MPA 775

LEGAL STRUCTURE IN HOSPITALS

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MODULE 1

UNIT 1 HISTORY OF HEALTH CARE IN NIGERIA

CONTENTS

1.0 INTRODUCTION

Health Care in Nigeria can be traced to Pre-colonial time made up of traditional healers and diviners. Colonial period was manned by the British which was the beginning of modern practice of health care delivery in Nigeria and the Post independence period with lots of improvement and challenges to the care providers and consumers.

As at today, Nigeria has a population of over 140 million with more than half in the rural areas with less infrastructures such as health care institutions with a common pattern of mortality and morbidity. It is this inequality in the Health State that Primary Health Care accepted as key to Health for All by the year 2000 AD in 1978 was formulated.

This unit presents to you the history of health care in Nigeria from Pre-colonial to the present period.

2.0 OBJECTIVES

At the end of this Unit, the learner will be able to:

- Trace the history of health care in Nigeria.
- Identify the major developmental changes in the health care in Nigeria.

3.0 MAIN CONTENT

3.1 Pre-Colonial, Colonial and Post Independence

The historical perspective of the evolution of health care in Nigeria covers three periods:

- Pre-colonial period
- Colonial
- Post Independence

3.1.1 Pre-Colonial Period

This is the period before the advent of Colonial government in Nigeria. The Nigerian indigenous and traditional health care providers, diviners, soothsayers, men, women birth attendants dominated the health care system.

Across the country then, the following traditional / native healers abound:

- Wombai …….. In the Hausa region as armies and Red Cross.
- Gozan ……. In the Nupe dominated areas as Barbar Surgeons.
- Adahunse / Alawo …….. In the Yoruba land
- Dibia …… In the Igbo land
- Abia Ibok ……. In the Efik and Ibibio

They engaged in circumcision, deliveries of babies at home, provided local security, treatment of diseases, appeasing “gods” on behalf of the people.

Because of their community-based approach, they were accessible and affordable while services were paid for in cash or kind.

3.1.2 Colonial Period

This period spans through mid- 17th century up to October 1st 1960 when Nigeria got her independence. There was the infiltration of Western oriented (modern) health care, which is traceable to the arrival of European traders who established men chantile houses.

The British colonial government provided military establishments with their health care personnel who provided segmented health services for the expartriates and priviledge few Nigerians.

The period also gave rise to the missionaries e.g. Cathedral Church of England, Methodist, Roman Catholics, Baptist to develop a health care system that will take care of people at the grass root and the less priviledge.

With the integration of the Army with the Colonial government, public health services originated and government offered to treat the local civil servants and their relatives.

3.1.3 Post Independence Period

This period from 1960 till date with lots of changing phases. The regionalized health services established in 1954 remained in operation after independence till 1967 when states were created leading to state Ministries of Health / Zonal arrangement.

The third National Development Plan during the regime of General Yakubu Gowon (Rdt) brought about some reforms into Health Planning between 1975 and 1980. The Basic Health Services Scheme (BHSS) was designed to provide comprehensive health care that was community based with emphasis on prevention, ensure community mobilization and participation in providing health services. The period also embarked on the development of health manpower to man the existing health care facilities.

The Federal Government implemented the BHSS by providing one General Hospital, four Primary Health Care Centers, 28 Clinics and four (4) Mobile Clinics in each Local Government Area of the community to provide equality in health for all.

The period also brought about the zoning of the country to six geo-political areas for the implementation of Primary Health Care. Schools of Health Technology were established nationwide to train and retrain personnel.

Today, we have 36 States and FCT Abuja in Nigeria with State Ministries of Health, the Federal Ministry of Health oversees all levels while the Local Government operates Health on a departmental level.

4.0 CONCLUSION

The Unit has traced the history of health care in Nigeria from Pre-colonial to the Post independence periods i.e. till date. Various developments at each stage presented and we can see where the health care system is today in Nigeria. Each period also developed within the framework of what was on ground thus giving an impression of improvement upon the past. It also provides the support and care needful towards solving some immediate problems that usually proved inadequate to achieve long-term goals.

5.0 SUMMARY

The history of health care in Nigeria has been the subject in this Unit. The history from Pre-colonial to the Post independence with emphasis on major events at each stage with significant landmarks.

6.0 TUTOR MARKED ASSIGNMENTS

Trace the evolution of Health care delivery in the colonial period.

7.0 REFERENCES/FURTHER READINGS

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UNIT 2 TYPES AND STRUCTURE OF HEALTH CARE INSTITUTIONS

CONTENTS

1.0 INTRODUCTION

Health care institutions consist of formal and informal organizations where preventive, social and clinical services are rendered to the members of the society. Each of the institutions has specific aims and objectives even though they all exist to promote health, to prevent the occurrence of diseases, to bring about a peaceful end for those suffering from terminal disease, and to treat human illness.

Most health care institutions form an arm of the government. Their social structure therefore follows the same pattern as other government institutions. The social system within the institution or organization is determined by the established procedures, which govern the relationships between individuals within the institutions. As in all other bureaucratic organizations, relationships within most health care institutions follow a pyramidal structure. There are master-servant relationships, and an individual's roles and status defines the position in the hierarchical structure. Health care institutions form a large social system, and within this system are other large sub-systems. The systems vary from one country to another and even slightly within the same country.

This Unit will expose you to the types and structure of Health Care Institutions especially in Nigeria.

2.0 OBJECTIVES

The student will be able to:

- State and describe various types of Health Care Institutions
- Explain the organization of the hospital
- Discuss how the government is an institution of Health Care Delivery in Nigeria.

3.0 MAIN CONTENT

3.1 Types Of Health Care Institutions

In most African Countries, there are at least five types of the health care institutions, closely intertwined but nevertheless distinct enough to be analyzed separately.

a. Private Hospitals

There are the private hospitals, which may or may not be profit-oriented. Some are individually owned while others belong to religious bodies. (e.g. the Catholic hospitals and the Seventh Day Adventist hospitals).

b. Drug companies and other suppliers

A second sub-system is the drug companies, medical equipment manufacturers and pharmacists. Pharmacies, which are important in our communities, may have drugs including antibiotics, analgesics, or steroids among others. in some African countries, all these drugs are accessible to people, even if they are contra-indicated. The role of the pharmacist is supposedly limited to dispensing doctor's prescriptions and selling common, unrestricted, non-poisonous drugs (aspirin, panadol, etc.), but pharmacists often do more and in many instances take up the roles of a doctor, nurse and dispenser. Since they are more accessible than hospitals, their clients may be greater in number than those of the government hospitals. In Nigeria, the situation has tremendously improved as a result of the activities of National Agency for Food and Drug Administration and Control.

c. Traditional medicine

A third sub-system is the less structured network of many different traditional folk and religious cults and organizations. They form an important pathway to health and they compete favourably with the government hospitals and primary health care facilities. Their role in providing psychological and social support to their patients account for their huge success in recruiting and retaining patients, especially those suffering from chronic diseases and psychosocial problems.

d. Public health system

A fourth sub-system is public health. In this era of primary health care, health promotion and prevention of diseases are crucial to the success of any health care system. Public health system is the sub-system whose roles are mainly health promotion and prevention and control of diseases. In general, the personnel working in the public health system do not practice curative medicine. They protect, administer and perform community-orientated services. Public health personnel detect diseases and if necessary they refer the sick to other medical personnel; they immunize to reduce the incidence of disease; inspect to prevent epidemics; educate people to have insight into the cause of diseases; make home visits to carry out surveillance on communicable diseases; visit public places to enforce the rules of hygiene; and notify the appropriate authority about the occurrence of certain diseases.

e. Curative medicine

The fifth and largest sub-system is the world of large government hospitals, clinics and nursing homes. Their roles are mainly curative and they form a very complex bureaucratic organization that will be described in details.

3.2 The Hospitals as a Social Institution

Hospitals can be classified in many ways: by their types of service, by their type of management or control, by their type of financial support, physical size, type of facilities, staff composition and numerous other features. Some are owned privately (by missions or individuals), while others belong to the government (Federal or State). All hospitals deal with people, but nevertheless they vary according to what kind of hospitals they are, the culture within which they operate, and the economic and social systems that support them. a hospital is an organization, which can not be viewed as an entity in itself, within which a certain art is practiced, but must be seen as having contacts and overlaps with other organizations. It receives funds, patients and staff from the society that support it, as well as instructions about how to use its resources. In return, it provides the society with the services of trained professionals. So the hospital and society are inter-dependent.

Although a hospital shares some basic attributes with any other large organization, it has its own distinctive traits, which place it in a special category for analysis:

1. A hospital is an organization which gives care and treatment

2. It deals with people and doesn't merely process inanimate objects

3. It operates within the context of the culture of the society, because the occurrence of disease and illness behaviour is influenced by the culture of the society
4. It is commonly expected to give priority to standards of service rather than to a consideration of cost-efficiency.
5. Demand for care tends to be urgent and in most cases treatment cannot be postponed.
6. Decisions must be made which have implication and
7. Authority, power and discretion are divided between the administrative structure and the professional (doctors, nurse, pharmacist, etc). Hence there is interdependence and the need for co-ordination between all hospital employees.

3.3 The Organization of the Hospital

Nigeria, many successful attempts have been made to reframe the social organization of hospitals to improve their effectiveness. For instance, there have been efforts to decentralize decision making in order to make hospital services more responsive to patients' needs and to improve the relationship between the various categories of workers in the hospital. Nevertheless, the social structure still remains bureaucratic. There is a hierarchy in which each employee is assigned a specific set of functions and authority over certain areas. At the top is a director, a medical doctor, who is responsible for seeing that assigned tasks are carried out, that the suitable personnel are available to perform the jobs, that the organization remains in order, etc.

It is worthy of note that since the early 1980s there has been a radical or evolutionary change in the pattern of administration of hospitals in several African countries. Professional staff, especially medical doctors and nurses, currently play a major role in the administration and management of hospitals and other health facilities. The hospital's organogram usually shows that the position of the chief medical director or medical superintendent, usually held by a medical doctor, is an executive position. In other words, the medical or superintendent is the overall head of the hospital and is only accountable to the Hospital Board of Management.

The office of the hospital administrator is therefore under the direct supervision of the medical doctor. Furthermore, with the emergence of (Primary Health Care) in the early 1980s, the role of nurses and public health practitioners cannot be overemphasized. In many African countries, nurses are currently the backbone of primary health care programmes due to acute shortage of medical doctors. This is especially

so in the rural areas where the majority of the people live. As part of their expanded roles, nurses perform the roles of managers and administrators of health facilities.

The implication of this is that nurses must be conscious of the effect of bureaucracy on the delivery of health services. As managers, nurses must be sensitive to the needs of their clients and their client's expectations about public health facilities. One such expectation is efficiency and accountability. Patients / client expect that they should spend as short a time as possible when they come for treatment, yet due to the effect of bureaucracy patients often spend countless hours before they receive treatment. Hence, many patients prefer to receive treatment from traditional healers who, they believe, will not take much of the time. This has a serious implication for achieving the objectives of PHC, because people may develop negative attitudes towards the use of PHC facilities. The roles being played by public health practitioners, such as environmental health officers have also expanded tremendously. The control, prevention and eradication of be reckoned with.

3.4 Government as an Institution of Health Care Delivery

A government is responsible for the overall planning and organization of all the political affair of a country. Its functional capacity ranges over all issues, which can affect the members of the country as a group or as individuals – social, psychological, political, and physical problems. These can be broken down into the following needs: governments often establish various departments or ministries, each specializing in answering a specific need though the responsibilities of these departments may overlap. As an example, let us examine the situation in Nigeria.

The Ministry of Health of the Federal Government of Nigeria, together with those of the states, is the chief provider of health services in Nigeria. Each State Ministry of Health is legally responsible to the Federal Ministry of Health. As an institution of health care delivery, each ministry performs all or some of the following roles:

- Policy making
- Finance
- Planning and Organization
- Educating / Training
- Discipline of workers
- Recruitment of personnel
- International liaison
- Standardization of care

The Federal Minister of Health and one Commissioner of Health in each state are the political head of the health ministries. Next to the Minister in hierarchy is the Permanent Secretary who is a civil servant and responsible for the day-to-day running and organization of the health services. For administrative purpose, the Ministries of health at both federal and state levels are divided into Directorates (e.g. Directorate of Primary Health Care, Medical services, Nursing, Hospital Services, specialist or expert in the field (For example, the Directorate of Nursing should be headed by a nurse). One of the points being made here is that there are several professional, administrative and technical units being supervised by the Permanent Secretary, and that these units, referred to as Directorates, are being administered by the various directors. In each directorate, there is a vertical structure comprising of senior professional officers, principal nursing officers and senior nursing officers; and from one level to the other, there is a vertical relationship. An officer is expected to move from one level to a higher level through promotion.

The role of the Federal Ministry of Health can be divided into four parts:

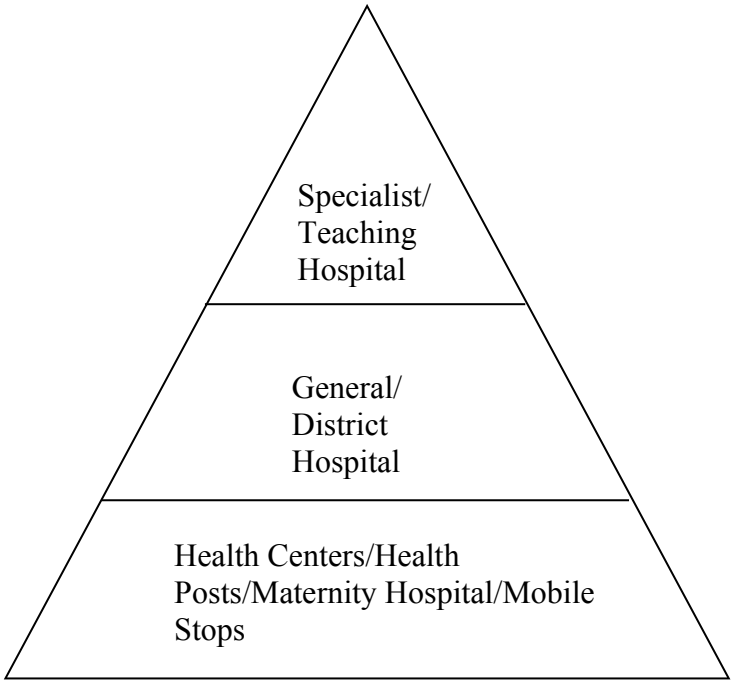
- Policy making
- Liaising between hospitals and international bodies, e.g. W.H.O. and foreign governments.
- The provision of funds for manpower training and establishment of specialized training programmes and research (e.g. in medical schools and teaching hospitals)

- The provision of funds for different state ministries of health, either for capital projects (building of hospitals, medical schools and so on), current expenditure, or reimbursement for training programmes.

At present, because of the Nigerian Government's commitment to decentralize health care though the expansion and improvement of primary health care services, the Federal Ministry established a College of Health Technology in each state of the federation under the primary health care system. These training schools were established to increase the capacity of the government in providing primary health care services to meet the needs of both the urban and rural communities. However, it is important to note that one of the main reasons for establishing the college is to reduce the rural-urban differentials with regards to the availability of health workers in the rural areas.

The Federal Ministry of Health is not directly concerned with the running of the secondary and primary health care facilities; it is the responsibility of the state ministries and local government. Each state has a set of hospitals, which operate a referral system. They are

organized to provide the three levels of care: primary, secondary and tertiary. The types of health facilities in this system are illustrated in Figure 4. However, tertiary hospitals are under the direct supervision of the Federal Ministry of Health.



Level of Health Care and Types of Health Facilities

4.0 CONCLUSION

Hospital is an organization which gives care and treatment which also deals with people and not merely processing machines and tools need to be resourced in terms of human, money and materials both in quality and quantity as the needs of the consumers are multifaceted which must be met in order to be relevant to the society where it operates.

5.0 SUMMARY

The students have been exposed to the types and structure of Health Care Institutions in Nigeria and what has made the institution different from other social institutions within the same society.

6.0 TUTOR MARKED ASSIGNMENTS

Enumerate and explain functions performed by the Federal Ministry of health

7.0 REFERENCES/FURTHER READINGS

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UNIT 3 LEVELS OF HEALTH CARE SERVICES IN NIGERIA

CONTENTS

1.0 INTRODUCTION

This Unit will focus at the various levels of health care services in Nigeria, the functions of each level and how they inter-relate with each other. Health is a subject of concurrent list in the constitution of the Federal Republic of Nigeria as a result of its importance to the teeming population.

2.0 OBJECTIVES

At the end of this Unit, the learner should be able to:

- List the levels of health care services in Nigeria.
- Describe the functions of each level
- Explain the inter-relatedness of the levels.

3.0 MAIN CONTENT

3.1 Organization At Federal Level

The official "organs" of the health system at the Federal level consists of:

(a) The Federal Ministry of Health
(b) The National Council of Health

We shall talk of the organization and function of each one of them.

(a) The Federal Ministry of Health

The Federal Ministry of Health as headed by a Minister. It is a political appointment. Currently, the Federal Ministry of Health has 5 directorates / department. These include:

i. Department of Personnel Management
ii. Department of Finance and Supplies
iii. Department of Planning, Research and Statistics
iv. Department of Hospital Services.
v. Department of Primary Health Care and Disease control.

The following are the responsibilities of the Federal Ministry of Health

i. Take the necessary action to have a review of national health policy and its adoption by the Federal Government.
ii. Devise a broad strategy for giving effect to the national health policy through the implementation by Federal, State and Local Government in accordance with the provisions of the constitution.
iii. Submit for the approval of the Federal Government a broad financial plan for giving effect to the Federal component of the health strategy.
iv. Formulate national health legislation as required for the consideration of the Federal Government;
v. Act as coordinating authority on all health work in the country on behalf of the Federal Government, with a view to ensuring the implementation of this national health policy.
vi. Assess the country's health situation and trends, undertake the related epidemiological surveillance and report thereon to Government.
vii. Promote an informed public opinion on matters of health;
viii. Support State and through them Local Government in developing strategies and plans of action to give effect to this national health policy.
ix. Issue guidelines and principles to help states prepare, manage, monitor and evaluate their strategies and related technical programmes, services and institutions.
x. Promote co-operation among scientific and professional groups as well as non-governmental organizations in order to attain the goals of this policy;
xi. Monitor and evaluate the implementation of this national policy on behalf of Government and report to it on the findings;

International Health

The Federal Ministry of Health shall set up an effective mechanism for the co-ordination of external cooperation in health and for monitoring the performance of the various activities. Within the overall foreign policy objectives, this national health policy shall be directed towards:-

i. Ensuring technical co-operation on health with other nations of the region and the world at large.
ii. Ensuring the sharing of relevant information on health for improvement of international health.
iii. Ensuring cooperation in international control of narcotic and psychotropic substances;
iv. Collaborating with United Nation agencies, Organization of African Unit. West African Health Community, and other International Agencies on bilateral and / or regional and global health care improvement strategies without sacrificing the initiatives of national, community, and existing institutional and other infrastructural arrangements;
v. Working closely with other developing countries, especially the neighbouring states within the region which have similar health problems, in the spirit of technical cooperation among developing countries, especially with regard to the exchange of technical and epidemiological information;
vi. Sharing of training and research facilities and the co-ordination of major intervention programmes for the control of communicable diseases.

(b) The National Council of Health

The National Council of Health is composed of the following members:

i. The Honourable Minister of Health (Chairman)
ii. The Honourable Commissioners for Health (States)

The following are the functions of the National Council of Health.

The National Council on Health shall advise the government of the Federation with respect to:

i. The development of national guidelines.
ii. The implementation and administration of the national health policy; and
iii, Various technical matters on the organization, delivery, and distribution of health services.

The council shall be advised by the Technical committee.

Technical Committee

The Technical Committee of the National Council on Health shall be composed of:

i. The Federal and States Permanent Secretaries (M.O.H)
ii. The Directors of Federal Ministry of Health
iii. The Professional heads in the state Ministries of Health
iii. A representative of Armed Forces Medical Services;
iv. Director of Health Services, Federal Capital Territory, Abuja.

Expert Panels

(a) The Technical committee shall set up as required, appropriate programme expert panels including the representatives of health related Ministries:

i. Agriculture, Rural Development and Water Resources
ii. Education
iii. Science and Technology
iv. Labour
v. Social Development, Youth and Sports
vi. Works and Housing
vii National Planning
viii Finance

(b) Health related bodies

i. National Institute of Medical Research
ii. Medical Schools
iii. Schools of allied health professionals
iv. Non governmental organizations
v. Professional associations (Health) e.g. NMA, NANNM, PSN, among others.

3.2 State Level

At present there are 36 states and the Federal Capital Territory, Abuja and has many types of health administration. In all the states, the management sector for health lies with the Ministry of Health while in some states, Health management Board also participate in the management.

i. State Ministry of Health

Organization: The state Ministry of Health is headed by an Honourable Commissioner, while in Health Management Board, there is governing Board with an Executive Secretary. The Commissioner is the Political head of the Ministry while the Permanent Secretary is the administrative head. There are Directors manning the directorates assisted by Deputy and Assistant directors.

Functions: The State Ministries of Health directs and co-ordinates authority on health work within the State via:

i. Ensuring political commitment
ii. Ensuring economic support
iii. Winning over professional groups
iv. Public information and education
v. Financial and material resources provision
vi. Intersectoral action
vii. Coordination within the health sector
viii. Organizing primary health care in communities
ix. Federal system
x. Logistics system
xi Health Manpower recruitment and retaining
xii. Priority health programmes.
xiii. Health technology.

3.3 Local Level

There are 774 Local Government Areas in Nigeria with various health facilities operating under the hinges of primary health care.

The Local Government Headquarters coordinates the activities of the health facilities providing manpower, funds, logistics and control.

The Local Government is headed by elected Chairmen during political era with council members. Supervisory councillors are also appointed to oversee various aspect of Local Government activities including Health and Social Services. The health department is always headed by a Primary Health Care coordinator.

3.3.1 Functions of the Local Government

- Provision and maintenance of essential elements of primary health care: environmental sanitation; health education

- Design and implement strategies to discharge the responsibilities assigned to them under constitution and to meet the health needs of the local community under the general guidance, support and technical supervision of state health Ministries.

- Motivation of the community to elicit the support of formal and informal leaders.
- Local strategy for Health activities.

Examine this illustration, which provides an overview of health care delivery system at

The three levels of health care i.e. primary, secondary and tertiary levels. As you know a full range of primary health care (first level contact of individual, family and community health system) are being rendered through the agency of primary health centers.
Secondary Health Care is being provided through the establishment of cottage, General Hospitals where all basic specialty services are being made available.

Tertiary care is being provided at Teaching and Specialist Hospitals where super specilaity services including sophisticated diagnosis, specialized therapeutic and reliabilitative services are available.

4.0 CONCLUSION

The health of the population of the Country determines the strength and the future of that country hence the understanding of the levels of health care services in Nigeria is crucial to the learners especially with reference to the adage that says “health is wealth” as a healthy Nation is a wealthy Nation.

5.0 SUMMARY

The learner has been exposed to the three levels of health care services in Nigeria their functions and interrelatedness.

