The first line of defence

In an address to an annual study conference in Cheltenham in May, Anthony Carr, ANO, Newcastle-upon-Tyne, challenged the role of the health visitor in relation to perinatal mortality rates in England and suggested radical changes in the payment of child allowances to mothers. He supported his ideas with close examination of the roles of the midwife and district nurse. This week, in the first of two parts, he investigates that 'rather splendid title', the primary health care team

First, 'primary'. This can be defined as 'first', 'original', or 'of the first order in a system of successive branches'. It can also mean 'chief'. Thus, the health care team is first in the health care system. The first line of defence, or attack if health education is involved.

The client or patient has a continuing or intermittent contact with this team in the majority of cases. Through the general practitioner the patient is referred to hospital and they in turn refer back to the general practitioner and the team.

Let me ask a question of you all. Where do you think most of the population of the United Kingdom is at this very moment?

They are either at home, school, at work, on holiday, or even attending conferences such as this. Those in hospital for any sort of medical or surgical treatment have about 227 000 beds available to them, that is including geriatrics, the chronic sick, and obstetrics. Add to this provision for the mentally ill and mentally handicapped and this totals up to something like 376 000 beds available, or 306 000 occupied.

About 45 000 people attend hospital on an outpatient or accident and emergency basis each day. So today, on average, 351 000 patients will be in hospital either occupying beds or visiting a department for some reason. That is just 0.675% of the population.

Yet our population is over 50 million. Sometimes I feel that in our large district, area and regional organisations we forget that although nearly all the population will need some sort of outpatient or in-patient review at a certain time of their life, for the vast majority of people that stay or review will be extremely short. What I am trying to say is that people are out there, not in hospital.

Remember, the developments that have helped the population most to reduce the diseases that kill them included the provision of pure water, proper sewage, immunisation and vaccination, and the discovery of antibiotics.

Many of the diseases treated both in hospital or by the primary health care team today are diseases of civilisation caused by habits which conflict with a true concept of health. Smoking perhaps being the prime example. Nurses by and large remain unconvinced or show their lack of concern by smoking themselves. They are therefore unable to influence to any great extent their client's behaviour.

The second word 'health' speaks for itself, except that hospitals are orientated towards the treatment of disease, and to an extent the community team can develop an attitude which only recognises disease. We have to remind ourselves continually that good health should be our major objective and not just the task of the treatment of people with disorders, important as that is.

Soul

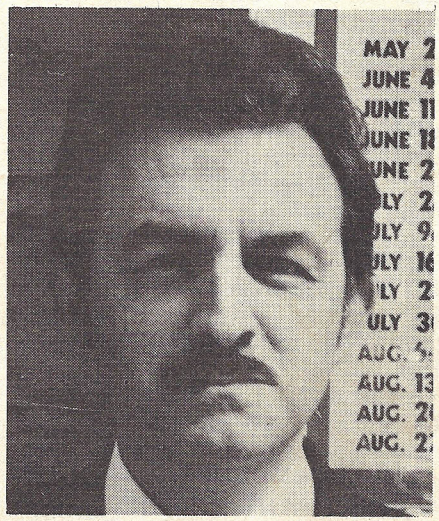
Health is more than just surviving the week. While people have fears, complexes, anxieties, guilt feelings, what price the cured physical body? I believe a man is more than flesh, he has spirit and soul. Is it possible that our ministry only reaches out and touches his flesh?

Are nurses in the community, apart from health visitors, really taught anything about people. The health team should be able to convey hope and encouragement, showing genuine interest in the patient's life and, at times, soul-destroying conflicts. The new district nurse curriculum attempts to introduce the district nurse to the concept of caring for the whole person not just the effects of his disease.

This leads me on to the third word 'care'. This is a very important word. To care means 'to be anxious, to be concerned, to provide, look after, watch over'. Another word used in the dictionary is 'heedfulness'. This means 'to observe, to look after, to attend to'.

The question I ask of the profession today is do we really care? Are we really heedful of the needs of others? I am excited by the introduction of the approach to nursing termed 'the nursing process'. Whatever else it means it gives an opportunity of treating people as individuals and seeing the person as a whole person in physical, psychological, emotional and spiritual terms.

If you belong to a primary health care team today, let me ask you, 'do you really care, do you really feel?' Often, the patient and his family can judge best who really cares. Note, not who carries out the procedures correctly, but who enters into their experience,



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shares their sorrows and joy, and their personal aspirations. This depends on much more than the training received or education achieved, important as those things are.

Many members of the team have the great privilege of sometimes entering into another person's sufferings. This caring is more than teaching, more than demonstrating; this special care comes from seeing what a person is and how he or she is motivated in life, the types of values that are held, the kind of faith that is believed in. May all of us here today be truly 'caring' people in the way we know best.

