INDIVIDUAL STUDY

The development of the family care team in rural communities in Britain, Israel and Holland

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Health care, as Fry (1969) has emphasised, has no universal standard. Health itself is not an absolute quality. Absolute health does not exist.

This survey is concerned with the health care of rural communities and in particular with the Family Care Team (F.C.T.).

The emergence of the family care team is the most important development in rural practice during the past 25 years; but the term means different things to different people. To me it means a tightly-integrated combination of medical, sociological and nursing expertise at the point of primary contact.

Holland and Israel were the two countries chosen for comparison with the United Kingdom, first because they are small and easily covered in depth during a six week visit to each; secondly because they contrast well. One is long-established, traditional and stable, while the other is an emergent State with its institutions and services still in the melting pot.

Israel

There are two main impediments to the formation of a unified National Health Service in Israel.

1. Rivalry between the Government (Health Ministry) and the Federations of Labour (Histadrut).
2. Diversity of medical ideology.

Rivalry

To understand the present dilemma, it is necessary to go back 50 years to the early days of the Mandate. At that time, in the absence of a central Jewish Government, it fell to the Histadrut (the Jewish Federation of Labour) to provide sickness cover and medical facilities for the ever increasing number of immigrant Jews.

The first step on a country-wide basis was taken in 1920 when all the mutual aid sickness societies were brought under a single administration—that of Kupat Holim, the largest of them all.

Between 1920 and the final emergence of Israel in 1948, Kupat Holim developed and consolidated. It built its own clinics and hospitals and staffed them with trained personnel. By the time the Health Ministry came into being in 1948, the medical and social care of the workers was firmly in the hands of Kupat Holim. It was doing a good job; it had become wealthy and influential; and had won the confidence of the workers.

Even now, more than 20 years later, Kupat Holim is widely regarded as one of the principal institutions of the workers' movement and entrenched resistance against a change in control is still fierce.

Eventually a unified health service must come. True, Kupat Holim pays lip service to the Government. 'The Ministry is the supreme authority in the field of health and medicine'. But what is authority without adequate resources?

The rift goes all the way through health care from the top to the bottom. The Government controls most of the hospitals and 70 per cent of public health and preventive medicine, while Kupat Holim controls practically all family medicine for the insured population, 30 per cent of public health and preventive medicine and a few hospitals, some of which, like the Beilinson built in 1935, are first class.

The struggle is unashamedly political. As in the United Kingdom organised medicine is

bandied about the political arena, each faction using it to further its own brand of social doctrine. Whether it is preferable for doctors, nurses and social workers to be under the control of a single strong political organisation, such as the Histadrut, or under the control of whichever party happens to be in power for the time being, is indeed an open question.

Diversity of medical ideology

During the past 60 years, each successive wave of immigrants has included doctors and nurses already bearing the professional hall-mark of their country of origin.

In the 1930s contributions to the emerging medical scene were embarrassing, both in their number and variety. There were too many doctors grounded in too many medical traditions; each intent on imprinting his own pattern of practice on the new communities as they took shape all over the land.

At that time intellectuals, artists and professional men came mostly from central Europe where Nazism was beginning. There was, therefore, a preponderance of doctors brought up in the polyclinic—specialoid method of delivering primary care. When the first Israeli Government took office in 1948, it was not surprising that the existing Kupat Holim system should be rubber-stamped.

Broadly speaking, the original Kupat Holim pattern, which lingers in large areas of the country, is based on the concept that certain specialists should be provided right down to primary contact. These 'community specialists' work in clinics both large and small, all quite separate from the hospitals There is a sharp distinction between the hospital specialist and the community specialist: the latter has no beds.

In the clinics, the paediatrician, the gynaecologist, the psychiatrist and sometimes the otologists all work at primary contact level, side by side with the 'general doctor' who deals with what is left over. This amounts to a truncated form of general practice mainly confined to adult males and the aged.

Such systems are known to work in many parts of the world, particularly in communist states and adjoining countries. But these Jewish medical men and women who were required to slot into this rigid structure were the very people who had just managed to escape the tyranny of another kind of regimentation.

