The chameleon, the Judas goat, and the cuckoo

MARSHALL MARINKER, FRCGP
Professor of Community Health, University of Leicester

Animal crackers

THE title of my lecture is puzzling. In one sense I chose it to be simply that—a puzzle. Just because the words are not part of that language in which we talk about doctors and their patients, they are arresting, they form an impediment to further discussion, they seem to demand from the lecturer some immediate statement about meaning, about precise definitions. What can the chameleon, the Judas goat, and the cuckoo have to do with medicine, or with medical education—my two themes?

In a monograph, entitled *The Order of Things,* Michel Foucault quotes a Chinese encyclopaedia in which animals are divided into the following categories: (a) belonging to the Emperor, (b) embalmed, (c) tame, (d) sucking pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camelhair brush, (l) etcetera, (m) having just broken the water pitcher, (n) that from a long way off look like flies. What is extraordinary about this taxonomy is not the nature of its constituents: there is nothing intrinsically shocking in the notion of animals belonging to the Emperor, or embalmed, or tamed, or for that matter fabulous. What is shocking is the proximity of one idea to another. What is unthinkable is the system of thought which brings this list together in precisely this way.

Hilda Thomson

The day before I began to write this lecture, I saw a patient, whom I will call Hilda Thomson, during a morning surgery at a village health centre. She was new to the district, having moved into the village about three months ago. She was in late middle age, a large, rather untidy woman with an angry-looking face. It was clear that she did not have very high hopes of the consultation. She told me that she had increasingly severe pains in her arms and legs, and that these had been made infinitely worse by a visit to an osteopath in the city. Her only reason for visiting him, she said, was the signal failure of doctors to help her in the past.

Some years ago she had been diagnosed as suffering from rheumatoid arthritis and in support of this story produced from a canvas bag some eight or nine bottles containing examples of most of the current remedies for this condition and, of course, by way of an hors d'oeuvre and a dessert, a selection of choice psychotropic drugs and a sleeping tablet. The pain had been made much worse by the move to the village. Three years ago, she and her husband had bought a grocery shop in the nearest town and had commuted about thirty miles from their previous home. A year ago her husband, Peter, who had previously taken a large part of the burden of the shop, had had a coronary thrombosis. Since then he had become a complete invalid, demanding constant attention, refusing to venture beyond the garden gate, and taking no part at all in the running of the business. She had been taking the sleeping tablets for three years, but habitually woke in the small hours of the morning. Three years ago blood tests had suggested the diagnosis of rheumatoid arthritis. Inspection of her joints now revealed little evidence of the disease, although her eyes filled with tears when I began to examine her. She told me that the Government was unfair to small shopkeepers and that nobody in society cared about the 'little man'.

What I wish to suggest is that the problem which is posed for us by the classification of animals in the Chinese encyclopaedia is similar to the problem posed by the events and perceptions of the consultation with Hilda Thomson. After all, what astonishes us in the Chinese encyclopaedia is not the elements of the taxonomy, but that mysterious schema which links them together. Foucault comments on "the stark impossibility of thinking *that*". It is starkly impossible because we cannot imagine what the taxonomy was meant to accomplish. It is simply not recognizable. The only link that we can see between animals belonging to the Emperor, animals included in the present classification, and those drawn with a very fine camelhair brush, is that they appear together in the imagination of a long dead encyclopaedist.

What about the present imagination of the general practitioner who encounters Hilda Thomson? Consider his list: serological evidence of rheumatoid arthritis in 1970; the purchase of a grocery shop in 1975; the coronary thrombosis of the patient's husband; an angry face and voice; a shopping-bag full of tablets which have not helped; tears of pain when the wrists and knee

joints are palpated; and a belief that society does not care about the 'little man'. Just to utter the contents in the way that I have done is to invite Foucault's comment on "the stark impossibility of thinking *that*". Yet, a habit of practice, if not yet a system of thought, encompasses both the results of the serological tests and the political complaint. It is not easy to say on which plane of the imagination these ideas meet. The task of the academic general practitioner is to articulate them so that they make more sense to the young student who will be encountering Hilda Thomson in his professional future than that meeting which I have described of animals which have just broken the water pitcher, sucking pigs, and sirens.