6.0 TUTOR MARKED ASSIGNMENTS

1 List and explain the levels of health care delivery system in Nigeria.
2 Why is not possible for each level to operate in isolation?

7.0 REFERENCES / FURTHER READINGS

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UNIT 4 HOSPITAL AS AN ORGANIZATION

CONTENTS

1.0 INTRODUCTION

This Unit will expose you to hospital as an organization being a system with several components with specialized individuals and the problems faced by this social organization which it has to strife to solve on daily basis.

2.0 OBJECTIVES

At the end of this Unit, the learner should be able to:

- Explain why hospital is an organization
- List four (4) problems of the hospital as an organization
- Discuss (5) characteristics of a hospital

3.0 MAIN CONTENT

3.1 The Hospital as an Organization

This is a social component, and a system made up of people with specialized technology. It has certain characteristics, which differentiate it from other forms of organization. We can describe the hospital as a socio-technical and problem solving system whose main objective is to provide effective health care services (personalized and specialized care irrespective of the fact that the individual can afford to pay or not). As an organization, it formally defines the roles of its members constrained only by it's own socio-technical limitations which are related to its own society / societal demands. Hospital prescribes the demand of its members, the relationship which is task oriented, impersonal authority oriented.

The hospital defines the roles of its members, the hospital is also different when we talk of the levels of cadres and skills of its participants. There are people with extreme different skills, diverse background and all of them must work together to achieve the goals of the hospital, people having general and specialized skills.

Professionals have strong demand for personal independence in their work and they have an aversion to organizational regimentation (they want to be independent in their thinking and functions). However, the hospital can not function effectively without a good deal of compliance with its members with the existing rules and regulations in the hospital of practice. These rules and regulations may be in to the tenents of the professional callings even though the hospital requires that one obeys the rules and regulations you must not compromise patient's care.

3.2 Problems of Hospital as an Organization

Apart from the above distinguished characteristics, hospitals do face some problems which the hospital must address and resolve if it is going to be an effective organization. The following problems must be addressed by the hospital in order to be an effective organization. There are seven problems the hospital must address if it has to survive as an organization viz.

1. Organizational Adaptation

This is the ability of the hospital to adapt itself to the external world and carry on an effective interchange with that world at all times. This may include the ability to respond successfully to relevant changes in its environment, to obtain resources and personnel, maintain advantageous relationship with its community and generally to influence its environment in the ways to benefit the system and its members.

2. Organizational Allocation

This problem deals with the ability of the hospital to deploy, allocate and utilize the available resources which include facilities, fund and personnel in the most appropriate manner. To handle related problems of access to an information among the participants, also to ensure participation among the concerned in decision making process and question of allocation of tasks and functions among departments, groups and members.

3. Problem of Co-ordination

The ability to articulate, interrelate and regulate the activities of various participants. To continually coordinate in time and space in many diverse and interrelated activities of the different members. How does the hospital coordinates the activities of the doctors, nurses, accountant, laundry etc. to contribute to the health care, if the hospital fails to do this, it fails to function as an organization.

4. Organizational Integration

This deals with the ability of the hospital to integrate itself (unite itself). This will include all necessary functions associated with the problem of integrating the individual members into the organization and securing the cooperation. It also includes integrating all parts. Also, development of common organizational values and shared norms, attitudes and mutual understanding must be integrated. Each members need to be socialized into the life of the organization.

5. Organization Strain

This deals with the ability to resolve or minimize and manage the tensions and conflicts which may arise within the organization which must be addressed by the hospital. If it must be effective particularly frictions and confrontations among the key groups. The key groups that are always having frictions are doctors and nurses and others. the hospital must also look at the strain among highly interdependent groups and members and among unequal status participants (Nurses and cleaners, professional and non-professionals) the hospital must try to manage stress and strain throughout the system, hospital can set up grievance committees.

6. Organizational Output

The hospital must possess the ability to reach and maintain high levels of output if it is going to be an effective organization in terms of quality, quantity, acceptability and cost.

The hospital deals with patient-care and provision of health services to the community, in order to attain the high level of quality, quantity, acceptability and cost, there must be qualified staff, enough staff, needs of the community must be met and at affordable cost. The problem of output will also involve the ability to maximize the efficient and reliable performance by all department, groups and members. This assumes that a system of personal goal achievement and job satisfaction on the part of the members is entrenched.

7. Organizational Maintenance

This is the ability of the hospital to preserve it's identity and integrity as a distinct and unified problem – solving system or to maintain itself and its basic character and viability in the face of changes which are constantly occurring in its environment. The hospital must look for a way of maintaining itself.

4.0 CONCLUSION

The hospital has distinguished characteristics which makes it unique, the hospital has its own socio-technical personnels that delivers qualitative service. The hospital prescribes the demands of its members, the relationship which is task oriented, impersonal and authority oriented. But despite all these characteristics, hospital has its own inherent problems which it should always strife to find solution to.

5.0 SUMMARY

The unit has presented to the learners a hospital as an organization and problems encountered by this unique social institution.

6.0 TUTOR MARKED ASSIGNMENT

1. List and discuss five (5) problems faced by the hospital as an organizations.
2. What is the relevance of hospital as an organization to man?

7.0 REFERENCES/FURTHER READINGS

Akinsola, H.A (1993) A to Z of Community Health and Social Medicine in Medical and Nursing Practice

MODULE 2

Unit 1 Hospital as a system
Unit 2 Hospital by departmentation
Unit 3 Communication in the Hospitals
Unit 4 Effective communication through organizational structure

UNIT 1 HOSPITAL AS A SYSTEM

CONTENTS

1.0 INTRODUCTION

Scholars concerned with the administration of complex organizations began to view an organization as a system in the late 1950s. To understand a phenomenon we must recognize that the whole is greater than the sum of the parts. In other words, the systems view point challenges the reductionist approach where the individual part is the level of analysis and emphasizes that "it the whole, the combination and interrelationships of parts that will provide the greatest insight" (Mitchel, 1978).

2.0 OBJECTIVES

At the end of this Unit, the learners should be able to:

- Explain what a System is
- List the types of Systems
- List the basic system concepts relevant to hospital

3.0 MAIN CONTENT

3.1 Definitions

There are several definitions of the term ‘systems’. Some of these are provided below:

1 Hall and Fegen (1956) defined a system as ‘ a set of objects together with relationships between the objects and between their attributes’.

2. To Flagle, Huggins and Roy (1960), a system is ‘an integral assembly if interacting elements designed to carry out cooperatively a predetermined function’.

3. Griffiths (1964) defined a system simply ‘as a complex of elements in interaction’.

4. Choforas (1965) viewed a system as ‘a group of interdependent elements acting together to accomplish a predetermined purpose’.

5. According to Berrien (1968), a system is ‘a set of components interacting with each other and a boundary which possesses the property of filtering both the kind and rate of inputs and outputs to and from the system’.

6. A system can be defined ‘as a complex of elements standing in interaction’ (Bertalanffy, 1968).

7. Rapoport (1968) viewed a system as:

   (1) Something consisting of a set of (finite or infinite) entities; (2) among which a set of relations is specified, so that, (3) deductions are possible from some relations to others or from the relations among the entities to the behaviour or history of the system.

8. Blendinger (1969) sees a system as ‘an organized ‘something’ that has direction to it and some degree of internal unity. The structure of organization of an orderly whole which clearly shows the interrelationships of the parts to each other and to the whole itself’.

9. According to Immegart and Pilecki (1973) a system is ‘an entity composed of (1) a number of parts, (2) the relationships of these parts, and (3) the attributes of both the parts and the relationships’.

10. Kast and Rozenzweig (1979) viewed a system as ‘an organized, Unitary whole composed of two or more interdependent parts, components, or sub-systems and delineated by identifiable boundaries from its environmental suprasystem’.

11. Sherlekar (1984) defined a system as 'an organized complex whole, combination of things or parts forming a complex or Unitary whole'.

3.2 Hospital as a System

From the foregoing definitions, two basic threads serve as a common denominator. These are that a system comprises:

(a) 'elements' or 'parts' or 'objects' or 'components' and
(b) the use of the term 'interdependent', 'interrelated' or relationships, which indicates that the parts and their properties are 'tied together in time and space. However, the general system theory is concerned with the study of the system as whole. It holds that to understand the whole, begin with the whole and not with the components.
Buffa (1976) has identified five points that convey the essence of the systems approach.

These are:

1. Defining the problem in systematic terms originally.
2. Taking the system as a whole as the starting point.
3. Representing the complex interactions among the components.
4. Recognizing the need for compromise and trade-off among competing criteria and values.
5. Predicting the performance of the system as a whole prior to the creation of the system.

A systems approach to hospital administration attempts to view the school as a unified, purposeful organization, or as a system composed of interrelated parts. It maintains that instead of dealing separately with the various parts, hospital administrators should look at the system as a whole. This is due to the belief that the activity of any part of the hospital system goes on to affect that of every other part.

3.3 Types of System

All systems can be divided into two classes: These are natural and man-made or designed systems. Natural systems refer to a collection of connected, coordinated, naturally occurring objects. For example, the solar system comprising the sun and the planets that revolve around it. The man-made systems consists of many sub-classes. Lee (1970) has identified four of them as procedural, physical, social and conceptual.

By procedural systems, Lee meant a coordinated set of consistent principles, rules and procedures which may, or must, be followed to resolve or solve problems or perform some tasks. For example, Mathematics may be regarded as a collection of self-consistent, co-ordinated principles, rules and procedures. It consists, among other things, of the means of calculating solutions to specific problems by means of entering specific numerical values into generalized procedural formulas. Legal systems are also procedural systems.

Man-made physical Systems are coordinated and connected assemblies organized collections of physical elements intended and designed to serve a common purpose. For example, the braking system, or the clutch system of a car.

Social systems are organized and coordinated groups of people working together to serve mutual interests and perhaps to achieve a common purpose. In health administration, is primarily concerned with social systems such as the hospital.

Finally, the Conceptual System is a class of a consistent theory, or coordinated body of facts, principles and hypotheses by which some aspect of reality may be ordered, explained or understood e.g., the Newtonian system.

3.4 Basic System Concepts of Relevance to Hospital Organizations

Several concepts have been offered by system theorists, some of which are useful for the understanding of hospital administrator. A number of these relevant concepts are highlighted and discussed below:

Components: Refer to the parts - the smallest meaningful units that interact with each other to fulfill the purposes of the system.

Boundary*:* Is more or less arbitrary demarcation of units that are included within and that are excluded from the educational system. It is the boundary that separates the system from its environment and filters the inputs to and outputs from the system.

Environment: Refers to everything (physical and social factors) external to the system (i.e., its boundary) that has the potential to affect all or part of the organization. Every system, sub-system or supra-system has an environment.

Inputs: Those messages or stimuli that trigger off the internal components of a system to perform those activities for which the system was designed. Such inputs may take the form of people, materials,

money, and / or information. Inputs are all elements that enter the system across its boundary. Inputs cause or enable the components to interact or affect the ways in which the components interact in fulfilling the system's purpose(s). Although inputs can be relatively diverse or uniform, Buckley classified them as being only two types, energy and information:

(a) **Energy Inputs:** Physical materials or forces are imported to the system and enable the components to move and therefore to interact physically. The energy inputs to hospitals as systems include fuel, electricity, air and sunlight entering from the environment and the caloric energy the people bring (from the foods and beverages they infest) that enables them to move about and work.

(b) **Information Inputs:** Signals that enter the system and indicate to the components how or when they are to interact. Information inputs to hospital include students' actions and statements, community members' comments, legislative mandates, Ministry of Health or Health Management Board's directives, and all messages that affect the **interactions among components.**

Outputs: Refer to all that the system produces, either by design or accidentally. That is to say that outputs can be intentional or unintentional. A system's output always entails altering the inputs.

Open Systems: Have relatively highly permeable boundaries. Consequently, they receive inputs and provide outputs.

Closed Systems: Have relatively rigid, impermeable boundaries; as such there are very few inputs / outputs - i.e., few exchanges of energy and information with the environment points out that no social system as being relatively closed or open.

Subsystem: Refers to a system that exists within a larger system. All systems, except the very smallest, are composed of sub-systems, if the hospital is taken as a system, then administrative and support services units/departments and wards can be considered as its sub-systems.

Supra system: A larger system of which a particular system is a part. For example; a hospital can be considered as a system, existing within a larger system, hospital district / General hospital. In this case, the hospital is a sub-system with respect to the district, and the district is a supra system with respect to the Teaching hospital.

Equilibrium: The tendency of a system to achieve a state of balance or stability among the many forces or factors operating upon the system or within it. Chin distinguishes between two different types of equilibrium, namely; stationary equilibrium and dynamic equilibrium. A stationary equilibrium exists when there is a fixed point or level of balance to which the system returns after a disturbance. A dynamic equilibrium (also referred to as a steady state) occurs when the equilibrium shifts to a new position of balance after disturbance.

Disequilibrium: A state of instability or imbalance in which some components of the system overload others.

Entropy: Related to the concept of organizational equilibrium. It is the tendency of organizations overtime to move towards randomness, chaos, disorder, lack of patterning, disorganization or 'death'; that is, the tendency towards a decrease in order and an increase in disorder within an organization.

Negatropy: The tendency of an organization to combat 'death' or disorganization (entropy). It is also referred to as negative entropy.

Equifinality: Refers to 'a property of a system which permits different results from similar inputs and similar results from alternate inputs'. In other words, it is a condition where identical output conditions appear to be derived from different initial inputs, and identical inputs appear to achieve different results. The application of the concept to organizations suggest at least three ideas.

1. The initial inputs to an organization do not determine the extent to which a goal will be realized; that is, organizations such as the hospital may have differing levels of inputs in terms of human and fiscal resources, teaching methods, facilities and have similar goal achievement (outputs).

2. Organizational outputs may vary widely, even-through the inputs are 'equal'.

3. There is no 'best way' to achieve a given organizational goal; rather, there may be a number of acceptable alternatives ways. Lipham and Hoeh (1974)0 point out that the principle of planning, organizing, simulating, coordinating and evaluating. Any one or a combination of these activities may lead to equally desirable outcomes.

Feedback: The process through which the organization learns. It is the input from the environment to the system, telling it how it is doing as a

result of its output to the environment. In other words, feedback refers to response to output which enables a system to modify its subsequent functioning. Granger (1971) simply refers to it as 'a return communication or reaction to information processing behaviour'. Silver (1983) put it more lucidly when he states that feedback is the process which entails drawing some of the system's outputs back into the system as information inputs, so that possible discrepancies between intended outputs and actual outputs can be sensed.

Feedback may be either positive or negative. Positive feedback is information that there is no discrepancy, that the outputs are those intended. It serves to reinforce the system's action. negative feedback is in opposition to a system's action and stimulates the system to corrective activity in order to adapt to change - that is, to maintain a steady state in order to be able to fulfill the system's purpose.

Synergy: That the whole is greater than the sum of its parts. In hospital administration, this implies that as the separate departments within the hospital or hospital board or Ministry of Health cooperate and interact, they become more effective, efficient and productive than if they had acted in isolation.

Flow: A term sometimes used to refer to both inputs and outputs. For example, a system such as the hospital has flows of information, energy, material, students and other resources (including human). These enter the system from the environment as inputs and exit the system as outputs (services, educated persons).

Throughput: Also referred to as the 'black box' or 'transformation process', or 'conversion process', it is the processing of information energy and resources available to social or open systems.

4.0 CONCLUSION

Hospital is a such a complex system that a better understanding of this by the hospital administrators and even the society will help the hospital to meet its purpose. Hospital is essential to man in order to promote health, prevent illness, treat disease and rehabilitate in order to prolong life.

5.0 SUMMARY

The Unit has presented the hospital a system, the complexity of the hospital, various types of system were discussed and basic systems concepts of relevance to hospital organizations.

6.0 TUTOR MARKED ASSIGNMENTS

Why is Hospital a social system organization?

7.0 REFERENCES / FURTHER READINGS

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UNIT 2 HOSPITAL BY DEPARTMENTATION

CONTENTS

1.0 INTRODUCTION

Departmentation involves grouping of workers or activities with similar characteristics into a single department or unit. This facilitates communication, coordination and control thus contributing to the success of the hospital. It creates semi-autonomous units with independent responsibilities, providing satisfaction to the managers which in turn improves efficiency and effectiveness. It also facilitates control and supervision thereby making the expansion of the hospital easier to handle.

This unit will expose the learner to various departments in a typical hospital and their interdependence in nature.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Explain the concept of departmentation in the hospital setting
- Discuss the various departments in a typical hospital.

3.0 MAIN CONTENT

3.1 Hospital by Departmentation

Globally, World Health Organization having charged as an organ of UNO to act as the world's directing and coordinating authority on human health, the aim of departmentalization in the health sector is the mutual understanding and solution of patients physical, social and emotional problems. But the operative human element among the health workers including the administrative officers militates strongly against this aim. The value of any system to an degree of effectiveness of the services rendered collectively by the organization. Structural and

functional capabilities in the health sector which annually receives a sizable investment in men, money and materials, depend on the commitment of the health workers themselves.

Human relations advocates disturbances of human reactions and communication as a central problem in the hospital system. Staff conflicts and administrative disturbances occasioned by intra and extra professional infighting and malice have influence on patient care and staff behaviour. While functions differ in duration, intensity and possibly in importance, the departments performing them are equally important from the administrative and professional points of view. Perhaps, this is why in Britain uniform weekly wages are paid to cleaners, managers and factory workers, and so on. Organization must have various departments, including those that must cope with emergencies, such as the security, intensive care unit, casualty, and so on, for effective health services and administration.

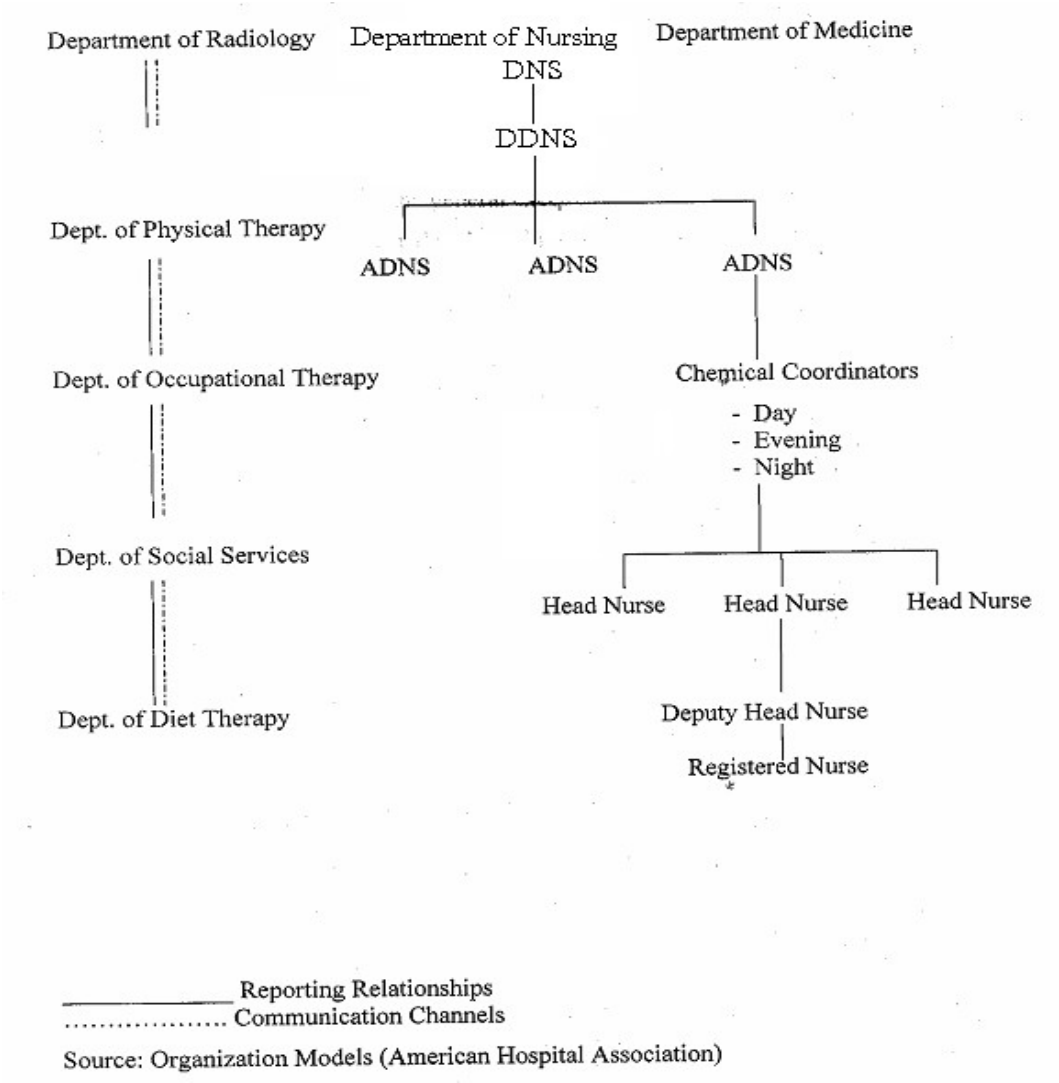
Departmentalization is designed to make matters and works to progress in definite arrangement possible so that an individual role - player in an organization needs detail information only about the behaviour of the individuals in his own unit but an aggregate summary information about the average behaviour in the other units. It ensures that each unit is responsible for a specific function and that it is not subordinate to the others as in lateral relationship; although they are all accountable to the line management.

In respect to their expert knowledge, professionals or the heads of department are always consulted before decisions are taken pertinent to their functions. As an example, the Heads of Departments are consulted by the management when decisions are being taken on the enquiry reports and recommendations on the activities of their subordinates as well as on matters on promotion and placement. They have sufficient authority to act within the frame work in the approved policy but must direct their actions through the executive or superior in the line organization.

Integration and adaptation of hospital as a social system depend on the acquisition and conformity to the cognitive, catechetic and normative definitions of the group of workers therein. Is the social relationship among the workers such that facilitates maximum participation by health team members? It has been observed that human conformity depends on the individual’s definition of the word, conformity. According to Jensen any social structure include attitudes, traditions, symbols, codes and thought contents.