Many were intoxicated by their newly found freedom—so much so that as the threat to survival receded they tended to become reactionary and found it difficult to allow their freedom of action to be restricted even by an authority of their own choosing and kind.

Lateral communications at clinic level are poor. The records kept by any one department, whether a community specialist's department, a general doctor's department or a nurse's department, are supposed to be readily available to other departments. But this is often not the case. Each jealously guards its own portion of the patient with the result that holistic assessment becomes extremely difficult. What is difficult in the case of individual patients is even more difficult when the family becomes the focus of care.

There is also lack of communication between hospital level and clinic level with the result that continuity of care is dislocated. This is particularly so in areas where the clinics are run by the Kupat Holim and the local hospital by the Government.

There is no doubt that this fragmentation of medical care, lack of integration of services and misuse of the general doctor's potential has led to widespread frustration and dissatisfaction among the younger men now becoming established on the periphery.

Murmurs of discontent were first heard in the early 1960s. These were given articulate expression in the late 1960s by work done at the Hadassah Medical Organisation and subsequently at the University Medical School at Tel Aviv. At both centres extensive studies have been undertaken into the social and medical needs of communities and families, for the most part by men grounded in Western medical traditions. They had come to realise that the existing system tended to perpetuate the rift between the Government and Kupat Holim by accentuating the artificial division between hospital and specialist and community specialist, and between curative and preventive services. It was also fundamentally alien to the professional attitudes and aspirations of the post-war immigrant doctors. Many of these, particularly in the field of primary care, had come from the United States and the Commonwealth, notably South Africa.

By this time the new State had been established for about 15 years, and the former fanatical hatred of the British—personified in the British soldier of the Mandate—had largely been forgotten. Senior administrators, as well as the up-and-coming men, were now able to turn and take a dispassionate look at the generalist system of community care, despite the fact that Britain was the chief exponent.

Indeed in recent years a most fruitful liaison has developed with the Royal College of General Practitioners in London, particularly in the field of education and management.

The generalist method

The Government and Kupat Holim now seem to be coming round to the view that the generalist method has two great advantages for Israel. It is economical in medical manpower, and by making family medicine a worthwhile job in its own right, it is attracting Jewish doctors from the West who already have the necessary background training. These men are not to be fobbed off with the truncated form of general practice that the earlier waves of Jewish doctors accepted. They are fiercely independent and with their progressive attitude which relates their personal professional effort to the growth of the new State, they make excellent pioneers o. the family care team.

The idea of a team for primary care is a natural development of the generalist concept, culminating in a pooling of expertise in the medical, nursing and welfare fields at the point of primary contact.

Within the past three years, significant strides have been made in this direction by individual doctors in country districts (Kanev, 1965). Backed up by Hadassah and Tel Aviv, and soon by two more Departments of family medicine at Haifa and Beersheba, they are slowly taking over those slices of primary care, up to now in the hands of the community specialists. It is a peaceful take-over and gains are duly consolidated by reaserch and evaluation. This is often done with the encouragement and co-operation of Regional Medical Officers of Kupat Holim, most of whom are more liberal minded than their predecessors. I saw practical examples of this development at Nehora (Arnon), Sasa (Spencer), Tel Mond (Sandler) and Thirah (Shohat), Maalot (Reid), Lodd (Kramer) and Horeah Yehuda (Sive).

Though, on paper, the country shows a very high ratio of doctors to population (1 to 450), the effective ratio is more like 1 to 1,000. This is partly due to lack of integration of the two national medical services with consequent overlap and wastage of manpower. Also many doctors are only part-time and a considerable number are in private practice in the large towns. There are 2,000 doctors in Tel Aviv. Kupat Holim employs 2,500 but of these 20 per cent are over the age of 60.

Even taking into account the current expansion of medical schools, this must mean a drop in medical manpower during the next decade. The shortage is likely to be felt on the periphery in rural family practice. It is here that the new generation of medical graduates, born and educated in Israel, show a certain reluctance to go. This is partly due to the glitter of hospital specialization with Beilinson at the top of the Christmas tree, and partly to a natural opposition to having to deal with mixed communities, many of which have a high Arab component.

