationship ... (and) the opportunity to obtain stimulus within it' (ibid: 173, 171).

There has certainly occurred here something of a shift of vocabulary from the terms of Balint's own work. But if Balint's psychoanalytic vocabulary has been translated here - by his own pupils - into one of life events and coping that was to gain an enhanced currency across the 1970s then, nevertheless, the basic rationality remains un-changed; the doctor is to act as a kind of temporary support during treatment, a 'container', as Bion would put

it, for the patient's underlying anxieties which are now expressed as illness.

What is the condition with which Mrs Gale was suffering? 'Depression' - defined as a 'reaction to situations which threaten self-perceived maturity' (ibid: 173) - clearly has a kind of ethico-political meaning. It is the absence of autonomy. And autonomy itself - certainly, as we have seen, the most positive ethical value for the doctor - is thus the highest ethical value for patients. It is not surprising, then, that the 'cure' of Mrs Gale entailed her perceiving only what she already knew herself; with the aid of the doctor who, as it were, 'lent' his maturity and autonomy to her she herself was able to return to maturity and autonomy. The capacity for reflexivity - perhaps better expressed as self-responsibility - is clearly a condition of a return to normality; the patient has to be able to monitor herself anew. So, although the doctor has used a certain amount of 'authority' it was only so that the patient might regain this self-perception; as is proved by the fact that after the event the patient realised that the doctor had done what she had wanted all along. Thus the case showed how:

'the doctor was concerned to allow Mrs Gale to retain her personal autonomy and that she saw herself as having done so since she told the doctor he had done what she had hoped for' (ibid: 171).

The case of Mr Gale seems to raise two themes. The first is the curative model implicit in the treatment itself, and the second relates to expertise in general. As for the model of cure, it seems clear that what is required is that the patient should be returned to a state of maturity, responsibility and autonomy; values, in fact, that we have already seen to be crucial for both trainees and trainers. There is an implicit model of pathology at stake here. Going to see the doctor seems to represent, by definition, a temporary lack of maturity and responsibility. The doctor acts as a 'support' whilst the patient is unable to support him- or herself without help. This is indeed why the doctor must be autonomous, mature, and self-responsible in an exemplary way; in order to take on the burden of supporting somebody else, of, as it were, temporarily supplying their maturity, autonomy and self-responsibility. And - second - this raises an interesting problem. For in the final analysis, what actually separates doctor and patient as ethical subjects?

1.iii. Patients themselves are, on the *logic of the* person-centred model, clearly conceived as possessing a certain form of expertise; namely into their own self. A recent volume on the nature of the consultation ('meetings between experts') has can serve as a summation of this theme:

'patients already act as experts in their own self-care and have to be considered as individuals who interpret and make sense of what

happens to them' (Tuckett et al. 1985: 14, also 217-9).

On the other hand, if patients have expertise, then doctors are themselves not unlike patients (cf. on this theme; Arney and Bergen 1985: 47). Bennet has expressed this shamanic idea very forcefully in his plea for medicine to adopt a psychotherapeutic model, by claiming that the doctor is by definition a kind of 'wounded healer', somebody who can only cure because he himself has suffered (Bennet 1979: 181-7; cf. Bourne 1976: esp. 492). In this case the doctor's expertise derives from his experience; he is not substantially different from those he has treated except in that he has turned it to the aid of others.

Most accounts, however, seek to rescue a dividing line between doctor and patient by allusion to various equivalents to that contradiction in the doctors functions that we referred to at the end of the last section, between the doctor's rational powers of 'pattern-recognition' and something more mystical, approximating to what Balint called the 'apostolic function'. Effectively all notions specifying the nature of the doctor's expertise have to emphasise the continued import of the latter in the face of its possible eclipse on the basis of the former.

Freeling, for example, distinguished between the doctor's power and the doctor's authority (Freeling 1978).

Authority, he says, is formal (deriving merely from the doctor's education, greater experience and so forth) but power is conferred on the possessor by those who are being treated:

'Power is accorded to those who show their patients that they can be trusted to use it altruistically' (ibid: 335-6).

Authority should not be used therapeutically, according to Freeling; when it is 'we fail to help our patients develop appropriate attitudes, perceptions and skills concerning control, and their difficulties may be confounded' (ibid: 338). But power is acceptable since it is, effectively, actually conferred by the patient: 'power is given to those "who can" it is not given to those who must possess authority before they dare "do"' (ibid: 336). A similar idea is expressed in less apparently mystical terms by Pendleton and Halser with their conception of 'intimacy':

'As intimacy increases, social distance decreases: as social distance decreases the doctor gives up the authority which is donned with the costume of the role and may be rewarded instead with the power given freely by one person to another, based on informed trust, to offer insight to the patient. The offer of intimacy by the doctor may well be one way of pursuing the aims of optimum development and avoidance of maladaptation by the patient. It must be emphasised, however, that intimacy can be offered, but must not be demanded. A demand

for intimacy backed by the authority of the doctor's role comes close to a rape of the patient' (Pendleton and Hasler 1982: 166).

Clearly the doctors are wrestling with perceived ethical problems here; in particular the recognition that their medical status itself confers psychological powers (indeed, this is what Balint had largely meant by the term 'apostolic function') and that the usage of person-centred medicine might itself imply the usage of such 'medical' authority. This 'libertarian' anxiety expressed about this is itself of interest in the light of our comments above concerning neo-liberalism; this desire to leave the patient in control so far as is possible and, even when using one's 'power' (in Freeling's sense) to rationalise this in terms of the will and demands of the patient. If, however, the doctor is to retain something specific that is expertise then it can be analysed along two axes, the formal and the substantive. Formally speaking the doctor's persona is continuous with that of the patient; his skills become discontinuous only, so to speak, in the context of time: the doctor's skills are distinguished from the patient only by their greater intensity (the wider depth of experience over time) and focus (a period spent in training). Similarly, the doctor's expertise largely seems to reside in knowing when to deploy himself, when, so to speak, to turn himself on. He does this, as we have seen, only at that point at which the patient has ceased to be an expert of his or her self and has displayed that

foundational symptom of all pathology in person-centred medicine; dependency. In the substantive sense, the doctor is a living incarnation of the value of the attributes of autonomy, responsibility, maturity and individuality themselves. He is both advertisement for them and, as we argued in the chapter on Balint, a living instrument for their dissemination. For of course, the doctor does not merely display the values of reflexivity, self-dependency and so forth; rather, his whole persona is designed to exemplify them. The doctor is a 'master of living' who has found his calling; and this is summed up by his being a master of how to use himself, his reflexive self-responsibility in all things.

The expertise that the general practitioner calls his own is the result of the equilibrium he has gained through his exemplary work upon his self. Through his self-reflection - stabilised by his relations with others in his peer group - the doctor becomes a kind of Archimedian point, a point of 'closure'; and on the basis of this, a receptacle for the 'dis-closures' of others. For his expertise largely resides in his being silent, a stable receptacle for the catharses of others ('Silence ... can be really productive'; Recordon 1972: 819). If 'confession' can be defined as the 'diagram of a certain form of subjectification that binds us to others at the very moment we affirm our identity' (Rose 1990: 240) then the GP is the stable surface upon which the subject can objectify himself. By being precisely like a 'surface' -

by being silent - the GP finds that he can illuminate the very individuality of the patient. Indeed many have testified to the skilled powers of 'listening' and its intimate connection to pure individuality:

'Good listening is difficult to achieve, especially when the doctor is under pressure, but it helps more than anything else to make the patient feel he is being treated as a unique person' (RCGP 1972: 15; cf. the comments in the Gillie Report, Central Health Services Council 1963: 30).

Similarly, Byrne and Long point out how one must listen selectively and extol the virtues of the use of 'silence', also pointing out that:

'[there] is a strong correlation between those doctors who use silence regularly and those doctors who have been influenced by the late Michael Balint' (Byrne and Long 1976: 15 & 36-7).