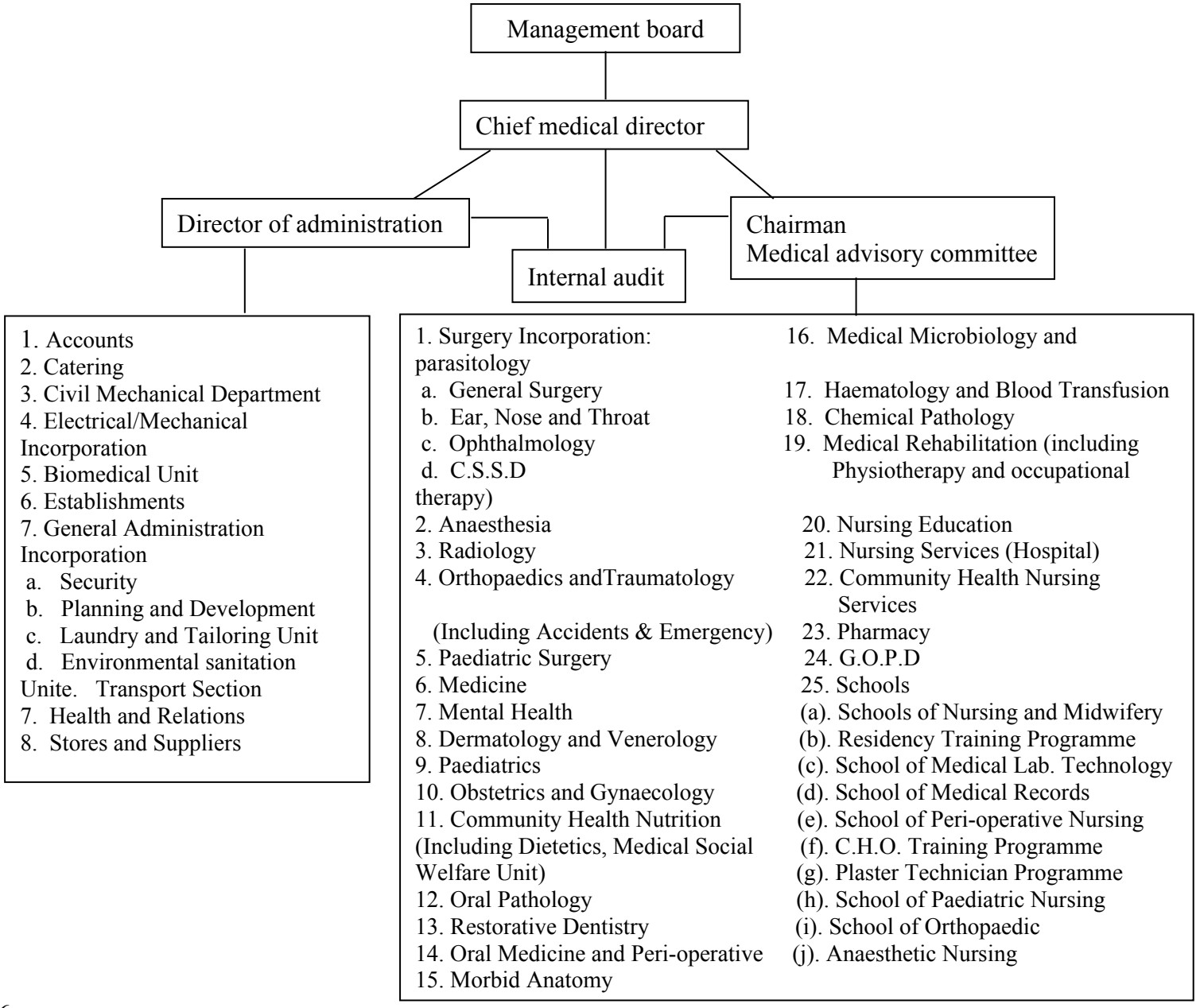
The limit of the capabilities of a health institution is determined by the resources available as well as on the attitude of those found or run it in terms of their interest in the organization activities, the results of the activities towards the total system and to the participants. The fixed social structure in a care setting undoubtedly given an aspect of performances which act as a stabilizing force on these activities. However attitudes, traditions, symbols, codes and egos should not be allowed to obstruct effective and willing cooperative participation. People in the healing professions should see themselves as those who foster and facilitate the healing process that goes on within the patient and bear in mind that the establishment of a healthy therapeutic relationship among the health providers reduces patient's anxiety and enhances effectiveness of the health care delivery. Rather than conflict, rivalry, envy and jealousy must be accepted and utilized in their right context as healthy, inevitable and progress prone factors in any human organization - even religious ones.

Such behaviours devoid of bitterness and rancour catalyzes the processes for personal and professional progress and developments.



Source: Organization Models (American Hospital Association)

The component units in the health care sector should on continuous basis be given commensurate responsibility, authority and resources to prosecute their individual activities, and made accountable. The units must be taken along in the short-and-long-term planning and if each makes and submits it a estimates it should be allowed to expend the money on its activities and render account to the general executive. This is the only way by which prudent spending on health can be expected and maximum health attained.



ORGANOGRAM OF A TYPICAL TEACHING HOSPITAL

4.0 CONCLUSION

Departmentalization makes decisions easier as they are made at a point near the operation, they are fast, thus making the divisions flexible to adopt to any changes that might occur. Also, it releases top management for more important central decisions. The expansion is easier since any other facility can be added if necessary.

It also makes for job delineation, accountability easier and communication better without much hinderance; although it has its own disadvantages but if properly and rationally used, it is more advantageous to the organization.

5.0 SUMMARY

The learner has learnt about departmentalization of a typical hospital especially teaching hospital which is a supposedly a referral centre. Departmentalization in hospital has its advantages and disadvantages such as duplication of work since each division will have its own staff and specialists. Also, since each division is responsible for profit and loss, sometimes the divisional interests may take priority over organizational goals.

6.0 TUTOR MARKED ASSIGNMENTS

1. Departmentalization has some inherent problems but despite this, it has its own usefulness to the organization and the workers, how?
2. List and describe the major departments in a Typical Teaching Hospital in Nigeria.

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UNIT 3 COMMUNICATION IN THE HOSPITALS

CONTENTS

1.0 INTRODUCTION

Communication is considered to be the most important and most effective ingredient in the hospitals. It is the vehicle through which the basic hospital management functions are carried out. Managers and administrators direct through communication, they coordinate through communication and they staff, plan and control through it. Hardly an action is taken in any organization without communication leading to it. Interpersonal communication is fundamental to all hospital activities.

Many operations have failed because of poor communication, misunderstood messages and unclear instructions. Even in life, in general, communication plays a very important role among friends, within the family and in all social circles.

Communication is the process of passing information and understanding from one person to another. It is transmitting and sharing of ideas, opinions, facts and information in a manner that is perceived and understood by the receiver of the communication. It is a meaningful interaction among people where the thoughts are transferred from one person to another in a manner such that the meaning and value of such thoughts is same in the minds of both the sender as well as the receiver of the communication.
In this unit, the learner will learn the concept of communication, the purposes, communication process, types and directions of

communication in organization, communication networks, barriers to effective communication and how to overcome communication barriers in the hospital set-up.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Explain the concept of communication
- State the purposes of communication
- Discuss the communication process
- List the types and direction of communication
- Explain the communication barriers and how to prevent and treat communication barriers in hospital organization.

3.0 MAIN CONTENT

3.1 The Purposes of Communication

Of all the management activities, none takes as much times as that of communication. If communication is hampered, the entire organization suffers, when it is accurate, thorough and timely, the organization can move effectively toward goal achievement. There at least four major purposes served by communication in a hospital system:

1. To influence the performance of organizational members - to motivate, direct, instruct and evaluate.
2. To clarify and express feelings
3. To serves as an information input or exchange.
4. To control (Scott and Mitchel, 1976).

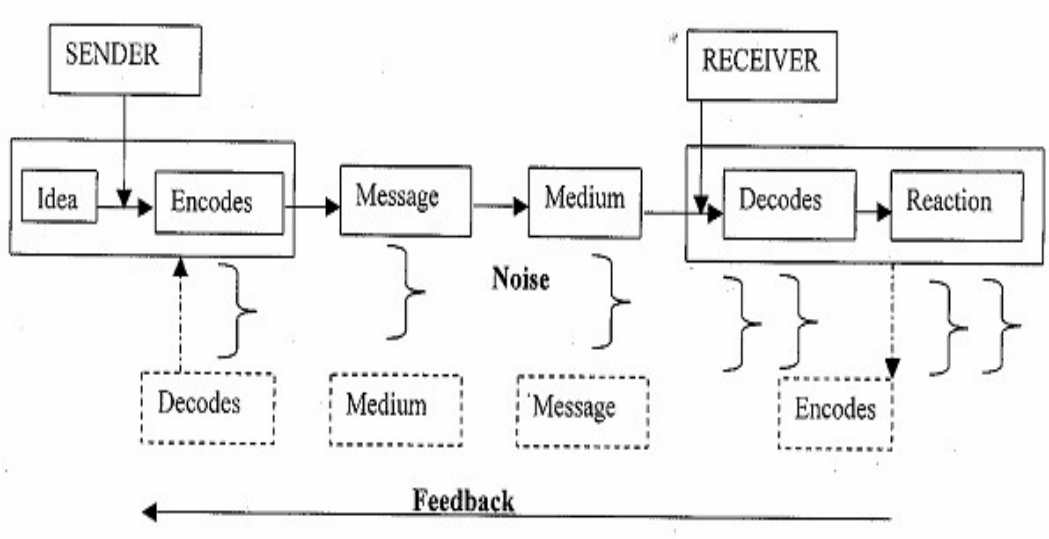
3.2 The Communication Process

In its most basic form, the communication process involves a sender, a message and a receiver (Wofford and Commins, 1977; Haney, 1973). This simple model shown shows the three essentials in communication.

3.3 Simple Communication Model

Indicating that if one element is missing, no communication can take place. As stoner (1978) points out in relation to this fact, 'We can send a message, but if it is not heard or received by someone, no communication has occurred'.

However, the basic elements of communication are more than just the three mentioned in the simple model, as can be seen. This shows that there are a number of critical elements in communication. These are the sender, encoding, the message, the medium, the receiver, feedback and noise. The process can be briefly described as follows: there is an individual or group (sender) who has an idea to transmit to another individual or group. In order to do so, the sender transforms the idea or message into a meaningful form (encoding) and sends it by written or verbal means (the medium). The message is received by the receiver and decoded (translated into a form meaningful to them or the group). The receiver acknowledges receipt of the message and reacts (or does nothing about it) or responds (feedback). The intended message can be distorted (noise) at any stage in the process.



Critical Elements in the Communication Process

3.4 The Communication Process

The Idea: The first critical element of the process is an idea, thought or impulse in the mind of the sender or communicator. The intent or idea may or may not be sufficiently clear to be communicable to the receiver.

The Sender*:* He / She is the source of intiator of the communication. In an organization such as the school, the sender is a person with the needs, desires, ideas, intentions, information and a purpose for communicating.

Encoding: This involves translating the sender's intent or ideas into a systematic set of symbols or gestures so that the receiver can understand what is being communicated. The major form of encoding is language.

The Message: The result of the encoding process is the message. It is the physical form into which the sender encodes or expresses the information. This may take the form of speech, written or gestures.

The Medium: This is the channel through which the message is carried; that is, it is the carrier of the message. In schools this may take the form of telephone, face-to-face communication, group meetings, written records or memos, reports, etc. Nonverbal media are gestures or body movements, facial expressions tone of voice, etc.

The Receiver: This is the recipient of the transmitted message. There may be several individual receivers for any given message.
Decoding: It is a technical term for the thought processes of the receiver in translating or interpreting what is heard or sensed. Receivers interpret (decode) the message in light of their past experience and various personal frames of reference, In general 'the more the receiver's decoding matches the sender's intended message, the more effective the communication has been'.

Feedback*:* This is the process by which the communication roles are reversed; that is, the sender in turn receives a message about the impact of the original message, even though it may not be expected, direct, or immediate. Thus, the communication process tends to be cyclic, not linear.

Kreitner (1977) has identified three types of feedback usually found in organizations, namely: information, corrective and reinforcing. Informational feedback does not stress whether something is right or wrong. It is therefore not evaluative; it is the information that one person gives to another that may be of value to the work of the first. Corrective feedback is evaluative and instructional because it deals with the need of the receiver to correct something in the sender's message.

Reinforcing Feedback. Occurs when a particular message that has been sent clearly and / or correctly is followed by a positive acknowledgement by the receiver.
Noise: This refers to anything that disrupts or distorts, filters or interferes with the intended message. Although interference can occur at

any stage of the communication process, Gibson et al., (1973) have observed that most interference arises at the encoding and decoding stages.

Responses*:* It should be noted that on the basis of understanding or decoding, the receiver responds - does nothing, carries out the order, stores the information.

3.5 Types and Directions of Communication in Organizations

Types of Communications

There are three methods available to the administrator in a school for sending messages in the social system: verbal, written and combination.

Verbal Communication. This is the use of the spoken word either in a face-to-face setting or through telephone calls. It is by far the most prevalent form of communication in schools, and is also referred to as oral communication.

Written Communication. In organizations such as the school that can take many forms, including letters, memoranda, telegrams, annual reports, procedure manuals, notes, newsletters and other publications.

Combination Process. This involves the use of written and verbal communication.
Directions of Communication Flow in Schools
There are a number of possible distinct directions of communication flow within a school; vertical, downward, upward, horizontal and diagonal.

Vertical Flow. Vertical Communication includes both downward and upward flow of information through the chain of command, i.e., between superiors and subordinate in an organization such as the school. It is a two-way communication process.

Downward Communication. This flows from individuals as higher levels of the hierarchy to those at lower levels in an organization. It may either be written or verbal. It is usually conceived of as paralleling the school's hierarchy of authority. The most common forms of downward communications are official memos, organizational publications, policy state3ments, manuals, procedures and so on. The main purposes of downward communication is to direct, command the instruct. Katz and Kahn (1978), however, have suggested five basic purposes served by downward communication:

1. to provide specific task directives or job instructions;
2. to provide information about the rationale of a job;
3. to provide information about organizational policies, procedures and practices;
4. to provide subordinates with performance feedback.
5. to present information of an ideological nature to assist in the inculcation of goals.

Downward communication may also be used to inform employees about an organization's goals and about changes faced by it.

Upward Communication. This is communication that flows from subordinate to superior. It is that form of communication that originates at the lower levels in the organization and flows to the higher levels; while upward communication is necessary to provide feedback on downward communication, it does not occur where subordinates do not trust superiors and fear reprisal. The main function of upward communication, is to supply information to upper levels about what is happening at the lower levels. This type of communication includes progress reports, suggestions, explanations and requests for aid or decisions. However, four major types of information involved in upward communication: '(1) the level of performance and achievement of employees, (2) identification of any unresolved problems and issues faced by employees; (3) ideas and suggestions for improvement in an organization; and (4) how employees generally feel about their jobs, fellow employees and the organization.

Horizontal (Lateral) Communication. Horizontal communication includes all transmissions of information that flow laterally within an organization. It takes place (a) between employees on the same level, (b) between or among peers within the same work group, or (c) between groups of equivalent status across departmental boundaries. Horizontal communication frequently occurs through meetings, written memos and informal interpersonal communication. Horizontal communication facilitates organizational coordination (between units) and problem-solving and enables organization members to form relationships with their peers.

These relationships are an important part of employee satisfaction. Finally, lateral communication often reduces the communication burden of superiors and also reduces communication inaccuracy by putting the relevant people in direct contact with each other.

Diagonal Communication. It refers to all transmissions that cut across an organization's chain of command. It most often takes the form of interactions between line and staff. Although diagonal communication

probably is 'the least - used channel of communication in organizations, it is important in situations in which members cannot communicate effectively through other channels'.

3.6 Communication Networks

Communication networks refer to the patterns of communication channels in a social organization. There are several possible networks. It need to be pointed out that at least in principle (and to a high degree), as the number of people in a group increases arithmetically, the number of possible interrelationships increases more rapidly than a group size does. For example, in a group of five people, there are N(n-1) ½ or 10 channels of communication possible.

Hospital administrators can design their work units in such a way as to facilitate effective communication between component units within the hospital. Networks serve different purposes in organizations such as (a) regulate behaviour, (b) promote innovation, (c) integrate activities, or (d) inform and instruct group members.

Communication networks differ in terms of centralization and decentralization, as well as in terms of their effectiveness, efficiency and member satisfaction. Of the four most common networks, the all-channel and circle networks are highly decentralized, whereas the Y and Wheel are more highly centralized. The wheel or star is the most centralized network because all communications flow from and to any one individual, while all - channel network is the least centralized, i.e., most decentralized. The research findings of a number of researchers have revealed that network effectiveness depends on situational factors. For example, the Wheel and the Y networks are more effective in accomplishing simples tasks while the circle and the all – channel are more effective on complex tasks.

Furthermore, individuals in more central positions in the network tend to be more satisfied. Since individuals in the all - channel and circle networks are equally central, these two networks tend to produce higher levels of total member satisfaction. Effective communication is very important for the effective working of a unit / department but difficult to achieve. A number of barriers are responsible for ineffective communication.

3.7 Seventeen Barriers To Effective Communication Are:

1. People using symbols having different values
2. Members of a group having different values
3. Members of a group having difficult perceptions of a problem

4. Members laying emphasis on status
5. When there is conflict of interest
6. Making decisions by majority vote rather than seeking consensus.
7. Attempts to keep feelings out of a decision.
8. Use of words to present thinking.
9. Lack of desire to understand the other person's point of view or feelings or values or purposes.
10. Lack of acceptance of diversity
11. A one-way concepts of cooperation
12. Feeling of superiority
13. Vested interest.
14. Feeling of personal insecurity
15. An obvious attempt to sue.
16. The concepts that the sender and receiver have of their roles.
17. Negative feelings about a situation.

3.8 Overcoming Communication Barriers In The Hospital

A hospital administrator and others within the hospital system, who from time to time initiate communications for purposes of attaining objectives and goals, can prevent barriers to communication if proper care is exercised and the following points taken into consideration.

1. Use clear and concise words.
2. Select proper channels to convey messages, that is, use the channel that is most appropriate for the situation.
3. Encourage feedback.
4. Use multiple channel(s) of communication that will work most effectively with those you want to communicate (personal discussion, memo, etc) with.
5. Use face-to-face communication wherever necessary.
6. Use repetition if the message is complicated or necessary.
7. Follow up important verbal discussions with a note.
8. Be sensitive to educational or official status.
9. Carefully cross-check by reading through letters or memos that are ready for dispatch.
10. Establish proper communication climate by establishing mutual thrust between you (the sender) and the receivers (clients, patients & others colleagues etc.) and also maintain credibility.
11. Regulate information flow and use the informal communication channels (use the grapevine).
12. Time messages properly.
13. Develop effective communication skills, including listening skills.
14. Remove inter-group hostility.
15. Be mindful, while you communicate, of the overtones as well as the basic content of your message.

16. Take the opportunity to convey something of help or value to the receiver(s).
17. Be sure your actions support your communication.

3.9 The Seven Commandments Of Communications

There are seven commandments that are expected to guide communication process in order to achieve effective communications. These are:

1. **Credibility**. The receiver must have confidence in the sender. He must have high regard for the source's competence on the subject. This climate of belief starts with and is built by performance on the part of the practitioner.

2. **Context**. A communications programme must square with the playback. The context should conform with and not contradict the message.

3. **Conten**t. The message must have meaning for the receiver and must be compatible with his value system. It must have relevance for him. The context determines the audience, since in general people select those items of information which promise them the greatest rewards.

4. **Clarity**. The message must be put in simple terms. Words must message has to travel, the simpler it must be. An institution must speak with one voice, not many voices.

5. **Continuity and Consistency**. Communication is an unending process. It requires repetition to achieve penetration. The story must be consistent.

6. **Channels**. Established channels of communication should be used channels that the receiver receives and respects. Creating new ones is difficult. Difficult channels have different effects and serve effectively in different stages of the diffusion process.

7. **Capability of Audience.** Communication must take into account the capability of the audience. Communication are most effective when they require the least effort on the part of the recipient. This includes factors of availability, the receiver's knowledge.

4.0 CONCLUSION

Communication is a dynamic process. It is an indispensable process in hospital setting because it is the means by which decisions are made and implemented. The effective and efficient accomplishment of health goals and objectives depends very much upon effective communications with a variety of people, including clients, patients and other hospital workers personnel. In the light of this fact, the structure of a hospital should be adaptable not be a barrier to communication. The absence of confusing lines of authority and overlapping functions, the presence of proper procedures and adequate co-ordination mechanisms as well as better communication between and among units tend to facilitate communication within a hospital and its external environment.

5.0 SUMMARY

This unit has exposed the learner to a wide range of issues in communication as communication is a pivot of any organization as lack of adequate communication will lead to lack of trust and confidence among the workers and the employer and may lead to suspicious behaviours of all parties in the hospital organization including the clients and patients.

6.0 TUTOR MARKED ASSIGNMENT

1. Why will large hospitals with many hierarchical levels have more communication problems than small ones with only a few levels?
2. Why is effective communication is so important in a hospital setting?

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UNIT 4 EFFECTIVE COMMUNICATION THROUGH ORGANISATIONAL STRUCTURE

CONTENTS

1.0 INTRODUCTION

Communication is a tool that stands out in our day to day life. It is a process by which messages are transmitted from one person to another person or groups with a view of bringing about changes in behaviour.

An understanding of communication will assist to determine, plan and implement effective and efficient care.

In this unit, we shall look into how organizational structure will enhance effective communication.

2.0 OBJECTIVES

At the end of this Unit, the learners should be able to:

- Explain what a communication is
- List the types of communication
- Explain the process of communication
- Explain how organizational structure enhances effective communication

3.0 MAIN CONTENT

3.1 Types of Communication

The various types / methods of communication are:

- Verbal (oral)communication: This includes speaking, speeches, lectures.
- Non-verbal communication: This includes facial expressions, gestures, physical contact, voice tones, personal appearance, time and space management.
- Visual communication: Logos as in billboards advertisement, stickers.
- Written communication: Books, letters, reports, statistics, internal memos, newpapers, journals, news magazines
- Use of information technology: This includes computer, telephone, telex, fax, e-mail.

3.2 The Process of Communication

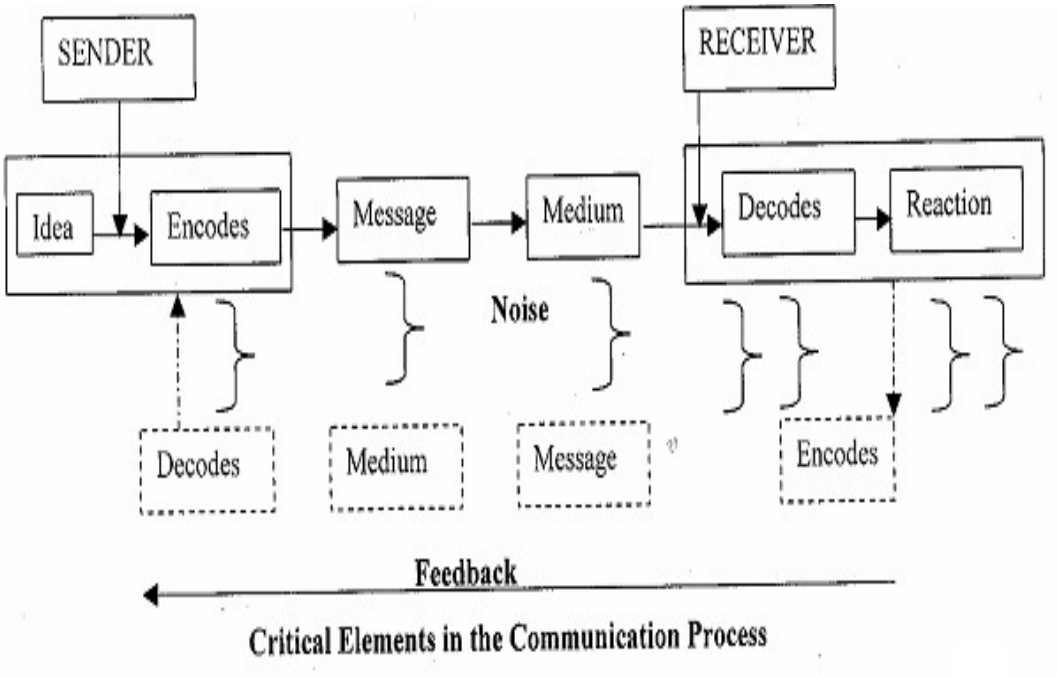
In its most basic form, the communication process involves a sender, a message and a receiver. This simple model shown which shows the three essential communication.

