Group dynamics and the domiciliary health team*

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GREAT pressures are being brought on the medical profession by our sociological colleagues to accept the implications of recent sociological thinking, in particular, the place of the team concept in delivering medical care in contrast to a long tradition of individualistic and highly personal doctoring. A look at ourselves as social and biological units, rather than as professionally-trained machines, might not be out of place.

The primary aim of medical care is to help patients, as individuals or groups of individuals, to solve or ameliorate their clinical problems. The range of these problems for which there is appropriate therapeutic action has long been so vast that no one human brain can encompass the full range of assessment of the problems, let alone the necessary action which such assessment indicates. Specialism has been the answer to this, first in separating nursing and administrative problems from clinical problems, then surgical from medical and, latterly, an enormous fragmentation of all these main divisions. The success of such specialism has depended on the clarity with which each specialist's field of knowledge and interest can be defined and with the ease with which problems appropriate to his skills find their way exclusively and specifically to him. In the past this has devolved either on to the general practitioner, acting in his capacity as primary assessor, or on to the patient finding his own way to the appropriate specialist.

While the field of primary assessment may or may not become so complex that it also demands an approach based on a team of specialists rather than one primary generalist assessor, it is now generally agreed that the primary function of the general practitioner, and any team which may supplement his present activities, is the primary assessment of previously undifferential clinical problems (Scott 1966). The general practitioner is also concerned with the reassessment, disposal and continuing coordination of those problems (Morrell 1969) in so far as this can be achieved within the limitations of domiciliary practice and the knowledge of the domiciliary health team. The efficiency and effectiveness of the primary assessment is enhanced by any element of clinical continuity between the assessor or assessors as personal and family doctors and the patient with his clinical problem. This continuity could also be achieved by nurses or social workers, for they could also establish personal relationships with the patients.

It is against this general functional background that we should examine the rôle of the team who must fulfil these functions and the structuring of such a team. Such an analysis must be concerned not only with the rôle or functions of the team as a whole but also with the structure of each of the rôles of the individuals which constitute the team, and the rules which regulate the inter-relationships of those undertaking their various rôles with one another.

In what follows the formal structure of any rôle as part of the formal structure of society is deliberately separated from the individual who from time to time occupies

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that rôle. This view is implicit in Shakespeare's comment that "All the world's a stage and all the men and women merely players".

The basic stable units of all human society are first individuals as individuals and, secondly, dynamic human groups formed by the inevitable interaction of individuals.