Clearly it would be unwise to over-interpret this material. No doubt, the contemporary notion of treating the patient as a 'person' entails different modalities in different contexts. In this 'programmatic' dimension of the general practice literature, however, a more or less clear model of the doctor's expertise can be drawn up. Here, the function of general practice expertise is largely the promotion of 'confession'. For example, Byrne and Long conclude an account of what they see as an

exemplary consultation with the comment that the doctor:

'has consistently taken the view that this consultation is complete and only requires the patient to go away and think. He has caused her to verbalise a whole range of fears and confront issues and to him that is enough' (ibid: 18)

The point about such verbalisation is that it is itself a form of self-recognition on the part of the patient; a taking of responsibility for the self. Indeed, we see here that the taking of responsibility for oneself is not merely conducive to health but is itself an aspect of health; and, in other words, health takes on a distinctly ethical dimension (on this notion of taking responsibility for oneself and one's health, see RCGP/Channel 4 1982).

In short, there is at work here something like a project of 'responsibilisation', wherein the primary task of the doctor is to help others to take responsibility for themselves. Paradoxically enough, the doctor is encouraged to use the dependency of patients in the general project of liberating patients from their bonds. A sentiment that appears relatively early in the literature:

'We, in general practice, have the task of liberating people who are enslaved by their emotional dependence on others and, in giving them help and spirit, we must never lose sight of the ultimate aim of encouraging them to throw away their social crutches, stand on their own feet and live independent lives' (Williams 1967:

260)

Later, in 1982, doyen of anti-medicine Ivan Illich himself - addressing a sympathetic audience of the Royal College of Practitioners in Dublin - urged general practitioners to take upon themselves the role of 'de-medicalisation'; again, to free patients from their dependency upon the medical profession (Illich 1982). A strange irony perhaps; that the solution to this dependency should be the renewed ministrations of the profession itself.

2. An Accounting Rationality: Economics and Self-Surveillance

So far, the discussion has sought to illuminate a line of force running from the Balintist prescriptions concerning the apostolic powers of the doctor towards a modified therapeutic vocabulary that has something in common with wider neo-liberal themes. But now if we take the other side of the doctor's capacities of self-surveillance considered at the end of the last chapter - that more 'rational' dimension relating to the doctor's powers of pattern-recognition - we can see that this also displays powers of alignment with some of the values of a neo-liberal governmentality.

3.i. Prominent here is, in fact, an economic rationality itself. For it is striking how closely the theme of reflexive self-surveillance ties in with the neo-liberal

economic emphases of audit and financial responsibility, indeed with the neo-liberal privileging of the economic sphere as an obligatory passage point for governmental mobilisations of all sorts. Of course, in a rather literal sense psychoanalysis and its offshoots have long maintained a link with 'economic' forms of thought, for example, in that the psyche is itself conceived as a kind of 'economy' of forces with flows, inputs and outputs. Balint himself found economic metaphors tempting; for example, in his notion of the 'doctor-patient relationship' as a 'mutual investment company'. But, although it is no doubt embedded within this commonplace parallelism, there is a link between psychological forms of thought and 'economic' reasoning which - though no less literal - is somewhat different. Or rather, more of a re-alignment than a straightforward 'link'; for this was no doubt the product less of a natural affiliation than an effort, a labour of alignment. What is at stake here is a kind of 'accounting' rationality; the priority given to reflexivity and problem-solving in both forms of thought.

This point can be established immediately. We wish to draw attention to the way in which this rationality of self-surveillance which we have seen extending from the heart of clinical activity itself actually links (across an entire 'philosophy' of all aspects of practice) explicitly in some quarters to a veritable business ethic. An influential manual of practice management from practitioners based at Exeter University (Jones et al.

1978 3rd ed. 1985; cf. Philips and Wolfe 1977) can usefully serve as a yardstick for this. For this work seeks to be both person-centred and financially sophisticated.

In the course of an opening chapter designed to explain 'the philosophy which underlies ... working arrangements and decision-making' the authors praise the work of Michael Balint (whose views 'have influenced and decisively influenced, the last twenty-five years of the development of the discipline of general practice'; Jones et al. 1978: 8) for the basic insight that:

'[in] order to be good general practitioners we must first understand ourselves. We must understand the strength and weakness of our personalities, the way we affect other people, and the way we cope with some of our more important inner feelings' (ibid: 8).

Building on the insight that 'the personality of the doctor is thus of special importance ... the key to succesful medical care' the authors go on to outline how self-management on the economic level is a vital part of the doctor's self-understanding. Indeed, that economic audit is part of general self-surveillance, thus underlabouring for professional values and indirectly improving standards of patient care:

'The doctor no longer feels a prisoner of forces beyond his control. It is our experience that once practitoers do organise feedback and do

know what is going on then professional morale rises dramatically' (ibid: 163).

Thus if practitioners take responsibility for their own 'book-keeping and accounts' (chapters 14 & 15) including the mastery of 'extended income analysis' and 'extended expenditure analysis' they will come to appreciate all the more 'the direct relationship between financial management and the ability to provide a service to patients, staff, and partners' (ibid: 231).

Obviously, it needs to be stressed once more that what is entailed here is a re-alignment of themes rather than their straightforward 'inheritance' from Balintism. There is nothing in Balint's own work to suggest that he was in favour of general practitioners taking over the financial running of their practices. What is interesting is the way in which the basic rationality of self-surveillance is used; that is, how Balintist themes have lent themselves to being taken up and modified in these directions.

2.ii. We can also cite further evidence of an alignment (or, what is always the same thing in any case, a re-alignment) between 'economic' forms of problematisation and whole-person medicine in general practice by reference to the theme of 'quality' which became a dominant pre-occupation of the College in the 1980s. Thus in 1983 the College launched a 'quality initiative':

'to encourage high standards by asking doctors to describe their services and to introduce the

principles of quality assessment into their everyday clinical practice' (RCGP 1985 [Quality in General Practice]: 1).

This concern - although voiced in terms of a new theme to complement that of vocational training that had dominated the College's activities in the 1960s and 1970s - was also recognised to be in strict continuity with the themes of the project of training itself; above all in the common link upon self-surveillance and self-assessment. In particular, the key notion of 'audit' certainly straddles both concerns. As the College put it:

'This interest [in quality] accelerated with the development of vocational training for general practice because doctors had to think seriously about what they did and why, in order to explain their actions to their trainees. Standard setting and performance review activities in teaching practices, started at the level of the individual doctor and practice and are beginning to lead to the building of general standards' (ibid: 3).

Of course the principles of audit, review and self-assessment was directly linked to the strictly 'clinical' concern to monitor oneself and be reflexive - with the help of one's peers - in order to use oneself on patients. Doctors, let it be noted, were quite explicit about this link between economic and psychotherapeutic rationalities. If there was no doubt a certain re-interpretation of the significance of past activities here, then the basic sense

of a common genealogy was correct. Indeed:

'Balint seminars ... were in fact one of the earliest examples of critical audit in UK general practice' (Pendleton et al. 1986: 6).

When conceptualised in terms of 'audit' this principle was able to link up a very wide variety of elements, including - as Marinker extolled - professional values themselves:

'Medical audit brings together a number of elements previously seen as having only an implicit connection', going on to include functions of the clinician, the epidemiologist, the 'medical ethicist', the manager and even the politician (Marinker in *ibid*: 4).

Meanwhile:

'discussions about medical audit, in what priority, by what means, to what ends, are certain to involve a conscious display of values about the practice of medicine' (*ibid*: 5).

Similarly, what most impressed Avedis Donabedian (the American guru of the 'audit' craze) about the College's work on quality (especially in RCGP 1985b) was that it placed professional values at the foundation of the very possibility of audit, and thus even at the very epistemological basis of general practice itself as an independent discipline:

'It builds directly on the only firm foundation for professional excellence: the sharing of knowledge between peers, the assumption of personal responsibility by individual

practitioners, and the commitment to a lifetime of learning through continual self-study' (Donabedian in Pendleton et al. 1986: 181)

How are professional values to be linked to a specifically 'economic' rationality? A look at one of the most famous (even notorious) documents in medical neo-liberalism should be sufficient to make this link explicit (Secretary of State for Health 1989; cf. Rose and Miller 1991).