Sender ⟶ Message ⟶ Receiver

3.3 Simple Communication Model

Indicating that if one element is missing, no communication can take place. “We can send a message, but if it is not heard or received by someone, no communication has occurred”.

However, the basic elements of communication are more than just the three mentioned in the simple model, as can be seen below which shows that there are a number of critical elements in communication. These are the sender, encoding, the message, the medium, the receiver, feedback and noise. The process can be briefly described as follows: there is an individual or group (sender) who has an idea to transmit to another individual or group. In order to do so, the sender transforms the idea or message into a meaningful form (encoding) and sends it by written or verbal means (the medium). The message is received by the receiver and decoded (translated into a form meaningful to them or the group). The receiver acknowledges receipt of the message and reacts (or does nothing about it) or responds (feedback). The intended message can be distorted (noise) at any stage in the process.



The Communication Process - The Critical Concepts Explained

The Idea*:* The first critical element of the process is an idea, thought or impulse in the mind of the sender or communicator. The intent or idea may or may not be sufficiently clear to be communicable to the receiver.

The Sender*:* He / She is the source of initiator of the communication. In an organization such as the school, the sender is a person with the needs, desires, ideas, intentions, information and a purpose for communicating.

Encoding*:* This involves translating the sender's intent or ideas into a systematic set of symbols or gestures so that the receiver can understand what is being communicated. The major form of encoding is language.

The Message: The result of the encoding process is the message. It is the physical form into which the sender encodes or expresses the information. This may take the form of speech, written or gestures.

The Medium: This is the channel through which the message is carried; that is, it is the carrier of the message. In schools this may take the form of telephone, face-to-face communication, group meetings, written records or memos, reports, etc. Nonverbal media are gestures or body movements, facial expressions tone of voice, etc.

The Receiver: This is the recipient of the transmitted message. There may be several individual receivers for any given message.

Decoding*:* It is a technical term for the thought processes of the receiver in translating or interpreting what is heard or sensed. Receivers

interpret (decode) the message in light of their past experience and various personal frames of reference, In genera, 'the more the receiver's decoding matches the sender's intended message, the more effective the communication has been'.

Feedback*:* This is the process by which the communication roles are reversed; that is, the sender in turn receives a message about the impact of the original message, even though it may not be expected, direct, or immediate. Thus, the communication process tends to be cyclic, not linear.

Three types of feedback usually found in organizations, namely: information, corrective and reinforcing. Informational feedback does not stress whether something is right or wrong. It is therefore not evaluative; it is the information that one person gives to another that may be of value to the work of the first. Corrective feedback is evaluative and instructional because it deals with the need of the receiver to correct something in the sender's message.

Reinforcing Feedback. Occurs when a particular message that has been sent clearly and / or correctly is followed by a positive acknowledgement by the receiver.

Noise*:* This refers to anything that disrupts or distorts, filters or interferes with the intended message. Although interference can occur at any stage of the communication process, Gibson et al., (1973) have observed that most interference arises at the encoding and decoding stages.

Response*:* It should be noted that on the basis of understanding or decoding, the receiver responds - does nothing, carries out the order, stores the information.

3.4 Communication through Organizational Structure

Communication is fundamental to any organization which is treated as a managerial function for the correct performance of activities, positive relationships between and among organization members for the overall attainment of organizational goals. An organizational structure should therefore be designed in such a way as to make communication effective.

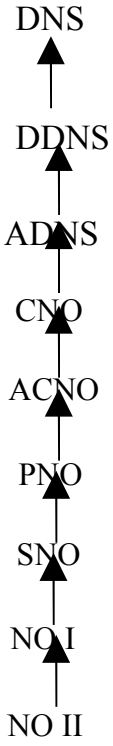
In any hospital structure, provision should be made for horizontal and vertical coordination. The organizational chart should show positions and functions of officers. It should be a framework of the formal relationship that should be established in any organization. It should be designed in such a way as to help people to work together in

implementing plans and make decisions. It should also help the administrator in the area of communications and relations.

3.4.1 Designing Hospital Structure

The hospital structure can be vertical or pyramidal showing functional relationships and chains of command of subordinates.

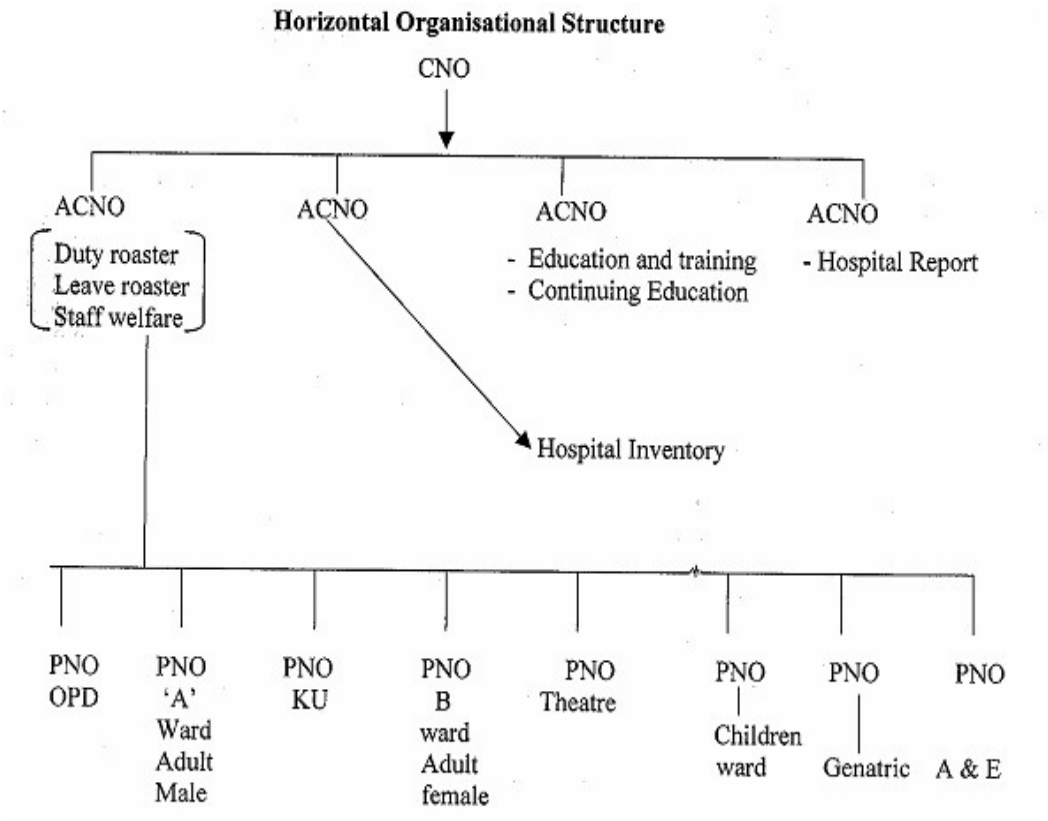
Vertical organizational structure



The organizational structure can also be horizontal which operates from left to right. It lay emphasis on functional relationships rather than hierarchical levels.

KEY

DNS: Director of Nursing Services.
DDNS: Deputy Director of Nursing Services.
ADNS: Assistant Director of Nursing Services.
CNO: Chief Nursing Officer
ACNO: Assistant Nursing Officer
PNO: Principal Nursing Officer
SNO: Senior Nursing Officer
NO: Nursing Officer



Organizational structure leads to effective communication as without communication, an organization is either dead or non-existent. Without authority, structure and division of labour, information would be diffused and anarchy would also result as each person would do what he feels like doing according to his value preferences for example, a worker may decide to come to work when he likes, carry out whatever activities he feels like doing and not be accountable to anyone. Structure gives room for order and discipline for the smooth running of the unit.

4.0 CONCLUSION

Communication is fundamental to any organization for the correct performance of activities, positive relationships between and among members of the organization for the overall attainment of the organizational goals.

5.0 SUMMARY

In this unit, we have been able to see that organizational structure that is very clear, unambiquous will make communication effective while the overall goals of the organization will be attained with ease.

6.0 TUTOR MARKED ASSIGNMENTS

What are the merits and demerits of:

1. Vertical Organizational Structure
2. Horizontal Organizational Structure

7.0 REFERENCES / FURTHER READINGS

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MODULE 3

Unit 1 Hospital Management System
Unit 2 Human Environment
Unit 3 Interpersonal Relationship in Shifting System
Unit 4 Group Dynamics in Health care System

UNIT 1 HOSPITAL MANAGEMENT SYSTEM

CONTENTS

1.0 INTRODUCTION

This Unit will expose you to Hospital Management System where a typical multiple Hospital System (Medinous Hospital Management System (HMS)) will be presented to you for proper understanding.

2.0 OBJECTIVES

At the end of this Unit, you will be able to:

- Discuss a typical Hospital Management System.

3.0 MAIN CONTENTS

3.1 Hospital Management System

Medinous Hospital Management System is powerful, flexible and easy to use and was designed and developed to deliver real conceivable benefits to hospitals and clinics. And more importantly it is backed by reliable and dependable Medimous support.

Medinous Hospital Management System - HMS - Solution for Hospitals

Medinous is a Hospital Management System - HMS designed for multispeciality hospitals to cover a wide range of Hospital administration and management processes. It is an integrated client server application that uses Visual basic as the front-end GUI builder and Oracle as the database.

3.1.1 Registration

The Registration module is an integrated patient management system, which captures complete and relevant patient information. The system automates the patient administration functions to have better and efficient patient care process.

- Patient Registration Details
- Inpatient and Outpatient Registration
- Medical Alerts Details
- Appointment Scheduling (Patient / Doctor wise)
- Doctor's Schedule Summary
- Doctors Daily Schedule List
- Patient Visit History
- Medical Record Movements
- Appointments for Radiology tests and Operation Theatre
- Patient Visit Slip
- Sponsorship Details

It provides for enquiries about the patient, the patient's location, admission, and appointment and discharge details. Furthermore, this

system even takes care of package deals for a cost. Medical Record keeps an abstract of clinical data about patients. It allows easy records on patients.

3.1.2 Billing

The Patient Billing module handles all types of billing for long-term care. This module facilitates cashier and billing operations for different categories of patients like Outpatient, Inpatient and Referral. It provides automatic posting of charges related to different services like bed charges, lab tests conducted medicines issued, consultant's fee, food, beverage and telephone charges etc. This module provides for credit partly billing and can be seamlessly integrated with the Financial Accounting Module. The billing module is extensively flexible by which each of your billing plans can be configured to automatically accept or deny. The system is tuned to capture room and bed charges along with ancillary charges based on the sponsorship category. The Billing Screens is used for In-patient and Outpatient Billing and Invoicing. Further more the charges for various services rendered can be recorded through service module and this can be used for billing purposes.

- Payment Modes / Details
- Sponsorship Conditions Details
- Patient Billing Details
- Package Installment
- Approval from Sponsor
- Company Sponsorship Details
- Package Registration
- Sponsor Verification
- Retroactive Processing
- User-defined Billing Cycles
- Automatic Room and Board Charges
- Recurring Ancillary Charge Capability
- Auto-generated Codes and Billing Criteria
- Provision for Pre-billing
- Extensive Third-party Billing

The system supports multiple reports utilizing various print options with user-defined Parameters.

3.1.3 Financial Accounting

The Financial Accounting Module deals with Cash/Bank, Receipt/ Payments, Journal Voucher and General Ledger etc. Books like Cashbook, Bankbood and Ledger book can be generated. This modules generates reports like Trail Balance, Balance Sheet and Profit and Loss statement.

The Financial Accounting screens describe about the Account Payable, Account Receivable and General Ledger. Also describe the activities related to IP, OP, Bank related activities and provision to clearing the Supplier Invoice and keep track of the Account Receivable and Revenue related activities. The services that are covered by the sponsor companies, Insurance Agencies, Family Accounts, Individual Accounts, sponsorship details of the patient, Health Card Insurance are recorded in the system.

3.1.4 Fixed Assets

The fixed Assets Module deals with all the activities that are related to the Fixed Assets part of financial accounting. This included the activities that are related to identifying an item and then allocating depreciation, managing its movement, Maintenance, Revaluation.

3.1.5 Payroll

The payment and Personnel module deals with pay (and deduction) calculation, printing of certificates, and PF statements, gratuity statement and provides a monthly analysis. Maintenance of employee bio-data, attendance/ overtime details. It also reports on a encasements etc. The personal and payroll department is responsible employee relationship appointing the staff, maintaining the employee database, fixing allowance and entitlements, leave sanctions, loan termination process, maintenance of hospital document details, tenancy contracts and vehicle registration etc.

3.1.6 Outpatient Management

The outpatient module serves as an entry point to schedule an appointment with the Doctor or consultant Doctor for medical consultations and diagnosis. This module support better and timely consultation decision by providing instant access to comprehensive patients visits are divided into New, follow-up and review. This module also handles report of laboratory tests and other examinations. External Doctors visit to in patients can be on ". some patients may avail only the hospital facilities like lab, radiology, nuclear, physiotherapy and so on.

- Medical Alert Details
- Consultation Duty Roster
- Diagnosis Details
- Triage Details
- Patient's Appointments
- Daily / Weekly Schedule Summary
- Appointment Scheduling / Rescheduling
- Outpatient Medical observation Details
- Investigation / Treatment History
- Clinical Services Details
- Group / Packages Registration Facility
- Common Billing Clinical Services
- Doctor's Diagnosis Statistics

Furthermore, Confidentiality of Doctors observation, previous History of patients visits, online Request for investigations and so on, are the special features in Doctors observe system calculates the cost for the services rendered to the patient and reflects in appropriately resulting in smooth billing process.

3.1.7 Inpatient Management

The inpatient module is designed to take care of the activities and functions pertain management. This module automates the day-to-day administrative activities and provide other modules, which leads to a better patient care. It provides comprehensive admission of patients and ward management: availability of beds, estimation, Agreement collection of advance, planned admission, emergency admission and so on. The inpatient deals with ward management: shifting from one ward to the other, bed available administration of drugs, nursing notes, charge slip and so on.

- Admission cost estimation
- Admission Approval
- Admission request
- Doctor Transfer Details
- Nursing Notes
- IP Medical Observation
- Pending Drug Request
- Surgery Scheduling Details
- Discharge Notification Summary
- Expected Date and Time of Discharge

The module tracks every visit made by the patient and caters to follow-up visits of patient multiple appointments.

3.1.8 Pharmacy

Pharmacy module deals with the automation of general workflow and administration made of a pharmacy. The pharmacy module is equipped with bar coding facility, which make medical items to the patient more efficient. This module deals with the activities such as:

- Enquiry
- Quotation
- Purchase order
- Online approval
- Pharmacy drug configuration
- Pharmacy stored configuration
- Drug issues to patients and billing
- Unit dosage facility
- Supplier information
- Maintenance of drug inventory
- Automatic reorder level setting
- Purchase Requisitions
- Purchase order
- Online request for stock from various sub-stores
- Online Stock transfer
- Maintenance of stock at different sub-stores
- Return of items nearing expiry
- Destruction of expired items
- Physical stock verification and adjustment
- Goods receipt
- Stock Transfer (inter store stock transfer)
- Stock Adjustment
- Stock in Hand reports

In addition the online prescription facility assists and facilitates the physicians to the prescription details and as well reflects the medication billing details in the billing module.

3.1.9 General Stores

General stores and inventory module deals with purchase of items, issue of items, main automatic reorder level setting, online request for stock from various sub-stores, online maintenance of stock at different sub-stores, physical stock verification and adjustment, supplier etc.

3.1.10 Laboratory

The laboratory module automates the investigation request and the process involved results to the concerned department / doctor of the hospital. Laboratory module starts online request from doctors and also allows laboratory personnel to generate request module supports to perform various tests under the following disciplines: biochemistry hematology, microbiology, serology, Neurology and radiology. Tests are grouped under and sample type (specimen). Based on the request the user can input the sample number. Results can be entered based on the sample type either to one test or the test result requires approval, the supervisor has to approve the result and it is concerned doctors.

- Sample Result Entry
- Test Association Details
- Specimen Association Details
- Antibiotic Details
- Result Range for Test
- Investigation Request
- Bulk Sample Request
- Sample Details
- Samples Received from External Laboratory
- Samples Dispatch to External Reference Laboratory
- Investigation and Treatment History

Test report can be made confidential. Tests can be performed only after the billing is exempted when the case is declared as urgent. In addition, this module facilitates referral patients.

3.1.11 Radiology

Radiology module caters to services such as X-ray, Scanning, Ultra sound etc. Scheduled resources is possible. The system stores all the result details of various tests and makes the Test Results. These Tests are carried out both for Inpatient and Outpatient. The system details (like patient number, Test report like X-ray, Scanning details) and for each generates a unique number for the image.
Investigations can be done only after the billing is done. This rule is exempted when though as urgent.

3.1.12 Nuclear Medicine

The main function of this module is to conduct the various Tests and make a report of the Results and a unique number is generated for each image. The tests are carried out in Outpatient. Appointments have to be

fixed by the Patient before the test. The conduct analyses the result and makes a report based on the findings.

3.1.13 physiotherapy

This module facilitates tracking the services given to patients depending on recommendations. Physiotherapy sessions are carried out both for Inpatient and Outpatient has to be fixed by the patient for these sessions. All the appointments to the Physiotherapy will be through the consultant. There are appointment.

3.1.14 Dental

Dental module caters to the service rendered by the dentists. Treatment and follow-up tracked using this module. Progress readings can be recorded through this module.

3.1.15 Service

The service module deals with all the services available in the hospital and the charges are stored through this module. There are various services that are available in the hospital.

Service master: This master gives the details about package details, Group details.

Room Type master: This gives the details about Room Type (Ex: Private, Semi-private, Suite etc) and their charges.

Consultation Charge master: This gives the details about Doctor and the charges follow-up, Review and Call-on.

Revenue Type master: This gives the predetermined charges for various service giver Ambulance, Anesthetists Fee, Baby Cot etc).

3.1.16 User Manager

The User Manager module basically deals with security through controlling the access available in the application. Any user associated with a user group can access only those that the user group has rights. It also deals with the System Related Activity like User Monitor Group Master, User Master and view the User Group Lookup of employee database company documents, User defined error message, Generating Daily Statistical Summary.

4.0 CONCLUSION

No doubt Medinous Hospital Management System is a solution for hospitals as it is designed for multispeciality hospitals to cover a wide range of Hospital administration and management processes.

5.0 SUMMARY

The learner has now learnt the Hospital Management System, a detailed of what Hospital system should be and when fully operational especially in the teaching hospitals, the service delivery will be easier, accountability can be guaranteed and it will be obvious if some parts of the system are not measuring up to the standards.

6.0 TUTOR – MARKED ASSIGNMENTS

State and explain ten function of Nuclear medicine

7.0 REFERENCES / FURTHER READINGS

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UNIT 2 HUMAN ENVIRONMENT

CONTENTS

1.0 INTRODUCTION

We have been examining the structure and management of healthcare delivery for meeting

The health needs of man within his environment. This unit will discuss human environment in totality.

Human beings are constantly interacting with their environment. The environment influences human beings and vice versa. The relationship between human beings and the environment is a dynamic one, never static. The environment greatly influences the quality of life one enjoys. People need the environment that they can constantly manipulate so that they can develop their potentials. An environment that stifles may result in abnormal personality. The importance of the environment has been demonstrated in an account of creation. The Garden of Eden provided an environment that was physically pleasing with soil that supported all plants and animals in symbiotic relationship. Adam and Eve provided social supports to each other and were spiritual in harmony with God. Everything was beautiful and peaceful. From this scenario, it could be deducted that the environment assumed the three dimensions of the

physical, the psychosocial and the spiritual, the three being inter-related and inter-dependent. Any disruption in one area would affect the other areas. Adam and Eve's problems started with social disharmony, which affected the other two parameters. One could see the concepts of adjustment and adaptation at work.

What started millions of years ago in terms of equilibrium among the elements in the universe remain with us till today. This unit will discuss the importance of a conducive environment in the promotion and maintenance of good health. The presentation will start with definitions and end with the discussion of Nursing responsibility towards the provision of a healthy and safe environment.

2.0 OBJECTIVES

At the end of this unit, each learner should be able to:

- Define 'environment'
- Describe briefly the components of the environment
- Describe at least two ways by which the environment could affect Man's health
- List at least three professional activities of the nurse that would support a safe environment for a client.

3.0 MAIN CONTENT

3.1 Definitions of the Environment

The environment may be defined as the aggregate of human beings, things, conditions or influences surrounding human beings. It is all of the many physical socio-cultural, socio-economic, and physical and psychosocial factors that influence or affect the lives and survival or people. The promotion and maintenance of a wholesome environment is a major concern of most world governments including Nigeria.

A principle concerning human beings and their environment implies that any environmental condition that interferes with the being, is a threat to the human organism when he is no longer able to cope with it sufficiently well. Some people tolerate their environment better than others do. Also each individual may experience variations in ability to tolerate certain conditions depending on other factors in the situation. Concern for the physical as well as the sociological environment is global in nature. Nigeria is part of the global movement to make the world a safer place to live in. there is an agency in Nigeria, specifically for responsible for monitoring the environment and implementing

measures that would make it safe, the Federal Environmental Protection Agency (FEPA).

Here are some examples that violate a wholesome environment. The human organism enjoys optimum functioning when the air breathed is sufficiently free of physical and chemical pollutants so that irritation to the tissue is absent or at least negligible. But exhaust fumes from vehicles on our roads cause so much irritation to the eye and respiratory tissues. The noise emanating from music sheds and shops and every residence endanger our hearing mechanism.

In recent years, Nigeria and the world population growths, and rural urban migration are leading to unprecedented congestion. Every where is being built up with temporary sheds, which often become permanent. Human welfare is being compromised due to lack of access to nature and beauty. All these should be of concern to nursing. An instability at the physical level can eventually affect the totality of well-being.

3.2 Types of Environment

The environment can be classified into two major types: External and internal. The External Environment consists of:

- biological environment, which considers all living things such as plants, bacteria etc.
- social environment, this is unique to human beings. It is concerned with the relationship between human beings and their environment.
- Physical environment consists of non-living portions of the environment such as air, water and land.

3.3 Effects of Environment on Well-Being

Now that the types of environment are identified, you will now proceed to learn how each type affects the well-being of individuals.

3.3.1 Physical Environment

The type of physical environment in which a person lives can lead to an increased incidence or certain health problems. For example, people living in urban areas with heavy industries are exposed to smoke and air pollution. People who live in rural areas are less likely to have this type of health concern, but they may experience other problems such as snake bites, contaminated water supply, and decreased access to healthcare.

The environment may restrict daily activity. The hustle and bustle in our cities has restricted the daily activities of many older adults. This has a negative consequence on the conditions of bones and joints. Women in their post-menopausal years are known to suffer from osteoporosis a result of long-term reduced physical activity.