This is not to say these young men are in any way afraid; far from it, but in the present political climate, it is difficult to shed all prejudice; and prejudice is not conducive to the practice of medicine in any form, least of all in the family-doctor situation when rapport is paramount.

The care of mixed Jew-Arab communities seems to be largely in the hands of ex-Commonwealth and ex-American doctors who, by virtue of their background and upbringing, are eminently suited to dealing with mixed populations.

Developments in Israel

Within the next decade, however, this source of family doctors will disappear and the Israeli born and bred doctors will be expected to take on this role themselves. With the image of family medicine being steadily built up by Departments of Social and Family Medicine at the three (soon to be four) universities, this recruitment may not prove to be as difficult as it does now.

Galilee most nearly resembles rural practice in the remoter parts of the British Isles and here

a typical practice consists of a couple of villages of 400 persons each and two or three small kibbutzim, in all amounting to a list of two or three thousand. In the medical centre at each village or kibbutz, the doctor holds a four-hour clinic once or twice a week and sees all cases filtered out by the resident nurse for his attention. The village or kibbutz head nurse is the usual agent of primary contact and deals with a far greater clinical range and takes much more responsibility than her British counterpart.

Most general doctors in country districts still have community specialists sharing medical centres with them, but an increasing number are gradually taking over the comprehensive care of the family in parallel and closely integrated with the head nurse who is already well established on a wide footing.

This form of synthesis of the family care team is an interesting variation of that seen in Britain where the nurses and health visitors join the family doctor in his existing relationship with patients; and it lends weight to the contention that the final picture of a family care team should be a homogenous whole irrespective of who has joined whom in the course of its formation.

Throughout Israel the ratio of home visits to clinic attendances is very low (about one in ten). This is a reflection on the very considerable part played by the nurses not only in sifting out first calls and undertaking repeat visits, but also in health education. There are whole-time health educators attached to most local authorities.

Similarity of aims

Wherever I travelled in the three countries, I was impressed by the similarity of aims of general practitioners as a whole—particularly those actively engaged in teaching and planning.

This appears to be due to two main factors—the integrating influence of the World Health Organisation and the liaison role of the sister Colleges of general practice in each country. The single-handed man working without ancillary help was everywhere a curiosity.

The concept of the family care team is now firmly accepted as the best means of bringing together social, nursing and medical support at the point of application. For rural communities this is absolutely valid. Yet in spite of this identification of opinion and objective, the fact remains that implementation is very uneven between the three countries and indeed, within each one. Two main impeding factors are common to all three countries.

First—professional conservatism on the part of doctors, nurses and social workers; and second—political factors.

Implementation of the team concept

Hanging back by general practitioners is least evident in the United Kingdom and most evident in Holland where the average earnings are high and the feeling amongst many well-established men is that any change can only be for the worse. I estimated the ratio of average gross earnings from all sources of doctors doing the same standard of medicine in the three countries was 2 Israel: 3 United Kingdom: 5 Holland.

In Israel, too, there is reluctance on the part of the older men, but for different reasons. A large number immigrated in middle life and are now elderly. Nearly all who are concerned with community care are employed by Kupat Holim and most are community specialists of one kind or another. Further extension of the family care team system on generalist lines is inevitable; but when it comes it will mean radical reorganisation, and for the older men disruption of their pattern of work and livelihood. Naturally they hang back.

I asked a young Israeli doctor, concerned with the organisation of community care, how he would deal with this problem. 'We can only wait for them to die out' he replied with the utmost seriousness.

A leading Scottish practitioner echoed these sentiments in a somewhat muted form. His reply to the question was 'I cannot deal with cerebral arteriosclerosis'.

Cross Organisations in Holland

The Dutch nurses, social workers and mother's helps are all organised by the three Cross organisations against a strict religious background which goes back hundreds of years. The White and Yellow Cross is the Catholic organisation; the Orange Cross, the Protestant; and the Green Cross represents the Humanist faction. They are each fiercely independent of each other

and of the medical profession. A nurse will, as a rule, only attend patients of her own persuasion and this makes the service, as a Dutchman put it—'patch-work'.

The Cross nurse of a village is provided by the sick fund with a house which incorporates a treatment room and space for a well-baby and mother's clinic and loan equipment. Several of the newer premises are built adjoining the doctor's centre, but as yet the two have nowhere been incorporated under one roof.