What, then, for the general practitioner in the medical school, have the chameleon, the Judas goat, and the cuckoo in common? For they do have something in common: they form a taxonomy, but I will not reveal it yet.

Physic and its teachers

In an article called "The Death of the Professor of Medicine", Peart (1970) addresses the problems of teaching the knowledge, skills, and attitudes of clinical medicine in the absence of a teacher who sees himself as a generalist. The consultant physician today, like the professor of medicine, is almost always a specialist. This gives rise to a problem not because the specialist physician is not capable of carrying out generalist functions—that is to say that the neurologist is not capable of performing a rectal examination, or the gastroenterologist is not capable of using an ophthalmoscope. The problem which I have encountered is that these specialists often lack confidence in their ability to teach medical students these tasks.

In my own medical school, it has been argued that only a cardiologist is qualified to teach the examination of the heart and that it is desirable that both a neurologist and a neurosurgeon should teach the examination of the central nervous system. I make no apology for revealing these secrets of the medical school curriculum, because I do so in order to emphasize the dilemma of modern academic medicine. The common elements of the clinical encounter—the taking of a history, the making of an examination, the search for further evidence from the laboratory or the x-ray room, the clarification of the problems, the selection and monitoring of treatment—are all taught from the point of view not of a coherent discipline but from the fragments of some past discipline, fragments torn off and sent spinning into orbit around the patient by the technological explosion of contemporary science. One of the most startling consequences of introducing general practice to the medical school, and I think not intended either by the host or the recent invader, is that the myth of medicine, general medicine as a basic and coherent discipline, is confronted and questioned.

To come straight to the nub of my argument, I believe that the task of general practice in the medical school is to reconstruct the discipline of medicine, to make coherent and whole what modern technology has shattered. However, that is *not* the reason that we were invited in from the cold. Until recently, the goals of medical education were implied rather than stated. Since the 1858 Medical Act, the intention was to produce a safe practitioner on qualification and it was only with the publication of the Report of the Royal Commission on Medical Education (1968), one hundred and ten years later, that there was a formal change of intention to the production of a basic or undifferentiated doctor.

There is more than a certain irony in the historical coincidence that departments of general practice began to appear only when it became apparent that undergraduate medical education was something quite different from the training of future general practitioners. This coincidence gives credence to my thesis—that the task of general practice in the medical school is to create a modern equivalent of that discipline which was lost when the professor of medicine died.

I shall also expound a secondary thesis: that the declared intentions of the *arriviste,* now that he is on the scene, constitute a major impediment to the carrying out of this task.

Prevalence and relevance

One of the earliest criticisms which general practice made of a medical education located in the hospital was that the range and severity of diseases which doctors meet in the community are different from those met in the hospital. The differences constituted one of the most potent arguments for the introduction of general practice as a subject in the undergraduate medical curriculum. The teaching hospital could not in itself arrange for adequate learning about the diseases most prevalent in the community.

I wish to enter an important caveat about this criticism of hospital-based teaching. The selection of conditions which are seen in the teaching hospital is predicated by the nature of hospital medicine. This is not a criticism but an explanation.

The Clinic

As long ago as the eighteenth century, the Edinburgh Clinic was organized so that "those cases which seem most instructive" might be brought together. In tracing the birth of a modern teaching hospital to its roots in the eighteenth century, Michel Foucault in his *Naissance de la Clinique* (1973), uses the word 'clinic' with two meanings. It describes not only the teaching hospital, but also the medicine practised within it. The same word embraces both the location of the practice and the system of ideas which it houses. The clinic, in this sense, is no longer simply a meeting place between the doctor and his patient. It is a system of thought, a field of pathology, a language which articulates the human experience of being unwell. The development of a

pathological nosology generated the language which we use to describe what we see and, at the same time, excluded from the discourse those parts of the encounter between the doctor and his patient with which the new language could not deal.