Here is a new word – osteoporosis. Check the meaning from your English Dictionary as well as from the Medical / Nurses' Dictionary.

The environment in which one works and the type of physical activity engaged in, in terms of occupation, affect individual well being. Those who work in a coal mines, cement factories, flourmills, tobacco factories are subjected to environments that make them prone to lung disease. Those who work in rice paddies (wet land in which rice is grown) are known to be more prone to guinea worm infection. In short, what you should learn from the discussion is that the environment affects the lifestyle of the inhabitants.

3.3.2 Socio-Cultural/Environmental

Each culture defines health and illness in a manner that reflects its previous experience. You will recall from the course that culture was defined as the sum of traditions, practices, beliefs and values developed by a group of people and passed on most often by the family from generation to generation. Cultural factors determine which health behaviours people perceive as 'normal or abnormal'. Cultural influence also determines whether or not a person seeks health care, and how a person seeks such care. Health practices are also based on cultural beliefs. Let us look at one or two examples.

You must have heard or read about female circumcision being practiced by some cultural groups in Nigeria. The reason proferred is that it would deter sexual promiscuity as the girls grow up. While there is virtue in discouraging promiscuity, the method being employed has left many women grossly incapacitated for life. What a price to pay for being born into such a cultural environment!. Take another cultural practice that forbids meat and eggs to be fed to children because the children will grow up stealing. While the rationale appears to be morally acceptable but the child is being deprived the right to good health through good nutrition from being born into a particular socio-cultural environment.

3.3.3 Socio-Economic Environment

In many countries of the world, economic status is a major determinant of the quality of the physical and psychosocial environment available to individuals. We see that persons in the low-income group tend to

congregate in the crowded inner city slums, where cleanliness and sanitation are poor, air polluted by stench from public drains and refuse mountains. All these endanger well-being and often lead to high incidence of communicable and infectious diseases. The picture is more dismal when the people in these areas are outside the health care system because they could not afford the cost of healthcare.

On the other hand, people of high socio-economic status could afford to locate themselves in healthy environments; and could afford good medical care. But in spite of the problems of adjustment and adaptation, human beings continue to find solutions to problems created by his environment.

3.3.4 Spiritual / Religious Environment

Spirituality refers to person's beliefs about a divine or a higher power or force, and related practices. Religion is an organized system of worship often directed towards the divine being, power or force. Spirituality and religion can affect a person's views of and actions towards health, illness and health care. For example, some religious groups regard illness as a form of punishment from God, and therefore refuse medical treatment or prevented care from being given. Some religious groups ban the use of drugs and alcohol for whatever reason. Being born and socialized into this type of environment means denying oneself or cause to be denied the rights to health care.

Conditions or circumstances in the external environment can be classified as life supporting or as hazardous. On the agents essential to survival are air, water, nutrients and shelter. Other agents favouring survival include people and a variety of other living organisms, from microorganisms to highly complicated multicultural organisms of both plant and animal origin. Even essential agents may be harmful when exposure is excessive or unbalanced. As an example, oxygen is required for survival. However, continued high concentrations of oxygen damage the respiratory membrane, and can cause blindness in newborn babies.
You have learnt about the external environment and some of the adverse effects it could have on health. The next emphasis is on the internal environment. By the end of this section you would have come to appreciate the inter-relatedness and interdependency of the external and internal environment; and that Man is not so easily dissected.

3.4 The Internal Environment

The environment listed in 3.3 above lies outside the body and is in contact with the skin, mucous, membrane, and the sense organs. The

internal environment is made up of the fluid surrounding the cells and carrying material to and from them.

Similar to the dependence of health on stability within the external environment, health is also dependent on the maintenance of relative stability of the physical and chemical characteristic of the fluid comprising the internal environment. Survival of the cells and maintenance of their functions are dependent on conditions in the cell's immediate fluid environment. It is from this environment that the cell obtains a continued supply of nutrients and into which it discharges its wastes. For all cells, this immediate environment is a pool of water in which a variety of substances such as sodium chloride and glucose are dissolved. For a unicellular organism such as the amoeba, the fluid environment is a pond or puddle of water.

Human beings and other multi-cellular organisms, the fluid environment consists of blood, lymph, and interstitial fluid form the immediate environment of the cells. These fluids are known as the internal environment. The fluids composing the internal environment not only serve individual cells as such, but are the medium by which all body cells are united and affected by the activities of all other cells within the entire organism.

The physiological process which maintains most of the steady states is termed homeostasis, which implies variations within limits as long as the individual is capable of making appropriate adaptations to change.

3.4.1 Maintenance of Homeostasis

The maintenance of homeostasis depends on a variety of elements. Substance required by cells must be available in adequate quantities. Material supplies include water, oxygen, and a variety of nutrients, including sources of calories, tissue-building materials, electrolytes and regulators not synthesized or present in the body. the intake, storage and elimination of excess supply are regulated so that the level of each substance is maintained within well-defined limits.

3.4.2 Structure Supporting Homeostasis

The healthy organism is capable of responding to disturbances in such a manner that damage is prevented or repaired. The kinds of structures that fulfill this function include the following:

- Structure where required substances are absorbed from the external environment and when necessary, modified so that they can enter the internal environment. For example, oxygen is absorbed into the

blood unchanged. The air from which oxygen is taken however, requires conditioning. Nutrients usually require reduction to simpler forms before they can be absorbed and provision for the elimination of indigestible substances is also necessary.

- Materials enter or leave the external environment through semi-permeable membranes that separate the internal from the external environment. These semi-permeable membranes act to protect the internal environment from too rapid a change or from the entrance of potentially harmful or unusable particles.

- Structures to transport materials from point of entry to cells and from cells to points of elimination or exit such as the heart and blood vessels.

- Structures that store or eliminate excesses of intake and by-products of metabolism. For example, glucose is stored as glycogen in the liver and muscles, much of the excess is stored as fat. Excess sodium is normally excreted in the urine.

- Structures that make movement in the external environment possible. They enable the individual to seek food and water, to alter the environment to suit his needs, to overcome or avoid danger and to find a partner.

- Structures that reproduce themselves to replace worm-out cells, to repair injury or to produce a new organism.
- Structures that protect the organism from injury.

- Finally, structures that regulate and integrate the activities of all individual cells and aggregates of cells so that the organism functions as a whole.

3.4.3 Conditions of Homeostasis

Conditions that must be maintained within limits include:

- Osmolality
- Blood pressure
- Cation-anion balance and concentration,
- Hydrogen ion concentration, and
- Body temperature

Conditions in the external environment must be within the limits to which human beings can adapt. For example, the capacity to adapt to

extremes of temperature, high altitude, water and food supply, and physical trauma is limited. However human beings are liable to live in some hostile environments the nurse must set exemplary examples by her personal behaviour.

The practice of washing hands thoroughly indicated in order to control the spread of infection. The nurse knows that oxygen supports combustion, so she takes appropriate measures to decrease the likelihood of fire in the room of someone receiving oxygen therapy. Public education directed towards safe environment both in the healthcare institutions and homes watching electrical cords and connections, medications, house cleaning solutions and so on.

Water supply, good ventilation and clean air, balanced food, personal hygiene and environmental sanitation are all concerns of nursing. Florence Nightingale in her treatise on what nursing should do, wrote: "nursing ought to signify the proper use of fresh air, light, warmth, cleanliness, quite, and the proper selection and administration of diet-all at the least expense of vital power to the patient". All these are vital elements in the external environment that are necessary for homeostasis in the internal environment.

In subsequent Units you will be introduced to how nurses should identify and meet basic human needs both in theory and in practice.

4.0 CONCLUSION

Environment is all of the many physical and psychosocial factors that influence or affect the life and survival of the individual. Environment is subdivided into external and internal. External environment lies outside the body and is in contact with the skin, mueous membrane and the sense organs. The internal environment is made up of the fluid surrounding the cells and carrying to and from them. similar to the dependence of health on the stability within the external environment, health is also dependent on the maintenance of relative stability of the physical and chemical characteristics of the fluid comprising the internal environment. For human beings and other multi-cellular organisms, blood, lymph and intestinal fluid from the immediate environment of the cells. Materials utilized in the internal environment come from the external environment through specialized structures.

Therefore, the quality and state of the external environment determines the state of the internal environment. For man to be in a health state, there should be equilibrium between the external and internal environment. Hence a safe external environment determines the quality

of the internal government. Conditions in the external environment must be within the limits to which an individual can adapt to.

Management of the environment for positive clients' health is possibly the most nearly independent function of the nurse. Florence nightingale recognized the importance of the natural environment in the care of the sick and in the prevention of illness.

5.0 SUMMARY

Human beings and their environment are constantly interacting and influencing each other, how the relationship is dynamic and how human beings manipulate their environment to meet their needs.

6.0 TUTOR – MARKED ASSIGNMENTS

What are the effects of the Environment on the Man-being

7.0 REFERENCES / FURTHER READING

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UNIT 3 INTERPERSONAL RELATIONSHIP IN SHIFTING SYSTEM

CONTENTS

1.0 INTRODUCTION

Interpersonal relationship is a form of communication which occurs between two people or within a small group. It is often face to face, healthy and most frequently used in hospitals which allows for problem solving, sharing of ideas, decision making and personal growth.

Interpersonal relationship is a major tool for effective Health care delivery encounter with clients such as carrying out any procedure requires exchange of information. The workers understanding of the communication skills will also assist in relating with other staff members who may have different opinions and experiences. A meaningful interpersonal relationship offers a great deal of help by the health worker to a client.

This unit will examine the interpersonal relationship with its effect on the therapeutic management of clients.

2.0 OBJECTIVES

At the end of this Unit, the learner will be able to:

- Describe the concept of interpersonal relationship and its application to health care delivery system.
- Discuss the phases of a therapeutic helping relationship.
- Explain the variables of interpersonal relationship and the applied models.

3.0 MAIN CONTENT

3.1 Interpersonal Relationship

Communication begets relationship. Without it, there is no organization as this is the only means of influencing the behaviour of the individual. Interpersonal communication / relationship goes on directly between individuals (nurse and client), either verbal or non-verbal.

Verbal: Words that we hear or see in writing.

Non-verbal*:* Sounds, sight, odor and touch.

Pre-verbal*:* Proceeds the ability to form words e.g. screams in babies.

Interpersonal relationship is utilized in nursing activities such as counselling, collecting a blood specimen, taking a medical history, group situations like classroom, committee meeting, intra professional dialogue, with physicians, social workers, therapists and even relatives of patients. These help the workers later to develop an intra-personal thought to develop measures of assisting in the care of the client.

3.2 Variables of Interpersonal Relationship

There are variables in interpersonal relationship. These include referent, sender, message, channels, receiver and feedback. A careful understanding of these (knowing that communication is complex, involving many verbal and non verbal symbols and messages exchanged between persons) is crucial as any slight change or modification can affect the overall expected result.

Referent: This represents the stimulus, which motivates a person to communicate with another. It may be an object experience, emotion, idea or act. It is what ignites the relationship.

Sender: This is the encoder, the person who initiates the interpersonal relationship. The sender now may be the receiver later.

Message: This is the information being sent or expressed by the sender.

It must be clear and organized no professional jargon while relating with the patient. If symbols are being used, it must be concise and not mixed up.

Channels: This represents the medium through which it is being sent. This can be auditory, visual and tactile sense. Placing a hand on an individual while relating depicts the use of touch as a channel.
Receiver: This is the decoder, the one to whom the message is sent. But the receiver and sender have so much in common as they can interchange their roles in the relationship processed.

Feedback*:* This is the message returned to the sender. It helps to reveal whether the meaning of the message is received.

The nurse in interpersonal relationship with client assumes major responsibility unlike in the social relationship when both persons involved assume equal responsibility for seeking openness and clarification.

3.3 Techniques of Interpersonal Relationship

The workers send messages in the verbal and non-verbal modes, which are closely bound together during interpersonal interaction with clients and relations. During the art of speaking, we express ourselves through movements, tone of voice, facial expressions and general appearance. As the worker learns the skills communication, is also expected to master the techniques, these includes:

- **Clarity and brevity**

Effective communication should be simple, short and direct. Fewer words spoken result in result in less confusion. A nurse taking patient history starts with bio-data, what is your name? Where do you come from? Because of the variable involved, clarity is required to get the appropriate answer. Using examples can even make an explanation easier to understand. Repetition also makes communication easier. Brevity is best achieved by using words that expresses an idea simply "tell me where you feel the pain most" is better than "describe to me the location of the discomfort." This is necessary especially while eliciting information from patient or relation when arriving the hospital.

- **Vocabulary**

Lack of understanding of the sender's words and phrases the receiver can make communication unsuccessful thereby affecting relationship. Nurses should avoid professional jargon while relating with patient, as they may become confused and unable to follow instructions. The first expression and outlook can frighten the patient, relating with patient, as they may become confused and unable to follow instructions. The first expression and outlook can frighten the patient.

- **Denotative and connotative meaning**

Single words do have different meanings. While denotation meaning is one shared by individuals who use a common language, connotative meaning is the thought, feelings or ideas that people have about the word. The expression of "The condition is serious" may suggest to families that clients are close to death, but a nurse does not see things that way. When nurses communicate with clients, they should carefully select words that cannot be easily misinterpreted. This is important when explaining conditions, treatment, or purpose of therapies to patients and relatives.

- **Pacing**

Interpersonal relationship gives credence to pace or speed. Talking rapidly, using awkward pauses and speaking too slowly can convey an unintended message. The nurse should avoid awkward pauses during an explanation instead use proper pacing by thinking about what to say before saying it. The nurse should also observe for non-verbal cues from the client that might suggest confusion or misunderstanding.

- **Timing and relevance**

The nurse must be sensitive to the appropriate time for discussions. The best time for interaction is when a client expresses an interest in communication. Individual's interest and needs are considered alongside with appropriate timing in order to achieve optional results.

- **Humour**

Humour is a powerful tool in promoting well-being. Laughter helps relieve stress-related tension and pain, increases the nurses effectiveness in providing emotional support to clients, and humanizes the experience of illness. Humour has been shown to stimulate the production of catecholamines and hormones that enhance feelings of well being, improve pain tolerance, reduce anxiety, facilitate respiratory relaxation, and enhance metabolism.

The workers can use humour in conversations with clients by cracking jokes, sharing humorous incidents or situations. This procedure quietens a fearful, tense, emotionally grieved and tense patients. Humour opens up a patient to share their griefs and be more self-disclosing. It is an effective approach in helping clients to interact more openly and honestly.

4.0 CONCLUSION

The health worker uses skills of interpersonal communication to develop a relationship with clients that allows understanding of them as total persons. This helping relationship is therapeutic, promoting a psychological climate that brings positive client change and growth. The relationship also focuses on meeting the clients needs. Although the worker is expected to gain much satisfaction from the relationship in order to carry out her expected role to the clients, clients should be the primary recipient and determiners of benefits.

Interpersonal relationship seeks to provide physical and psychological comfort to the client. The worker's action considers the client's preferences. A helping relationship between the nurse and client does not just happen; it is built with care as the health worker uses therapeutic communication techniques. The characteristics involved in the interaction are trust, empathy, caring, autonomy and mutuality.

5.0 SUMMARY

This Unit has examined interpersonal relationship in Nursing with information on variables and techniques of interpersonal relationship.

6.0 TUTOR MARKED ASSIGNMENTS

1. (a) List the six variables of interpersonal relationship.
   (b) List and comment on the importance of the five (5) techniques employed in interpersonal relationship.

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UNIT 4 GROUP DYNAMICS IN HEALTH CARE SYSTEM

CONTENTS

1.0 INTRODUCTION

Group dynamics is essential for the successful health care delivery in Nigeria as every member in the health system is important, interrelated and interdependent, the inefficiency or inaction of a member of the group will have adverse effect on the entire group system hence the importance of the group dynamics can not be undermined.

This Unit will focus on group dynamics and will point the students to the fact that each of them is important in the various groups he / she belongs.

2.0 OBJECTIVES

At the conclusion of this Unit, the Students should be able to:

- Explain the concept of group dynamics
- List the essential properties of a group
- State some principles of group dynamics
- Discuss the various types and levels of groups in the society.

3.0 MAIN CONTENT

3.1 Introduction

The term group has been variously defined in standard dictionaries. The definition germane to the aims and objectives of guidance and counselling is that a group is the collection of individuals who interact psychologically with a purpose to pursue or achieve a common goal. The group members join the group towards realizing the groups objectives. In counselling, a group consists of two or more persons who voluntarily have contact and interaction intended to produce change in each member. Due to voluntary participation, members interact with and influence each other.

Group dynamics refers to a sort of political ideology concerning the ways in which groups should be organized and managed. The ideology emphasizes the importance of democratic leadership, the participation of members in decisions, and the gains both to society and do individuals to be obtained through cooperative activities in groups. The critics of this view have sometimes caricatured it as making "togetherness" the supreme virtue, advocating that everything be done jointly in groups which have and need no leader because everyone participates fully and equally.

Group dynamics according to Shertzer and Stone (1976) is the interacting forces within groups as they organize and operate in order to achieve their objectives. The forces in the group which enhance the effectiveness of the group are varied and these fall under the category of group dynamics. These forces or mechanisms in a group may be in the form of leadership style, role playing, observation as well as feedback to the group members' interaction, nature of the goal, ways and means of achieving these goals and other related forces. Group dynamics involves the forces which account for group cohesion whereby members work out the group norms and interact meaningfully and purposefully to achieve the objectives of the group.

3.2 Essential properties of a group

As earlier mentioned, a group refers to a number of persons who communicate with one another often over a life span of time and who are few enough so that each other is able to communicate with all the others, not at second hand, through other people, but face-to-face. Some of the essential properties of a group are as follows:

(a) A dynamic interaction: If members will learn from each other, there must be some kind of relationship and subsequent interaction base on which this relationship will develop. In short, the members must be interacting with one another.

(b) A common goal: For the group to have a common goal, members should be willing to give feedback willingly to each other.

(c) Volition and concept: Members should not be forced to belong to a group, but rather, they should join groups voluntarily having the idea of what the group stands for. Members who are forced to join a group may not be able to tap the potentialities of the group they belong.

(d) An appropriate number of members: There should be an appropriate number for the proposed function. The number of size of a group will determine to a great extent the effectiveness of the group, because the feelings will easily come out. The smaller the size the greater the relationship or interaction.

(e) Capacity for self-direction: Members should be alive to their responsibilities. If the group is voluntary and meaningful, the willingness to govern and control will evolve and the group will move in terms of self-direction.

3.3 Principles of Group Dynamics

It has been discussed hitherto that group dynamics refers to the forces operating in groups which give rise to them and the consequences which these forces have on the modification of the behaviour of the members of the group. Group dynamics that is oriented towards change in behavioural adjustment can be viewed in three ways: firstly, the group can be seen as a source of influence over its members; secondly, the group itself may be a target of change. In order to assist the individuals to change or modify their behaviour, it may be necessary to change the standard of the group, the leadership style, the emotional atmosphere, and even some of the groups objectives; thirdly, assistance to individuals through groups can be done effectively through the organized efforts of groups as agents of change.

Some of the principles of group dynamics that are applicable to guidance and counselling are as follows:-

a. Principle of shared responsibility: Whenever a change is to be effected the group goals, information plans and effects must be shared by the group members.

b. Principle of attractiveness of the group: The degree of attractiveness of a group to the members will determine the influence of the group.

c. Principle of sense of belonging to the group: Members should show some signs of commitment to the group. This will enhance their active participation in group activities.

d. Principle of individual members status: It is obvious that if one of the members of the group is highly respected by other members, he would have great influence on the other members of the group.

e. Principle of behavioural censorship: Here activities that will make members deviate from the norms of the group are usually rejected by members of the group because of the attendant sanction.

f. Principles of readjustment: A change in a section of a group will likely produce a strain in others. The solution to this is for members to readjust in other sections.

3.4 Types and levels of Groups

Different groups originated in America in relation to group dynamics. They are as follows:

1. The T-groups

T-Groups originated in the U.S in 1947. T stands for training. It aims through workshops and conferences at educating the participants about human relations, enhancement of interpersonal skills and the development of individuals equipped to provide leadership in changing organizations. Hence, the primary focus is on inter-personal interaction and on group dynamics as revealed by member functioning. Participants of this group are involved in experiences designed to help them learn from their own behaviours and others.

T-Groups are involved in an experience in which they learn from their behaviour. Group members learn to recognize the effect they have on others and how others see them. the objective of this group is to learn by use of group process rather than facilitating personal growth.

2. Sensitivity Training Groups

This group is experienced-based and interactive designed to facilitate development and self-change. Sensitivity training is a generic name that was coined to refer to the small group training conducted by the National Training Laboratory. Its primary focus is on members interpersonal behaviours. Attention is paid to group role and processes only as this illuminate on personal dynamics. The outcome of this group

includes clarification of life values, increased sensitivity to and acceptance of self and others, and overall improvement in personal adequacy.

Goals of sensitivity training groups include facilitating personal, increased sensitivity to the feelings of the individual sometimes a trained psychotherapist.

3. Laboratory Training Groups

The term refers to an educational method which emphasizes experience – based learning activity. The word laboratory connotes the fact that the learning environment is experimental in that participants go beyond their usual pattern of interacting with individuals and groups. It presents the learner with a situation in interpersonal group or organizational system encounter in daily life.

4. Personal Growth Groups

This group is designed to strengthen the individuals ability to experience people and events more accurately. Emphasis shifts from the group itself to a Rogerian conception of the individual within the group. The leader's attention centers on the expression of feelings by the group members. It is meant not for the disturbed but for normal people who are seeking further personal development, hence, the term growth. The encounter group enhances the exploration of the individuals potentials and how best to eliminate blocks to the realization of their full potentials.

5. Encounter Groups

These are usually brief, intensive, face to face interaction not necessarily restricted to verbal communication. Strong emphasis is on openness, honesty, and expression of strong feelings, self-disclosure and spontaneity (including physical expressions of feelings) are encouraged. Its therapeutic goals that are related to feelings, range from those indistinguishable from goals of conventional counselling to those of consciousness raising greater expression, or simply the enjoyment of a mutual experience. They seek personal growth to rediscover and use the affective part of themselves.

6. Marathon Groups

Marathon group is the most intensive encounter group of all. It meets for a long time at a stretch of time. In some marathon groups, members may take short sleep periods but in others, this is discouraged, in the belief that prolonged contact and physical exhaustion accelerate and intensify the interaction between group members and the expression of feelings that normally submerge. A high value is placed on self-expression, honesty, and aggressive confrontation between group members.

The group does not deal with anything except its chosen task, which usually is the expression and exploration of immediate feelings. The intensity of the marathon experience operates to bring about personality changes, in the direction of self-understanding and self-acceptance, which often endure.

7. Group Therapy

This is the application of therapeutic principles to two or more individuals simultaneously to clarify their psychological conflicts so that they may live normal lives. A psychiatrist or a clinical psychologist serves as a group leader. It finds its root in medicine, sociology and religion. Its innovative factors include imparting of information, installation of hope, communication of universality (patients learn that their illness is not unique), socializing techniques, interpersonal learning and group cohesiveness.

