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# "HEALTH TEAM: ITS OBJECTIVES AND COMPOSITION"

by

Dr. Sayed Aga Zafir, M.B.B.S. (Pb) M.P.H. (Harvard)
Officer in the Ministry of Health and Social Welfare, Pakistan

The health needs, available facilities, priorities and patterns of service tend to vary from country to country and at different times in any particular country. International standards in basic concepts of health services are of great utility, but the necessity of their local adaptation is inescapable. The determinants of variations are not only the economic, geographic and educational factors but also the cultural and historical ones. A brief consideration of remote and recent history of man in this respect will reveal that growth rates and evolution have been very unequal in different parts of the world, and the 'remote' is still represented, today.

## Remote and recent origin of health care.

Health service in its most rudimentary form must have been provided in the remotest period of human history, imaginable. To cite any possible details of such a service would be trespassing in the realm of speculation, though with reasonable license and freedom from fear of any serious challenge. In the remote history of man, individuals of a group or tribe with common ancestry are most likely to have evolved or stumbled upon some practices of health care of children, apart from suckling (nursing) for example protection from or after-care of physical injury. Magic and superstition probably soon played a major role in religion and health practices and primitive religion and primitive medicine became inseparable. Bathing in streams or pools might have been found pleasant, stimulating and wholesome and adopted as a community ritual. Osler (1) commenting upon the origin of nursing said, "nursing as a practice originated in the dim past where some mother among the cave dwellers cooled the forehead of her sick child with water from the brook ... " Through cumulative experience the stream of knowledge of false facts and true, gathered volume and flowed down the ages, dispersing with the migrations of the human race, and from what can be pieced together now, intermittently getting lost in the morass of

unaccountability, re-emerging and clearly discernible through well-known periods and epochs of civilizations, till it reached us in these modern times. The movements and migrations of the human races across geographical regions and continents and into various climes necessitated modifications and additions into the treasure-troves of culture and health practices, both NEEDS were thus refined and re-met.

A respectable stream of knowledge about health and medicine meandered through the various regions around the Eastern Mediterranean; collections of evidences have been rediscovered recently from time to time and have been dated since about 4000 B.C. Several civilizations where health practices progressed considerably seem to have been contemporaneous or closely following upon one another. Outstanding examples of such civilizations are the Minoan in Crete, Babylonian and Assyrian in the former Mesopotamia, Egyptian, Greek, Chinese, Indian, Persian and others. The Jews (Israelites) during their historical sojourn through Egypt, Mesopotamia etc. had the rare privilege of acquiring insight into several health systems and evolved the famous health code of Moses which was fairly complete and the first of its kind. More rational and scientific medicine developed in Greece after certain wandering Hellenic tribes invaded the area and settled down where the Aegean people, allied in civilization to that of Crete, lived. The new-comers to Greece had the advantage of being free thinkers as they were not bound by the local superstitious traditions, accumulated through the ages, but took advantage of all that was valuable in the earlier progressive culture. Great thinkers like Plato, Socrates, Aristotle, Sophocles, Hippocrates and others came and contributed to Medicine and learning in general. Hippocrates, father of medicine, was a great clinical observer, a painstaking recorder and laid the foundations of modern medicine. The Arabs under Islam proved great scholars of old Greek works of medicine and improved and greatly added to them between the seventh and twelfth centuries. Pavey[2] writes, "They studied physiology and hygiene and their 'materia medica' was practically as advanced as that of England at the beginning of the twentieth century.. Hygiene was one of the foundation stones of their moral code .. The Islamic physicians were the first to develop clinical teaching in hospitals .. the Arabs were far ahead of the Christians in their kindly treatment of the mentally afflicted. Under the Arabs in Egypt, hospital organization was very advanced." About 'Al Mansur', a great hospital in Cairo in 1284 A.D. Pavey writes, "there were out-patient clinics, diet kitchens, an orphan asylum and a chapel. It also possessed commodious lecture rooms and an extensive library. It had a staff of male and female nurses and as was usual in these hospitals, a staff of musicians and story-tellers." During this period, under the influence of Christianity several