Epidemiology

That the epidemiological differences exist is unanswerable. By the same token, it is important that diseases should be taught in the nature reserve of the community and not only in the zoological gardens of the teaching hospital. But the *fact* that differences exist between incidence and prevalence of diseases can be taught as well (perhaps better) by epidemiologists—we do not need the general practitioner to teach about the differences in the numbers of diseases. The national morbidity surveys which record these figures are the result of research made about general practice, perhaps even in general practice, but it is epidemiological research; the conceptual tools and the methodology which articulates those tools are in no way special to general practice. If they belong to anyone, then they belong to the epidemiologist.

Differing distribution of morbidity

In the name of vocational relevance, it has been argued that the teaching of clinical medicine should shift dramatically from the study of patients with lobar pneumonia in the hospital to a study of patients with such conditions as acute bronchitis and acute tonsillitis at home, simply because the latter conditions are much more common than the former in our society. But it is important not to blur the argument. What cannot be asserted is that there are differences in the nature of diseases manifested in the hospital and diseases manifested in the patient's home. Only the distribution of morbidity will be different. The basic concepts of disease processes, the pace and sequence of events, the appearance of tissues, both to the naked eye and through the microscope, the notion of cause and our classification both of causes and effects are not materially different in the study of lobar pneumonia and acute tonsillitis, and they are unaffected by the location of these events.

Indeed, since the notion of a disease is essentially abstract—an ideal model, a template against which the more untidy experiences of individual doctors and their patients can be tested and observed—the clinical teacher could quite properly argue that extremes, however rare, are the best models for teaching.

No one could suggest that an encounter with Hilda Thomson, who complains miserably of pains in her knees, a husband who abdicates his manhood, and a society which no longer cares for the 'little man', is useful for learning about the pathogenesis, symptoms, physical signs, x-ray and laboratory characteristics, or natural history of the idea of rheumatoid arthritis; still less that the taxonomy of joint diseases will be best explicated by countless encounters with men and women who complain of an ache here or a pain there which can only be ascribed to a pathological event by the most strenuous exercise of the iatric imagination.

The *idea* of the disease is best taught on the best models available, and the best models available occur in the hospitals. This is a tautology. The *raison d'etre* of the modern hospital is the discovery and manifestation of diseases and their management. By definition it is in the hospital that the best diseases—the most florid, the most spectacular, the most intriguing—will manifest themselves. Of course these same diseases exist outside the hospital also. But here they are disguised, they lurk beneath the surface of appearances and events, so much so that the anger in the patient's face may distract our gaze from the results of the Rose-Waaler test, or the overwhelming presence of the person, Hilda Thomson, may mask the *idea* of her rheumatoid arthritis.

The patient and his world

Beyond the arguments concerned with incidence and prevalence, general practice has claimed to present far more clearly than the hospital the psychological and social variables of clinical practice. Indeed, in the Todd Report (1968) it is stated that the importance of the behavioural sciences in the undergraduate curriculum was most often presented to the Commission in terms of the needs of general practice.