As is well known, the intention behind Working for Patients is the promotion of a 'personal' health service (ibid: 6-7; providing a service which 'treats patients as people'; cf. 48) combined with the maximisation of economies upon resources compatible with this end. The motto of this interesting work might have been 'delegation with accountability'; everywhere it is sought to combine the conferring of power (and autonomy as to its use) with the obligation of responsibility for it. Central here is the notion of 'self-government' whether in the hospital service or the more micro world of the general practice surgery. Commending the RCGP on its 'quality' initiative the report states that:

'General practice will play an even greater role in assisting patient choice and directing resources to match patient needs throughout the whole Health Service as a result of the government's new policies. The Government believes that, in order to play this key role to

the full, general practice will need strengthening in four areas; patient choice [by the maximisation of communication: 55], audit ['based on peer review and on self-audit by GPs and GP practices': 56], prescribing costs [collecting data on prescribing patterns], and management' (ibid: 54).

Clearly, person-centred medicine has points of alignment with this project, especially in its conception of the general practitioner as an autonomous and responsible agent of self-audit; an agent, in fact, in a kind of general chain of responsabilisation and delegation.

Once again, it should be made clear what is being claimed here. It is not being claimed that person-centred medicine seeks deliberately to ally itself with more or less 'Thatcherite' policies in relation to the health service. After all, was not one of the major complaints about the legislation that it served to undermine the integrity of the 'doctor-patient relationship'? Yet, what is certainly a conflict upon an 'ideological' level can be seen to be an at least potential alignment upon a 'programmatic' level. In fact, this chapter might be said to have shown that two modifications or re-alignments were at stake. First, as we have seen, certain Balintist themes were re-aligned from within general practice; those relating, on the one hand, to the model of cure (make the patient autonomous, responsible and mature) and, on the other, to matters of self-surveillance, audit and quality. Second,

is the mobilisation from outside of some of these themes of self-surveillance. Here, the importance of audit and reflexive surveillance have made general practice potentially fertile ground for the incursion of neo-liberal governmental rationalities. And, after all, it is how a discipline such as general practice is problematised by others that will always be decisive upon a 'governmental' level.

2.iii. There are, however, two themes that specifically - and, more directly, that is, upon an 'ideological' level - pit the ideals of general practice against the otherwise solidaristic and welfarist ideals that are traditionally regarded as being at the centre of the functions of the Health Service.

First, the theme of the sanctity of the private contract. For of course, general practice has always been something of an enigma within the health service in that general practitioners are not supposedly employed by the 'state' but are so-called 'independent contractors' ('a self-employed person who agrees to provide a service for someone else': Jones et al. 1988: 11) who contract for their services with Family Practitioner Committees. Of course, there are strictly clinical reasons for this; in fact, the general practitioner is really a kind of bulwark against the 'state'; his real contract is with the individual patient whose interests he serves. A salaried system, for example, would totally undermine such a state

of affairs since it would involve 'impersonality, lack of consumer choice, a diminution of the individual within the system' (ibid: 12-3). In fact:

'Those who follow Balint and the belief that the human aspects of the doctor-patient relationship are central will believe that the balance must tilt towards some version of an independent contract. Impersonality must threaten personal care' (ibid: 16).

This sense that general practice is, as if by way of its very 'essence', partly about the activity of 'rolling back the state' is reinforced by the evidence given by the College to the Merrison Committee (RCGP 1985d). Noting the vital importance of the preservation of full clinical responsibility in the hands of doctors ('essential to the satisfactory relationship between doctor and patient'; ibid: 7) the report notes that independent contractor status is central to this notion of self-responsibility, its preservation being 'essential if patients are to have an independent medical advocate and advisor in a state-dominated health service' (ibid: 8).

Let us note in passing, at this point, that even when person-centred general practice moves towards the very edge of welfarism - in the domain of 'prevention' - it typically tends to personalise even this field. It is not at all that it resists the category of the 'social' but rather that it converts this category itself into a dimension of the 'personal' (e.g. Cargill 1965: 81ff.).

Again, this is achieved by a technique that takes 'time' as its key frame of reference. For the point about prevention is that it is 'anticipatory', it should occur before disease has actually set in. But prevention - 'anticipatory care' - here is firmly attached to persons rather than circumstances or environments; above all, it consists of health education within the consultation itself. Thus even when it relates to the realm of the 'social' most clearly (bad housing, deprivation and so forth) the point of application seems to centre most typically upon the promotion of individual coping strategies for dealing with such circumstances rather than upon such circumstances themselves (RCGP 1983: this, incidentally is not a criticism; for the assumption is presumably that 'social' preventive strategies are up to other - especially - government agencies).

Second, we may point out a further 'ideological' function of general practice (and indeed all properly 'clinical' thought) which has a bearing upon its 'governmental' utility. This is its strict 'anti-rationalism' (to laden this phrase with all the meaning given to it by, for example, Michael Oakeshott). The whole of person-centred clinical medicine is geared to an empiricist, pragmatic approach that vaunts the virtues of experience and the high sanctity of the individual; an 'art' form in fact. Person-centred medicine is an 'appraisive vocabulary' that views everything through these values; indeed it is itself a kind of system of evaluation that is able to pass

judgement on anything that fails to meet its criteria. But 'ideology' is really the wrong term here. For person-centred medicine is neither a 'mere idea' nor is it in some manner 'false' as this usage would suggest. On the contrary, it is productive of values, it is a criterion of truth and - as we have tried to demonstrate throughout this chapter - it is, rather than a mere set of ideas, a kind of technology; a closely worked out series of linkages, associations and problematisations that seeks to bind both its practitioners and others to its logic and to offer up an entire mode of ethical orientation to the world.

3. Concluding Remarks

In this chapter we have sought to outline the basic design proper to person-centred medicine. This has been described as a 'regime' of self-surveillance. This term was intended to highlight the way in which the notion of self-surveillance - self-evaluation, self-monitoring - has been a central problematisation at all levels of general practice; from the paradigmatic self-scrutiny of the individual doctor, paradigms of diagnostic activity, running a practice and so forth to the way that the profession as a whole scrutinises itself and the 'state of the discipline'. Hence, from the 1960s - and, no doubt, in no small part due to the founding emphasis of Balintism upon the self-constitution of the doctor - general

practice posited its condition of coherence upon this notion of self-surveillance; or, more specifically, of self-cultivation through self-surveillance. As a coherence-condition this paradigm actually afforded a certain kind of validity that had advantages over previous forms. For the paradigm of self-surveillance also enabled the qualification of general practice in this period as a certain kind of 'regime of truth' (to use Foucault's term). Here the 'verification' of a form of treatment derives from a kind of 'ascecis' of the doctor; the conditions of proper practice are produced through self-cultivation. This provided the grounds for the positing of a sense of 'exclusive insight' proper to the general practitioner that went beyond the mere accumulation of 'experience'; the notion of a limited but important 'change of personality' resulting from group training provided the conditions for the general practitioner's activities to be effectively self-validating (cf. the distinction between 'clinicians' and 'officers of health'; above page 102). Hence, in a curious way, in spite of being what might be described as an 'auditory' rather than an 'inscriptional' rationality, the regime of self-surveillance was actually more 'scientific' than its predecessors in that it was able to provide the grounds - as it were internal to itself - of its own validity.

This 'regime' was designed to work in a particular - one might say, 'technological' - manner. From the basic principle of self-surveillance, a whole progression of

'identifications' was erected that ran through the persons of trainer, trainee and - finally - the whole person. Thus the emphasis on the doctor and his personality was conditioned upon the aspiration to found a 'patient'-centred medicine; one worked upon doctors in order to 'mobilise' the whole person. There is no need to labour the central paradox here. For the ideal of patient-centredness is hardly a sacrifice on the part of the doctors. In fact, the direction of that 'progression' that leads from that particularly 'exemplary' kind of doctor, the trainer, to the whole person can also, of course, be reversed. The aspiration of patient autonomy also - and simultaneously - valorises the aspiration for the ('professional') autonomy of the doctor. Hence the anti-medical ideal of the complete autonomy of the patient functions, in part, as a rationalisation of the professional ideals - and above all, the demand for professional autonomy - of the general practitioners themselves. Patient-centrism is validated only at the cost of doctor-centrism.