religious orders for nursing and care of the sick and poor were established in Europe. The Arabs had not only kept burning the torch of 'Greek medicine', but made it brighter during the so called "dark ages" of Europe, by their own contributions, before passing it on to Europe towards the end of the middle ages, for further evolution into modern medicine. This was soon followed by the start of the Industrial Revolution in the West, when economic growth of various Western countries began making strides, bringing about wide differences in their wealth, education, urbanization and general progress. This situation then, foreshadowed the present-day wide differences in the practice of medicine. The advent of the germ theory of disease since the days of Pasteur in the latter half of the 19th century, the introduction of techniques of asepsis by Lister immediately thereafter and subsequent gradual additions to the list of disease-organisms through discovery, have been great modern achievements. The advances of present-day medicine are too numerous and too well known to necessitate further description. The 'atomic age' has its own great demands on medicine and the pace of progress is breath-taking.

The most curious fact is that the caravan of the human species in life and blood, as it travels the road of Time today, represents a great stretch of period from primitive to modern times. While some segments of the caravan have always remained behind, others have alternately forged ahead and receded. The spectrum is spectacular and like a book open at many pages at the same time, it exhibits varying NEEDS and priorities in health as well as in other fields. Modern doctors of the scientific system of medicine, doctors of various indigenous systems like Ayurvedic and Unani (Greek) in the Indo-Pakistan subcontinent, magic doctors or medicine-men of various tribes in Africa today exist together in these countries and practice their own type of 'medicine'. Over and above this situation the state of economic development in various countries varies widely. The health needs, health priorities, health teams, their objectives and composition would thus of necessity differ considerably from country to country.

Health needs and objectives.

A recapitulation of the definition of health included in the constitution of the World Health Organization, that, "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" gives some idea of the health needs of individuals and communities. The same are further elucidated by Winslow's (3) definition of public health, an amended version of which by the Expert Committee(4) reads as follows:-

"Public health is the science and art of preventing disease, prolonging life and promoting mental and physical health and efficiency through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of social machinery to ensure to every individual a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity."

The report on the first session (5) of the Expert Committee on Nursing recommended:-

"fundamental research with the assistance of social scientists to determine the real health needs of people in two or more different societies and to determine how nursing can best function to meet these needs through health teaching, participation in preventive programmes, care of the sick and other methods.*

The second report(6) of the committee reaffirmed the necessity for such fundamental research as a basis for designing realistic health programmes. For purposes of immediate discussion it accepted as universal health needs: food, shelter, clothing and an environment which sustains health; information on the use of available natural and social resources; and care in sickness. Essentials for meeting these needsare stability in human relations and an economic status sufficiently high to permit the attainment of necessities for health."

Another broad indication of the human health needs is contained in article 25 of the "Universal Declaration of Human Rights"(7) which reads as follows:-

"1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

"2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."

Hiscock(8) has well expressed his views on the organization of health programmes in these words, "since it is recognized that the health of the individual is the ultimate objective of all health programmes, the public health

authorities should aim to integrate the health programme with the hospital and medical care programme in those communities where properly organized hospital and other facilities exist."

In conclusion it may be said that in any given situation although the health needs may be many the objectives will have to be practicable and in accordance with the priorities, economic feasibility, availability of trained personnel and other resources in the country. The health functions of the concerned authorities may thus vary from place to place and in a given situation from time to time.

Health functions in a community health programme.

There are two distinct approaches to the function of rendering service in terms of health and medical care:-

a) Personal basis, for example as given in the hospital, out-patient clinic and domiciliary service.

b) Community basis, for example as provided in environmental sanitation with all its services of housing, water supply, sewerage, insecticide sprays, control of atmospheric pollution, monitoring and control of radiation contamination, etc.