But what are the foundations for this claim by general practice? After all, it could be properly argued that the patient in the teaching hospital is no less in the grip of social forces, is no less tossed in the storms of his own emotional life, than the patient sitting in the general practitioner's consulting room. Indeed, admission to hospital, precisely because it is a crisis in the patient's life, may magnify and illuminate the social structures, dynamics, and the personal feelings of the protagonists. The older primigravida who has just experienced a stillbirth, the young man whose diabetes has become unstable, the patient recovering from self-poisoning, will certainly be interviewed by a number of health care workers, social workers, clinical psychologists or psychiatrists, whose central task is the explication and exploration of these aspects of the patient's life. What, then, is the basis of the special claim of general practice? In the past, much has been made of the social proximity of the general practitioner to his patient. The history of general practice gives some credence to this pleading. Our predecessor was the apothecary, more a tradesman than a member of a learned profession. He worked neither from a consulting room in a fashionable district, nor in the forbidding institutions of Poor Law or municipal hospitals. He kept a shop on the corner of the street where the patients lived. Rivington (1888) described the surgeon-chemist, or the red bottle and blue bottle practitioners, in the following passage: "An open shop is kept with glass cases containing tooth-brushes, nail brushes, patent medicines, Seidlitz powders, Eno's fruit salt, soap, scents, delectable lozenges, chest protectors and feeding bottles." Further up the

scale of general practice, as it emerged in the nineteenth century, was the surgeon-apothecary who eschewed retail trade but gave advice and a bottle of physic for a moderate sum—a shilling was a common charge. Rivington makes the following interesting observation: "As the scale is ascended, the surgery retires more and more into the background until it reaches the interior of the dwelling, where it is no longer exposed to the vulgar gaze." In the beginning we see the still delicate balance in general practice between the door which is left open for immediate accessibility, and the door which is closed behind an intimate and personal relationship.

It is here in the social proximity of doctor and patient, in the recent historical fact that among the urban poor the doctor shared the poverty and squalor, that we must look for some of the roots of the present mythology that general practice is uniquely concerned with the patient as a person. William Pickles, of Wensleydale, one of the founding fathers of contemporary general practice, was proud to boast that there was no man, woman or child in his practice whom he could not greet by name (Pemberton, 1970). In Ann Cartwright's (1967) study of patients and their doctors, 66 per cent of the people whom she interviewed thought that their doctor would know them by name if he met them in the street.

The data are scarce, or at best confusing. In contrast the rhetoric is strong and at times disturbingly uncompromising. In its self-description, in the statement of its educational goals, in the whole thrust of its argument, general practice declares itself to be centrally concerned with the social causes and consequences of illness, with the patient as a unique individual and, above all, with the family.

Primarily, particularly in this country, general practice has been the location of almost all the research, not to say creative writing, concerned with the doctor-patient relationship. At the beginning of the 1950s, when John Hunt was planning the foundation of the College of General Practitioners in respectable Sloane Square, Michael Balint, in the more bohemian purlieus of Regent's Park, was beginning his long exploration of what went on between doctors and patients in the general practitioner's surgery. Although only a few of us in general practice were privileged to work with Balint himself, the impact of his ideas, even the language which he coined in order to explain our behaviour, has become an integral part of the subject which we profess to teach.

The rhetoric is impressive, the reality disappointing. Systematic observations of the consultation in general practice suggest that the interaction is very much under the control of the doctor. Even when the doctor is not dealing with such imponderables as the patient's feelings, but with the basic stuff of clinical medicine, lumps, ulcers, and the like, the dialogue hardly reveals what Buber would call an 'I—Thou' relationship. Ann Cartwright (1976) quotes:

Doctor: Apart from these palpitations you're really very healthy, aren't you?
Patient: Yes, yes. Well, I mean, I have varicose veins you know?
Doctor: Oh, yes.
Patient: And I've got a small ulcer, but it's dry now.
Doctor: Mm.
Patient: On my right leg I have a small ulcer.
Doctor: Yes, that's very good.
Patient: But it's drying up gradually. One day I think it's gone completely but it hasn't. It comes back. But . . .
Doctor: Now here's the letter to see about your eyes.

A medicine of persons

It was in the eighteenth century that medicine finally began to develop a scientific discourse which was applicable to the unique individual. Not only was this the great age of medical classification with which we associate the name of Boissier de Sauvages, but it was also the age of Thomas Sydenham. Sydenham's place as one of the founding fathers of modern medicine is said to rest on his empiricism, on his refusal to embrace any philosophy of medicine but rather his determination to observe and examine each individual patient with the open mind of a natural historian.