CONCLUSION

1. A Perspectivism of the Present

The purpose of this study has been ultimately to draw up an anatomy of person-centred medicine in general practice. We have attempted to illuminate the differentia specifica of the person-centred regime - Balintism and the 'regime of self-surveillance' - in relation to other programmes in general practice from which it differs. Such a 'negative' approach is integral to the tasks of a 'history of the present'; to produce what Paul Veyne has described as an 'inventory of differences'. The present is not tied to the past on the basis of the evolution of a progressive 'identity' ('general practice') but marks a break from the past. Hence this study was not undertaken on the basis of a 'narrative' methodology. Its very condition of possibility entailed a certain perspectivism whereby the difference of other regimes of discourse in general practice was established on the basis of certain 'present-centred' themes. The analysis was not situated in evolving 'historical' time, but in - as Canguilhem puts it - an 'ideal-space time'. One could certainly write an evolutionary account of ideas about general practice, but

that has not been our method here. Rather, in this study, person-centred medicine has constituted less the culmination of a continuous narrative than the 'reflective origin' that stands - paradoxically, one might think - as both the condition and the object of the analysis itself.

Thus the analyses of the worlds of clinical medicine, the work of James Mackenzie, the epidemiological model deployed by the early College of General Practitioners, Balintism, etc. were largely dependent upon an assessment of themes in relation to the present. Taking the instance of Mackenzie, we were not only concerned to show how his programme was designed to work and within which discursive conditions it was embedded, but also to illuminate how it distinguished itself from current themes characteristic of our own present. These related especially to the person of the doctor (what kind of medical subject is presupposed by Mackenzie's programme?), the role of psychology (minimal), and the question of the patient. But beyond this, our very methodology has been guided by present-centred concerns. The grid of analysis - the heuristic configuration that has been labelled epistemological articulation, organisational adequation and 'governmental consciousness' - was itself tied to this perspectivism of the present; and this point relates to person-centred general practice as the 'object' of the study.

2. A Machination of Forces

What seems to be most significant about the person-centred regime of self-surveillance from the viewpoint of the sociology of knowledge is the way in which it has tied together these epistemological, organisational and governmental demands. Its success relied largely in the way it was able to draw these themes as tightly together as possible; thus, the form of knowledge, the pattern of organisation and the 'telos' of 'government' all merge in the exemplary figure of the doctor. This insight can be used on the one hand for passing perspectival 'judgement' upon previous regimes, and, on the other hand, for drawing up an assessment of the person-centred rationality of general practice itself.

2.i. The Birth of Clinical Medicine

Foucault's account of 'the clinic' provided an exemplary instance of the tying together of organisational, epistemological and 'governmental' demands. Above all, the structure of clinical knowledge - where to 'discover' and to 'know' became of the same epistemological order as to 'teach' - provided an example of epistemological economy and coherence; a coherence that was grounded within the spatial-organisational order of the teaching hospital which was an amalgamation and modification of various structures (the university, the old form of the hospital, the 'free field'). In addition, we observed what was

termed the 'governmental consciousness' of clinical medicine; its foundations upon the Enlightenment notion of a 'medicine in liberty' with the liberal underpinnings of the 'contract'.

But the concept of the clinic is a 'popular' as well as a 'scholastic' one. These popular connotations feed into what we have understood as the 'anti-medical' dimension of clinical thought. The clinical spirit - understood, to be sure, in a more spontaneous sense than the series of discursive relations examined by Foucault - is also at work in the other medical programmes considered in this study. In opposition to the forces of reduction and specialisation a demand for a 'return' to the clinic has often, within general practice, accompanied the critique of the legacies of clinical medicine. Against the narrowing of clinical rationalities (behind hospital walls, into laboratories, specialisms) tends to be posited a return to that archetypal confrontation at the 'bedside' - doctor and 'sick man'. All of the general practice regimes considered here have taken this clinical reference as a guiding spirit of their concerns. What is the basis of this spirit? Mackenzie's emphasis upon experience in situ and the use of the doctor's senses (without instruments); the epidemiological emphasis upon the 'free field' and the sick individual hidden from hospital structures; Balint's emphasis upon the doctor's powers in the situational context of the consultation - all of these are posited as 'returns' to long-established clinical

principles. And if there has indeed been a common basis to this return, what has been important has been not simply a nostalgia for the 'real world' of people (treat the patient and not the disease) but a polemical relation of opposition to everything that might threaten the project of a 'medicine in liberty' (for example, perceived overemphases upon the corpse, the machine or instrument, the hospital, the specialty, etc.). The 'medicine in liberty' and its constant failure and re-constitution is perhaps what best constitutes the spirit of the clinic. What has made this impulse for a 'return' problematic has been, above all, the changing governmental context in which medical programmes had to situate themselves.

2.ii. Mackenzie

It was James Mackenzie who most forcefully set out to tie the fortunes of a more or less traditional clinical medicine to the discipline of general practice. For Mackenzie, only the general practitioner, with his immediate access to pathology and the patient, was in a position to re-site clinical ideals around the themes of early diagnosis and the functional prognosis of disease. Today the work of Mackenzie is well-recognised by those who have formed the main objects of interest in this study; those writers associated with the Royal College of General Practitioners. Yet a corollary of our analysis of Mackenzie's programme is that there can be no question of a straightforward 'return' to Mackenzie's principles (nor

besides a criticism of his work for not fulfilling the demands of various modern schools of thought). Part of the reason for this is epistemological. Mackenzie's work was grounded first and foremost upon the workings of a particular organ, the heart; the programme he produced was indeed a 'physiological' version of general practice that has not meshed well with modern person-centred ideals. But more important were the 'governmental' implications of this physiological programme. This turned upon the link between the physiological 'effort' of which one was capable and the obligations (especially in relation to labour) that might be demanded of the individual. Such a physiological model might certainly have a degree of penetration in the context of what was termed, following Luhmann, the 'social state' - that is, that form of provision which provided social security for certain sectors of the population; namely, those with specific tasks or obligations in hand (that is, 'labourers') in relation to the maintenance of the well-being of population. However, a model of health based upon 'reserve strength' and the capacity for 'effort' would not align well with ensuing governmental rationalities.

2.iii. The Free Field

In contrast to Mackenzie's 'social' programme, the taxonomising regime of the 'free field' that dominated the early works of the College of General Practitioners has clear affinities with a 'welfare' state rationality;

that is, a governmental rationality based upon universal provision. By the post-war years, the sphere within which general practice sought to intervene had become the universalist space of the population as a whole. It was only within this space that certain privileged targets came to appear, such as the child and the mother. This had clear implications in relation to the 'governmental consciousness' of the discipline. General practice now became conceivable as a network of observers conducting a surveillance of the entire space of the population. If it is the case, as Michel Foucault and others have suggested, that one of the primary tasks of any mentality of 'government' is to align the micro and macro dimensions of its activities then here we have a clear example of the programmatic realisation of this aspiration; the dream of a multiplicity of like-minded observers monitoring each pathological fluctuation (however minor) in the population. Yet in the free field the macro world is merely the sum of micro parts; individual practitioners going about their tasks. Hence the vocabulary of 'collectivity' amongst practitioners. But the clinical dimension of this micro domain was scarcely able to connect with the macro world (except in a certain exceptional contexts as with the matter of Pickles's evidence to the Royal Commission on Population). The effect of this was that the sick individual, held to be the central focus of the general practitioners tasks, actually became elided from view.

3. On the Specificity of Person-Centred Medicine

3.i. Balintism

Person-centred medicine (chapters 3 & 4) also sought for itself a particular governmental consciousness. This became more or less well-aligned with the long-standing 'ontological' infrastructure of general practice, that demand that the basis of general practice was its 'frontline' attention to the individual patient. What was this governmental consciousness? On the one hand, there is certainly an element of 'welfare' in the work of Balint and his successors. After all, they are working within a space of universal provision. On the other hand, what is at stake is a rationality that is by nature opposed to some of the founding governmental values of welfare; the demand for collectivism, solidarity and so forth. If this dimension of Balintism has been termed its 'neo-liberal' governmental problematic then this should not be taken to mean that general practice becomes from the 1960s straightforwardly a neo-liberal rationality working to undermine the values of the welfare state. Rather, Balint's work made possible a certain rupture with a welfarist governmental consciousness, which then made possible subsequently a limited alignment of general practice with neo-liberal forces and influences.

So what was highlighted in Balint's work that can serve to mark this mutation? Whilst on one level the attempts by

Balint and his successors to highlight the importance of the individuality of the doctor represents only a stage in a long line of similar concerns, the fact that this was done in terms of the subjective reflexivity of the doctor does indeed represent a point of discontinuity with the earlier literature. Three dimensions of this discontinuity can now be briefly discussed.