Human society is based on an interlocking set of social systems and subsystems

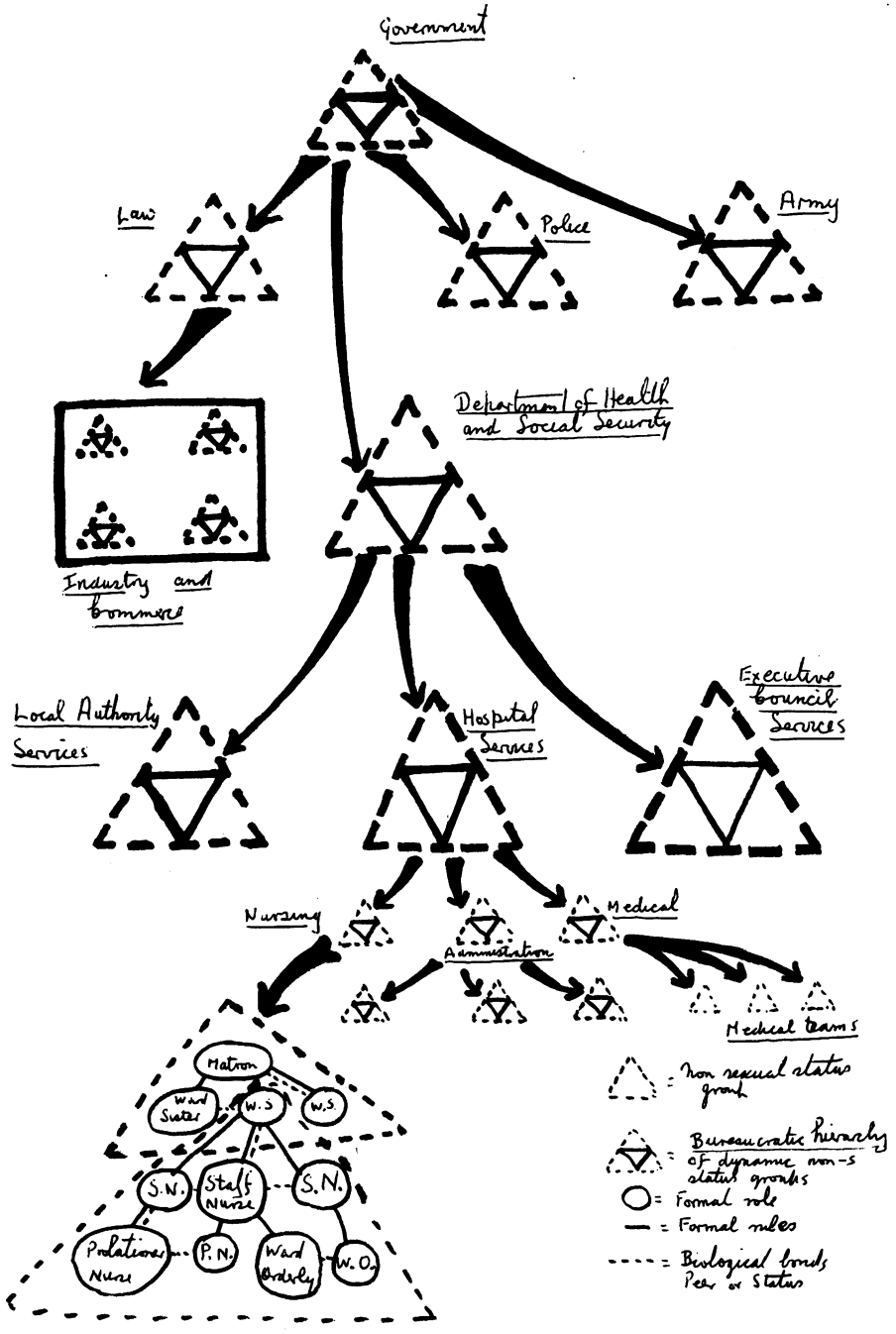

Figure 1
Modern nation state

(figure 1) each of which is based in turn on a hierarchy of dynamic human groups. Human society and its constituent subsystems are therefore only as stable as the dynamic groups of interacting individuals who constitute that society.

There seem to be two basic types of human groups in modern western society (figure 2). The first are the sexual dynamic groups of the nuclear western family, the second are the non-sexual dynamic groups of 6–30 members which form the basic units of the formal structure of western society.

Formal structure of western society

Western society is, in effect, a hierarchically-structured set of subsystems by which all the activities of that society are finally expressed; political, legal, military, educational, medical and industrial, to mention the most important (figure 1). The apex of the main hierarchy is the political subsystem and at the apex of this subsystem in Great Britain is the Cabinet. Each of these subsystems is in turn hierarchically structured. For example, the medical subsystem in Great Britain consists of three interlocking hierarchies: The hospital services, the local authority services and the general practitioner services. The hospital services consist in their turn of three interlocking hierarchies: The administrative, the medically qualified and the nursing hierarchies. All these subsystems are, in effect, hierarchically-structured sets of dynamic human groups which form the ultimate stable units in all hierarchically-structured social subsystems. Examples of such groups are the Cabinet at the apex of the whole system, to boards of management at the apex of the hospital system.

Western society has evolved in this way simply because this is the most stable basis for a group system involving human beings. Each basic dynamic group consists of a hierarchically structured set of rôles whose relationships reflect the basic status-seeking and other essential needs and activities of the human beings who will occupy the rôles (figure 1).

Society, via its formal structure, provides a hierarchically-arranged set of suitable dynamic groups. It also determines the structure of each of the rôles in each such group and the rules which bind together not only those undertaking the rôle in any particular group but also bind the groups into the hierarchic formal structure of each of the main subsystems. The formal system should also supply the rules for regulating the relationships of all main subsystems. This is mainly achieved by the laws of the land, written and unwritten. This formalization, for example, has also resulted in the evolution of the standardized committee and its procedures as a primary basis for the formal structure of the whole of our industrial, commercial and governmental systems. The stability of society will depend ultimately on the degree to which the formal structure of society fits in with the needs of the individual social men who occupy the rôles and follow the rules. Each individual will occupy several rôles in the formal system. The ordinary member of the Board of Management may be the senior member of a group lower in the hierarchy, for example, as production manager in a factory or head of the accounts department in a hospital. This overlapping and interlocking of the dynamic groups may be deliberately built into the formal system, as in our example, or be accidental.

Human society exists only by the interaction of the basic dynamic groups with one another to form an interlocking set of social systems and subsystems. Individuals who are in their turn the basic stable units achieve this by fulfilling certain basic needs to associate with their fellows in small dynamic groups while suppressing or otherwise modifying certain of their basic needs as individuals.

The human dynamic group

This section explores the motivations of the individuals who interact to form the