Much of medicine's claim to a human approach and a concern for the patient as a person rests on the clinical tradition which Sydenham founded. The doctor must listen intently and question the patient minutely about the march of events in the development of the disease. He must examine the body of the patient with infinite care in order to discover the height of the fever, the contour of those tumours, the geography of those palsies which signify the disease.

But there is a paradox which lies at the root of modern medicine. The science of persons—whether we are talking about pathology, human pharmacology, psychology, or sociology—is concerned to discover in the individual truths which are demonstrable not in individuals but in groups. The natural history and clinical findings of measles, mumps, cancer of the breast, or schizophrenia are true only of the ideas of these diseases. Clinical method is concerned to compare the reality of the unique individual with the model of the ideal disease. The degree of proximity between the reality and the ideal will determine the diagnosis and the confidence with which it is made.

The benefits of this clinical method have been enormous. It has made possible a scientific medical discourse about the individual and the method has been followed in the behavioural sciences. But this discourse profoundly determines the way in which we look at ill health, the ill health which we are prepared to recognize and value, and the relationship within which the commerce between doctor and patient takes place. John Powles (1973) wrote: "This (engineering) response pervades the whole of contemporary medical culture—the organization of medical care, the education of doctors, and the character of the doctor/patient

relationship." Jean-Charles Sournia (1962) sharply focused the link between contemporary medical science and the doctor/patient relationship when he said, "We observe (the patient) in the same way that we observe the stars or a laboratory experiment". In talking about the birth of the clinic in the eighteenth century, Foucault (1973) described this clinical method as being ". . . a simple confrontation of a gaze and a face, or a glance and a silent body, a sort of contract prior to all discourse, by which two living individuals are trapped in a common but non-reciprocal situation".

I am trying to advance the argument that a medicine which regards the patient not only as object but also as subject continues to exist in general practice, even though it can be discerned only in the shadows cast by the towering edifice of the hospital. It persists precisely because the patient refuses to be ill according to the best precepts of modern medical education. These days we talk a great deal about patient-compliance in relation to treatment. Almost nothing is said about patient-compliance in illness and diagnosis itself.

The complaint against the medical profession that it uses a private language in order to talk about diseases pales into insignificance when we consider how far we have brought our patients with us in sharing the ideas and values which we use in the discourse about disease. For example, consider the extraordinary phenomenon of depression as a late twentieth century diagnosis. In a review article on depression (Parry-Jones, 1973) the following were described as classical psychological changes: lowered mood; difficulty in thinking; loss of interest; delusional ideas; hallucination and depersonalization. The following were described as classical physical changes: sleep disorders; weight loss; constipation; reduced libido or sexual potency; disturbances of menstrual function. Watts (1966) lists no fewer than 71 possible presenting symptoms of depression. Parry-Jones (1973) adds the burden of the following four categories in which the diagnosis of depression should be uppermost in the mind of the doctor: somatic complaints with no demonstrable physical signs; atypical features in established physical diseases; neurotic reactions; and changed patterns of behaviour.

Contemporary psychiatry has invented a nosography of diseases modelled closely on diseases of tissues, organs, and chemistry. For the most part, this nosography refers to beliefs or fantasies which are acceptable only because they are consonant with modern biochemical explanations. Slowly but surely the patient is learning to present the human experience of unhappiness to his doctor in terms of depression. A different system in France teaches the patient the vocabulary of liver disease in the face of similar human experiences. The whole of nineteenth century European literature which expressed the *Weltschmerz* or *mal du sciècle* of the times might, had modern psychiatry then been invented, have been reduced to the dimensions of a prescription for amitriptyline.

