III

Dr J. H. Medalie (*general practitioner, Israel. Health Centre: part-time lecturer in Social Medicine*): If the practitioners in the audience were asked, " How many of you consider yourselves to be family practitioners? ", there would probably be an 80 per cent reply in the affirmative. Yet, despite this, one of the secrets of our profession is, " What is family practice? " We all talk about it and take it for granted, but at this time when your College is busy looking at itself and the future, there is little need for an apology in bringing up the subject of family practice. What is it? Does it exist? How can we turn this ' art ' into more of a ' science ', without in the process becoming less human?

The state of health of an individual is the resultant of many interdependent and interacting processes, both within himself as well as with his environment—physical and social. The society and culture in which a person lives—children more so, but adults too—is interpreted to him and influences him mainly through the intervention and screening of his primary groups of relationships, among which the family is the most intimate. The latter thereby vitally contributes to the state of his physical, emotional and social parameters of health. If this hypothesis is correct, the true evaluation of an individual's state of health and disease can best be diagnosed and treated if his integration into his primary group is adequately understood.

A family practitioner, in my framework of thinking, is a physician who treats all members of a family, and who takes cognizance of the interaction between the different members and the way this affects and is affected by, the state of health of the individual members.

The three aspects of family practice that I would like briefly to touch on are: first and foremost, the content of the practice; secondly, organization for it, and last but not least, education towards family practice.

The content of family practice is carried on at different levels, simultaneously by the family physician during the course of every work day. Let us look at these different levels of practice and discuss their implications, by taking a case example.

The first or most superficial or " symptomatic " level is the one where a woman, aged 36, comes to the physician complaining of a sore throat, and stating that she has a high temperature. Without

much more ado, the doctor examines her throat, palpates her cervical glands, feels her pulse, then diagnoses acute follicular tonsillitis and prescribes treatment. The complete examination procedure might have taken two to three minutes, and he might or might not see the patient again for this particular episode of illness.

Whether we like it or not, and whether we admit it or not, this level of practice is very common, and the more institutionalized medical care becomes, the more this level tends to occur. Probably its worst form is seen in certain army sick parades!

The family doctor, too, sometimes practices at this level, and the only point in his favour is that there is an important difference between the treatment of the above woman by her physician who has been her family doctor for ten years and knows her intimately—and the physician practising this level of medicine, who has never seen her before.

The second level (case approach) where the physician doesn't see the woman as a person, but as a case—interesting or not, depending on the amount of physical pathology he finds. These physicians usually examine 'the case' thoroughly, and would have found in the above-mentioned woman a low rumbling apical pre-systolic murmur transmitted to the axilla, and his diagnosis would be a case with acute follicular tonsillitis; mitral stenosis as a result of previous rheumatic fever attacks; râles at both lung bases; some albumen in her urine—for investigation. All this certainly makes her an 'interesting case', and he investigates her pathology most intensively without consciously taking into account her feelings, and the effect the illness has on her and her surroundings. Some physicians practicing at this level often go into the pathology in such detail that, without being aware of it, they give the patients a kind of security and good feeling, which is of great emotional importance to the patient. However, this does not always occur; and the opposite effect occurs when the patient is not an interesting case, in which event the patient very often is, or feels, rejected by the doctor. One of the results of this, is that the patients of physicians practicing at this level often use other non-medical sources for help with their emotional problems, and tend to have a 'rough time' if their illness is primarily of emotional origin. These patients also tend, too, to visit many doctors, hoping to find help somewhere.

The third level of 'whole person' approach is one in which the patient is seen as a 'whole person', in that his illness is seen in the context of a patient with physical, social and emotional attributes. The above-mentioned woman with the acute tonsillitis, mitral stenosis, albumen in her urine, is found to be a person who, while intellectually understanding her illness, that is, the connection

between the throat infection, possible recurrent rheumatic fever and her heart, regards her condition as part of a " punishment from God ", for having tried to procure a self-abortion during her last pregnancy some ten years ago, and accepts it as such. She was unsuccessful in the attempted abortion, and went through to full term, when she had her baby in most difficult circumstances, in that she went into congestive cardiac failure. Since then, she dreads the thought of another pregnancy, because of the fear of death. Although her health limits her activities to a certain extent, she feels that she is coping with her duties in the home.