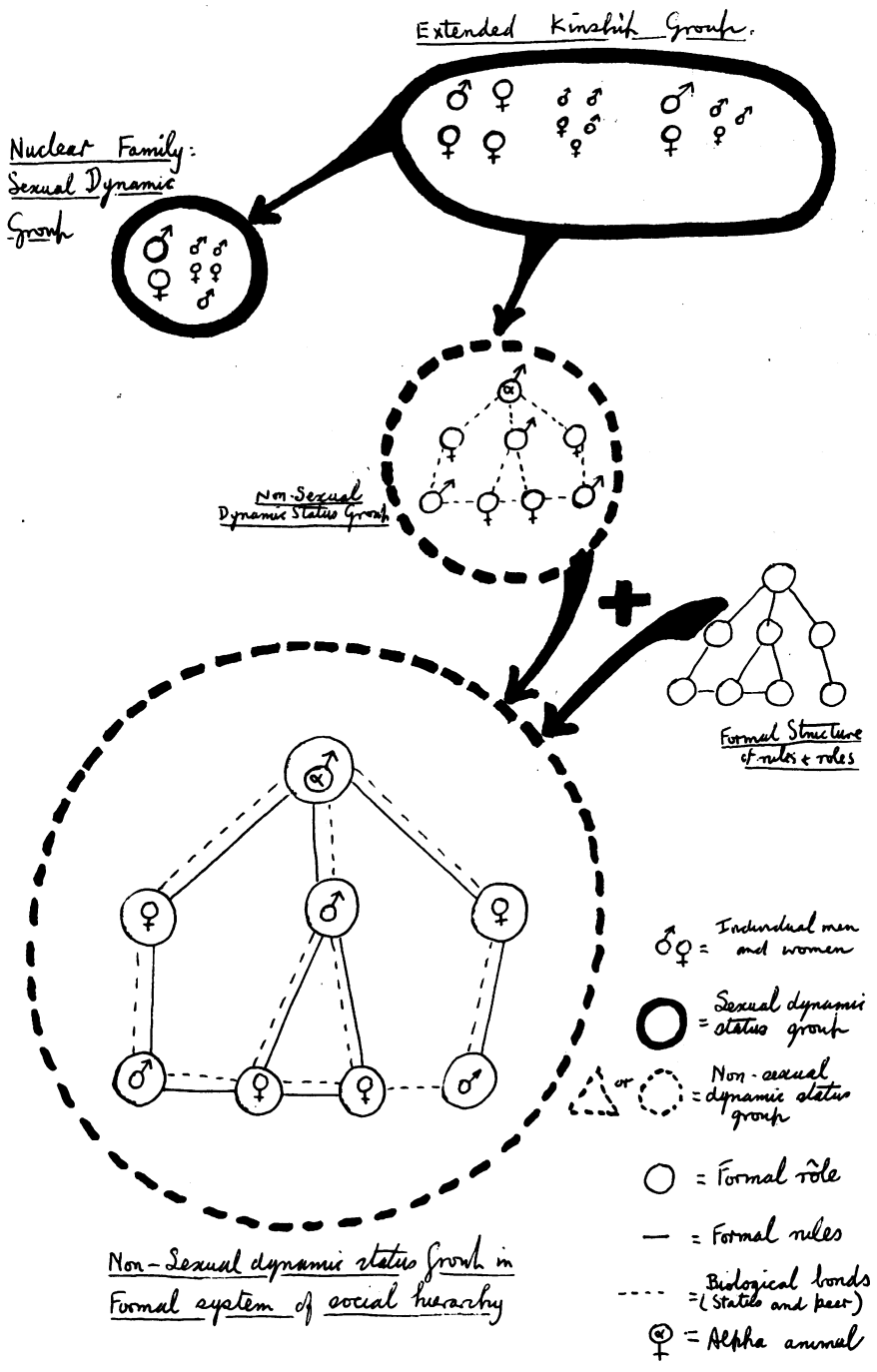

Figure 2
Human groups

two main basic types of human dynamic groups in western society. The first are the *sexual dynamic groups* or nuclear family groups which provide the individuals who will occupy the rôles in the second basic *non-sexual dynamic* groups. The sexual dynamic groups in their turn are supported by the activities of the formal system of hierarchically-structured, interlocking and overlapping, non-sexual dynamic groups. These two different groups had their evolutionary origin in the extended family or kinship group which alone constituted the basis of primitive society. The evolutionary power and stability of cultural systems based on this unitary basic group is still evident in the culture of the Jews and the Mafia. The evolution of western civilization has been marked by the increasingly sharp differentiation between the nuclear family or sexual dynamic group and the non-sexual dynamic group.

All subhuman primate groups seem to derive their structure from the interaction of two main behavioural characteristics of the individuals who interact to form the social groups (Chance 1967) (figure 3). The first of these, 'attention-paying' behaviour,