In spite of this there is evidence at Doesburg, Stolwijk, also in the new polder towns in Oostelijk Flevoland, that real progress towards doctor-nurse integration is being made. Most doctors I saw were strongly in favour, but the rigidity of the Cross organisations throughout the country as a whole is likely to be an obstacle for some time to come. An appropriate motto for the Dutch general practitioner is 'Integration by stealth' (Mulder).

The doctor's assistant in Holland

Special mention must be made of the 'doctor's assistant' in Holland (not to be confused with the American medical assistant). Almost every Dutch general practitioner employs one or more of these highly trained and versatile women. They combine the functions of receptionist, secretary, surgery nurse and, sometimes, dispenser. When there are several they rotate in their duties so that the organisation is never unduly disturbed by absences. The extent of their nursing is limited to dressings, injections, taking blood samples and carrying out simple laboratory tests. They do not work outside the doctor's premises.

The doctor's assistant is, in fact, an extension of the doctor's sphere of action within his medical centre and she is not expected to contribute extra skills to the team as, for instance, the health visitor or the social worker in Britain, or the head nurse in Israel.

The demarcation line between the doctor's assistant and the Cross nurse is very definite, and is yet another factor hindering the formation and integration of family care teams in the Netherlands.

Nurses in Israel

In Israel the prestige of the head nurse of a settlement or kibbutz and of a public health nurse in a town is very high. She compares in professional stature with a redoubtable ward sister in Britain, or a Scandinavian public health nurse. Consequently she brings her contribution to the team programme with authority and the balance of the team as a whole is more even. There is less professional self-consciousness than is evident in family care teams in the United Kingdom. They 'muck-in together' far more easily.

Generally speaking, in Israel as in Britain, nurses are divided according to whether their main function is preventive or curative.

Those in white are curative—either graduate (S.R.N.) or practical (S.E.N.)—and employed by Kupat Holim. Those in blue and those in green are preventive (H.V.)—employed by Kupat Holim and the Government Service respectively.

Many with whom I spoke deplored this hard and fast division in functional terms and in some settlements (e.g. Nehora, Horeah Yehuda and Maalot) the head nurses combine both roles. This is also the practice in most kibbutzim where the head nurse is paid by Kupat Holim and by the Government Service at the same time because she combines the two functions.

Nurses in Britain

The British practice nurse is the general practitioner's answer to the hesitation on the part of nursing organisations to allow their district nursing sisters to become too involved in family care teams. Only when it is too late have the nursing organisations in Britain realised their initial shortsightedness and now decry the private employment by general practitioners of practice nurses (*Journal of the Royal College of General Practitioners*, 1969).

At the same time it cannot be denied that a practice nurse undertaking domiciliary visits in addition to surgery duties may well encounter difficulties when a district nursing sister, employed by the local authority, considers her territory is being poached. Another district nursing sister may, of course, welcome the co-operation. These individual attitudes often reflect higher policy which in Britain varies greatly from one local authority to the next.

Social workers

The attitude of the social workers varies. In Israel there are as yet few medical social workers, but those I met were very forthcoming and keen to participate in team work and had a very clear picture of their extensive contribution to the team programme. In Britain and Holland they are bedevilled by professional self-consciousness. The Dutch are particularly aloof. I asked one medical social worker in a hospital whether she made regular contact with general practitioners on patients' discharge—'Oh no, certainly not—unless of course the patient expressly asks me to do so'.

In Britain legislation has led social workers to believe that they can, by themselves, form a viable profession working independently of doctors. If this is to deprive family care teams of their invaluable contribution to holistic care at primary level, it will be a retrograde step and a tragic one.

In contrast to the dampening effect of professional aloofness in Britain, and more so in Holland—not only on the part of doctors, but also amongst para-medical disciplines—it is refreshing to experience the situation in some of the kibbutzim and immigrant settlements in Israel. Examples such as Kibbutz Sasa in Galilee and the Nehora settlement in the Negev are admittedly exceptional, nevertheless they indicate the direction in which primary Israeli medical care is developing and their achievements, always fully recorded and often published, are being noticed.