8. Organization Development

The origin of organization development was in the laboratory – training and T-Group procedure. It incorporates the variety of group strategies designed to bring about changes in an organization in order to increase its effectiveness and efficiency. Organization development focuses on the individual and the group assuming that changes there would bring about changes in the total organization.

Reasons for constituting a Group

a. Underachievement and the desire to motivate workers can bring about the formation of a group. However, studies have shown that the performance of those who participate in this group has not been better than those who did not participate. One of the reasons cited is that the group meetings are few which may not make for much changes. Some of the studies revealed that some of the participants even received lower grades, but showed

increase in self-acceptance. In essence, the groups offered support and not motivation.

b. Hospital Administrators frequently structure groups to provide information that would reduce the anxiety and uncertainty experienced. Studies have revealed that participants of such groups showed greater knowledge of requirements (entry) than those who do not participate, and they made more appropriate decisions.

c. Groups are also formed to facilitate developmental tasks. Some of the goals are how to establish group relations with peers, improving communication, developing social skills, and enhancing the self concept. While the rationale may differ from group to group, the emphasis is on the type of relationship in which case the group is small enough to provide for intimacy and extensive participation.

Stages of Group Development

Groups are complex social systems in which many variables change simultaneously. Hence, an individual entering a group unaware of all the dynamics of the situation, may find the state of flux disturbing, confusing and embarrassing. Such an individual needs the help of an experienced administrator to discern order and patterns in the process. To provide the most meaningful experience for participants in the groups they lead, administrators must understand how groups develop and how they evolve through a systematic process.

Stage 1: The Initiation of the Group

The behaviour of members during the initial stage is relatively related. Problems presented are usually discussed rationally and members of this group help them to formulate a concept of the role each member is expected to play in the group. Hence, the early stage of the group is thus characterized by a degree of caution and self-verification behaviour.

The primary task for the members in a new group is to determine a method of achieving their goals. This means, in part, that they must resolve their social relationships in the group. Frequently, individuals or under what is expected, how much of their selves will have to be revealed, and what type of commitment will have to be made to others. only that which is safe to describe is revealed during this stage.

For a while a culture evolves in the group that maximizes the opportunity for most members to play their private roles. However, as

time goes on, more and more reality begins to intrude into their perceptions of one another. Through this, there is a shared relationship. It is through the process of developing this change relationship that a new reality is formed which permits the members to confront one another. The first major concern of counsellors is to provide a situation that reduces threat to the members, thereby permitting them further self-exploration. To be helpful to the group, a counselor should establish a relationship which is expected by the counsellors. This includes genuineness, experiencing of positive regard for members and expression of emphatic understanding.

Stage 2: Conflict and Confrontation

In this stage, members manifest dissatisfaction with the operation of the group. After initial acquaintance of stage 1, members are frequently frustrated in their attempt to evolve new patterns of behaviour through which to work towards group goals. The discrepancy between individuals' real selves and their stereotyped images of the group may lead to conflict. Group members may challenge other's reactions to them and insist on their rights. Conflict also arises when certain issues are discovered to be more complex than the group members originally perceived.

Confrontation is a technique used by the counselor to invite a member to examine his or her behaviour and its consequences more carefully. Confrontation is a challenge to the members to become integrated. It permits the counselor and other members to express real thought and feeling and provides a model to help the client learn to accept and express thought and feelings and to test perceptions against other members reality. Through confrontation, clients learn to recognize and face the inter-and-intra personal discrepancies that are an inevitable part of life.

Confrontation can be beneficial or detrimental to the individual. Therefore, to achieve beneficial confrontation, counsellors should take cognizance of the following guidelines:

i. It should be offered in a spirit of accurate empathy.
ii. It should take place tentatively especially in the early stage of a group.
iii. It should be proportionate – to the relationship between the two individuals in the interaction.
iv. It should be used in successive approximations. This is like that issue of tentativeness.
v. Do not use commands, judgmental or accusing statements.

Stage 3: Cohesiveness

This refers to the sense of solidarity or "we-ness" or "groupness" of the group. It also refers to the attractiveness of the group for its members. It usually follows the stage of conflict and confrontation as the group gradually develops feelings of cohesiveness. There is an increased mutual trust and group morale. The primary interest of the group is with its intimacy and closeness. Infact after a period of conflict, the group may want peace at all cost and may develop a false type of cohesiveness as a form of protection.

How can a leader's behaviour facilitate group cohesiveness? A 4-step approach is suggested as follows:

i. He must define operationally exactly what behaviours indicate the presence of cohesiveness.
ii. He should diagnose the level of cohesiveness in the group.
iii. He may intervene by modeling cohesive behaviour. Intervention here means that he can come in and demonstrate what it is. Then they may be asked to repeat it after he can reinforce them.
iv. He should assess the impact of his intervention. Here, he may record the same statement that was measured earlier to assess the level of cohesiveness.

In conclusion, many counsellors feel that when the group reaches a stage of
cohesiveness it is successful and they permit the group process to stop.

Stage 4: Productiveness

When a group achieves some degree of stability in its pattern of behaviour, along working process begins. Members are now deeply committed to the group, they reveal more of themselves and their problems in living. The established group now direct itself towards individual as well as group goals attempting to produce something of a general and lasting value. At first, the group was dependent upon the letter for concepts and models, but now the members have developed some leadership skills.

At this stage, the administrator serves as one source of internal standard but not the only one. interpersonal bonds are strong, so evaluation, criticism, discussion and re-evaluation can be undertaken. Greater objectivity, greater ease in making decisions and more flexibility in controlling group process results.

Stage 5: Termination

This is one of the most significant aspects of a group process. It is the tradition from the group to the members daily lives. It is one of the most difficult and emotionally involving process for the members because it arouses feelings of separation, loss, dissolution, impotence, dependency, death and abandonment. But pleasant or not, termination is built into the group process form its very beginning because the intention of the members is to eventually leave the group. It is made easier if the leader has emphasized the importance of taking action and making changes in attitude and behaviour.

The common forms of termination are:

i. The termination of the unsuccessful client (member)
ii. The termination of the successful client
iii. The termination of the entire group.

Towards the end of termination, members anticipate the loss and feel the need for closure. They make various attempts to deny the full impact of their separation, some suppressed frustration, insecurity and anger may emerge before termination. Perhaps, these were unexpected or unheeded throughout the group sessions. Members often withdraw by first expressing their negative feelings about others, then their positive feelings.

Members frequently insist that the group would never end because each person will carry the group away with him or her. They seek confirmation that their choice to join the group was a good one. They thank one another for their contributions and they feel that the results will be evident after the group is over and they are on their own.

Preparation for the Group

There should be some preparation of the counsellor as well as of each member prior to actual initiation. The following points will form the basis of such situation – the setting, the size, selection, composition, open or closed group, duration, preparation for interview and structure.

1. The Setting

The counselor must locate an appropriate place for the group to meet and establish policy about the duration of the group, duration of each session, admission of new members, and the size of the group. The setting must afford some degree of comfort, awareness, privacy and must be free of distractions such as tables, chairs, carpeted floors, audio or visual recording equipment etc.

2. The Size

A consensus of the literature suggest that the ideal size for a group in counselling is seven or eight members, with a range of 5-10. The lower limit is determined by the fact that when the group is much smaller, it ceases to operate as a group and individual counselling seems to ensure within the group setting. Also opportunities for utilizing the dynamics within the group are reduced. Lastly, such a pressure is put on each individual that he or she cannot choose to remain silent and so the comfort level is reduced. The upper limit is determined by the fact that less time is available for working with individual problems where there are additional members. As the group becomes larger it becomes difficult for the less forceful members to express their ideas. The competition for "air time" becomes critical. An administrator might expect one or two members to drop out during the early stages.

3. Selection

An administrator can increase the chances of success within the group by careful selection of client. Clients should be thoroughly screened so that the counselor will understand as much as possible about them. the counselor may wish to review a history of the clients family background, childhood, adolescent and other development areas, awareness of the medical history.

Success is certainly increased by selecting clients who volunteer the experience since they are then more open than to help an individual who are coerced by family and friends. The age span of members should be as small as possible, probably not more than 3 years for adolescents who have a large variation in mutuation.

An important prerequisite for admission to a group is stated individual goals. There must be verbalized contact regarding personal change. All group members should have relationship with the therapist prior to entering the group. This is very important because there is always a great deal of anxiety associated with group membership in the early

stages. This relationship will help members to handle the initial anxiety until they begin relation with other group members.

4. Composition

Should a counselling group be homogenous or heterogeneous? That is, should it comprise of one set, age, socio-economic level, of problem areas as opposed to varying these factors within the same group? Whether or not to select homogeneous client is an issue that each administrator has to resolve personally.

Due to limited amount of research specifically relation group composition to group process and outcome, there are no firm rules available. However, the following guidelines regarding group composition are in order: when attempting to solve the issue of homogeneity / heterogeity, it is helpful to look at the range of "patient / normal" interpersonal skills and behaviours of the members. Since group maintenance is an important issue in a patient.

Population of a more homogeneous group is suggested in order to decrease the initial discomfort and anxiety of the group members. When group members are "more normal", they can tolerate greater degrees of discomfort and conflict with less risk of premature dropouts.

Using the concept of compatibility rather than homogeneity is better. Compatibility would ensure personal attraction, cooperation and productive interaction among others.

5. The Open or Closed Groups

Before beginning a group, you have to make a decision as to whether open or closed group. A closed group does not admit new members and it meets for a pre-determined number of sessions or until the group decides to terminate. On the other hand, an open group replaces members as they leave the group so that it continues to function without a predetermined conclusion.

Differences between Open and Closed Groups

a. Time Perspective - The members of a closed group are given adequate notice of the time of the meeting. In the case of an open group, members are not aware of the transitory nature of their relationship.
b. Equilibrium – Equilibrium is concerned with adjustment needed in the group as membership changes. Disequilibrium is a basic shortcoming of an open group, and a constant state is non-

functional. The counselor should maintain such a flow of members in and out of the group. This will ensure the retention of enough members and provide an appropriate heterogeneity to ensure a steady state of equilibrium.

c. Frame of Reference – Frame of reference means the ground against which the figure is perceived. In an open group, members have a larger population as a frame of reference with which to compare themselves than in a selected group.

d. The Changing Membership – This is the most obvious distinction between open and closed groups. Possessions of powers by one member over another is a function of changing membership. Power is relatively permanent in a closed group. In an open group, any member may leave thereby changing the balance of power.

6. Duration

Most groups take considerable time to warm up to personal communication and to work through some of the major themes in the session. It has been suggested that it is difficult for groups to get personally involved and productive in less than one and half hours. Also they become less productive and reach a point of diminishing return after two hours. The number of times the group will meet is also important. Although some intensive groups meet two to five times a week, the majority of groups meet once a week.

Time limit can be used by some members to protect themselves and avoid getting involved in working through specific problem areas. A disadvantage arises when a group has not sufficiently worked through the stages of interaction to such a point that it has productively met group and individual goals. In such a case, the termination would be frustrating.

7. Preparation Interview

During the preparation interview, the counselor should inform members about meeting place, length of each meeting, number of group meetings per week and total number of meeting. Such interview can help clients to recognize and work through misconceptions, unrealistic beliefs and expectations of the group counselling.

8. Structure

There are different opinions in this area. There is structured atmosphere and unstructured atmosphere. An unstructured atmosphere is more relevant to clients needs. It is conducive to self exploration and the group can gain awareness of the psychological relationships among its members. However, distress and anxiety are inherent in it. So members device their own structure through tasks, rules etc. and resort to some habitual ways of coping with anxiety by using defence mechanisms.

On the other hand, a structured environment enhances development of good behaviours that can facilitated group development and client improvement. It is strongly suggested that structured atmosphere be used in the early stages of group process.

4.0 CONCLUSION

Hospital as a group of health workers requires some degree of stability in its pattern of behaviour as a long working process is needed. For this reason, stimulating structured and unstructured atmosphere is required and enhanced stable / hospital policies.

5.0 SUMMARY

Attempt has been made in this Unit to explain the concept “group dynamics”, types and levels of groups including the stages of group development.

6.0 TUTOR MARKED ASSIGNMENTS

1. Examine the stages of group development
2. Attempt a definition of group dynamics. What are the principles of group dynamics?

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MODULE 4

UNIT 1 HEALTH ADMINISTRATION AND BUREAUCRACY

CONTENTS

1.0 INTRODUCTION

The Students will learn about health administration and bureaucracy in this Unit, the principles of hospital administration, factors influencing health administration, what qualnnifies hospital as a bureaucratic organization, reasons for bureaucratic system of administration, advantages and disadvantages of bureaucratic hospital facilities.

2.0 OBJECTIVES

At the end of this Unit, the students should be able to:

- Explain the principles of hospital administration
- State the factors influencing health administration
- Explain what qualifies a hospital as a bureaucratic organization
- Discuss reasons for bureaucratic system of administration
- List the advantages and disadvantages of bureaucratic hospital facilties.

3.0 MAIN CONTENT

3.1 Introduction

According to Bossert et al. (1998), Ministries of Health in low and middle income countries have the reputation for being among the most bureaucratic and least effectively managed institutions in the public sector. According to these authors, designed and initiated in the 20th century and given wide responsibility for financing and operating extensive public hospitals and primary care systems in the post-war period, they became large centralized and hierarchical public bureaucracies, with cumbersome and detailed administrative rules and a permanent staff with secure civil service protections. The ministries were fragmented by many vertical programmes, which were often run as separate entities, dependent on uncertain international funding. Today, they constitute complex organization with large scale bureaucratic administrative set up. This is the situation in Nigeria today.

The idea of bureaucracy or officialdom was first developed by Max Weber who referred to it as the whole basis of authority in a society. Weber believed that for the successful operation of an organization, work should be administered in a strictly bureaucratic manner. In other words, without bureaucracy, organizations are incapable of achieving the highest degree of efficiency. Bureaucracy is a process in administration and management, which is universal globally. It is the basis of organization and order but if not carefully applied it might produce inflexibility and delay. In a bureaucratic setting, there is hierarchy of authority and power is based on status. It is the position that one occupies that is respected and not the individual that occupies the position perse.

A health administrator works in health care institutions, which consist of formal and informal organizations where preventive, social, clinical, academic, research and administrative services are rendered. The overall aim of the health care system is to improve the health status of the members of the society. However, each of the institutions within the health care system has specific aims and objectives. As a large social system, the health care system is a bureaucratic institution that forms an arm of the government. The social structure of the health institutions

follow the same bureaucratic pattern as other government institutions. As such, the social system within the institutions is determined by the established procedures that govern the relationships between individuals within the institutions. As in other bureaucratic organizations, the relationship within health care institutions follows a pyramidal structure. That is, there is master-servant relationship and an individual's role and status define his position in the hierarchical structure.

The questions are: what is bureaucracy? What qualifies an organization to be regarded as a bureaucratic institution? What are the underlying reasons for inventing the bureaucratic system of administration? What are the advantages of bureaucracy and what are the disadvantages?

Bureaucracy is a system of administration based upon organization into bureaus, division of labour, a hierarchy of authority designed to dispose of a large body of work in a routine manner. Viewed from a negative perspective, it can be defined as any administration in which action is impeded by unnecessary official procedure and red tape. As shown by these two definitions, one can observe that democracy is a double-edged sword - on the one end, it is very advantageous while on the other hand, it is very obstructive. These issues are discussed later in the chapter.

3.2 The Principles of Hospital Administration

For an administrator to perform efficiently, his activities should be guided by some basic principles. These include:

1. Principle of hierarchy

In all bureaucratic organizations, members of staff are arranged in vertical order according to order of seniority, i.e., subordinate-super ordinate hierarchy of line position, e.g., officer, senior officer, principal officer, etc.

This principle is also referred to as 'scalar process' because line of positional authority and responsibility run upward and downward through several levels with a broad base at the bottom and a single at the top in order to preserve the 'unity of command'. In bureaucratic or formal organizations, each member of staff knows who is his supervisor and each supervisor also knows whom he is expected to supervise. The advantage of this arrangement is that it ensures smooth flow of instructions or orders from top to the bottom. It is recognized that if a subordinate is made to take orders from several supervisors or superiors, he ends up being confused, inefficient and irresponsible. By following this principle, the authority of making vital decisions is entrusted with a specialized person who is located at the helm of the organization or unit.

2. Principle of authority

This principle is based on the belief that before a leader or administrator can have an effective control on the staff, the authority allocated to him must be sufficient. His authority and responsibility must be clearly defined and understood by everybody in the organization.

3. Principle of responsibility with matching authority

The responsibility given to an officer must be matched with authority. For example, if you delegate a responsibility to one of your subordinates (e.g., to supervise the work of the cleaners), such responsibility must be matched with an authority to give the cleaners an appropriate punishment if they fail to carry out the cleaning exercises effectively. Otherwise, the cleaners will not obey the subordinate's instructions. Responsibility without authority makes a leader a toothless dog that can only bark but cannot bite.

4. Principle of span of control

The term span of control refers to the number of subordinates which an individual has to supervise. The span of control is such as to permit as much decentralization of decision-making as is needed. This principle is meant to help the administrator in making quality decisions so as to help the organization to achieve its set of goals. Decentralization of administrative responsibilities increases effectiveness and efficiency in attaining organization objectives.

5. Principle of communication

In any organization, communication should flow from the top to the bottom and from the bottom to the top. In other words, there should be a two-way channel of communication, both vertically and horizontally. Effective communication helps organizational staff to understand the policies, values and objectives of the organization. From time to time, the staff must be informed about what is going on in the organization. One of the major causes of crisis in organizations is gap in communication. Gap in communication often breeds misconceptions, distrust, rumours and low staff moral that can in turn lead to labour unrest. Low staff morale due to communication gap often leads to low work output.

6. Principle of Organizational Structure

The administrative structure of an organization should be dynamic, i.e., it should be subject to continuous changes and adaptations as conditions

warrant. Like any open system, there should be changes in the organization's basic objectives, staff size, plans, nature of institutional relationships, etc to reflect new demands and challenges.

3.3 Types of Leadership

Leadership styles can be grouped into three as follows: democratic, authoritarian and laissez-faire.

Democratic Leadership

A democratic leader carries out the wish of the members without dictating or forcing his opinion on the team members. He allows members to participate in running the affairs of the team either directly, by involving them in formulating and executing policies. A democratic leader is always fair and objective in his judgment.

Authoritarian Leaderships

This is the opposite of democratic leadership. Here the leader is the alpha and omega. He determines the team's policy, directs every step and dictates tasks. He may be subjective in his evaluation of members or subordinates and he is very conscious of his position.

Laissez-faire Leadership

This is not a common style of leadership because of its limitations. In this method, the leader does not exercise his authority as in the two above. He gives the group freedom to do as they wish but supplies information or advice when requested to do so. He does not make impart on the members but only serves as a figurehead. However, this leadership style can be used if the leader is confident about the ability of all his staff to perform efficiently without supervision.

As a general comment, one can contend that no leadership style is perfect and in practice, administrators should combine different styles, especially democratic and authoritarian types. For example, if team members are matured, hardworking and can work independently, an administrator can adopt democratic styles of leadership. On the other hand, if the group members are carefree, indolent and agitative, the administrator may need to handle them with iron hand, i.e., adopt authoritarian leadership style until he can observe an improvement in the groups's performance. It is worthy of note that authoritarian leadership style should not be a permanent feature of an administrator's way of dealing his subjects because it might lead to conflicts, tension, protests and serious crisis within the organization.

3.4 The Factors Influencing Health Administrative Performance

The level of efficiency of an administration largely depends on the extent to which the principles of administration are well applied, recruitment of staff is done without bias orfavouritism, staff morale is kept high, the physical condition is good, interpersonal relationship within the organization is good and there is proper communication. The following factors should be considered in relation to the level of administrative performance.

1. Red tapism

In government institutions and private organizations, the staff is expected to follow some rigid procedures or routines. This excessive rigidity by officials often leads to red tape or bureaucratic bottleneck. For example, in hospitals, patients spend long periods in the outpatient department, consulting room and pharmacy before they can collect the drugs. This often leads to prolonged suffering for the patient and their relatives. Many people prefer to go to traditional healers or Traditional Brother Attendants just because of the immediate attention that they are likely to receive there. In order to improve the level of efficiency of an administration, the issue of red tape should be critically examined and if possible set aside so as to provide for quick service, especially in hospitals and health centers. In the hospitals, health professionals should give appointment to their clients, specifying the exact time. By asking all your clients to come at the same time, the tendency is that they will have to queue up and stay for al long period before each of them can be seen or attended to. In Nigeria, with the introduction of the National Insurance Scheme, private involvement in health service delivery will increase substantially, thereby increasing in geometric proportion the level of competition. Hospitals that cannot set aside red tapism might pack up prematurely because clients will have a wide choice. In South Africa and Botswana, this has been their experience.

There, the private hospitals are administered like any big private company, like hotels and manufacturing industries and clients are treated like hotel guests. They are valued and provided with services exactly at the appointed time. If you missed your appointment without prior arrangement, the computer will indicate if there is a space and you will have to wait. Otherwise, they will give you another appointment within a short period, provided it is not an emergency.

2. Punctuality

Irregularity and unpunctuality lead to laxity, thereby causing inconvenience to the public. If a leader himself is always unpunctual to work, he is a bad example to his subordinates and he will find it difficult to enforce punctuality at work among other and rules. Clocking of arrival time can solve this problem if the staff find it difficult to honour their commitment to be punctual and regular at work.

3. Abuse of power or position

Administrators should avoid abuse of power by all means possible. All resources should be used for the purpose for which they are meant. Abuse of power often leads to lack of confidence in the administrators and internal unrest. It can lead to corruption, high handedness and low output.

4. Formalism or bureaucracy

Bureaucracy is meant to improve the performance of an organization by laying down the rules governing the behaviour of its workers or staff and prevent misuse of power. Unfortunately, some administrators apply bureaucratic rules to cause inconveniences for the public. Such rules are applied so rigidly by some administrators for their own selfish end thereby causing an obstruction in the flow of information and job performance. The corrupt officers in many organizations use bureaucratic rules to cause prolonged delay and manipulate the rules so that they can perpetuate corruption and embezzlement.

3.5 What Qualifies an Organization to be regarded as a Bureaucratic System of Administration

For a system to qualify as a bureaucratic organization, Max Weber, who was the greatest exponent of bureaucracy, specified eight requirements as follows:

- The regular activities of the organization should be distributed in a fixed way as official duties.
- A specified sphere of competence has been marked off as part of a systematic division of labour.
- The official is subject to strict and systematic discipline and control in the conduct of his office.
- All operations are governed by a consistent system of abstract rules.
- The organization of offices follows the principle of hierarchy, i.e., each lower office is under the control and supervision of a higher one.

- Officials are subject to authority only with respect to their impersonal official obligations.
- Candidates are selected on the basis of technical qualifications.
- Being a bureaucratic official constitutes a career. There is a system of promotion according to seniority or achievement or both.

An analysis of the points listed above would show that the engine of the health care System is being powered by bureaucracy, and whether in the hospital or primary health care facilities, bureaucratic practices form the tradition.