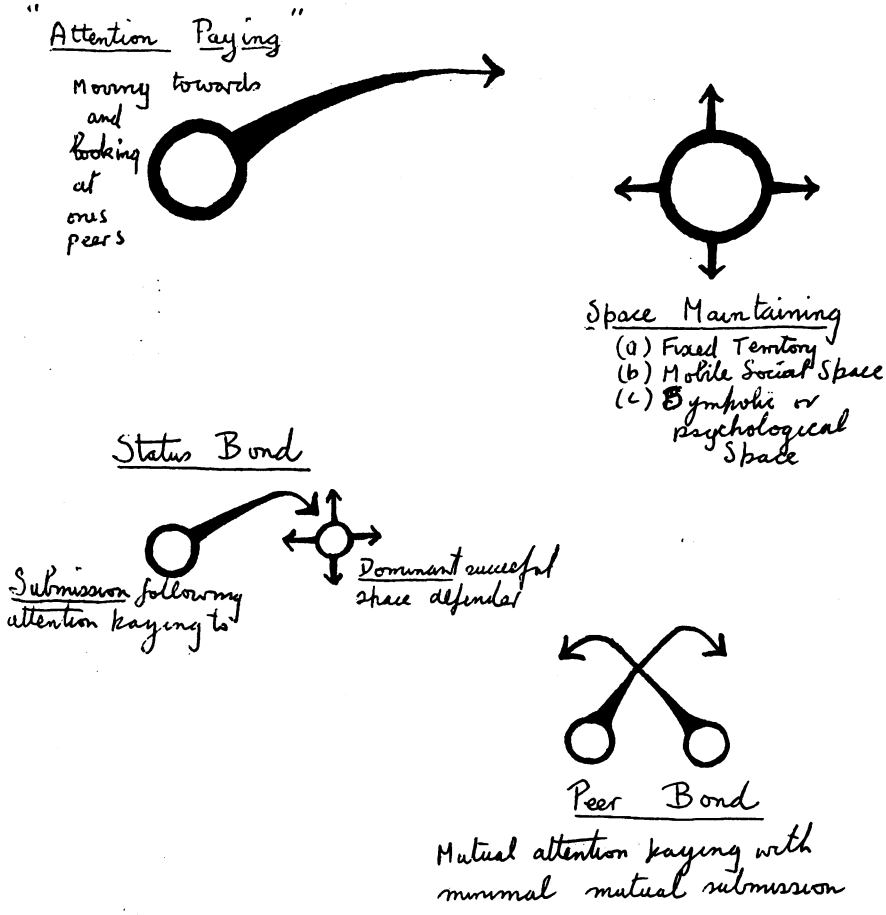

Figure 3
Group dynamics

is the need to seek the physical company of one's peers and to pay attention to them, either by moving towards them or looking at them. The second is the need of all individuals for a minimum of social space or 'space-maintenance' behaviour. The aggressive defence of space, whether fixed territory, the dynamic social space of the baboon or the

symbolic space of human idea, attitude and value systems, always increases in intensity with the degree to which an intruder encroaches on, invades or threatens to invade the space. Even the least aggressive, if pressed enough, will defend their space, sometimes even 'to the death'. Successful space-maintenance is followed inevitably by suitable submissive responses by the space invader.

For example, Hamadryas baboon groups, as they flow over the savannah arrange themselves according to the strength of these two basic motivational elements in each individual of the group. The apex of the status hierarchy is usually occupied, not necessarily by the individual or 'alpha animal' with the greatest need for social space, but by the individual who needs to pay least attention to his fellows. He must, of course, also have a minimal degree of need for social space and sufficient aggressiveness to maintain it, or he becomes, not the central point of the group but an outcast or outsider.

Young, potential alpha-animal baboons, who have not yet developed sufficient physical strength or wisdom, may, therefore, find themselves, not at the centre or apex of the group, but at the periphery. In extreme cases, and particularly if 'attention-paying' drives or needs are low, this young animal becomes a solitary. Subsequently, if he has the resources and stamina to survive, he may, when older and more mature, return to another group and on this occasion oust the current alpha-animal and replace him. Chance (1969) maintains that 20 per cent of alpha-Hamadryas baboons follow this path of development. The mature alpha-Hamadryas baboon, under the influence of optimal feeding and grooming and possibly other less clearly defined benefits of his exalted position, develops a magnificent 'academic' cape of light grey fur, marked with dashes, dots and streaks, which is in its turn a compulsive, attention-paying cue for other less well endowed baboons.

The interaction of these main behavioural activities, 'space-occupancy' and 'attention-paying', determines the specific status structure of any particular species of primate in any particular situation. The inter-personal relationships are built around basic 'cue and response' units. These cues and responses for man include the speech symbols for the symbolic space created by natural language, as well as the grimaces, sounds and gestures which he shares with the other primates. Like his primate ancestors who occupy open territory, the interplay of 'space-maintenance' and 'attention-paying' behaviour provides the basis for the bonds which unite individuals in human non-sexual dynamic groups. These bonds are of two main types. There is *status bonding* in which the cues and responses, whether determined by a formal system of rules and procedures or by informal *ad hoc* interaction of the rôle holders, depend on a maximum of submissive responses by those lower in the status hierarchy to those higher. There is *peer bonding*, in which there is maximal mutual attention-paying and a minimum of mutual submissive responses. Peer bonding, with its reliance on idiosyncratic and personal cues and responses, takes time for its development. The only virtue of status bonding is that appropriate cues and responses can be formalized in advance more readily than for peer bonding. It is no accident that the social structure of western civilization, and its bureaucracies in particular, are based on status bonding, for only status bonding can cope with the pace of change in rôle occupancy which is demanded by modern life.

In addition to these cruder requirements, human society uses the unique rôle-taking and rule-following attributes of language-speaking man to motivate the activities of its subsystems. Man grows up like one of Shakespeare's players, as a rule following rôle-taking individual (Piaget 1951, Crombie 1966), as well as with a basic need to associate with his peers in dynamic groups (figure 2).

The needs of social man are so great that most individuals in open society will form informal groups outside the formal system, as private clubs for dining, sport or other activities. These clubs vary from the simple human groups which meet more

than once in a public house to those which develop a strong formal structure of rules and rôles of their own, either as a written or unwritten constitution, a formal structure which ensures the continuity of the group system rather than the rôle occupants.