These two approaches are sometimes, rather erroneously, considered to be co-extensive and synonymous with curative and preventive medicine respectively. A good many preventive services are personal, for example vaccinations, periodic medical inspections, school health, maternity and child health, occupational health services, etc. These two types of services when administered, however, make a long list of health provisions. The Expert Committee on Public Health Administration[6] has given a full list of such responsibilities of which only broad headings are reproduced here.

I. Services Provided Directly by Health Authorities or Jointly with Other Authorities.

1. Environmental

2. Personal and Social

   (1) For the health
   (2) For the handicapped
   (3) For the sick

3. Control of Communicable Diseases

   (1) Quarantine
   (2) General epidemiological control (including immunization, isolation and disinfection)

4. General

   (1) Health promotion
   (2) Regulation
   (3) Supplies
   (4) Recording and analysis

5. Professional education

6. Research.

II. Other Services that Contribute to Health
(Here Social Welfare, Education, Labour Standards, Recreation, Population and Family Planning etc. are indicated). Thus it is apparent that the functions of health personnel in a total programme are elaborate and extensive. The relative importance and priorities of various health functions have will need to be determined in the light of local circumstances.

Teamwork and its implications;

Two workers or more coordinating their efforts in any field comprise a team. The following may be considered some of the important implications of team work:-

1. The total output of a team in quantity or quality should be more than the mere summation of the individualized outputs of its workers.

2. The team should be of an appropriate size to take optimum advantage of useful inter-personal relationships and group dynamics amongst members.

3. Each team member should know his own individual role precisely and of others broadly, for effective understanding and collaboration.

4. There should be division of labour, thus necessitating some specialization for each worker.

5. There should be leadership and direction in the hands of one of the members who, by training, has the best overview of the work involved. Leadership "may be described as the ability to organize the resources of a group in such a manner as to vitalize its common objectives, with the maximum degree of efficiency while promoting to the fullest the development of each of its members."(10)

6. During the dynamics of team-work there should be adequate delegation of authority with equivalent responsibility from senior to junior members of the team to keep the team well knit, interested, alert and progressive.

7. Mutual feelings of approval, a sense of belonging and security should pervade the team to enable it achieve its purpose to the maximum.

Varying compositions of Health teams.

A human family is an eternal team for most purposes including health, and a health team is a functional family. The demands of modern medicine in terms of extensive funds of exact knowledge, varieties of skills and techniques, diversity of aptitudes and temperaments, necessitate the employment of a vast multitude of people in the various spheres of health activities. The whole

organization of a health department of a country from the Minister for Health to the lowliest attendant or peon is a prodigious health team. Leavell and Clark[11] have said, "The community health team needs workers with a broad spectrum of training ranging from the neuro-surgeon to the hospital wall-washer. A modern hospital uses essentially all types of workers found in a well-operated hotel, plus the great group working to restore patients to health." A team of such size or an army of workers, however, does not fulfill the requirement for good interpersonal relationship as most of the members do not personally know one another.

The basic health team may be said to consist of doctors, nurses and auxiliaries. Several centuries ago Susruta [12] of India expressed the view that "the physician, the patient, the drug and the nurse are the four feet of medicine upon which the cure depends." Specialization in modern medicine tends to cause a mutation and draws away these basic personnel into innumerable fields of special training and work with a re-arrangement of mutual ratios in accordance with the nature of the work and the availability of their numbers.

These re-arranged teams entrusted with medical care or care in sickness have grown enormously with the growing complexity of modern methods of treatment, particularly in advanced countries where industrilization and urbanization have gone ahead. Similarly the public health and preventive work has gone apace in these countries with a corresponding evolution of the basic team, to which group the term "health team" is conventionally more applicable than to the personnel engaged in the care of the sick. The main institutions which render medical care are hospitals, out-patient clinics, health centres, etc., supported by an elaborate or minimum laboratory organization. In under-developed countries where resources are poor, the rural component of the population is much larger than the urban. Hospital facilities are not enough to cater even to the needs of the city people. It thus poses a problem as to which need, rural or urban, should be met first and to what extent. Also, the question arises, how much of the basic health needs of the people should be met free by the Government and how much should be made available through private practitioners after payment of fees or premiums of medical insurance. In the Scandinavian countries, Government effort in health and medical care is closely co-ordinated with doctors in private practice. Thus it forms part of the team for both curative and preventive work.