First dimension; the doctor. In person-centred medicine the doctor takes on a novel epistemological function. In fact, as was argued earlier, all forms of 'clinical' medicine lay a certain emphasis upon the perceptual powers of the doctor. If we can follow Foucault here; with the disappearance of the disease as a 'species'-entity, pathology becomes tied to the corporeal density of the body so that a 'subject of consciousness', endowed with the powers of empirical experience, is required to decipher its presence. A re-iterated emphasis upon the powers of the doctor - a shifting of epistemological focus - occurs also with the various forms of 'anti-medicine' that we have been discussing in this study. A medical rationality pitted against 'reifying' notions of disease appears inevitably to end up by laying an enhanced emphasis upon the powers of the doctor.

The person-centred approach in general practice turned this 'doctor-centrist' emphasis to its own epistemological account. It located the persona of the doctor as the central focus of clinical practice itself. The concern

with the subjective reflexivity of the doctor that was at stake here entailed not just an augmented valorisation of the general practitioner's 'professional' powers, but a transformation in the very epistemological structure of general practice. Foucault has distinguished between two modes of 'telling the truth'. The first 'Cartesian' mode situates truth within the anonymous forms of Reason itself; truth-telling is a matter of 'evidence' rather than 'ascesis' (Rabinow, ed. 1986: 371). Thus, in this Cartesian mode, the subject can be non-ascetic; indeed, as Foucault says, the subject of knowledge can in principle be anybody. In the second mode, truth-telling requires a prior - 'ethical' - labour upon the self; one has to have constructed oneself as a particular kind of persona in order to have access to truth. Here, then, an epistemological demand is attached to a particular ethic of self-culture. The regime of self-surveillance follows a similar kind of logic; in order to be able to practice his craft the doctor must be practiced in all of the 'techniques of self' proper to his profession, techniques which can be summarised under the heading of a constant observation of self (with the help of peers and others). And as we have seen, it is only upon the basis of such techniques being acquired by the doctor that they can be, as it were, transferred to the person of the patient; for, as we saw earlier, the doctor is held also to be an 'exemplary persona', a figure with whom the patient should 'identify' in certain respects. There is perhaps a lesson here for those who are interested in producing analyses of

the 'social consequences' of person-centred forms of medicine. Such analyses typically begin with the patient, the target of medical power; whereas, in fact, the patient is only the final result of the process, the 'end-product' of an entire 'technology'.¹

Second dimension; technology. The concept of technology implies a structure or a network that is 'outside' the individual, that compels him or her to approach self-understanding. Just as the birth of 'the clinic' entailed the founding of a general science of the 'individual fact' so the person-centred perspective is distinctive in that it constitutes a general technology for the production, mobilisation and deployment of 'personal qualities'. 'Technology' here is meant in an organisational as well as an epistemological sense. It refers to the way in which the doctor's persona is problematised as the central relay for the production of 'knowledge' in general practice. The term also refers to the means by which this is to be achieved - the group practice, the teaching seminar, the 'doctor-patient' relationship in the consultation, etc. What is at stake here is an invention of a technical order.

The notion of technology perhaps seems inappropriate in the context of a psychotherapeutic rationality like that of person-centred medicine. After all, are not technologies by definition exclusive of persons? But perhaps, as Nikolas Rose has suggested, it is time to

complement a 'social' understanding of technology with a 'technological' understanding of the social. For only by looking at this technological level can one begin to assess the nature of the varied objects and concepts that a particular discipline will allow to appear. This can be illustrated with reference to the theme of 'person'-centredness itself. As we have noted, the idea that general practice is a discipline entitled to claim unique access to the individual has been a long-standing one. However, it is the particular 'technology' of general practice that transforms this demand into a conceptual fabrication. And the kind of patient that will appear will depend upon the technological apparatus in question. For instance, as was seen with Mackenzie's work, one can construct an anti-medical technology that will be 'patient'-centred without being 'person'-centred. Similarly the project of taxonomy sought to invoke the 'sick individual'. On its own terms, it failed to do this. In short, it is the technological apparatus that turns words and representations ('treat the patient and not the disease') into something like concepts, that is, workable formulations within discourse.

This notion of technology also has a particular resonance specifically in the context of person-centred medicine. For this rationality was specifically predicated upon a resistance to the perceived 'technological' aspects of medicine; its specialisms, obsessions with innovations, diagnostic apparatuses and so forth. But person-centred

medicine is a technology that has the merit - so far as anti-medicine is concerned - of not looking like a technology; all of its operations appear to be entirely spontaneous, naturalistic and immanent to the properties and qualities of persons. The role of psychological knowledge has been instrumental here. Psychology has provided a vocabulary (of persons, groups, relationships) capable of conferring both the capacity for the visualisation of intervention within a particular range of phenomena - an exclusive 'field' of general practice. Psychology both programmes a field and makes it programmable; it constructs an object-world composed wholly of persons and relationships and provides the grounds for intervention within that world.

Where David Armstrong's has suggested a progressively developing encounter between the psycho-sciences and medicine, we have here evidence of a new relation between psychology and medical knowledge. Psychology does not merely 'influence' prevailing modes of medical treatment. Psychology here is not 'applied' to a field; rather, it helps to construct it. Nevertheless, the impact of psychology is also evidence of a fundamental continuity; even of something like a genuine 'return' to clinical principles. For psychology provides the tools for a reassertion of the clinical principles of the exposure of individuality on the one hand, and of the maintenance of a certain form of liberty, on the other. Individuality: psychology provides the doctors with a sensitivity to

individual difference. This link materialises in the fusion of personalities within the doctor-patient relationship; in 'using' his personality, the doctor is able to mould himself to the personal characteristics of the patient, to provide - all but instinctively - the correct form of treatment and advice for that particular individual. Liberty: but psychology, as we have seen, never proceeds in this task through direction or instruction. The usage of psychological knowledge and techniques seems always to have been accompanied by an anxiety concerning the ethics of medical power, an anxiety that one's methods might be contrary to liberty and freedom. No one is more suspicious of medical reductionism than an 'enlightened' general practitioner, attuned to psychological influences in the 1960s and 1970s.

In short, psychology offers itself increasingly as the basis of the solution to the problem of the 'betrayal' of enlightenment, discussed in the introduction to this study; it is a technology well-fitted to the project of recuperation. It is presented as a rational form of knowledge (rational in the sense that it is coherent, and - with the help of one's peers - reproducible) which does not betray the principle of the sanctity of personal qualities.

Third dimension: medical power. The notion of technology, of course, always implies a 'telos', a purpose for which technology serves, an end which it seeks to achieve. If

person-centred medicine in general practice has been a technology of something then it has been a technology of the self; seeking to bring about in its targets a modified relation to self. It is to this 'telos' that we now turn.

3. ii. Before putting forward our own assessment of person-centred medicine as a form of medical power, a preliminary methodological foray will be in order. The vocabulary of social control and its equivalents would be inappropriate here. This concept seems to ally a rather general and in itself unremarkable phenomenon - the fact that therapeutic (and other) discourses have effects upon their targets - with the suspicion of repression tied to these effects. But one should not seek to encompass too much diversity with blanket-notions of control. If it has been the case - as writers such as Foucault, Elias, Weber or Oestreich have attempted to demonstrate - that the programmatic of the shaping of subjectivity has been in part constitutive of what we think of as 'Western modernity' then this should not lead us to view the project of shaping simply as one project. One must attempt rather to describe these technologies of human conduct and subjectivity in their locality and specificity without overstating their common features and, perhaps more importantly, without overstating their rates of 'success' or effectiveness. For in the end discursive technologies such as the one we have been outlining in relation to general practice are indeed just discourses. There is a gap, that is to say, between what they seek to do and what

they typically achieve. The mistake is to assume that the recognition of this implies either a denigration of discourses as such or a form of idealism asserting the primacy of discourses over behaviours. For discourses are not sets of ideas (this is why other terms have been used; 'rationality', 'technology' and so forth, which emphasise that discourses are subject to practical - 'non-discursive' - conditions of emergence and restrictions of scope); they are more like tools people use and draw upon to make sense of the world and to act upon that world. Discourses, then, are generically 'performative'; to describe general practice as a person-centred discipline is to take a step towards making it so. Moreover, discourses have a privilege in another sense. For it is only through 'discourse' itself that the rates of success or failure of discourses as such can be measured. The discursive regime of person-centred general practice thus works primarily - and most importantly - as an aspiration.