Stability of human groups

The stability of non-sexual dynamic groups seems to depend on the interaction of the basic 'space-maintenance' and 'attention-paying' motivation of each individual with a range of other external factors. The first is the length of time over which the group members can interact together. Almost any kind of continuing social interaction between individuals increases their degree of respect and regard (Darwin 1874) or liking for one another (Homans 1951), a degree which is proportional to the intensity of the interactions and the length of time over which they occur. In this peer bonding there is a minimum of mutual submissiveness and a maximum of mutual attention-paying in the form of mutual symbolic grooming. This presupposes that there is a complementary 'attention-needing' component of animal behaviour as well as 'attention-paying'. The presence of such a component cannot be objectively demonstrated in the way that Chance (1969) has so elegantly demonstrated 'attention-paying'.

The second is the clarity, specificity and exclusiveness of the structure of each of the rôles in the dynamic group as laid down in the formal structure of the subsystem.

The third is the closeness with which these rôles conform to the needs of individuals to take different status relationships in hierarchically-structured groups. For example, these requirements have determined the structure of committee procedure with its chairman, other officers and members, each with clearly defined general rôles in the status hierarchy. We cannot all be alpha-animals and, on the whole, most of us do not wish to be. The details of the rôles and the rules which bind the rôle structure together are varied in detail according to the formal needs of the subsystem to which the group belongs.

The fourth is the reliability and consistency of the cue and response units by which the interactions between rôle holders are regulated. The most stable of these cue and response units are those based on atavistic remnants of our primate past. The compulsive attention-paying cue of the 'academic gown' has been mentioned, but many human grimaces, facial expressions and particularly those associated with the eye, are of the greatest importance. These atavistic elements, interacting with ritualized patterns of sound and colour, form the basis for the cues and responses which can bind the largest types of human groups or crowds together. Regular repetition of any ritualized procedure, political, religious or academic, is also included in this group.

The fifth factor is any external threat of invasion of the group space. This can be a threat of physical territorial invasion or a threat to the shared symbolic space of the group in the form of idea, attitude and value systems of political, religious or other beliefs, or of the group's 'way of life' in general.

The sixth factor is communal orgiastic behaviour involving dance, song or almost any co-ordinated rhythmic group activity.

Obviously, group-bonding usually involves the interaction of more than one factor and in many cases, such mutual interactions produce bonding which is more than additive.

Group practice requirements

It is against this general theoretical background that we may now examine the present situation in general practice and the practical problems of the structuring of the domiciliary health team in the future. The traditions of general practice have been built around the independent contractor, the successor to the individual general practitioner of the last century. The reasons for the persistence of this pattern for so long

need not concern us here, but suffice it to say that this stability or inertia, depending on the viewer's point of view, had its roots in the clear demarcation, by the formal system in which he operated, of the professional attitudes, values and status limitations of the practising doctor as a strict professional code of conduct and ethics. This had its function in protecting society and stabilizing the status and cultural continuity of professional doctors. It was also responsible for the instability of the dynamic groups which constitute professional partnerships in general practice, for these preclude a formal status structuring of the rôles in the partnerships (figure 4). Instead, the partnership groups became peer groups in which all were formally equal in status and had similar, if not identical, rôles to fulfil. The stability of such groups was dependent entirely on the respect and regard or liking between members which resulted from continuity of inter-action over time. The system allowed this continuity and, for the time being, will continue to do so, but the introduction of any career structure (Eimerl and Pinsent 1963, Crombie 1965), by increasing the turnover of rôle occupants, will inevitably weaken the stability of this type of group. It is no accident that in situations or subsystems, where individuals move with some rapidity from one rôle to another, as in the Civil Service, either to further their careers and rôle status, or for other reasons, these subsystems have a formal system incorporating a rigidly-defined status hierarchy.