3.6 What are the Underlying Reasons for Inventing the Bureaucratic System of Administration?

In spite of the complains that people globally have against bureaucracy, it will continue to serve as an important element of administration, which is inseparable from it. As an organization becomes larger and larger, the system becomes complex and without a system of administration that can accommodate this complexity, management and leadership become a Hercules's task. In a large administrative apparatus, therefore, bureaucracy and bureaucratic practices are functionally necessary. As a process and an element of administration, there are five underlying causes of bureaucracy as follows:

- **Complexity:** The modern state is very complex and the magnitude of the services it has to render to the public is very enormous. This makes it necessary to have an expert administration that must be able to cope with formulation, execution, and enforcement of rules and regulations, which involve division of labour, specialization, organization and management of a large group of people. All these in return imply hierarchy.

- **Size:** The larger an institution, the higher the tendency towards inflexibility and impersonality. In large organizations, the procedure for providing services consists of a long routine and procedures that usually causes delay and stress to the client. In such organizations, if care is not taken, efficiency might start to decline and concern for human element might also disappear and become irrelevant.

- **Accountability**: In order for government officials and managers to minimize the occurrence of mistakes while performing their procedures, they tend to take pains to examine every issue from all possible points of view. Furthermore, in the civil service and other large organizations, in order to avoid being accused of partiality and favouritism, there is the need to establish a uniform body of precedent for application to cases that arise. Accuracy and

accountability are two important attributes of an efficient organization. In the pursuit of this, rules and regulations are established, forms are devised and memoranda are circulated on daily basis. Since those operating the rules and regulations are bound by them, an element of inflexibility is created.

- **Specialization:** Specialization is a potential source of bureaucratic tendencies. It tends to restrict and narrow individuals, just as hierarchy makes institutions rigid. However, both hierarchy and specialization are necessary for the efficient discharge of complex functions. On the other hand, both add to the number of factors that produce inflexibility and impersonality.

- **Pattern of organization:** The pattern of organization of an institution is very vital to its efficient running. It is the way an institution is organized that determines the structure of the institution and the hierarchical process of functions and persons. As bureaucratic organizations, large-scale companies or institutions clearly define the chain of command, stratify their workers according to ranks and make explicit the pattern of authority. These are attributes of bureaucracy that are indispensable to large-scale organizations, like the health care institutions.

3.7 The Advantages of Bureaucracy with Reference to Health Facilities

As previously stated, bureaucracy and bureaucratic practices are functionally necessary for the operation of a large administrative apparatus, including the health facilities. They constitute an instrument for the achievement of quality assurance and efficiency in large organizations. Bureaucracy is concerned with the most efficient means of planning and control. In a strictly bureaucratic administration, like in the teaching and training hospitals, precision, speed, unambiguity, continuity, discretion, unity, strict subordination, time consciousness, reduction of conflict and prudent management of resources are raised to the optimum, at least in principle. In the health facilities, specialization and hierarchy help in the efficient discharge of complex functions. For example, in University Teaching Hospitals, such as the University College Hospital (UCH), Ibadan, patients are treated strictly by specialist doctors and nurses who have adequate knowledge of the disease, and the skill and experience to offer efficient services.

Secondly, in the hospitals and clinics, all the health professionals are constantly conscious of public accountability and are therefore anxious not to make mistakes that would expose them. When mistakes occur, there are procedures to investigate them and recommend appropriate

sanctions for those found guilty either by commission or omission. For example, recently, two cases were exposed in some daily newspapers that raised the issue of professional misconduct and negligence. One was a case of a child that was said to have been born with HIV negative status but who became positive after receiving blood in the hospital. The second case refereed to a child who was born with a HIV positive status and later developed diarrhea and had to be given fluid, parenterally. The child later developed a gangrenous arm as a result of infection at the site of the needle and had to be amputated. The government promised to examine the two cases from all possible points of view and make sure that justice was done. In both cases, justice was done eventually.

3.8 The Disadvantages of Bureaucracy with Reference to Health Facilities

The negative aspects of bureaucracy often attract attention world wide because the practices and operations are often overdone. In other words, there is usually an excessive development of bureaucratic routines, which often get in the way of discharging efficiently the functions of an organization. As a process, bureaucracy has inherent elements, which make it cumbersome and unattractive to the consumers of services, especially in hospitals and clinics. In most hospitals in Nigeria, patients, especially mothers, often arrive as early as seven o'clock in the morning or earlier but might not go back home until late in the day due to bureaucratic bottleneck.

Even patients who were brought in under an emergency situation are often kept on wheel chairs and stretchers for hours due to routines that are fragmented and performed without any element of flexibility. Although the situation has since improved due to the application of primary health care approach but the vestiges of those bad old practices still remain in several hospitals and clinics. Hence, many patients fear going to the hospital for treatment and would rather come when the situation has reached an emergency stage.

This is one major reason why some patients still prefer to seek treatment from traditional doctors or traditional birth attendants (TBAs). Recently, the author attended a workshop as an observer where the issue of high maternal mortality in both urban and rural settings of Nigeria was discussed in relation to the poor handling of labour and delivery by traditional birth attendants. The picture that was painted by the nurses, environmental health officers and doctors who attended the workshop as either facilitators or participants was very gloomy because the rate of delivery by TBAs was still very high while the skills remain very poor and the complications of labour continue to increase at geometric rate. The point being made here is that if the primary health care facilities and

secondary facilities are not bugged down by administrative bottleneck and complexities, Nigeria has enough resources to ensure that every pregnant mother receives adequate antenatal and postnatal care.

Mothers and their children have the right to live and they should not be sent to early grave due to lack of confidence in the public health care system.

4.0 CONCLUSION

For hospital to function effectively and efficiently it must have a system of administration, despite the inherent problems in bureaucracy, it has been discovered as the best way of administering hospital facilities if it must be productive, meeting the demands of both the consumers and proprietors of health services. Proper understanding of the bureaucratic administration will assist the health service providers / administrator in order to run the health organization effectively with little problem whatsoever.

5.0 SUMMARY

The students have gone through the meaning of health administration and bureaucracy, principles of hospital administration, factors that influence health administration, what qualifies a hospital as a bureaucratic system of administration, advantages and disadvantages of bureaucratic hospital facilities.

6.0 TUTOR MARKED ASSIGNMENT

Despite the inherent problems in bureaucratic hospital facilities, why is it still being used today in Nigerian hospitals?

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UNIT 2 FACTORS RESPONSIBLE FOR INEFFICIENCY IN THE GOVERNMENT HEALTH INSTITUTIONS IN NIGERIA.

CONTENTS

1.0 INTRODUCTION

There is no doubt that even though health financing by government in Nigeria is ridiculously low compared with other sectors but at that little funding made available, there is a gross inefficiency in the government health institutions in Nigeria which does not reflect the meager resources allocated to it year in year out.

This Unit is expected to identify some factors responsible for the decay and possible measures to control the situations.

2.0 OBJECTIVES

At the end of this unit you are going through you should be able to:

- Identify and discuss some factors responsible for inefficient Government Health Institutions in Nigeria.
- Explain measures to control the identified factors.

3.0 MAIN CONTENT

3.1 Introduction

Compared to the other government sectors, the health sector has received the highest level of negative comments both in the

communities and by the mass media. Like other parts of Africa, the Nigerian public believes that the public health institutions are highly inefficient and insensitive to the needs of the patients / clients. It is the perception of the consumers that many doctors and nurses are rude, lack emotional support skills and have divided interest. The public believes that health workers often fail to show patriotism and dedication to work. in recent time, the society, collectively, is engaging its mind with issues occurring in the society today which the society perceives to be a sign of downward trend in skills acquisition by the health workforce compared to the past generation of health workers. The public believes that the training programme being implemented in the health educational institutions in the current period lack the ingredient to produce efficient and effective health professionals. The question is: what are the indices being used to measure efficiency by the public? How effective are those indices? Who should be blamed for the lapses or what are the dynamics of the problems of inefficiency in the public health sector? One major issue that should be appreciated is that it is highly complicated to measure and value the health services being provided in the public health sectors because such services are seldomly expressible in concrete terms. Since such services are quantifiable only by measuring the effect on mortality, morbidity and the quality of life, the public has a vague idea about the impact of the public health services on the health of the society.

This, however, does not exonerate the health professionals from the serious misconduct, which often characterizes the behaviour of many professional health workers. After all, the WHO (2000) did not mix words when it observed as follows:

"Globally, many system are highly unresponsive. The health system has become highly impersonal and inhuman in the way it process people. A common complaint in many countries about public sector health workers focuses on their rudeness and arrogance in r elation with patients. Waiting time for non-emergency surgery varies considerably among industrialized countries and is the subject of much criticism of ministries of health".

WHO (2000) addressed the issue raised by the author above, that is: what are the indices being used by the society to measure the level of efficiency of the health workers? WHO (2000) explained that health workers' responsiveness to patients' needs can be measured by assessing two major elements, which can further be subdivided as follows:

Respect for Persons

This can be subdivided as follows:

- Respect for the dignity of the person.
- Confidentiality or the right to determine who has access to one's personal health information.
- Autonomy to participate in choices about one's health.

Client Orientation

This includes:

- Prompt attention: immediate attention in emergences and reasonable waiting time for non-emergencies.
- Amenities of adequate quality, such as cleanliness, space and hospital food.
- Access to support networks, such as families and friends.
- Choice of provider, or freedom to select which individual or organization delivers one's care.

3.2 What is Inefficiency?

Inefficiency can be defined as a person's or group's inability to perform a task or function to the best advantage or to be wasteful or incompetent. It can also be defined as a person's inability to produce the desired result within a reasonable time. In relation to quality assurance, inefficiencies refers to a health professional's inability to perform according to standard. Since efficiency refers to an input-output relationship, which means maximum work achieved for a minimum input or resources, inefficiency therefore implies inability to process the input to produce maximum output or services within a reasonable time or period.

3.3 Causes of Inefficiency

The cause of inefficiency can be categorized as follows:
Institutional Factors: These include the following:

(a) Bureaucracy: As previously discussed, bureaucracy is functionally necessary for the operation of a large administrative apparatus. But in the government health facilities and institutions in Nigeria, there is always the issue of excessive development of bureaucratic routines that get in the way of discharging efficiently the functions of the organization. For example, in the hospitals, the insurance of forms is needlessly multiplied and excessively elaborated to the extent that it might take a patient a long period to obtain cards or complete registration before seeing a doctor.

(b) Numerical imbalances: Nigeria is one of the countries in the sub-Saharan African region experiencing varying degrees of shortages in qualified health personeel. In Nigeria, it is not that there is obvious limited training capacity but due to low pay for available health personnel, there is a serious problem of brain drain. As a consequence, even within Nigeria, there is growing formal and informal private practice. Of greater consequence is the fact that globalization has led to greater mobility of staff and opportunities for overseas job placement for nurses and doctors has grown tremendously due to the improvement in the economy of the industrial countries and relative peace globally. The shortage of experienced and even non-experienced nurses and doctors is causing severe problems in service delivery.

There are two types of imbalances in human resource supply: training and skill mix imbalances and distribution imbalances and both problems exist in the Nigeria health system. In the case of training and skill mix imbalances, health workers, especially in rural areas, are often unqualified for the tasks they perform because of distribution imbalance or lack of training opportunities or there is a mismatch between skills and the needs and priorities of the health care system. It is worthy of note here that neither formal training nor professional qualification necessarily equates with skill and experience in dealing with a specific health problem. Regarding distribution imbalances, Nigeria, like other sub-Saharan African countries, has serious urban / rural imbalances among its health professional human resources and also faces problem in meeting the needs of specific groups, such as the poor, the rural dwellers and the handicapped. In most health facilities, there is a few number of professional staff to attend to a large number of patients. For example, in a ward of over forty helpless or bedridden patients, there might not be more than three or four nurses. Furthermore, in an outpatient department having over five hundred patients per day, there might be only two or three doctors and pharmacists on duty. In many rural areas, the situation is even worse due to urban / rural imbalance. In many remote villages and hamlets, the delivery of health services is usually left in the hands of either voluntary health workers or people who have very little training or young nurses or community health workers with little or no experience. Health administrators should be conscious of the fact that except if the situation regarding social amenities in the rural areas is improved, health providers will continuously tend to concentrate in the urban areas.

(c) Poor resource supply and maintenance culture: In spite of the nature of the national health policy which is based on the philosophy of primary health care, the government health facilities are still poorly equipped and there is little or no culture of maintenance. Today, in Nigeria, the primary health care facilities and hospitals have been relegated to prescription centers because patients have to buy almost every prescription and medical supplies from the private chemists. In the wards and specialized centers, there is lack of essential equipment and the few that are available are in poor condition. However, recently, the Federal Government embarked on a project to refurbish the Federal Teaching Hospitals, which again, are concentrated in urban cities.

(d) Low morale among health workers due to lack of motivation: Since the period of military intervention in government, there has been little or no incentive for workers. The situation of government workers in Nigeria is very pathetic. Compared to their colleagues in many parts of Africa, especially the southern African countries, health workers are poorly paid. The salary might be paid late or not paid for several months in some institutions; and even when paid, the amount cannot last up to a week because of high inflation, coupled with unemployment among most family members who need to depend on the only one member of the family who is gainfully employed. Health workers, like their other counterparts, find it difficult to buy a good car, build their own houses or send their children to good schools due to poor financial status. In Nigeria today, among government workers, there is serious poverty in the midst of huge national resources. Poor implementation of socio-economic policies to ease the suffering of the common man leads to mass poverty which often results to poor or negative work ethics as well as low morale. The implication of this is that workers can no more be patriotic because their households are in poverty, i.e., their incomes place them below the Poverty Datum Line (PDL). In the developing countries of Africa, the PDL is based on six categories of items which are considered to constitute the basic needs of a family as follows: food (the minimum necessary to maintain physical health), clothing (to meet standard of legality, decency, practicality and warmth), household goods, shelter, safe drinking water and protective environment. With the condition of workers in Nigeria, it is difficult to meet the challenges of using above the PDL.

(d) Poor leadership and lack of supervision: Due to low morale, the superior officers do not pay much attention to proper supervision of staff. Since the jobs cannot provide them with their needs, there is

little or no patriotism and only few people care about the outcome of the services being rendered. Both the leaders and those being led often develop poor attitude to work. Some supervisors have little or no relevant experience to supervise their subordinates effectively either because they were promoted based on nepotism or lack of experienced people to occupy the vacant positions. For example, the political development in Nigeria some years ago resulted in the creation of many new states. The end result was that suddenly, some health workers in the new states were picked and catapulated into higher positions which would certainly not have been the case in the normal course of events before the new states were created. For example, in the early 1970s, in the Western state, there were several specialist doctors and nurses who had spent many years in the hospitals and served meritoriously. But when the new states of Ondo and Ogun were created, these elderly, experienced doctors and nurse were transferred to their states and many of them resigned out of annoyance and frustration.

(f) Frequent transfer and premature retirement or massive purge: The habit of sending health workers, especially nurses, on transfer frequently often leads to frustration and apathy because it creates problems for the family and can lead to marital problems. The end result is that the person concerned shows little interest in the work and becomes apathetic. In many states of the federation, due to lack of vacancies in the government ministries, workers are retired either due to long period of service or age.

(g) Political factor and nepotism: People holding political offices in many states often take over the role of health administrators to recruit and promote staff. In some states, the admission of students to the training schools is often carried out by politicians in charge of supervising the health institutions and the implication of this is that students are admitted on the basis of whom they know or political influence. In other words, due to nepotism, students with poor ordinary level results are admitted into the training institutions.

(h) Trade Unions and power struggle: Since the time of the military in government, due to shabby treatment of workers, especially non-payment of salary and delay in the payment, trade unions have assumed enormous power, which often leads to frequent strike and trade disputes. On several occasions and quite frequently, workers withdraw their services due to trade disputes with the government or management. This has almost ruined the good name of the government health institutions because of the drastic effect of the strikes on patients and relatives, especially those on admission or

who were expected to be operated on within the period of the strike. At times, the relationship between the administrators and trade union leaders is one of acrimony and antagonism rather than partnership.

This often affects the quality of care or output.

Personal or individual factor

This can be categorized as follows:

(a) Poor experience or lack of administrative skill and knowledge: Due to brain drain, the most experienced doctors and nurses have migrated out of the country in search of greener pasture. This often leads to the situation where young doctors and nurses are put in-charge of health facilities as administrators and team leaders, especially in primary health care centers. In many hospital wards, newly qualified nurses and doctors are made to occupy leadership roles. This often leads to poor leadership, bullying the subordinates, confusion, lack of direction and inefficiency.

(b) Poor personality: Some health workers exhibit poor attitude to work due to factors inherent in them. Such workers often display little or no human feeling towards their clients and might end up not being able to satisfy the needs of the clients.

(c) Divided interest: In order to be able to afford the basic necessities of life, such as food, housing and clothing, many health workers engage in other gainful activities. In fact, some workers treat their primary assignment or job as if it is a part-time job so that they can have enough time for their activity, such as buying and selling of essential commodities or private practice. In every part of Nigeria, many doctors, physiotherapists, x-ray technicians and nurses engage in private practice at the expense of their job. WHO (2000) emphasized this point as follows: “Many physicians work simultaneously for the government and in private practice. When public providers illegally use public facilities to provide special care to private patients, the public sector ends up subsiding unofficial private practice. Health officials are aware of practice-related laws but know that enforcement is weak or non-existent. Professional associations, nominally responsible for self-regulation, are too often ineffective. Policies to change the balance between provider’s autonomy and accountability need to be monitored closely in terms of their effect on health, responsiveness and the distribution of the financial burden”.

(d) Misuse of time and energy: Due to indiscipline in some institutions, some health professionals spend their time gossiping and discussing politics. At times, nurses gather in the nurses' room to discuss issues related to local politics for hours, waiting for the closing time to come so that they can go home. Patients and their relatives are often aware of this bad practice but often keep quiet in order not to risk being victimized or fear of being neglected. In many hospitals, relatives serve as care-providers for their patients by feeding, bathing or cleaning their sick relatives on admission.

3.4 The Cost of Inefficiency in the Health System

The clear symptoms of inefficiency include poor performance, deteriorating health facilities due to lack of concern or apathy. Physical capital deteriorates in a more visible way and the patients turn to the private sector (which might not be able to offer better services but are more costly) in search of better quality care. Due to inefficiency in the health facilities in Nigeria today, very large numbers of preventable deaths and disabilities occur, there is unnecessary suffering by the patients and their relatives, injustice, inequality and denial of basic rights of individual for treatment and care. The effect is mostly severe on the poor, the elderly, children and their mothers and the chronically sick who are driven deeper into poverty by lack of financial protection against ill health. Poorly structured, badly led, inefficiently organized and inadequately funded health systems may do more harm than good to the health of the populace. In the face of high level of inefficiency, consumers' interests are weakly protected and the notion of the Patients' Bill of Rights is never promoted. Worse of all, the machineries established to investigate and deal with violations quickly and fairly are never applied or not in existence in some work settings.

3.5 How to Improve Efficiency among the Health Workers

Any effort geared towards improving the level of efficiency in the health facilities should take into consideration all the factors discussed above. One of the major factors in improving efficiency in the health facilities is to equip health administrators with the knowledge and skill in human resource management. They should be experts in administration and management and not just experienced professionals, such as doctors and nurses. This is discussed in Chapter 9.Both the workers and the management must be clear about the goals and objectives of the institution and work together to meet the needs of the staff and the organization. A situation where staff welfare is relegated to the background often leads to apathy and low output. The point being made here is that it is only when the workers feel fulfilled and satisfied that

they can perform efficiently and give quality services. Most health workers in Nigeria spend their working hours to face the challenges brought about by children's education, feeding, shelter and transport. Their mind is far away from their work and quite often, they think about life after retirement. In a country where full salary is not enough to meet the basic necessities of life for one or two weeks, how can the so-called retirement benefit, which is seldomly paid, be enough to carry on with life at old age!. Therefore, the government should give serious thought to the plight of workers. After adequate measures have been taken to improve the quality of life of the workers, effective mechanism should be introduced or reintroduced to check the excesses of the government health workforce.

Today, the hospitals are treated as a battlefront to deal with conflicts between the workers and the management / government. All these should be done away with. In modern management, the health workers and administrators should work as a team to achieve a common goal. Hospitals and health centers should be run like a business or company where the goal of all the stakeholders is how to achieve objectives are planned.

According to WHO (2000), three types of human resource strategy have been pursued with some success as follows:

- Making more efficient use of available personnel through better geographical distribution, especially to bridge rural-urban gap in human resource allocation.
- Greater use of multiskilled personnel where appropriate.
- Ensuring a closer match between skills and functions: Formal training of health workers, particularly highly skilled staff, like doctors, nurses and public health professionals, should reflect the actual task expected to be performed. Other wise, the resources expended on the training programme might be wasteful and the situation demoralizing.

Based on the above, the following suggestions are made:

- The welfare of staff should always be given priority. However, part of the responsibilities of the health administrators and the management in Nigerian hospitals today is to forestall the present situation whereby once staff have been paid their salaries and other emoluments from the recurrent budget, there will be little or nothing left to spend on equipment, medicine, consumables and maintenance of facilities. In accordance with the principle of management, this is evidence that there is either poor funding of health institutions or simply too many staff, often reflecting the training of staff relative to

population norms or need-based planning, rather than in accordance with resource based planning.
- Need to define or redefine institutional goals clearly and to make it explicit to every worker.
- Adoption of total quality management (TQM) technique as discussed in chapter 13.
- Proper training of all health professionals and opportunity for continuing education for all.
- Constant review of programmes and activities with the view to improve the quality of services.
- Optimum use of talents and ability of workers to achieve organizational goals.
- Promotion and advancement should be based on merit.
- Policies should be established to guide practice and facilitate supervision and evaluation of staff.
- Staff transfer should be treated with caution to avoid frequent transfer, disruption of children's education and separation of couples.
- The needs of the patients' or consumers should receive priority when industrial / trade disputes are being addressed. The situation whereby nurses and or doctors arrange to discharge seriously ill in-patients in a hurry during the period of strikes or any trade dispute is very ungodly and absolutely immoral.

Which of us would want to be carried home (conscious or unconscious) on a stretcher either with a drip set in-situ, with a Foley's Catheter-in-situ (which is dripping blood), with under-water drainage tube, with trachea tube in place or oxygen? Or which woman (nurse or doctor) would want to be sent back home during labour or just immediately after delivery, with continuous bleeding or retained products of delivery or having eclamptic fit or a child with difficult breathing? All because of a grievance with the management. The picture that hospital workers often send to the public in such situations is that every death is part of a statistics and it does not matter who is affected or how many people die. Whereas, according to societal norms and God's expectation, a death is a loss too many in a family or community!

Recently, specifically July 2006, the author participated in conducting an interview for admission into the university where he works. During the interview, one of the interviewers asked a female candidate the following question: Why did you decide to join the nursing profession? The girl said: My mother died during labour because she was discharged from the hospital where she booked because there was a strike and since that day, I decided that I would become a nurse if God should give me the grace. That was a very emotional moment for most of us and I could feel the sober mood of the girl being interviewed. Did this girl consider her mother's death as part of statistics? Of course, no! To her, it was a

disaster and a tragedy too great; and although a single death, it was a loss too many for her family.