I do not want to give the impression that general practice disdains the medicine of diseases. That would be quite a wrong reading of my message. What I have been at pains to do is to point out those many untidy facts and perceptions which persist beyond the discourse of tissues, organs, and chemical reactions. In the case of Mrs Hilda Thomson, the discourse about tissues and organs brilliantly articulates the idea of rheumatoid arthritis and helps to explicate the remedies that we can offer. But these solid three-dimensional objects, like swollen deep-red synovial membranes or clots of blood, do not take us very far in understanding the relationship between Hilda and Peter Thomson, his heart attack, her arthritis, her anger with him for withdrawing from his commitments, the reasons for his retreat, her feelings that nobody, society, the Government, or perhaps simply the doctor, cares for the 'little man'.

This part of medicine, because it is outside the discourse of tissues and organs, hardly appears at all in the written tradition of modern medical science. However, it persists in the oral tradition of medicine, and in my day it persisted in the oral tradition of clinical teaching in the medical school. I think that it did so for two reasons. The first is that the medical school teacher of earlier generations was often still a generalist; but of equal importance was the fact that he was not an academic. Particularly in the English medical school, the tradition of academic departments is very recent.

What is the role of the academic clinician? What, in the language of Thomas Kuhn (1962), are the paradigms in which he works? His major task is to advance the knowledge of his subject, and to do so he thinks and works within the boundaries of scientific fashion—within the paradigms of physiology and biochemistry. Of course these intentions are good and the results are enormously valuable to mankind. But the system of values which this way of working creates—the view of man as an object not a subject and the belief that the clinical task is to distinguish the clear message of the disease from the interfering noise of the patient as a person—constitutes a threat to medical humanism.

Specialism, which we created because the burden of our knowledge became unbearable, subserves this dehumanizing process. The threat is made more menacing still when, in both teaching and practice, the domain of the patient's feelings and emotional life is treated as though it too were a fragment of specialist medicine, to be dealt with by the psychiatrist.

Much more important than learning the names of diseases, or even recognizing their components, is the learning of the clinical process. For the future doctor it is the quality of his thinking, rather than the sum of his knowledge of facts, which will characterize the quality of his clinical work.

General practice is the best location for the teaching of clinical method. My reason for this claim is that general practice has failed to keep step with the developments of modern medical technology. It is precisely because clinical problems of general practice are not encrusted with the immemorabilia of modern

clinical technology that the logic of clinical thinking can be made evident when Peter Thomson collapses in his shop with a pain in the chest, or when Hilda Thomson comes to the surgery with a story of persistent pains in her wrists.

But what of the rest of the story? The general practitioner is faced with a number of competing images of Hilda Thomson. Small joint pains with evidence of early thickening or deformity, and a positive Rose-Waaler test some years ago, project one image. But there are clues, even in this short consultation, that there has been intense domestic bargaining for the role of sick person. There is evidence not only of inflamed synovial membranes, but also of inflamed resentments. The sleepless nights, the hint of sexual abstinence, at least since the coronary thrombosis a year ago, and the sense that medicine and osteopathy can provide no relief from the pain constitute fragments of a diagnosis which is missing from the written tradition of clinical medicine.

The problem of choice in medical diagnosis is akin to the problem of choice in art or poetry. Statements in art contain many truths which do not compete with one another in the way that scientific formulations compete. Of course the dispute between rheumatoid arthritis, tuberculous arthritis and gouty arthritis, must be resolved in the diagnosis of Hilda Thomson's painful wrist. But we do not need similarly to resolve the images of her anger towards her husband, her resentment of society, her sexual frustration, her rejection of medication, or her anxieties as a shop-keeper, in the same way. Nor do these images compete with the pathologies of her joints or of her husband's coronary arteries. The sum of all these images constitutes the approximation of a truth about Hilda Thomson's problems.

It is these rich realities which lie behind the somewhat arid statement that the general practitioner composes all his diagnoses simultaneously in physical, psychological, and social terms. Since I believe this concept to be central to the act of general practice, I would like to deal now with two commonly held misapprehensions about it.