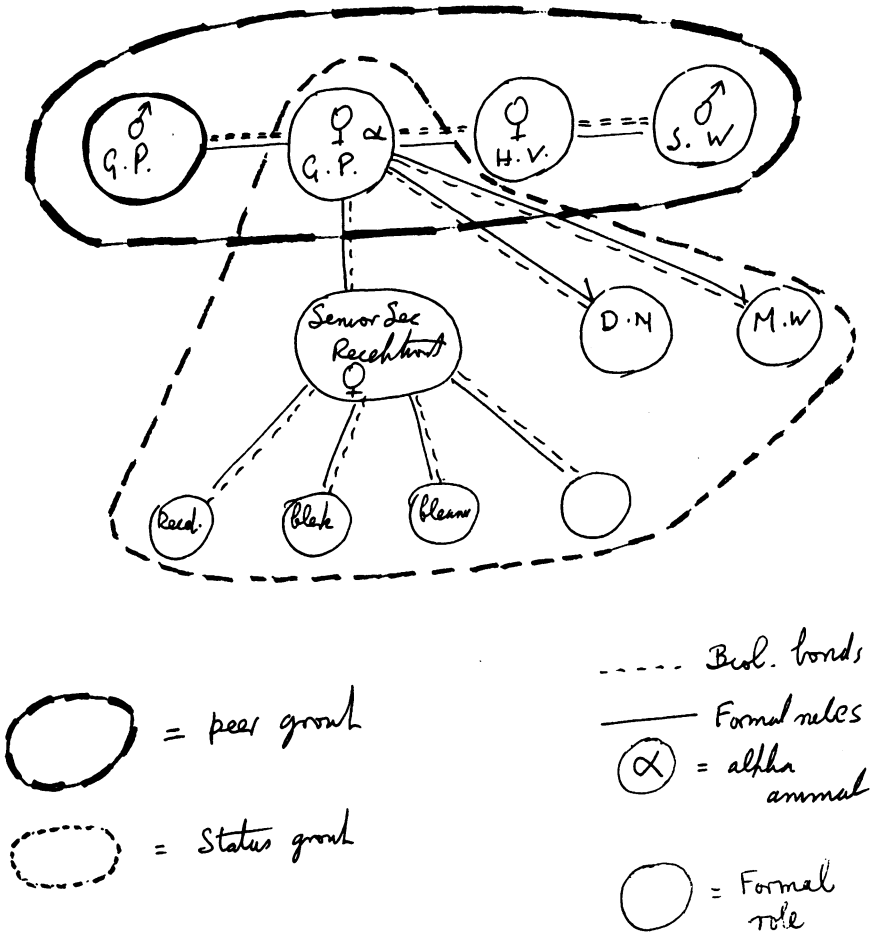

Figure 4
Traditional modern group practice

It is already obvious that true group practice involving more than six peers of equal status is difficult to maintain. Objective evidence is essential before making final judgements. It is also obvious that a loose group of 12 or more practitioners can operate satisfactorily as multiple groups of three or four true partners. This enables the system to benefit from the economic advantage of housing these larger groups under one roof. This is also one reason for allowing some degree of professional specialization within these small groups. If this is therapeutic specialization no harm is done. The more any unitary professional function, particularly the basic function of primary clinical assessment, is split up and shared between different rôle-holders, the more important become inter-personal communications between rôle-holders, both formalized and informal. The former depends on sets of predetermined rules, the latter on peer bonding and *ad hoc* mechanisms.

It is also obvious, though once again objective evidence is urgently necessary, that the relationship of medically and non-medically qualified personnel in this transition period can be far from satisfactory. In traditional practice, the secretary, and more recently the enlarged secretarial and receptionist staff, occupy a clearly defined rôle in a simple status group with the practitioner at the apex. It is not surprising, therefore, that this aspect of domiciliary practice has evolved so successfully in recent years. The groups of three or four general practitioners and their secretarial staff are at the moment the only stable core for any simple evolution of the present system.

Traditionally, the nursing profession has always occupied a status below that of the medically-qualified hierarchy and in so far as district nurses and midwives have been attached to general practice, this relationship has automatically ensued with resultant stability.

All this is in contrast to the situation where health visitor and social worker attachments have been attempted in group practices. Where the attachments are between individuals, the system works in the way that small peer group partnerships between doctors have always worked, particularly where continuity of the relationship in time has been achieved (figure 4). In peer groups in general, as distinct from dynamic status groups, stability is proportionate to the time over which the individuals have been interacting and to the clarity of definition of rôles. Stability is therefore inversely proportional to the opportunities for demarcation disputes and the size of the group.

The statements in the previous section are based only on personal experience which may be fallible or distorted for various reasons, but there seems to be an urgent need for objective data from a representative sample of group practices, to establish the characteristics of the groups in terms of the relationships outlined here and to measure the success of the groups in terms of their stability and effectiveness as a mechanism for delivering domiciliary care.

It is perhaps worth pointing out that group practice stability has to conform to certain conventions and these preclude the use of some of the group bonding mechanisms. For example, we cannot begin the day's proceedings by prayer, singing the national anthem or meeting around the 'flag', all acceptable in other fields. Perhaps unfortunately shared orgiastic activities are also precluded. On the other hand, the group bonding effects of external threats, actual or potential, are often only too evident. The threat may range from the Ministry through the various offices of the local authority, to other groups of doctors and, in the most extreme case, to the patients themselves.

Innovative and service functions

In all human institutions, the basic non-sexual dynamic groups have the two main functions of service and innovation. The first is biased towards continuing stability of function and therefore structure over time and has a formal structure which favours rigid clear-cut non-overlapping rôles arranged in an equally rigid, apical status hier-