One option the author wants to advocate here is that during industrial actions, when it comes to the care of in-patients or emergencies, nurses, doctors and technologists who want to continue to render services should not be molested. They should be left to satisfy their conscience. The number allowed to remain might be minimized not to dilute the effect of the strike but not to close our eyes to the needs of the patients and relatives.

4.0 CONCLUSION

Every effort should be geared towards improving the level of efficiency in the health care facilities run by the government so that there can be justification for the scarced resources that goes into health care delivery every year so that the needs of the citizenry can be met. One actually wonders that if health care is being run by private individuals / organizations and successful, then the government should be much more successful hence the attitude of the governed and government (workers and policies) must be re-engineered to a successful path.

5.0 SUMMARY

The students have been taken through factors responsible for the failure of government health care delivery system in Nigeria and possible measures that can be taken to reduce or eradicate the inefficiency. This means that citizens must change their orientation towards government health care delivery system i.e. the providers and consumers of health.

6.0 TUTOR MARKED ASSIGNMENTS

1. Identify five factors that may lead to inefficient government health institutions in Nigeria.
2. Discuss possible solutions to any of the three identified factors above.

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UNIT 3 INFORMATION MANAGEMENT IN HOSPITALS

CONTENTS

1.0 INTRODUCTION

Information is one of the intangible resources of an organization. The importance of information in an organization, cannot be over-stressed because it is indispensable. No matter the nature of the organization information is needed. Its indispensability or importance warrants its effective and efficient management. Information is also very costly and can be very scarce. Information is derived from data. When data is subjected to quantitative analysis through compiling and manipulating, qualitative information is derived which is used for decision making.

This Unit will expose you to the meaning of information in the hospital set-up, the characteristics of information, the need to manage information, sources of information, types of information, management information system and information technology.

2.0 OBJECTIVES

At the end of this Unit, the students must be able to:

- Explain the concept “information”
- List the characteristics of information.
- State why hospital workers should manage information
- Discuss the sources of information
- Explain what Management Information system (MIS) is
- Discuss what Information Technology (IT) is all about.

3.0 MAIN CONTENT

3.1 The Concept of Information

Information like many other words has many and varied meanings. Webster NewWorld dictionary (1980) defined information as "knowledge acquired in any manner, facts, data, larning, lore". Nwankwo (1985) said that information can mean interrelated or structured data, including collection, storage, processing and dissemination of news, data, .. facts, messages, opinions and comments required in order to react knowledgeably as well as to be in position to take appropriate decisions".

3.2 Characteristics of Information

Sander (1983) pointed out that information has attributes of a physical resources like such resources as manpower, money and materials. He said that information

(b) has value like money, raw materials or manpower.
(c) is measurable in terms of use, life and effects on other resources.
(d) can be valued in terms of collecting, storing, retrieving.
(e) can be budgeted and controlled.
(f) can be related in terms of cost and use value to management objectives.

3.3 Necessity of managing Information

Sometime ago, a state government in Nigeria sent a circular to her employees about the need to manage information. In the circular, the government expressed some worry and disappointment about the leakage of confidential and secret information contained in staff files. By information management we mean an act of planning, organizing, storing, retrieving, controlling data in an efficient way. We have information either verbally, in writing or on computer storage devices e.g. diskettes in large quantity. But what is important is to get the information processed so that it can be qualitative, appropriate, accurate, timely, concise, adequate or complete and inexpensive. Information must be managed in order to make it usable or relevant, understandable, clear, as frequently as possible, and provided in a suitable form. Unless information is managed the manager may acquire and store unnecessary information and this wasting his resources (efforts, time, money, etc.). Information has to be managed so that required information is available when needed at the right time and place.

Another reason for information management by managers is because organizations are growing at alarming rate, volume of the information received is very large, the information is received in many and varied forms, information is also sent out in different forms and above all organizations have become very complex and complicated.

There are different levels in organizations. In these organizations we have generalist and specialist managers. We also have top and middle level managers. Information required at the different levels may not be the same.

The top level managers are the policy makers. They make long-range strategic decisions and therefore the information they will need will be different from the information needed by middle-level managers who are responsible for tactical decisions and for implementing the decisions of the top-level managers. The lower-level managers who are responsible for day-to-day operational decisions of the organization will have different information from the top level and middle level managers.

Because of competitions in businesses the need to have accurate, timely, complete and concise information is essential.

3.4 Sources of Information

There are two major sources of information. They are internal and external.

Internal Sources of Information

These internal information come within the organization. These information may be obtained from written reports of committees, minutes of meetings, catalogues, sales records, receipts, invoices, trading and profit and loss accounts, balance sheets, computers, mail registers, application forms, employment data forms, tax cards, salaries and wages vouchers or sheets, production records, personnel records, log books diaries etc.

External Sources of Information

These external sources of information include sources of information outside the organization. These sources include the following: research organizations, banks, insurance, and other financial institutions, trade unions, professional organizations, chambers of commerce, gazettes journals, dailies, libraries, constitution, etc.

3.5 Types of Information within an Organization

Information are contained in documents. Both the documents and their contents are classified as general or open, confidential, secret, top secret, restricted and urgent.

1. **General or Open Information**: These information are contained in documents filed in general office or an open registry. As the title indicates, all the workers in the office where these files are kept can have access to them. However, they do not have any moral justification to disclose the contents of the documents to people outside the office without authority to do so.

2. **Confidential Information***:* There is usually confidential registry in some organizations where information about workers should remain confidential. For example students' results, patient's illness, evaluation of Annual Performance Evaluation Report (APER) forms and some disciplinary measures against staff are confidential matters which should not be divulged to anybody. Only specially trained workers are allowed to handle these documents. Any officer who leaks these information will not go unpunished.

3. **Secret Information:** These information are very sensitive to the organization rather than to the workers. They touch on politics, white papers, business strategies and very important decisions of organizations. Only top level managers and very senior civil servants are allowed to have access to this type of information. Some organizations have 'secret registry' where the documents containing these information are kept. Especially trained workers are put in charge of these documents.

4. **Top Secret Information:** These information are so important to the organization that only the Directors of the organization can handle and have access to them. the leakage of these information can destroy the organization or government permanently.

5. **Restricted Information***:* These information can only be discussed in a designated office. The information should not be for public consumption. They should not be discussed at home, market place, etc. although they are kept in the general or open office.

6. **Urgent Information***:* Some information may be classified as urgent because any procrastination in their implementation may be disastrous or very expensive. For example an information about the time a flight is to begin or about the life of a person should be regarded as urgent.

Communication or flow of Information

In order to justify the amount of money expended on processing data (input) before obtaining information (output) the information must be communicated to those who need them.

Information may be disseminated or transmitted vertically or horizontally. The top level manager may pass information downwards in form of delegation, instruction or query. The subordinate communicates upward by replying to query, giving reports and providing suggestions.

There are two communication systems: one-way system and two-way system (which requires a feedback is better). Information flow or communication of information may be adversely affected by noise or lack of concentration. Noise which is defined as "all influences which reduce accuracy" can occur at the stage when information is collected, communicated, received, and interpreted. One practical case of how information can be distorted is presented below and I wish it is practiced with a group. There was a class of 30 students. A phrase was whispered into the ear of one student in the front of the class. This student passed the phrase to the next student. This continued to the last student at the back of the class. When the last student was asked to write down what he was told, a completely wrong information was produced. This finding also shows the disadvantage of oral communication.

3.6 Management Information System (MIS)

In order to manage information efficiently, a system has to be adopted. Because information differs from organization to organization there are therefore many and varied systems.

A system is defined in many ways. It is defined as a set or arrangement of things so related or connected as to form a unity or organic whole. It is also defined as a set of facts, principles, rules classified or arranged in a regular, orderly form so as to show a logical plan linking the various parts. Another definition is that it is an established way of doing something, method or procedure, (Webster's NewWorld Dictionary 1980).
Certo (1980) defined a system as a "number of interdependent parts functioning as a whole for some purpose."

There are two types of system: closed and open systems. A closed system is one that does not interact with its environment. A clock is a good example of a closed system because regardless of its environment it will continue to function, worse weather or climate cannot affect the

working of a clock. An open system interacts with its environment constantly. This constant interaction with the environment determines its existence and its future. An organization can be regarded as an open system.

The management system is composed of organizational input, organizational process and organizational output, which interact interdependently to achieve one purpose e.g. profit

The management system is an open one because it interacts with its environment. Information system involves the capture, transmission, processing, storage, communication and retrieval of data, message or symbols which interact interdependently to achieve an objective.

Management information system therefore can be defined as a method of processing data efficiently so that the information received can be used for decision making necessary for the organization to attain its objective.

Sander (1983) defined management information system (MIS) as
A network of computer-based data processing procedures developed in an organization and integrated as necessary with manual and other procedures for the purpose of providing timely and effective information to support decision making and other necessary management function.

Computer and Management Information System

A computer is used to generate information for organizations because of its advantages. A computer in generating information performs five functions which are: Input function, storage function, processing function, control function and output function. The output function is concerned with bringing out the results of the processing system from the computer for use in decision making.

3.7 Information Technology (IT)

The Oxford Dictionary of Business (2002) defined Information Technology (IT) as “The use of computers and other electronic means to process and distribute information”.

Having looked at the traditional management of information in terms of equipment, stationery, and personnel activities (filing, retrieval, etc.) we can now look at the information Technology with regard to information management. Computer is used in modern offices to generation and process information for organization’s decisions.

Gone were the days of adding and listing machines for calculation. Computer and electronic calculators are now used. Computer can be used for business. For example, we can use computer to buy and pay for goods and services through networks of connected computers. There are in modern business such terms as electronic transfer of funs, e-commerce or telecommerce, e-banking or telebanking and teleshoping. We all know that you can cash money any where in Nigeria from many commercial banks without banking with them.

Onifade (2001, p 327) defined computer as "an electronic machine which receives and processes data in order to produce usable information required for decision making." The Oxford Dictionary of Business (2002) states that a computer is "an electronic tool that manipulates in accordance with a predefined sequence of instructions." A computer can store, retrieve, edit and merge data or information.

The properties, ingredients or characteristics of good information are accuracy, timeliness, completeness, conciseness, cost-effectiveness, frequency and relevance.

I want to assume that we have all seen a computer. A computer has four major components such as the Central Processing Unit, (CPU), Software, Monitor, and Keyboard. The details of their working are beyond the scope of this paper. We can use the following softwares for graphics, drawing and electronic messages: Windows, Pagemaker, CoreDraw, MSDOS, Microsoft Pages and Network Systems e.g. Internet.

The Auxiliary Storage Device

The storage devices which computers use, their advantages and disadvantages are:

Diskettes

The Diskettes that are available today are $3^{1/2}$ diskettes and have capacity of 144MB (Megabytes) recall that approximately 1000 Bytes = 1KB and approximately 1000KB = 1MB).

A diskette is inserted into the floppy drive of a system unit and therefore requires a floppy drive to function.

Advantages

1. Virtually all computers have floppy drives and that means diskettes can be used anywhere.
2. They are very cheap.

Disadvantages

1. It has low capacity
2. It is unreliable - get damaged easily.

Compact Disk (CD)

CDs usually have capacities between 250MB and 750MB. The CD is inserted into a CD drive in the system unit. All CD drives can read CDs but only CD writers drives can write information into Writable or Rewritable CDs.

Writable CDs- you can only write into them but cannot erase or modify their contents.

Rewitable CDs – you can write, erase and modify their content / information.

Advantages

1. It has large storage capacity and can therefore contain large documents and programmes.
2. It is reliable as it can last very long.

Disadvantages

1. Not all computers have CD drives and even many computers that have CD drives do not have CD Writers. O, you cannot readily use this storage accessory anywhere.
2. External CD Drives which can be carried about expensive and big / heavy / not portable.

Zip

Popular Zips today can have capacity of 100MB or 250MB. They require a Zip drive to work.

Advantages

1. It has large capacity.
2. The External Zip drive is quite small.

Disadvantages

1. Zip drives are not yet very popular.
2. 100MB Zip drive cannot work with 250MB Zip.

USB Flash Disk

This can have 64MB, 128MB capacities. It requires a USB port at the back of the system unit to function.

Advantages

1. It is very small and portable and does not require the use of a drive.
2. Its capacity is large.

Disadvantages

1. It is fragile
2. Old systems do not have USB ports

Magnetic tapes

This is one of the old backing storage devices. They are fast input and output media used as backing store devices. It can record up to 10,000 employees' records. It can have between seven or nine tracks. In the way magnetic tape records sound on a standard tapes recorder, it can equally record data.

Advantages

1. It is a fast medium of storing data
2. Alterations can be made on it.
3. You can update data on it.

Disadvantages

1. It is a serial processing device which means that in order to make an alteration you have to make a new type and you have to read through the whole tape.
2. It is old.

Magnetic Discs

Magnetic discs can be likened to gramophone records because information on magnetic discs is recorded on tracks.

Advantages

1. Unlike magnetic tape, information does not have to be read sequentially
2. You can access any record randomly and directly
3. It is easy to access a disc from a cabinet because you can easily label a disc.

Disadvantages

1. It is old
2. The capacity is small compared with modern devices.

The Computer and Filling System

There are four files which can be employed in the computer. They are storage, reference, back-up and archive files.

1. Storage file are used to store data on a daily basis. They can be used to create, update and maintain data and information.
2. Reference files are used to provide information which may be used for the processing of storage files.
3. Back-up files can use any of the auxiliary storage devices to store data or information as a means of protecting data information in case of any loss, damage or destruction of the original storage device of the information.
4. Archive files are kept to comply with legal or government regulations. They are to protect data that it should not be destroyed.

4.0 CONCLUSION

Information is an intangible resource. It is a processed data. Information is very valuable for the hospital decisions as every hospital worker is an informant for the progress and development of the hospital.

5.0 SUMMARY

The students have learnt in this Unit what "information" is, characteristics of information, why every hospital worker must manage information, sources of information, types of information within an organization, management information system and information Technology. And if every organization will be progressive and productive not having conflicts and crises on daily basis, that organization must invest on information and manage it well.

6.0 TUTOR MARKED ASSIGNMENTS

1. The importance of information in a hospital cannot be over stressed. Discuss.
2. List four characteristics of information.

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UNIT 4 STRESS AND ADAPTATION

CONTENTS

1.0 INTRODUCTION

Modern man is faced with the paradox of stress. Everyone experience stress from time to time and normally a person is able to adapt to long term stress or cope with short term stress until it passes. Stress places heavy demand on a person, and if the person is unable to adapt, illness can result.

Stress is an essential part of our lives providing us with the impetus for vitality, drive and progress. Stress is the body response to the daily or everyday pressure of the body reaction to excessive demand by the trying to maintain equilibrium among its internal process. Conversely, it is also stress which is the root of a multitude of sociological, medical and economic problem. Stress can be mild, moderate and severe with behaviours that decrease energy and adaptive responses. The leading cause of death today involves life-style stressor which precipitates stress with resultant effect on health-illness continuum. It is this cause and effect that this unit intends to examine stress and adaptation considering its concept, models of stress and stressor, factors influencing response to stress, adaptation and stress management for improved patients' care.

2.0 OBJECTIVES

At the end of this unit, the learner will be able to:

- Explain the concept of stress and stressor.
- Discuss four (4) models of stress as they relate to hospital practice.
- Describe stress-management techniques required for clients care.

3.0 MAIN CONTENT

3.1 Concept of Stress

There can be no stress without a stressor. Stress is any situation that can upset and prevent an individual from relaxing naturally. Stressor is the stimuli that precipitate the change in a man. Stress as a stimulus, do tax the adaptive capacity of the organism to its limits and which in certain condition can lead to a disorganization of behaviour and maladaptation which may lead to diseases.

Stress is common denominator of the adaptive reaction in the body. it is any situation in which a non-specific demand requires an individual to respond physiologically and psychologically as well as taken an action. Stress can lead to negative or counterproductive feelings or threaten emotional well being; threatens the way a person normally perceives reality, solves problems or think; threatens relationship and sense of belonging and a persons general outlook on life, attitude towards loved ones; job satisfaction, ability to problem solve and health status.
Response to stress is initiated by the individual's perception or experience of the major change.

The stimulus precipitating the response is called the stressor which may be physiological, psychological, social, environmental, developmental, spiritual, or cultural and represent unmet need. Stressors may be internal such as (fever, pregnancy, menopause and an emotion such as guilt; and external which originates outside a person such as marked change in environmental temperature, a change in family or social role or peer pressure.

3.2 Models of Stress and Stressor

Models of stress refers to classes of stress which are used to identify the stressors for a particular individual and predict that persons responses to them. These models are useful for planning individualized nurse care plan to help a client cope with unhealthy, non-productive response to stressors.
There are four (4) models of stress namely:

- Response Based Model (RBM)
- Adaptive Based Model (ABM)

- Stimulus - Based Model (SBM)
- Transaction - Based Model (TBM)

3.2.1 Response Based Model (RBM)

RBM special the particular response or pattern of responses indicating a stressor. Selye, S. (1976) in his classic research into stress identified two physiological responses to stress namely: The local adaptation syndrome (LAS) and the general adaptation syndrome (GAS). While LAS is a response of a body tissue, organ or part of the stress of trauma, illness, or other physiological change, the GAS is a defense response of the whole body to stress. Individual response to stress is purely physiological and never modified to allow cognitive influences, but RBM does not allow individual differences in response patterns (No flexibility).

3.2.2 Adaptation Based Model (ABM)

ABM states that there are four (4) factors that determines whether a situation is stressful or not. These are: ability to cope with stress; practices and norms of the person's peer groups; impact of the individual to adapt to a stressor; and the resources that can be used to deal with the stressor.
ABM is based on the fact that people experience anxiety and increased stress when they are unprepared to cope with stressful situation.

3.2.3 Stimulus-Based Model (SBM)

SBM focused on distributing or disruptive characteristics within the environment. The classical research of Holmes and Rahe (1978) identified stress as a stimulus resulting in the development of the social readjustment scale which measures the effects of major life events on illness. The following verdicts have been summed up for:

- Life changes events are normal.
- People are passive recipients of stress and their perceptions of the events are irrelevant.
- All people have a common threshold of stimulus, and illness results at any point after the threshold.

3.2.4 Transaction Based Model (TBM)

TBM views the person and environment in changing, reciprocal, interactive, relationship. It was developed by Lazarus and Folkman (1984) with a focus on the stressor as an individual perpetual response rooted in psychological and cognitive process.

3.3 Factors Influencing Response to Stressors

The response to any stressor is dependent on physiological functioning, personality, behavioural characteristics and the nature of the stressor. The nature of the stressor involves the following factors:

i. Intensity: minimal, moderate or severe.
ii. Scope: limited, medium, extensive.
iii. Duration: time lag
iv. Number and nature of other stressors

3.4 Sources of Stress

The common sources of stress are classified under the following headings:

(A) Stress problems at home: these include:

- Problem with co-tenants or neighbours
- Fear of attack by armed robbers
- Looking after dependants
- Problem with in-laws
- Problem of the aged
- Domestic demands

(B) Stress provoking situations in the society:

- Eratic supply of electricity water and fuel
- Reckless driving and traffic hold ups
- Insecurity
- Economic recession
- Social demands
- Lack of employment opportunity
- Under employment

(C) Stress provoking situation at work:

- Having too much to do

- Frequent shifting
- Too many patients
- High demands of the clients / patients
- Lack of good interpersonal relationship at work place.
- Unfriendly hospital policies.

3.5 Adaptation to Stressors

Adaptation is the process by which the physiological dimensions change in response to stress. The focus therefore in health care is on a persons family's or community's adaptation to stress because many stressors cannot be avoided. It involves reflexes, automatic body mechanisms for protection, coping mechanisms and instincts. Adaptation is an attempt to maintain optimal functioning. To do this, persons must be able to respond to such stressors and adapt to the required demands or changes. It requires an active response from the whole person (physical, developmental, emotional, intellectual, social and spiritual). Adaptation response can be physiological or psychological.

Physiological Response

This model of stress response can be either Local Adaptation Syndrome (LAS) or General Adaptation Syndrome (GAS). See 1 in 3.2. An example of LAS is reflex (pain) and inflamatory response. The GAS consists of alarm reaction, resistance and the exhaustion stage.

1st Stage - Alarm Stage

mobilization of the defence mechanisms of the body and mind to cope with the stressors.

2nd Stage - Resistance Stage

Stabilization is attempted and success if achieved the body repairs damaged tissue that may occur if not exhaustion is the next stage.

3rd Stage

i. **Recovery Stage**
   Repairs done, the body goes back to full functioning
ii. **Exhaustions Stage**
   The body can no longer resist stress and if continues, death may occur.
i. **Psychological Response**
   Exposure to stress threatens ones basic needs. The threat whether actual or perceived, provides frustration, anxiety and tension. The

psychological response otherwise referred to as coping mechanisms is adaptive behaviours which assist the person's ability to cope with stressors. These behaviours are directed at stress management and are acquired through learning and experience as a person identifies acceptable and successful bebaviours. The behaviour includes:

ii. **Task Oriented Behaviour**

Use of cognitive abilities to reduce stress, solve problems, resolves conflicts and gratify needs. The 3 types of task-oriented behaviours are attack behaviour, withdrawal behaviour, compromise (by substitution or omitting the satisfaction of needs to meet other needs or to avoid stress).

iii. **Ego Defense Mechanism**

These are unconscious behaviours that offer psychological protection from a stressful event. It is used by everyone and helps protect against feelings of unworthiness and anxiety.

3.6 Management of Stress

The management of stress is classified into 3 headings for easy assimilation and understanding.

i. Reducing stressful situation through:

a) Habit formation
b) Change avoidance
c) Time blocking
d) Time management
e) Environment modification

ii. Decreasing physiological response through:

a) Regular exercise
b) Humour
c) Nutrition
d) Rest
e) Relaxation

iii. Improved behavioural and emotional responses to stress through:

a) Support systems: family, friends, colleague, to be included in the stress management.
b) Crisis intervention
c) Enhancing self esteem

4.0 CONCLUSION

Each person reacts to stress differently according to perception of the stressor, personality, prior expectations with stress and use of coping mechanism.

The stages of illness development in stress-related diseases are 7 in all.

Stage 1: short stress situation (no risk)
Stage 2: moderate stress situation (at risk)
Stage 3: severe stress situation
Stage 4: early clinical sign
Stage 5: symptom
Stage 6: disease or disability
Stage 7: death

At any of this stage, there may be physical complaints such as nausea, vomiting, diarrhea or headache. Physical appearance also changes. The identification of the mind-body interaction is crucial for predicting the risk of stress-related illness. A nurse by mere studying the effects of a stressful lifestyle or event in a client can also assess the coping mechanism required by the client.

5.0 SUMMARY

This unit has examined the concept of stress and its relationship to health and illness. The various models of stress were also highlighted to help the nurse understand the causes and response to stress. Stress management techniques directed at changing a person's reaction to stressors were also discussed to assist the nurse in the helping client manage stress carefully.

6.0 TUTOR MARKED ASSIGNMENTS

List and explain the sources of stress in the hospital and suggest ways to overcome these sources.

7.0 REFERENCES/FURTHER READINGS

Hoffman-La, F. 1991 Stress: sign, symptoms, sources solution. Switzerland: Editions Roche, Basel

Maisamari, J. Y. 2002. Stress and Stress Management Strategies Kaduna: Joyce Printers & Publishers Co.