Two misapprehensions

The first is that there is a causal relationship between the psychosocial variables and physical disease. It would be folly to ascribe the inflammation of Hilda Thomson's synovial membranes to the inflammation of her resentments against so many people. There is no link of which I know between sexual dissatisfaction and joint pain. But the absence of a cause cannot mean that the doctor is absolved from a responsibility for considering all of the aspects of his patient's problem which are presented to him. The relationship is not causal but existential.

The second misapprehension with which I want to deal concerns the scientific validity of whole-person medicine. In a recent paper, Peter Sowerby (1977) argued that since all counselling and psychotherapy are rooted in such formulations as psychoanalysis, they must be resisted as lying outside the proper scientific province of modern medicine. The thrust of Sowerby's argument is that, as Popper (1963) and Henry Miller (1972) have pointed out, Freud's hypotheses are irrefutable, and cannot therefore be considered as a part of science. The closed-loop logic of psychoanalysis consists of the notion that if you do not accept the hypotheses of analysis, you reject them because you are sick—sick, according to the prescriptions of analytical theory. The model is neither science nor art, but religion and political philosophy.

A proposition that cannot be proved false has no status in science. But the psychological and social perceptions of whole-person medicine are not concerned with irrefutable *theories*. They deal with the refutable guesses of everyday clinical work. The speculations which the general practitioner makes do not embrace the bedding of Oedipus's mother, still less what Cleopatra thought she was up to with that snake. These pictures may enrich our understanding of the culture and the human condition, but they are not a part of medical science.

To match a grammar to the lexicon of Hilda Thomson's troubles, the general practitioner must speculate on what she means when she parcels her anger with her husband and the Government with the mounting pains in her knees. Such speculations are, and must be, entirely open to refutation. The doctor says, "Whenever you talk to me about your husband, you seem to be tense and angry. You don't criticize him to me, but you look daggers". Or, on another occasion, "Even though you were working even harder in the shop, you said that you felt much better when your husband went away for two weeks. Why was that?" The observations imply statements, and the statements are leaps of the imagination, but they are open to refutation. They may not yet be open to numerical analysis, but they can be checked against the evidence of human experience. As to the value of this kind of medicine, I can do no better than quote Paul Halmos (1965) on the importance of counselling in our own culture:

> "The picture we are forced to form, for the time being at least, is that counselling is to be justified by the moral sustenance it gives to both counsellor and counsellee, and by the moral affirmation of concern which the widespread practice publicly and visibly makes. It is justified because in its absence we would have to take up the callous and inhuman position of 'not even trying'. Let no one underestimate the causal significance of the large-scale organized gesture of desperately-wanting-to-help. The spectacle of professionalized benevolence is a source of moral renewal for this age, whilst the spectacle of rationalist criticism might not be as readily credited so much with a clear conscience."

Conclusion

I intended in this lecture to hint, no more, at the tasks of general practice in the medical school. I have used the

term 'general practice' as Foucault uses the term *la clinique* to describe at one and the same time a location of practice and also a philosophy of medicine. I would not want it to be thought that this philosophy of medicine which I value is always to be found in general practice and is never to be found among the other teachers in the medical school. This is simply not so. The virtue of general practice is that, by the very nature of its extended and untidy nosography, these aspects of medicine cannot be hidden either from the doctor or from the student.

It is yet another paradox of the arrival of general practice in the medical school that in order to create curriculum space we have had to create academic departments. The research of these departments will be, as with all other departments in the medical school, properly concerned with a measurement of the measurable. The danger that even now is threatened is that this may be all that will be taught.

It was this concern with the unwanted effects of creating academic departments of general practice which led me to my title, "The Chameleon, the Judas Goat, and the Cuckoo". On which plane of the imagination do the changes in Hilda Thomson's joints, the look of anger, her husband's interminable convalescence, and her complaint about society's lack of concern for the 'little man' meet?