At this level her diagnosis is, acute follicular tonsillitis and mitral stenosis—rales in lungs and albumen in urine to be gone into—in a married woman with two children, functioning fairly effectively in her home, accepts her illness as a retribution and is terrified of becoming pregnant again. The physician's investigation—which includes a short period of hospitalization—and treatment for the throat, urinary and heart conditions, are essentially the same as those carried out by the physician practising at the previous level. However, this is carried out in the context of an understanding of the woman's feelings as well as helping her in understanding the paths open to her in respect of her health state. An intensive investigation is made by a cardiologist to ascertain the severity of her heart lesion and what the best treatment for her would be. Among other things, the question of cardiac surgery is brought up, and the possibility that he might advise against further pregnancies, in which case she would have to consider contraception, despite it being against her religious beliefs, or even sterilization. In other words, this physician not only treats her acute condition, but, having an insight into her feelings, begins the process whereby she might change and radically improve her life situation.

This is indeed medicine at its best individual level, and through this excellent approach, which must benefit the patient considerably, there will also be most important repercussions in her family, even though their situation was not taken into account.

This brings us to the fourth level of individual-in-family approach, or the ' family level '. At this level, an investigation of the rest of the family—partly by the physician, and partly by other professional workers, such as the nurse and social worker—reveals the following main facts; the woman's immediate family consists of her husband, aged 39, and two children, a daughter aged 12, and a son, aged ten. The husband is an engineer, with a steady, fairly well-paid job, although he has not been promoted as fast as everybody thought he would. Other than occasional attacks of ' indigestion ', his health is good; but lately he has been drinking much more than he used to. This latter period corresponds with the period when he has been

spending more time out of the home with friends—among whom he is popular—and has not had much time to give to his children. Whatever period he does spend with them, he devotes to his daughter, and almost none to his son. Relations with his wife have been strained for some time. The deterioration began after the birth of the son, and are related to the amount of attention that his wife pays to their male offspring, as well as the fact that because of her fear of pregnancy and their religious taboo of contraceptives, sexual intercourse between them has become an infrequent and unsatisfying event.

The son, born to the pregnancy, which the mother tried to do away with, suffers from cerebral palsy with severe mental retardation. He is waited upon hand and foot by his mother in an attempt to over-compensate for the ' wrong ' that she did him.

The daughter is an obese, irritable girl, with an apical systolic murmur, who hates her brother, rejects her mother, and is very attached to her father. Her obesity is a recent occurrence, and now that her father does not spend much time at home, tends to go out as much as possible; but this is not easy, as she has not many friends. Those that she has she does not bring home, because she is ashamed of her brother. At school, she does fairly well, but her teacher believes that she is potentially capable of a much higher standard of work than she produces. Lately, she has also noticed that the child's appearance has become untidy.

The family relatives of both the woman and her husband have in recent years had very infrequent contacts with them, but in the event of a family crisis, could be relied upon to help. The neighbours had become less friendly since the birth of the son, and there seemed to be a mutual withdrawal process—the woman stayed more at home with her son, and the neighbours stopped visiting. Both the father and the daughter tended to look for friends outside the immediate neighbourhood.

Without detailing the specific ' family diagnosis ', it is obvious that before us is a family with " multiple severe inter-related health problems " which have reached the stage that the family stability is gravely threatened. However, let us continue. The woman's acute tonsillitis is cleared up, the albumen disappears from her urine and her lung fields become clear.

At this stage, the physician feels that a short period of hospitalization for detailed cardiological assessment is imperative, but knows that before he can remove the mother from this home, some intensive work has to be done to cover the roles that she usually fulfilled in the house. Without this, the absence of the mother, with the consequent necessity for alterations of roles in the family, could

conceivably lead to a total break-up of the family. The public health trained nurse and the social worker, with their knowledge of the extended family—his and her relations—as well as the community resources available, have both the understanding and skill necessary for preparing and helping the family cope with the period that the mother will be hospitalized.