According to the World Health Organization Expert Committee[13] the key persons in a comprehensive health programme "are the physician, the dentist, the pharmacist, the health engineer and the professional nurse. In order that

these highly trained individuals may serve most effectively, it is necessary to find auxiliary personnel to assist them in providing an adequate service to the greatest number of people." The same committee also gave a full list of various categories and specializations of medical and health, sanitation, dental, laboratory and other personnel.

Speaking of a balanced team in the United States of America or similar countries, Leavell and Clark[14] think, "the smallest team, the absolute minimum for economical effective service, is 1 Health Officer, 1 Public Health Nursing Supervisor, 8 to 10 Public Health Nurses, 1 Sanitary Engineer and 2 Sanitarians, 3 Clerks and a Health Educator" for a population of about 50,000.

In Pakistan the preventive and curative health services were integrated from the centre to the periphery, after independance, in accordance with the recommendations of the Bhore report[15]. Integration in the true sense, however, requires a fair comprehension of the philosophies and programmes of the two medical practices by the personnel of both, and sufficient mutual interaction to make such comprehension alive and meaningful. A fair standard of medical care is available for the population in most of the cities, but the basic health needs of the rural population which is more than 80% of the whole are still inadequately met. In the second five-year plan already commenced, there is a programme for establishing 300 rural health centres, each to cater for an approximate population of 50,000. Each centre with three Sub-Centres will provide some 10 services of out-patient treatment, maternity and child health, school health, personal preventions like vaccination, tuberculosis control, collection of vital statistics, environmental sanitation, family planning, health education and ambulance services. The team that will work at each centre will consist of one Male Medical Officer, one Female Medical Officer, one Health Visitor (to be later increased to four health visitors), four midwives or trained dais, one dispenser, two dressers, one laboratory technician and one clerk. As stated earlier the team will perform both curative and preventive health work.

The role of Nurse in the Health team.

Nurses are among the key members of the health teams engaged in preventive health work or the care of the sick. They provide the most exacting, "comprehensive and responsible care of a nursing nature which is available" [16] in a given country. "The stage of development of nursing varies greatly from culture to culture. It is also limited by the stage of development of medicine and public health ... The quantity of available nursing services varies among countries from those with none whatever for millions of people to those with one nurse for approximately 400 persons."[17]

"Nurses are needed in greater numbers than other categories of health workers because they have direct, individualized and lasting contact with people, sick and well. In this sense, nurses are the final agents of health services."(18)

Nurses have followed in the footsteps of physicians in terms of specialization and also in respect of assuming administrative responsibilities, both in the hospital wards and outside. The complexity and technology of modern medicine tends to reduce doctor-patient contact, but emulation of the physician in this respect also, would embarrass the nurse and the trend must be restricted to suitable limits. Auxiliary nursing personnel will have to be utilized but should not be the excuse for the flight of the nurse from the patient's bedside.

There are two main categories of nurses, the hospital nurse with subcategories according to specialty - paediatric, obstetric, psychiatric, operation theatre etc. - and the public health nurse or the health visitor. In Pakistan, the last named has a shorter period of training than a nurse and is more orientated towards maternity and child health work and domiciliary service. Health visitors, as stated earlier will be increasingly used for rural health services.

There is a great shortage of nurses in many countries including Pakistan. Here, it appears to be related to levels of general female education, cultural traditions of women not working outside homes, and inadequate status of nursing. Whereas all three are gradually being remedied, the status can be properly raised "only when nursing education is established on a sound basis comparable to that for other workers in the health field ..."(19)

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