To use the language of social control to describe the specificity of this aspiration would be misplaced first because, as we have noted, the rationality of the whole person is itself specifically a libertarian one that seeks to evade all the tendencies of techno-medicine that are reductive of the person, or which would seek to instruct or direct that person. We may decide that it fails in this. If so we might want to use a sociological language in order to account for this failure; to say, for example, that person-centred medicine is merely another form of

social control, that it seeks to shape humans by - speciously or tendentiously - invoking their 'freedom' and subjectivity (cf. the comments in Rose 1990: 240). Armstrong's work - in spite of his justified suspicion of the notion of social control - is effectively a variant of this. But Armstrong's work also invokes the rationality of the theses of social control in a slightly different sense. For he implicitly assimilates the targets of medical discourse with 'actual' people and thus overstates the effectivity of that discourse itself. This approach seems to assume that the elaboration of a programme automatically implies its realisation in some real world of behaviours which it has somehow 'constructed' through discourse (although cf. Armstrong 1983; 133, footnote 50). Thus, for Armstrong, medicine becomes like a 'panopticon' which represses - or equally, promotes - forms of subjectivity through the very exercise of visibililty. But this is to overlook the fact that, on the one hand, medicine simply does not have a single, unitary 'project' in relation to human conduct - which is precisely why we have focused here not upon tendencies within medicine 'in general' but upon the intellectual fabrication of one discipline, general practice - and, on the other hand, that people themselves can indeed escape the effects of discourses - or at least, of any single discourse. Patients as such, we would argue, do not exist. Subjects 'in actuality' are crossed by innumerable discourses; people are, as Deleuze felicitously puts it, 'groupuscules' rather than identities.²

Medical discourse does not simply 'produce' a kind of patient by its mere exercise in the surgery or wherever. The 'social construction' of the patient is not a literal - 'material' - endeavour; or, at least, it is not just this. David Silverman (e.g. Silverman 1987) - no doubt hoping to evade some of the idealist logic of the 'discursive' approach of Armstrong - has examined consultations on the basis of ethnographic observation with a view to classifying them as 'person'-centred, 'clinical' and so forth. Such studies are undoubtedly valuable. Silverman has shown, for example, how 'whole' person medicine can, when deployed in the surgery, in some circumstances be a self-defeating enterprise (Silverman and Bloor 1990). But such analyses misplace the functionality of medical technologies and discourses. In the surgery many influences are at work and many discourses will be invoked. One cannot reduce complex behaviours into composite models of 'discourse'; general practitioners and patients are all sorts of things - fathers, housewives, workers, sick, malignering and so on; so, in the surgery itself, a multitude of discourses will be drawn upon. In this sense, one has to take a more 'abstract' approach if one wishes to isolate the features of person-centred medicine. Certainly, as the work of Silverman effectively demonstrates, a condition of the discursive success of person-centred medicine has been its scope and penetration into the minutest aspects of activity within the consultation; or rather, in the way it has worked by attempting to elaborate lines of force of

maximum strength able to link up within general practice the macro and micro, the centre and the periphery, and so forth. Nevertheless, the significance of the rationalities that we have been discussing does not lie in their effectiveness (or lack of it) in the surgery alone. If this were the claim one would probably be justified in arguing that person-centred forms of thought had not been particularly significant. Rather, one has to locate the question of medical power or tutelage at a more general level, very broadly speaking a 'political' or perhaps an 'ethical' one rather than on the level of actual or behavioural clinical effects. It is to this question - that of an assessment of the 'power' of these discourses - that we now turn.

Once again, Foucault employs a distinction from his later work that might prove useful in the context of defining what person-centred medicine is a technology of. This distinction is between a 'technology of power' and an ethical 'technology of self' (Foucault 1988: esp. 18). The former of these, claims Foucault, works by determining a norm of subjectivity and then seeking to impose this upon the conduct of individuals. The latter works not by instruction or direction in relation to subjectivity but by supplying the means and ideas for others to work upon themselves. These are:

'Technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of

operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, or immortality' (ibid: 18; cf. the introduction to Rose 1990).

This distinction affords a means of distancing the analysis presented here from those such as that of Arney and Bergen which seek to invoke a generalised medicalisation of 'life' ('the management of living') as the predominant contemporary task of medicine. Arney and Bergen's analysis classifies modern medicine as a technology of power; medicine encroaches ever further upon previously un-considered domains such as alcoholism, pain and so forth. Thus more and more aspects of subjectivity are said to come under the control of medical power; the dominant metaphor here being one of an ever-increasing management of life. Aside from the fact that it almost certainly understates the long-standing interest that medical rationalities have actually taken in relation to such questions of 'life' management, this argument overstates both the aspirations and the effectivity of medical power (at least in its person-centred form). For what has been at stake here has been less a question of taking over previously un-acknowledged areas of interest so much as an enhanced attention to questions of self-cultivation in general (in relation to which 'problems of living' and so forth merely represent an appropriate 'ethical substance'). What is important is not that people

are normalised into certain forms of conduct as a result of this shift of attention, but that they are encouraged to use such problems (depression, organic illness, trivia, etc) as material through which to labour upon the self in order to achieve some kind of self-recognition and autonomy. What has been at stake has been less the demand for an ever-finer management of life-problems, an ever-creeping 'medicalisation' of life, but an attempt to use medicine as a medium through which the autonomisation of subjectivity can be encouraged (as such, the project has been entirely in line with one of 'de-medicalisation'; Illich 1982).³

Certainly, the mode of inculcation for this self-recognition and autonomisation does not derive from any form of more or less codified knowledge passed on from doctor to patient. Rather, to borrow a phrase, the doctor 'acts at a distance' upon the patient's subjectivity. There is no moral 'content' to his 'teachings'; rather, if - as Balint put it - 'teach he must', then the doctor does this through his own self and in, as we have seen, only in an exemplary fashion.

What is the nature of this 'exemplarity'? In the first case, the doctor has a kind of substantive exemplarity; he is the pillar of the community, a 'support' for the patient, a particular kind of 'individual' averse to all the humbug and trappings of 'theory', and so forth. This might be described as the 'ideological' function of the

doctor. Yet this aspect actually takes second place to a form of exemplarity which is actually rather empty of substantive content. This exemplarity takes on only a kind of formal nature; what is important is not that the patient should work upon him or herself in order to become like the doctor in substantive terms. All that matters is that the patient must be somebody who recognises the importance of self-cultivation, that is, somebody who in one way or another reflects upon his or her own attributes of 'self'. Thus the anti-normalising 'tolerance' of the person-centred general practitioner is not a cynical one, disguising a demand for the normalisation and ever more finely-honed management of subjectivity - rather, the aim is an autonomisation of subjectivity, an impulsion for subjects to think for themselves, to act upon themselves, to recognise who they are; in short, to become, as it were, entrepreneurs of their own conduct.

3.iii. But if this is an accurate rendering of the form of 'power' proper to person-centred general practice, we may ask whether we should accept or reject it. The answer to this must be an ambiguous one. There is a sense in which such technologies of subjectivity as we have been discussing are inevitable in our societies. The purpose, then, would be indeed more to understand - without necessarily seeking to evaluate - the 'ontology of ourselves' proper to the present; to reflect upon the kinds of subject we are increasingly called upon to become. This is not a useless form of activity; it might

lead to novel forms of inventiveness, for example, and prevent the 'hijacking' of such technologies for disreputable projects, or at least expose the weakness of such discourses in the face of such 'disreputable' projects; for example, the amenability of a theme such as person-centredness to projects such as that of the application of Thatcherite economic policies within the Health Service. But we can indeed go a little further than this.