archy. The classic examples are those of the armed forces and civil service. A subsystem with this type of structure has *ipso facto* an enormous inbuilt stability, a stability appropriate to any functions which will be unchanging over time but always at the expense of the ability to initiate and absorb change or innovation. Ultimately, this constitutes the core of any cultural stability, however emotionally distasteful. The second type of group is biased towards innovation and changing function, or maximal adaptiveness to changing problems and aims. However, such innovation and change will only be an improvement provided suitable selection processes are operating. In the absence of such selection processes, for example by pilot studies and controlled trials, random or chance variations or change in a complex system can only lead to degeneration, the inevitable 'corruption and decay' of Plato. The second type of evolutionary dynamic human group is one based on a peer group structure, where rôles are only loosely defined and deliberately overlapping and where inter-personal communication and interaction by continuous critical discussion is a necessity for the elaboration of any new sets of norms of rôle structures and relationships appropriate to new solutions. This dichotomy of group structure has been developed, for example, in industry where the first or Service type, based on groups with rigidly defined rôles in a rigid status hierarchy, is most appropriate to an industrial concern with clear-cut, long term commercial aims and standardized techniques and practices. The second or 'innovative' type of group, with its diffuse rôle structure of equal peer relationships, is most appropriate to an industrial concern during a phase of commercial or technical transition or exploitation.

In the present problem of the future of group practice the lesson surely is this. The problems of innovation, trial and improvement can only be approached by systems based on the second or 'innovative' type of group facing consistent selection processes in the form of pilot studies and trials. On the other hand, in situations where rapid staff turnover or other features disruptive to the development of strong peer bonds are operating, the fruits won by this process can only be enjoyed if the solutions in terms of fulfilling service requirements are turned over as far as possible to groups of the first or 'service' type.

This general statement requires two main qualifications. The service requirements will always demand an element of final trial and error to adapt any rigid formal structure to local variations of geography, communication networks and housing and also to the cultural and socio-economic characteristics of the population. However, once the norms are established for any area, the trend must be towards maximizing the group stability. The other factor limiting extreme rigidity of group structuring is the pace of technical innovation in medicine, particularly in therapeutic advances. Each new therapeutic advance demands adjustments in the diagnostic or clinical assessment processes, if the benefits of that therapeutic advance are to be brought to the maximum number of potential recipients in the shortest possible time. Since the primary function of domiciliary practice teams must inevitably be assessment, this demands in its turn a group structuring which can continue to adapt rôle functions, if not the status relationships between those rôles.

One obvious solution is to concentrate as much 'innovative' or evolutionary activity as possible into the smallest number of groups of the second type. Their primary function would be to discover solutions to the problem of devising new assessment methods to meet new therapeutic potentials as quickly as possible and turn these solutions into new rôle structures in the service groups with the minimum of alteration in the status structuring of the rôle occupants.

The second important qualification concerns the need for appropriate selection processes to sift the innovation proposed by the small sub-set of innovating groups. It is here that guidance must come from some centralized body. It should be stressed that

there can be no absolute or static measurements or criteria for the quality of medical care. Only improvements in the quality of the present system as such can be identified.

There must be a clearing house for ideas about such criteria and methods of identifying and measuring them by comparison with the prevailing system, if not against absolute scales. Included, for example, will be measurements of the attitudes and values of all participants including the patient of expectations, wants and needs, as well as measurements of assessment and therapeutic effectiveness. Assessment efficiency, for example, will be related to the balance between appropriate and inappropriate referral outside the group with unmet assessment needs. Therapeutic efficiency will be related to the balance between appropriate and inappropriate therapy and unmet therapeutic needs.

These problems have been with us explicitly for 20 years but have evaded solution, largely because the problems have been tackled on too diffused a scale with insufficient central co-ordination. The suggestion here is simply that innovative effort be deliberately concentrated and properly supported in suitable practices, backed up by a strong central organization.

The future

If this assessment be correct, there is a need for the deliberate exploration of the various alternatives for the structuring of the domiciliary health team as the simpler extensions of the present system.

For example, however pale a shadow of the original is the implemented version of the recent Royal Commission Report on Medical Education, the need for teaching both of undergraduates and postgraduates must increase rapidly. This increasing need can be met, in part at least, by initiating 'teaching' or 'academic' practices (Crombie 1965) which also include in their formal structure a career structure in domiciliary practice for the rôle occupants. Such a structure, running parallel to that which exists now in the academic departments of general practice, will be necessary if the quality of in-service teaching in domiciliary practice is to match that provided by the teaching hospitals for hospital-based medicine. This in turn will demand a rigidly structured hierarchic group, if such teaching practices are to be able to stand the strain of rapidly changing rôle occupants in the more junior levels of the hierarchy while continuing to deliver conventional domiciliary medical care (Richardson 1968).

The relationship of the medically and non-medically-qualified staff in such structured groups might then follow the more conventional pattern of hospital practice. Here the nurses, social workers and health visitors and the administrators would have their own status hierarchies running parallel to that of the practitioners. This is the extreme and most rigid type of structure.

At the other extreme would be a trial of the simplest unit of domicilary medical care, consisting of a small status group with the medical practitioner at the apex, one secretary and a nurse, or share in a nurse, who visited patients and worked in the surgery. The various social, geriatric and mental health workers and health visitors whose services are necessary for an improved domiciliary care service will probably never equate on a one-to-one basis with doctors. In this situation, where they must share their services with more than one doctor, their relationship should ideally be as peers. However, this will demand not only clear-cut definitions of rôle, if any success is to be achieved, but also the passage of sufficient time for peer bonding to develop. A domiciliary health team would consist of sufficient of these basic units to benefit from the economics of such grouping. Presumably this would mean a minimum of 12 such basic units. An intermediate variant of this would be a basic unit consisting of 2–4 practitioners practising as true peers, but with the associated staff in the ratios already described, possibly with some therapeutic and even assessment specialization.