The lasting impression of these and a dozen others was an identity of purpose within the team. They all seemed to know where they were going. Team motivation was high and integration of members good. They worked to well-defined programmes, which took health education and preventive medicine in their stride. In Edinburgh I sensed something of this, but there the achievement was more in organisational expertise rather than in the practical end results of family care.

Secretaries and receptionists

The British, as a whole, set great store by practice organisation, and their medical secretaries are highly trained for this purpose and seldom have additional nursing or dispensing duties. Where several family care teams are grouped together, the senior secretary often becomes the practice manager for the group.

In both the other two countries the role of secretary is a subsidiary one. The Dutch doctor's assistant combines it with her various other duties in the treatment room and the laboratory, while in Israel most of the paper work is done by the doctors and nurses themselves with only occasional delegation to a clerk-receptionist whose typing is often rudimentary and shorthand non-existent. I often saw both Israeli doctors and nurses inundated with paperwork that could well have been delegated to trained secretarial staff. This was one of the few deficiencies that I found in even the best family care teams. But the reason was plain—medical secretaries are expensive luxuries in the eyes of Kupat Holim, and today luxury plays no part in the daily routine of a patriotic Israeli. Most British doctors would consider this a false economy.

Rate of evolutionary change

The rate of evolution of peripheral medical care is dictated first by professional attitudes and secondly by political climate—the three countries under discussion provide fascinating contrasts.

In Israel the political situation is the main impediment with its wasteful and frustrating diversification, against which local professional ventures are only beginning to make their impressions.

In Britain the professions and the Government are fairly evenly matched. The chief brake on progress is the monotonous governmental stringency in the whole field of health. With this limiting factor the pattern of medical care is largely left to the professions to fashion as best they may, and the overall picture is one of uneasy compromise (B.M.A., 1970). Nevertheless, hard won advances are maintained—notably under the banner of the Royal College of General Practitioners whose dynamic policies influenced both the other two countries.

Whereas in Britain inter-professional friction hinders the complete integration of primary support services, in Holland there is little dialogue between the medical and para-medical bodies concerned. Consequently no heat is engendered, neither is there any great progress. The Dutch,

an extremely stable people, seem on the whole contented with general practice as it is, and this complacency is reinforced by deep-rooted conservatism, both professional and political (which in this context includes the religious background).

Opportunities for radical change

The only scene approaching radical change is in the polders where the exciting creation of new towns and new rural communities is a wide open invitation to innovate and to experiment. Fortunately the Dutch realise this and a start has been made to break down inter-sectarian barriers in community health care. In Oostelijk Flevoland, the Cross organisations have actually combined forces to produce a local nursing service relatively unimpeded by religious strictures. This could be the breakthrough for the Dutch family care system.

On balance, however, it is in Israel that the opportunity for sweeping changes is greatest. Here is a country which is rapidly emerging as a nation of consequence—here the winds of change are really being felt. But resolute medical statesmanship is vitally necessary at the top—now—before the dust is allowed to settle.

The Mann Report (1969) is a first step in this direction. One of the recommendations is the gradual replacement of community specialists by specialists based on general hospitals, and a restitution to the general practitioners of a measure of comprehensive family care. One drawback, however, is its over-identification of family medicine with hospital-based internal medicine, largely overlooking other important spheres of interest such as paediatrics, gynaecology and psychiatry. It fails to accept that family medicine is in itself a distinct branch of medicine and a branch, furthermore, that is not dependent upon one branch of hospital medicine more than upon another.

Generalists and specialists

The professional relationship between general practitioner and specialist differs considerably from one country to another. The long established British custom of consultation between family doctor and consultant in the home of a bedridden patient was fortunately preserved by the National Health Service Act of 1948. By making domiciliary visits special items of service attracting extra fees for the consultant, the family doctor has been enabled to continue these contacts which are virtually unknown in the other two countries under discussion.

Kupat Holim makes it possible in exceptional circumstances—but the payment is not attractive. The Dutch specialist, having his remuneration linked to his turnover of hospital inpatients, has no incentive to undertake domiciliary visits and much prefers to admit a patient for a few days lucrative investigation. Of the population in Holland, 97 per cent are insured against sickness and accident: those who are employed, or earning less than £1,850 per annum, are compulsorily insured, and the remainder insure themselves privately. There is, therefore, always a great pressure on hospital beds and the turnover is rapid.