In the introduction to this study a distinction was made between the task of 'critique' and that of 'detachment'; the purpose of a study such as this being to dismember discourses that might otherwise seem ethically obligatory. Person-centred medicine has above all two 'detachment'-possibilities. The first, is the tying of these forms of subjectivity to expertise; the fact that it is becoming increasingly imperative for people to turn not just to others, but to 'expert' others for help with their subjectivity. A dependency 'spiral' is at stake here; in order for people to become less subject to 'dependency', their very dependence upon the powers of subjective expertise will have to be exploited. And this gives us a clue as to why the person-centred project always seems to fail and yet to be promoted by its very failure; the escape from dependency requires ever more dependence. Or, in the specific context of this study, the logic of 'doctor-centrism'; the struggle against the powers of 'medicalisation' comes to imply a spiralling enhancement

of the doctor's expertise even as an 'opponent' of medicalisation. This is a question, then, of what might be called the 'functionality of failure'; the more the project fails, the more it seems necessary. Second, what might be questioned is the assumption of identity, the very notion of a project of subjectivity that seems to be in evidence here, along with its evaluative corollaries - the values of 'maturity' and so forth; here the task might be to question whether one's life should take the form of a coherent 'project' of subjectivity at all.

4. Social Theory and the Sociology of Morality

But diagnostics of this sort have not been the main objective of this study. Rather, we have used the technology of person-centred medicine as a kind of institutional 'laboratory' for considering the wider question of the significance of technologies of subjectivity in general in societies such as ours. This is a theme proper to the 'sociology of morality'.

Earlier the possibility of a form of sociology was invoked that would take as its subject-matter the ways in which human beings come to recognise themselves as subjects of the present. This would be a kind of 'philosophical anthropology' geared to the uncovering not so much of the constraints upon modern subjectivity as upon the 'obligations' that confront us as 'necessary'. Today the

project of anti-medicine seems like a necessary commitment; that is, the commitment to make medicine less of a reductive, necromantic, specialist activity and more of a 'person'-sensitive one. Who could argue with such a project? To contest, or even to analyse its workings may seem to be a question of bad faith; yet this again, we argued, should be a question for what we termed the 'history of the present' - the questioning of the divide that separates 'right' from 'wrong', 'true' and 'false' in the interests of opening up a space for the constant and impossible 'practice of liberty'.

Medicine today is certainly in need of such a spirit of inventiveness from those who would wish to subject it to a 'social' critique. Hence, the extraordinary sense of repetition and 'deja-vu' which one feels on encountering 'critiques' of medicine from sociological perspectives; return to the patient, be sensitive to the individual and so forth. Until one cannot help coming to the conclusion that such invocations, far from being instances of a radical spirit, are actually inscribed within the very conditions of medicine itself as a particular kind of activity. Moreover, social scientists - above all medical sociologists - and others often seem to be unaware of the fact that the anti-medical impulse has long been an aspiration within medicine itself and could hardly be said to originate from a logic of critique developed from beyond its borders. Hence it may be of more interest less to join this chorus than to subject anti-medical

discourses themselves - as 'exemplary instances' of the present - to analysis. This is what we have attempted to do in this study.

As the introduction to this study sought to demonstrate, medicine has long had a kind of strategic relation to the great theme of the betrayal of enlightenment. Clinical medicine has been both an exemplary instance of enlightenment rationality and an instance of the betrayal of that rationality. Take, for example, the connotations within everyday speech of the word 'clinical'; either an attention to patients (as opposed to laboratory work, etc.) or, conversely, a 'coldness', a 'detachment' of manner. This Janus-faced consequence of clinical medicine - you just have to hate it and love it - serves perhaps as a reminder of Foucault's well-known claim that, of all the human sciences, medicine is closest to the 'anthropological structure' that sustains them all (Foucault 1973: 198; and above: 56). This paradigmatic position perchance makes medicine something of a potential index, a privileged 'social laboratory', for measuring the tendencies and anxieties characteristic of our present.

So what are these tendencies and anxieties generally taken to be? Derek Sayer has recently offered a useful overview of the major themes linking the social sciences with the question of modernity (Sayer 1991; esp. 141-3). As he demonstrates, this relation can be reduced to one great theme; namely 'the contrast ... between personalised and

impersonal modes of administration and forms of power' (ibid: 141). Modernity in classical social thought is the progressive separation of rule, administration and governance from the qualities of persons; and the task of the social sciences is to restore a certain 'regard for persons' in social life and regulation.

But, perhaps what we have seen here in this study offers evidence - certainly of a 'local' but, given the medical context, perhaps not of an entirely marginal kind - of a shift in modes of governance that would have to be taken account of by the social sciences in their reflections on the state of 'modernity'. In the first instance, what has been at stake is a resurgence, a re-valorisation, of the old link between clinical thought and liberalism. Liberalism has been described as an 'ethos' which stresses the limitations of government (see e.g. Burchell in Burchell et al. eds. 1991); just as clinical thought gained its emergence, in Foucault's account, in a generically 'liberal' context so today a much-modified clinical rationality, making particular use of the ethos of psychology, once again sustains points of alignment with a particular kind of liberal order. Second, the re-forging of this link between clinical rationalities and liberalism entails an effective operationalisation of the demand that personal qualities should not be sacrificed to the obligations of a rational life-order. Hence, the felicitous admixture within person-centred discourse of 'scientific' and 'affective' vocabularies (the doctor's

powers; the consultation). Person-centred medicine is an example of a technology geared to the institutional reconciliation of the 'rational' prerequisites of coherence and reproducibility with the mobilisation of genuinely personal and individual - one is tempted to say, 'irrational' - qualities. In short, person-centred medicine provides evidence that it is now held to be possible to conduct a truly ethical life within a rational life-order; or, rather, that ethical values can be mobilised in a rational manner (cf. on this; the conclusion to Rose 1990). Hence, this clinical rationality can serve as evidence that an increasing aspiration of the present should be that the exercise of authority should reside as much within the qualities of persons as in the anonymity of rules and the logics of bureaucracy. Max Weber's vision of those 'last men' who sought to 'invent happiness' may have come true. Persons have become the instruments of rational discourse.

Hence, lastly, the instance of person-centred medicine perhaps affords evidence of the opening up of a kind of 'ethical space' in our societies (cf. Gordon 1986 and Rose 1990 who both broach this theme); a generalised valorisation of self-cultivation per se; or - as Foucault wrote of a different period - an 'insistence on the attention that should be brought to bear on oneself' (Foucault 1990: 39; and 37-68). Person-centred medicine is a good example of a form of discourse which has seen a general detachment of moral prohibitions from the

injunctions of expertise; where expertise has taken on an ethical import. Hence, the demand for a sociology of morality - one that would consider, as stated earlier, the 'supply-side' of our moral and ethical ideals - is one that may be particularly pertinent today; for the condition of its importance lies in the very nature of the 'present' itself.

FOOTNOTES

Preface

1. For the nineteenth century history of general practice, the outstanding study is Loudon 1986 (also Honigsbaum 1979 for the twentieth century), and for a (more contemporary) bibliography, Hammond 1983. Loudon observes, however, how difficult it has been actually to define the 'general practitioner'. The question of the self-definition of general practice is the main subject-matter of the present study.

2. In doing so, it will also be our concern to outline a somewhat different Foucault from the Cassandra of social control and 'medicalisation' so often portrayed in the literature; in particular recourse will be had to Foucault's early and late works, neglecting somewhat the 'power' phase of the mid-1970s. All sorts of writers cast Foucault amongst the prophets - above all, Illich - of medicalisation and professional monopoly (even an authority such as Ludmilla Jordanova in an otherwise very useful overview of approaches; 1983: 92). This thesis will seek to show the existence of a more subtle Foucault than is often portrayed; yet one who is perhaps rather closer

to Anglo-Saxon modes of thought than has been generally acknowledged (on Foucault's 'Anglo-Saxon' credentials, see Gordon 1986d: 831-2; and, for a similarly 'Anglo-Saxon' verdict, Bowker and Latour 1987).

3. This is not to say, however, that general practice has been the only 'anti-medical' discipline (in the particular sense meant here) within medicine itself. One thinks, for example, of the classic themes of 'social medicine'; for which, see the historiographical overview in Porter and Porter 1988.

4. Yet in focusing upon this organisational 'infrastructure' the omissions are again extensive. We have a great deal to say about the College of General Practitioners, yet little to say about the British Medical Association (BMA) or the general practice section of the Royal College of Physicians. We quote a great deal from the College journal, yet scarcely refer to The Lancet or even specific general practitioner publications such as Update or educational publications such as The Journal for Postgraduate Medical Education. This narrowness can, of course, be defended in principle; only at the College of General Practitioners has there been evidenced a consistent anxiety to determine intellectually - that is, above all, in a 'non-political' manner - what general practice is all about, and it has been this endeavour that we have attempted to isolate. As such, the study is a kind of 'case-study' of general practice, the evidential

criterion for which being a matter of intelligibility rather than exhaustiveness (on which distinction, Cousins and Hussain 1984: 3). Obviously, the merits or de-merits of this approach will be up to others to determine.