Finally, it may well be that the only system which will achieve any stability where doctors and non-medically-qualified workers work as peers will be one where the initial diagnostic and assessment screening of new clinical problems is carried out by the non-medically qualified. That is, where the real primary assessors are not medically qualified and where the medically-qualified personnel only deal with problems referred to them by the primary assessors. This is the system now working in industry and in many parts of Scandinavia and behind the Iron Curtain. In this situation, the ratio of medically qualified to non-medically qualified would be revised in that each doctor could handle the referrals from several primary assessors. In this situation, whatever the formal relationships of the inter-acting rôle occupants in the formal system, the practitioner would *ipso facto* be the senior member of a small status group, but peer group bonds would be more important than any formal status structuring.

In summary then, the stability of all systems based on non-sexual dynamic groups is directly related to; the strength of any peer bonds which may have developed, in turn dependent on the length of time which each occupant spends in any one rôle; the rigidity and clarity of definition of the rôle structures and the rules as cues and responses which bind the rôles together; the absence of overlapping between rôle activities; and the presence of a suitable status hierarchy implied in the rôle structures and rules. There is also the need to share a clearly defined symbolic territory in attitude, idea and value systems. Weakness in, or absence of any of these characteristics must be supplemented by a corresponding strengthening of all the others. The worst of all worlds would be achieved if each of the domiciliary health teams consist of a large group of individuals, with ill-defined rôles, rapidly moving from one group to another and where the structure of the group has no implied inbuilt status hierarchy. Apart from the stability of the system, the job satisfaction of the rôle occupants, all other things being equal, is dependent on the maximum of peer bonding and the minimum of status bonding for its own sake. Although ritual, formal drinking parties and other orgiastic encouragement to peer-bonding seem ruled out for cultural reasons, there is the seminar discussion group which, when run at the intensity of a 'Balint' session, can produce an enormous degree of group bonding, even when the patient benefits little from the content of the discussions. Such discussion groups are essential when formal communication systems between split rôles and therefore rôle occupants are non-existent and, although time-consuming, are essential. It may be that the price paid in time is too much.

The patient has hardly figured at all in this analysis, but he is, after all, the primary reason for our existence. The essential core of domiciliary practice is the maximal degree of continuity between one doctor and one patient with his clinical problems. This should obviously be given priority in all these pilot studies. The ultimate state of degeneration of these domiciliary health teams will be the medical super-market, if extreme care is not taken now in evaluation of the possibilities.

Conclusions

The quality of human life, which has reached a peak in the western world and this country in particular at this present time, is directly related to the relative value placed on the individual as an individual *vis à vis* the demands of his Group System. The main, if not the only, mechanism for maintaining a healthy bias in favour of the individual lies in the injunction to "love thy neighbour as thyself". It is a paradox of human existence that this personal ethic has evaded incorporation in the formal structure of any society which has achieved any degree of political success and cultural stability and that it continues to exercise its important effects via the influence of peripheral subsystems. This is because any system explicitly incorporating the Christian ethic is at a political disadvantage compared with any other system which does not accord this priority to the individual.

However, there are mechanisms within the formal system which can be invoked to indirectly maintain and support this healthy bias towards the individual. Among these mechanisms are the unitary personal advisers, of whom the doctor remains a prime example with his clearly defined and unshared personal rôle. This he shares with solicitors, teachers, priests and a growing, but not growing quickly enough, list of formal 'Ombudsmen'.

Improvements in the activitities of the Group System of Man should obviously be aimed at increased efficiency. However, increased efficiency should not be obtained at the expense of an ever-increasing complexity of the nexus of human relationships with which each individual must be involved. Reduction in the number of agencies and individuals with which any individual need be involved, reduction in the degree of fragmentation of any aspect of social life and a constant attempt to stabilize for the greatest possible length of time every item in the nexus of human relationships should be complementary aims to a simple increase in technical efficiency.

The construction of a balance sheet which would convince the instruments of our formal group system, including royal commissions and committees, of the wisdom of this bias ought to be a primary topic for discussion with our sociological colleagues and not just the business of demarcation disputes into which the dialogue is degenerating.

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Smoking habits of oral contraceptive users. CLIFFORD R. KAY, M.D., M.R.C.G.P., ALWYN SMITH and BERNARD RICHARDS. *Lancet.* 1969. **2,** 1228.

Preliminary analyses of data based on 32,000 women recruited for observation in a prospective oral-contraceptive study have revealed that oral contraceptive users are more likely to be smokers, and to smoke heavily, than non-users. The user and control samples are thought to be representative of their respective populations in the United Kingdom at the present time. The possible reasons for the difference in smoking habits are immaterial to the conclusion that it might contribute to any observed difference in morbidity between users and non-users.