The British domiciliary consultation benefits all concerned. It helps to keep hospital admissions within bounds, it lessens the gap between consultant and family doctor and enables the consultant to keep in touch with the outside world of primary contact. Each sees the other's points of view—not only in clinical matters but also on the broad front of health care.

It is true that in all three countries more and more use is being made of the postgraduate medical centres in district hospitals as the common meeting ground for specialists and family doctors. In Israel particularly, family doctors are good at keeping in touch with their patients in hospital, and through them with the consultants. This is partly a habit left over from the weekly half-days at hospital which are obligatory during the vocational period, and partly to make up for the paucity of hospital reports. There is no doubt that intra-professional relations in Israel are at a low ebb, and this is brought out strongly in the Mann Report. Where the family doctor does not visit the hospital regularly continuity of care could easily break down through lack of information.

In the Netherlands, though relations between consultant and family doctor are amicable, each tends to keep to his own sphere with the characteristic reserve of the professional Dutchman. Here again the postgraduate centres, usually combined with the University Institutes of General Practice, but sometimes with district hospitals, are gradually being adopted as common meeting ground.

Doctors' letters

Whether it derives from the good relationship between consultant and family doctor or whether it is itself one of the reasons for that relationship is a matter for conjecture, but the fact remains that far more value is attached to the doctor's referral note in Britain than is the case in either of the other two countries.

As a natural corollary the consultant's reply is likewise a matter, not only of duty, but frequently also of pride. To add to their value, most of these letters and opinions are neatly typewritten by a competent secretary.

In Holland—even more so in Israel—the referral note is frequently scribbled on a small piece of paper, and it is perhaps not surprising that some of the replies (where there are replies) are peremptory in the extreme. Some indication of the relative values attached to referral notes is given by the average size of the writing area on referral forms commonly used in each country. Israel—12 cm × 10 cm: Holland—15 cm × 12 cm; and the United Kingdom—20 cm × 18 cm.

The general practitioner's position

I was repeatedly asked how I saw the role of the doctor in the developing family care team. Is he to be a dictator, a captain, a chairman or an equal member at a round table?

In fact, he relates in two directions and the one influences the other. The first is outwards to the patients and the second is inwards to the team members. By first considering his relation to patients, his team relationship becomes more clear.

A clue is perhaps given by a look at the kibbutz situation, bearing in mind that in social terms the kibbutz is a form of extended family. Here the head nurse and the doctor, constituting as they do a well-integrated team, have different relationships with the kibbutz members. The nurse is accepted as a specially gifted member of the family—on 'hearth level'. The doctor (who must not himself be a member of that kibbutz) stands a little apart and on a somewhat higher level—as from the saddle of his horse outside the door, from which, of course, he may descend. The professional gap which, for the nurse is minimal, becomes more evident for the doctor.

On my travels I asked other country doctors whether they considered their role in the community to be a pastoral one with medical attributes, or a medical one with pastoral attributes. The best of them took some time to answer, and when the answer came it often blossomed into a lively discussion.

There is no doubt that the doctor is still, at least in rural communities, accorded a faint aura of magic directly inherited from the most primitive witch doctor, and it will take more than computers to divest him of this. By the authority implicit in his station he becomes the natural chairman of the team. Like all good chairmen he listens, correlates and guides—but only at his peril does he dictate.

When family care teams can be grouped together, which is less often the case in rural than in urban practices, opportunities occur for the part-time medical team member. With the increasing emphasis on prevention, den Haan (Rotterdam) suggests that the role of epidemiologist, together with responsibility for a group programme of preventive medicine could well be undertaken by a senior part-time member—in Britain, perhaps, the senior partner.

Israel is even more insistent on the preventive role of family care teams and at Nehora (Arnon) 40 per cent of the team's time is taken up with curative work and 60 per cent with preventive.

A woman doctor, working even part-time can be a valuable addition to a group, not only running special clinics such as family planning and well-mother-and-baby, but also as medical attendant to that small but significant minority who prefer to have a woman as their medical adviser.