Following the cardiological assessment, the problem of the treatment of this family came up. (When the patient was presented at the case-conference in hospital, the resident during his report, remarked: "Family history—nothing of significance"!) At the meeting between the physician, nurse and social worker, where all the details of the family were put together, the daughter's teacher and a paediatrician—who was very knowledgeable in congenital cerebral anomalies—were invited to participate.

The immediate effect was that the teacher, who had not known about the family situation, began to pay much more attention to the daughter, who responded very well to this, both in her appearance and her schoolwork. While this was going on, the physician-co-ordinated team worked with the woman and her husband, at first separately, then later together for some sessions, to help them understand the family situation and work through their guilt feelings and attitudes. In doing this, their relationships improved until they were able to face and eventually solve the problem of the son—placed in an excellent institution—with the resultant marked improvement in their family life. Once this had been achieved, the mother underwent the valvulotomy previously recommended, and subsequently kept to a rigid anti-streptococcal regime; she also began to use contraceptives. The use of the latter was made possible by enlisting the aid of the woman's denominational religious leader, who found the rationalization necessary to allow her to use contraceptives.

The follow-up of this family has to be a regular feature, and entails the joint efforts of a team of workers. This approach combines the 'whole person' level of the presenting patient—which in this family might just as easily have been any of the members—with taking into consideration the knowledge of the whole family situation, so that the comprehensive-type treatment discussed above, aided every individual member as well as reconstructing the family stability on a much firmer basis.

Finally, let us look at a list of those who were involved in the investigation and treatment of this family: the family physician—co-ordinating the whole group; a nurse; social worker; cardiologist; cardiac surgical team; paediatrician—with special knowledge of cerebral palsy; the daughter's schoolteacher; the family's religious

leader; the sister of the patient—while patient was in hospital.

Let us now turn to certain of the organizational aspects of family practice, which would allow more of our practice to be at the third and fourth levels, that is, ' whole person ' and ' family levels '.

As medicine becomes more organized and specialized, the numbers of individual independent practitioners will probably tend to decrease and give way to different types of associations of physicians, such as group practice, and health centres. The following remarks refer mainly to health centre practice, but may have applications to other types.

The quantity-quality struggle—the Q^2 ratio—is an ever-present one, but the so-called ' lack of time ' should not be used as a smoke-screen, or excuse for inferior medicine. First, let me remind you that a family physician knows, or will get to know, his patients over a prolonged period—years—so that he collects his information over many interviews in various situations. Despite this, from time to time it is necessary for a patient to be seen for a longer period, and the physician must be able to organize it. To do this, an ' appointment system ' is, I believe, a *sine qua non* for non-emergency cases. In addition to this, special sessions, or periods in the week, should be devoted to special groups of patients, depending on the needs of the practice and the physicians' interests. These sessions could be devoted, for example, to pregnant women, mothers and babies, diabetics, pre-marital and marriage guidance, as well as for patients who need an unhurried half an hour to help them with their emotional problems and so forth. It has always been amazing to me to see how quickly patients adapt to, and appreciate this type of organization of a practice.

These special sessions can also be utilized for other purposes. They can often, by bringing in a nurse, or a health educator, or a group worker, or a health visitor—the titles vary from country to country, in addition to the individual contact with the physician and nurse, be converted into a group session of people with a common interest. Thus, many discussion groups, demonstration groups, and other forms of group education came into being.