Harnessed

Lastly in my introduction, the word 'team'. There is sometimes great danger in examining in too great detail how the primary health care team does or does not work.

What is often forgotten is the unique contribution made by each member of that team. Each individual approaches the task in a different manner according to the skills required at the time.

A health visitor is not expected to do the work of the district nurse or midwife, or the midwife to do the work of a health visitor, unless qualified to do so. The general practitioner, by training and experience, has a different contribution to make.

To try and reduce these somehow to an overall contribution and then divide off into disciplines, I believe is to misunderstand what the team means. The definition of the word in the dictionary does not help here. It states 'a set of animals harnessed together', 'string of flying ducks'.

The definition is more helpful as it continues 'a set of persons working or playing in combination'. On the other hand, we may laugh at the first definition of 'animals harnessed', but is it not true that because we assume too much in our definitions, or misunderstand them, we become confused when things do not work out the way we think they should. Animals would much rather be free to roam than be harnessed together, but the results of the harnessing are, however, much more encouraging. Pulling together, even if on occasions discipline has to be used, is more productive than allowing the animals to do their own thing.

A set of people too may work in combination, joining together to co-operate.

It all depends on what is wanted from 'team work' whether it is achievable. It is made more difficult when various members of the team are employed separately. The general practitioner with his independent contract, the midwife often reporting to a midwifery division, while the health visitor and district nurse have responsibilities to different nursing officers in the community nursing division. All have different qualifications and have received separate specialist training. All perform different tasks.

Daily rush

Perhaps the obvious solution is for all nurses in the community to be given the same training. A word of caution here, however, because some countries have done this, not all with very satisfactory results. I have talked to public health nurses in Eire who say it is the health visiting that tends to be left undone in the rush of daily life in the urban areas.

Perhaps the first thing to recognise is that all these people have different roles to play. They should receive different training to equip them in their task, but provision should be made for them to join together during training so that at the beginning each other's role can be clearly understood and appreciated.

The second is that members of a team must meet regularly to assess not only the progress of a particular patient or family but their own success in dealing with people and with each other. Development of the relationship from that point onwards depends, I believe, more on the team itself than on external forces.

Having attempted to define the 'primary health care team' I would now like to continue by looking at the contribution of that team in terms of caring.

I would like to mention a tail-piece shown in a recent edition of the *Daily Telegraph*. A meeting was being held for parents and would-be parents, and a notice appeared outside the public hall relating to the subject of child-birth which concluded: 'Remember, the first few minutes of life are the most dangerous', to which someone had added in pencil 'the last few minutes can also be a bit dodgy sometimes'.

This allows me to speak briefly on 'the cradle to the grave' aspects of the primary health care team.

Child care

Let us look for a few moments at one area of care which involves the midwife, the general practitioner, and the health visitor. That is antenatal care. The midwife is heavily involved in the area of caring. Often, the community midwife is not a member of the primary health care team. I think she should be.

The health visitor and midwife must work very closely together so why not in the same team? I know it is a problem of numbers and I will consider later ratios of staff.

The Department of Health has recently expressed great interest in infant and perinatal mortality. In December 1978 the then secretary of state announced that the DHSS was to launch a major co-ordinated effort with the Health Education Council, Community Health Councils, and voluntary organisations, with the major aim of increasing public awareness of the scope for reduction in infant and perinatal mortality and handicap, and to promote local action in the community to improve understanding of services, to disseminate health education and to mobilise voluntary effort.

The perinatal mortality (that is deaths per 1 000 of all births occurring between the 28th week after conception to one week after birth) in Newcastle and Gateshead for 1977 (provisional) is 20.2 and 23.3 respectively, while the provisional figure for England is 16.9. Infant mortality (rate per 1 000 live births) rates are lower both nationally and in the two areas mentioned, but still higher than many other countries in the world.

Perinatal mortality

We cannot boast of the best health service in the world while these rates remain high, although they are generally declining each year. I will admit that many other factors play a part in these figures, including housing, employment, the environment, education and finance — many of these tied up in social class gradings.

I read in a summary on English perinatal mortality in 1976 that although this rate has fallen steadily over the last 20 years it is still 50 percent above the lowest national scale (Sweden: 11.3).

The writer continues by saying that substantial progress towards lower levels of perinatal mortality might be made if a greater proportion of all births were to be clustered at the optimum maternal ages of 20-29 years, if fewer mothers had more than 2 children, and if the rates experienced in social classes I and II could be extended to all babies.

I believe that for the statistical summary to become fact, a major revolution in thinking, the way we live and the way we apply social security benefits, has to take place.