Chapter 2

1. It is of paramount importance to make it clear that by 'anti-medicine' is not meant an ethos that rejects medicine wholesale, that is literally against all forms of medicine. Nor is this term meant to apply to the views of particular individuals; rather anti-medicine is, precisely, an ethos, a way of thinking that is drawn upon by different sets of people in different contexts. An after-dinner speaker bemoaning the spread of technology and calling for an enhanced attention to the individual, a medical historian using the theme of a medicine devoted to death as a principle of empirical coherence, and - certainly most commonly - a medical sociologist denouncing the 'medical model' or the 'machine metaphor'; all these are instances of the anti-medical ethos. But nor should it be implied by our account that anti-medicine is a wholly negative affair, that it is a priori wrong or misguided. On the contrary, writers have produced rich accounts of medicine from what is being labelled here an 'anti-medical' perspective. One thinks particularly of the work of Reiser (1978) on the history of medical technologies (the whole premise of which is that medicine has been moving further and further away from the person of the

patient) or the work of the sociologist Jewson (1976; cf. also such diverse sociological works as Morgan et al. 1985: 29; or Mishler et al. 1981: 237-44; and, for variations of the 'machine model', Hart 1985: 10-12; or Stacey 1988 - often Foucault is invoked in support of these anti-medical views; e.g. Illich 1977: 40).

Chapter 3

1. Obviously, some caveats will be in order here. The first concerns the 'internal validity' of Foucault's account of the French clinic. Obviously the way that this is assessed depends upon an understanding of the methodological 'status' of Foucault's analysis itself (discussed further below in the text). Nevertheless, for favourable verdicts on Foucault's account from French writers; Leonard 1981 (esp: 22-3), Jamous and Peloille 1970: esp. 121-2; and for an account of the French hospital in this period from the perspective of social history; Joerger 1984. Second, there is the question of the differences between France and England, which were naturally extensive. This question is complicated by the sheer heterogeneity of the hospital 'system' in this period; for an idea of this in the British context, see the articles collected in Granshaw and Porter (eds) 1989. However, as the discussion should make clear, what is important for the purposes of this study is less the empirical specificity of the hospital at this time, than the epistemological 'aspiration' behind the notion of the

modern clinical hospital per se; that is, the hospital as a kind of 'ideal-type'; it is this that has been constitutive of what is meant by 'the clinic'.

Chapter 4

1. Naturally this discussion does not exhaust the question of the relation between epistemological histories and social history proper. What is certain is that this is not an opposition between the naive empiricism of historians and the sophistication of 'epistemologists'. On the contrary, whilst social historians of medicine have been concerned to reflect upon their methods (for example, the articles in Porter and Wear 1987) there has been remarkably little discussion from within epistemological history of the relation such histories might have to social history itself - certainly Foucault's own work is ambiguous on this issue. A discussion that might act as a useful pointer in this direction, and which by no means underestimates the tension that might persist between social history and the history of 'concepts', Kosselleck 1988.

Chapter 6

1. The notion of the birth of the 'social' is a theme of much 'Foucauldian' sociology: see Donzelot 1979, Hirst 1981 and Burchell et al. 1991. More rarely is this notion distinguished from a 'welfare' rationality, as in

Luhmann's analysis. Main sources for social insurance in Britain during this period are Harris 1965 and Gilbert 1966.

Chapter 15

1. In the 1950s the Postgraduate Education Committee of the College had been concerned mainly with the issue of 'practice descriptions' and advice to young practitioners; now it becomes the hub of College activity defining the very identity of general practice.

Chapter 16

1. An important corollary of these developments was the - albeit as yet very limited - academic entrenchment of general practice; an entrenchment that at this time was confined in England only to Manchester and Birmingham Universities. The difficulties experienced by such departments as to the exact nature of their tasks was acknowledged with all the advantages of hindsight some two decades later in the 'Mackenzie Report'. This concluded that the general practitioner could not be expected to contribute to research as part of his daily practice; research being now a matter only for professionals (Howie et al. 1986: 18). However, academic departments themselves were to be confined mainly to educational research (that is, research into methods of general practice teaching),

rather than to research into the nature of the 'field' of general practice itself.

2. That is, the dream of a classification that would uniquely serve the demands of general practice - based on morbidity as opposed to mortality statistics - as a particular epistemological domain had disappeared. What did not disappear was the need for classification systems particularly amenable to the circumstances of general practice with its myriad of common and minor afflictions. Thus in 1974 the World Organisation of Colleges and Academies of General Practice (WONCA) introduced a new classification (based primarily on mortality statistics) appropriate to the conditions of primary care throughout the world; this replaced the previous College classification. Likewise the College was to collaborate on a second National Morbidity Study (which appeared in 1974); however, the notion that this would make visible a new field exclusive to general practice had now disappeared (on the difference between the two national surveys; Crombie et al. 1975).

3. In addition, this re-structured paradigm of epidemiology included attempts to record data from the domain of family relations; that is, to bring the the interpersonal environment itself into the domain of inscription. Prominent amongst these was the notion of the 'F' Book (Kuenssberg 1964). The notion of records containing 'family trees' of emotional relationships - a

model clearly aligned with that of genetic family trees - was regularly re-invented over the 1960s and 1970s (see inter alia Jameson 1968 and 1970; Wallace and Harvard Davis 1970; Birmingham Research Unit 1976; and Zander 1977).

4. Not surprisingly, perhaps, this emphasis on temporality was tied to the question of remuneration that so dominated the mid-1960s; hence the great interest in 'time-and-motion' studies (e.g. Wood 1962).

Chapter 18

1. Nor is it to argue that neo-liberalism itself implies necessary adherence to right-wing or reactionary values; on the contrary, its basis is more often than not emancipatory and humanist.

Conclusion

1. A methodological corollary to this; it can be suggested that analyses of medicine would benefit from a closer attention to the social construction of the doctor's persona (along the lines of what Temkin called, a propos of Zimmerman, the 'philosophy of the physician'); in short, an analysis of the 'doctor's view'. Nevertheless this by no means invalidates the project of reconstructing the 'patient's view' that has been so influential recently (e.g. for the eighteenth century; Porter and Porter

1988b). There is nothing in the approach presented here to suggest - as Armstrong has done - that this project is an epistemological 'impossibility' or a methodological anachronism.

2. Again, this should not be taken to imply that we are arguing that one cannot write a history of the 'patient's view' - or at least of the 'subject-position' of 'patienthood'! - throughout history. There is no need to succumb to that temptation - apparantly generic to Anglo-Saxon appropriations of post-structuralist thought - of over-interpreting the niceties of epistemology for the purposes of iconoclasm.

3. Thus what is at stake here is a kind of 'spiral' of dependency whereby the very dependency of the patient on the doctor (Balint's 'apostolic function') is used to encourage the breaking of dependencies. Thus dependency is seen as its own solution (see page 439).

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Abbreviations:

BMJ British Medical Journal

JCGP Journal of College of General Practitioners

JRCGP Journal of Royal College of General Practitioners (after College incorporation 1967)

RN Research Newsletter (CGP)

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ACKNOWLEDGEMENTS

A thesis is itself inevitably as much a matter of ascesis and 'self-cultivation' as it is an objective 'report on knowledge'. I wish, then, to thank some people who helped (I hope) to prevent all the self-surveillance of the last few years from ending in a complete and irreversible regression of personality. Aside from Ann Darlington (who, as archivist at the Royal College of General Practitioners, is entirely absolved from any responsibility whatsoever for my personality) I would like to thank Helen and Tony Osborne (heavily implicated), Kevin O'Callaghan, and, above all, Lucy Morton. Finally, Professor Nikolas Rose was the 'exemplary persona' and 'master of being' who admirably created and sustained the working conditions of dependency, inspiration, insight, hard work, professionalism and submerged threat that made completion of this study a distinct possibility; all my thanks to him.