In the health centre practice in Jerusalem, other groups were formed outside the consulting hours, and consisted of natural childbirth groups—usually with very successful results—teen-age groups, and play-groups for malnourished children, during which they received milk and food. In addition, some groups of young mothers were formed on the basis of friendship patterns; that is, a mother would invite some of her friends, who in turn invited theirs, so that a group of 10-15 friends would meet informally with a mem-

ber of the health centre staff on a weekly basis. I participated in one such group regularly for 18 months, and thereafter very sporadically; the group had an active existence for 4 years before disbanding itself. There is no doubt that the mutual interaction of the group had great significance educationally in influencing the behaviour of all the participants and made their and their family's adjustment to the newly developing community that much better. For me personally, it was an excellent learning experience in helping me to understand many practices and beliefs in connection with, for example, child rearing; it gave me a new insight into some of my patients, and in many ways aided my development as a family physician. Another unexpected result was that it led me—with other members of our staff—to enrol and participate in a course of group dynamics. These group sessions do not decrease the number of hours a physician works during the day—it often even increases it; but its main value is the improvement of the quality of the health education of the practice, and the mutual adjustment of the participants.

The next organizational point needing emphasis is records. These should be easily available to the physician, contain sufficient detail for intensive follow-up, be easily extractable for analysis, and finally, should be on a family basis, that is all the members of a family in one family folder or file.

Let me immediately say that we were able to carry out all the above without special trouble, but failed with the last point but one; our files are not easily extractable. We were forced to use additional recording systems, such as daily attendance sheets, special notification forms, and so on. And although it worked, it was cumbersome, and this duplication is not the best answer. Hopefully, the activities of your College in this direction—the 'E' and 'F' books for example—will provide us with the solutions. This is a most basic problem, and until it is solved, I fear that most of the widespread epidemiological research in general practice will be on a 'patchwork', or 'hit and run' basis.

Another aspect of records is what might be called the family working register. This is a technique of the 'well-baby clinic' modified for use in family practice. It consists essentially of a register of the families in one's practice, with details of the chronic illnesses or problems, age composition and special conditions, such as pregnant women. The purpose of this is to keep an accurate and up-to-date register, which will allow for efficient supervision from both curative and preventive points of view. The infants' page contains, for example, in addition to his name and address, his sex, date of birth, weight at birth, and columns to check the immuniza-

tions against diptheria, whooping-cough, tetanus, smallpox and poliomyelitis. In addition, special diagnoses and columns in which to enter the date of each periodic health examination by the nurse and doctor. Finally, a column for special remarks pertaining to the individual child. This makes it relatively simple for a nurse to keep a watch on immunizations, periodic health examinations and follow-up of diseases, thus fulfilling the preventive function of the practice. Obviously, this is not the only method which can be used, but we have found it to be a very important tool of practice.

The carrying out of some of the points mentioned previously demands additional skills and people to be added to the family practice team. Our basic daily team was a physician and public health nurse, who were supplemented in the neighbourhood by the municipal social worker. It took some years—in some respects very rough ones—to work out a functioning system whereby the work of these three professionals were co-ordinated and geared to the best interests of the family. A core feature of this co-operation was the weekly or fortnightly meeting between the three, to which others were invited to participate as necessary when discussing particular families. In this way, school staff personnel, labour exchange officials, community workers and clinical psychologists, participated from time to time at such meetings, for special purposes. A large health centre will often consist of a number of such family practice teams, and thus often organize health centre meetings of all the staff for a family review; a review of certain epidemiological aspects of a particular practice, or of the entire neighbourhood. It is these latter meetings that consultants and other specialists from the regional hospital should be invited to participate. If they do, they begin to have a different understanding and outlook towards family and neighbourhood practice, as well as from time to time coming up with some very valuable advice. Consultation should always be a two-way exchange of information, with both the consultant and the consultee gaining from the experience. In addition, the individual consultation with specialists is obviously a must; but allow me to mention two points about this. We were able to induce certain specialists to come to the health centre, and, for example, the gynaecologist, would see three or four women, each with their own family doctor, and then over a cup of tea would discuss one topic or woman with all the doctors. This type of consultation was most beneficial to the patient, the family physician, and, I believe, for the consultant, too. The other type of consultation which can be regarded as part of in-service training was the forum of physicians coming together in a group with the consultant psychiatrist. Many of you are familiar with this type of meeting, which I believe needs more definition and selection as to who should participate, because

as I have seen it in action, it answers the needs of relatively small numbers of doctors. However, it is certainly a step in the right direction, but should be combined with other methods of psychiatric consultation.