It is not on the planes of pathology, sociology, or psychology, but on that plane of the imagination which embraces the concepts of whole-person medicine. This sort of medicine requires from the doctor not only a knowledge of the language and grammar of diseases, but also of human mythology, a mythology which reaches deep into the origins of the species, the race, and the society. It requires from the doctor an ability to handle the ambiguities and contradictions both of his patient's experience and his own responses. It is in this sense that these disparate and messy ideas constitute a taxonomy of human health.

The chameleon, the Judas goat, and the cuckoo are part of a different taxonomy. It is a fragment from my own taxonomy of survival. The general practitioner in the medical school can use any one of a number of strategies to survive. He can be a chameleon, taking on the colouring of his new surroundings. By identifying with the value systems of the host community, by conducting respectable research, the professor of general practice may come increasingly to resemble his academic colleagues. He will have his place in the curriculum and the names of the diseases which he explicates, and the locations where he does so will in a short time become quite unremarkable.

He can be a Judas goat, leading the pack towards its own emotional and intellectual destruction in a closed system of medical education, escaping himself at the last moment to repeat the exercise again and again at each final MB.

Or he can be a cuckoo. He can plant his ideas in the medical school in much the same way as the cuckoo lays her eggs in an alien nest. In this way his alien ideas, so important to medical humanism, will continue to survive from generation to generation, even though the nests are built specifically for the purposes of an advancing biotechnology.

I described the taxonomy as a fragment of a bigger one. There are, of course, other strategies for survival than those of camouflage, collaboration, and sabotage which I have outlined here. But survival is not enough. The stuff of biology, not to say of the human spirit, is concerned with more than survival. It is concerned with adaptation, with change and with development. Academic general practice may represent the last remnant of a lost medicine concerned with the individual, or the first stirrings of a new medicine which will express similar concerns, but more sharply and more cogently than in the past.

Whatever the truth of this, the general practitioner in the medical school must, if he is to become credible, remain subversive. Respectability, either in terms of the bioengineering of current clinical practice or in terms of sound epidemiological research, may in the long run seduce him from that elusive discipline which he is trying to create. I find it hard to guess what the future will hold, but I believe that my colleagues and I will need cunningly to extend our strategies beyond those of the chameleon, the Judas goat, and the cuckoo.

References

Cartwright, A. (1967). *Patients and their Doctors.* London: Routledge and Kegan Paul.

Cartwright, A. (1976). In *Seminars in Community Medicine.* Volume 1, *Sociology.* London: Oxford University Press.

Foucault, M. (1970). *The Order of Things.* London: Tavistock.

Foucault, M. (1973). *The Birth of the Clinic.* London: Tavistock.

Halmos, P. (1965). *The Faith of the Counsellors.* London: Constable.

Kuhn, T. (1962). *The Structure of Scientific Revolution.* Chicago: University of Chicago Press.

Miller, H. (1972). In *Freud: the Man, his World, his Influence,* ed. Miller, J. London: George Weidenfeld and Nicolson.

Parry-Jones, W. L. I. (1973). *Update,* **6**, 491-496.

Peart, W. S. (1970). *Lancet,* **i**, 401-402.

Pemberton, J. (1970). *Will Pickles of Wensleydale.* London: Geoffrey Bles.

Popper, K. R. (1963). *Conjectures and Refutations.* London: Routledge and Kegan Paul.

Powles, J. (1973). *Science, Medicine and Man,* **i**, 1-30.

Rivington, W. (1888). *Medical Professions of the United Kingdom.* London: Longmans.

Royal Commission on Medical Education (1968). Report. Chairman, Lord Todd. London: HMSO.

Sournia, J.-Ch. (1962). *Logique et Morale du Diagnostic.*

Sowerby, P. (1977). *Journal of the Royal College of General Practitioners,* **27**, 583-589.

Watts, C. A. H. (1966). *Depressive Disorders in the Community.* Bristol: John Wright and Sons.