Team development

In Britain, the technical development of the team (as opposed to its functional maturity) is impressive. The quality of a worker's equipment and his morale are inter-related; but good equipment is wasted on workers whose hearts are not in the combined enterprise. It is not enough to provide even the best premises and equipment if you are merely going to throw together a number of skilled individualists and hope for the best.

In Britain the framework is potentially good but internal cohesion poor. In Israel it is the reverse. All too often in Britain the 'attached' nurses and health visitors regard themselves as 'ancillaries'—persons who 'help out' the doctor—rather than fully contributing members of a team. From this position of self-imposed inferiority they tend to assume the defensive in case they are 'put upon' or 'made use of'.

That word 'attachment' has a lot to answer for. It may mean anything from dangling at the end of a tenuous thread to clinging like a limpet. A better word is 'assignment'. This at least implies commitment, involvement and purpose—essential ingredients of any effective team.

The synthesis of a family care team inevitably takes something from the sacrosanct professional image of each member; and this must be given freely. In return a new dynamic organism is fashioned with a care potential far greater than the sum of its components. There is no room for professional self consciousness or reserve. If any member prefers not to become too involved he had far better go and find a job in the corner of a laboratory or become a consultant.

It is impossible for team members to become too involved. Involvement is their business.

If this is a true statement—and I believe it to be so—then the inescapable corollary is that attitudes of all potential team members should be attuned *in preparation* for the building of family care teams. This means integration during the formative period of individual training.

It does not mean any fusing of curricula, but it does mean frequent points of contact between students of medicine, sociology and nursing from their earliest days at university or training college. Not only meeting, but actively collaborating in common fields of health care, so that a mutual respect is engendered and a positive desire to pool resources in health care enterprises. Medalie (Tel Aviv, 1969), den Haan (Rotterdam) and Richardson (Aberdeen) are three heads of departments who are very much alive to such possibilities.

The general attitude in England seems to be that it is time enough to introduce interprofessional collaboration when the respective parties have been well-grounded in their own disciplines. Then it will be too late. Shutters will be up and blinds down. Integration begins by introduction and this should happen in the first undergraduate year at the same moment as the first holistic view of the patient is taken.

Of the three countries, Israel is likely to be the first to introduce this in meaningful form. In the older countries roots have become long and wiry and movement is resisted.

Conclusions

1. The family care team system is the most efficient and economical.
2. The chief obstacle to effective implementation is professional prejudice. This hinders not only the formation of teams, but also the functional integration of established teams.
3. A significant adverse factor is manipulation of community health services by political and religious factions.
4. Each country has its special problems, but some are common to all. Each has much to learn in this field from the others, also much to impart.

Although there are in each country vigorous bodies of professional opinion in favour of the family care team system, international collaboration in this field, including the exchange of ideas and personnel, is haphazard and largely left to individual initiative.

The immediate need is to intensify and develop collaboration through the existing international professional agencies.

Summary

Between March and July 1970, I observed 34 rural practices in Holland, Israel and the United Kingdom in order to compare and contrast the most effective means in each country of applying health care to rural communities at first contact level.

Acknowledgements

I wish to thank all those whose advice and help I was fortunate enough to have, especially: My sponsor, Dr A. Williams, Director of Medical Graduate Studies, Oxford. The Department of Health and

Social Security for leave of absence. The Clair Committee, British Medical Association, and the Education Foundation Board, Royal College of General Practitioners for financial grants. Dr Hugh Clegg, Dept. of Overseas Relations, Royal Society of Medicine and Dr Alan Gilmour, Personal Services Bureau British Medical Association for introductions abroad. Dr Arditti and Mrs. Schachor for arranging my programme in Israel. Professor D. C. den Haan and Miss C. Stuiver for arranging my Dutch programme. Mrs Jean Potts secretary to our own family care team, for industry and patience.

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CHILD-PROOF CONTAINERS

The Department of Health and Social Security has been asked by the Pharmaceutical Society of Great Britain to support a request that the British Standards Institute should investigate and test standards for child-resistant containers. The Department supports this suggestion.