The latter part of the above discussion leads into the next organization necessity. Time has to be found for in-service training. Keeping up to date, as well as learning new things, is a permanent accompaniment of a doctor's life, and must be taken into consideration in planning a practice.

In carrying out some of the points mentioned above for family practice, something has to be dropped from the present type of 'rush-rush' general practice, in order to cater for these additional aspects. One of the first things that has to go, is the fact that the family physician will not be available every minute of the day to see patients. This probably sounds terrible to some of you, and I know it took me a long time to adjust to this thought. Frankly, I found that the patients did not really suffer; I certainly did not. And lastly, whether we like it or not, it is happening to all of us, in one way or another. Therefore, let us accept the fact that in order to improve the quality of our family practice, we cannot be available to all our patients, all of the time. If this is accepted, let us plan to meet this new contingency. This can, and is, being overcome by numerous methods—by taking a partner into the practice, or an assistant, or a physician for residency-training—'trainee'—without, of course, doubling the size of the practice! In a not very long time, both physicians will know all the families sufficiently well, so that if one is unavailable, the other could see them and not be a stranger to them, or their needs. Thus, if the basic team for family practice is a physician, nurse and, if available, a social worker, then two such teams working together as one larger unit would probably be the essential group necessary to carry out family practice as here visualized in a modern 'developed' state.

Readily available, efficient, diagnostic services—including laboratory, ECG, and x-ray facilities—are an essential part of the practice.

Research into practice, both into the content and organization, will help to keep us in step with changing health needs of our practice. Hopefully, Dr Logan will have many of the answers for us.

A recent W.H.O. publication, *Training of the Physician for Family Practice*—W.H.O. Technical Report Series No. 257, W.H.O., Geneva 1963—identified four phases of medical education: undergraduate; graduate-internship; post-graduate, and continuing in-service training. The Report further adds, that during the undergraduate period, "the student should be given courses in sociology, psychology, social anthropology, population genetics,

biostatistics, et cetera ". While heartily agreeing with these subjects, may we enlarge a little on the ' et cetera ', and include under it some basic things which somehow seem to get lost between all the subjects.

Some of the things which come to mind are: the art of interviewing and observation. (Could anything be more basic than this?) The opportunity of working with a group of physicians who run an effectively functioning team with nurses, social workers and other professional groups; introduction into research methods—Doctors Crombie and Pinsent and others should be involved in this; introduction into educational methods on the invididual and group basis; family health and preparation for married life—surely the time is overdue for students to be taught about the sexual and other problems that can be anticipated at the various stages of family development? A period of family practice clerking outside of the hospital, and supervised by family practitioners—preferably in a group practice set-up, like a health centre; periods of about a week each, when he will observe and participate in the work of certain professional people whom he will be associated with in the future, for example, a social worker, a public health nurse (health visitor, a medical officer of health and an industrial and school physician).

These are a few thoughts which come to mind and should, I think, be included in the curriculum of the undergraduate, and which should be built to answer the basic question, "What common educational features do all types of physicians require today? " This, as the phase of widening clinical experiences and skills, might best be served by a two-year rotating internship. My feeling is that during the first year the departments in which the interne works should be uniform to everybody, whereas the second-year interne should have a wider and freer choice of departments, depending on the individual graduate's future objectives. Would it also be too much to expect that one day a series of psychotechnical aptitude tests can be given to the interne, in order to help direct him to that branch of medicine to which he is most suited?

This internship should lead straight on to the third phase, that of postgraduate training, divided as follows.

One or two years as an assistant in a family practice unit, designed for the training and supervision of young physicians—there should be an urban and a rural unit, and the potential family physician should divide his time between them. During all this time there should be continuing formalized teaching, such as lectures, seminars, consultation and conferences, a few times each week, and the graduate should be attached for part of the time to a family practice unit which is doing active epidemiological research in practice.

The next phase should be a full-time academic course, run by the medical school Family Medicine or Practice Department—the Edinburgh department, under Professor Scott is an epoch-making advance, and must have important repercussions—and should be orientated specifically for family practice, leading to a diploma or degree in this subject. I do not think that the degrees or diplomas in public health answer our needs, as they tend to draw physicians away from family practice.

Finally, he should have one year as a senior assistant in a group practice, during which time he would be expected, among other things, to investigate and co-ordinate the treatment of families with complicated health problems as well as carrying out an independent piece of research work, which could also be used as part of a thesis for his postgraduate degree.

At the end of this period, he could certainly be regarded as having fulfilled the obligations for being regarded as a specialist in family practice. The Yugoslavian experience in this respect has shown us the important gains that are achieved from specialized training for general practice.

In order to try and keep abreast of the remarkable advances in all fields of medicine, in-service training is an absolute must. This includes the clinical, pre-clinical, para-clinical and public health fields. The actual techniques used will vary from country to country, depending on the facilities, the interests and personality of the physicians themselves, as well as the cultural patterns in which teaching is usually carried out.

These techniques would include learning situations built round consultations, hospital ward rounds, case-conferences, seminars, short refresher courses and so on. But thinking back to the first part of this paper—the content of practice—it is fairly obvious that the family level approach is missing from this in-service training, and in order to take this into account, additional learning experiences should be created. These might include family case-conferences; participation in marriage-guidance conferences; courses on family epidemiology, and many others geared to helping us become better family physicians—a speciality in its own right—rather than making us frustrated, second-class citizens of the medical profession.

Is it also too much to ask that organized medicine will one day grant ' sabbatical ' privileges to the family physician, so that once in seven years he will be able to leave his practice and advance his knowledge?

In conclusion, may I thank you most heartily for the opportunity you have given me to "get things off my chest" to a group of your College, to whom most of us are looking, in the knowledge that

you are leading the struggle to find the best way in which the family doctor can best serve their patients in the modern state.

DISCUSSION

Question: Dr Medalie mentioned that he had succeeded in ensuring that doctors would not be always on duty for emergencies. If that is true, how did he manage to arrange the appointments system, and to arrange that they have regular times when they are not on duty?

Dr Medalie: We work in pairs. I work in the health service, but within the health centre each two doctors work together. We have our appointments system, but the emergency cases are seen by the doctor on duty. The duties alternate. If I had an appointments system from eight o'clock to twelve o'clock this morning, say, the other physician would be on home visits, but in the vicinity, and he would see the emergency cases. I am sorry if I gave a wrong impression. I was not working on my own, except for six years as a rural practitioner and then, of course, the only way we organized off-duty periods was to have week-ends off, and the nearest rural practitioner took all our calls.

Dr M. E. Arnold (*Wembley*): Could Dr Medalie give us a few brief points on the population of Israel, the health service structure, so far as general practice is concerned, the number of persons participating in the health service, the number of doctors and patients? Could he give us a few statistics and figures for comparisons?

Dr Medalie: Our country has 2½ million people. About 90 per cent of the population is insured with one or other form of sick benefit society. About 5–6 per cent of social welfare cases are paid for by the local authority, the medical part of it, and the other 4–5 per cent are true private patients. There are many doctors in Israel. If you work it out on paper, you find one to probably about 600 people; but, unfortunately, the average age of the doctors is high, well over 50—I think it is 56—and many doctors are not in active practice. In addition to that, the hospitals have a very high ratio of doctors per patient, whereas the general practitioner has a much lower one. But, in general, we have many fewer patients than you have here. I would imagine that, as a rural practitioner, one had about 2,000 patients, although they were spread out.

Dr D. H. Ryde (*South London*): Dr Medalie said that he had tried to encourage patients taking their friends along to have a group meeting. Over here it would not be so easy because some might be a colleague's patients. You could not ask ' opposition ' patients to come over. This would not do. I have tried this idea on a number of occasions. I have had young mothers' clubs and other discussion groups. They keep coming for a few months but, having