IL-MUSBIEH

MALTA UNION OF MIDWIVES AND NURSES

PROFESSIONALS IN OUR OWN RIGHT...
... SECOND TO NONE

- A COMMUNITY HEALTH CARE BASED SYSTEM
- GRIEF AND LOSS
- ARE WOMAN LOSING THE SKILL OF GIVING BIRTH?
- MALTA 3RD FROM LAST
- INFLUENCE OF THE MIND OVER THE IMMUNITY SYSTEM

Harġa Nru. 22 • Marzu 2004

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Telqa u ffullar f'San Luqa

Jiġi żmien meta wieħed jintebaħ bl-affarijiet sbieħ u koroħ ta' madwaru...u bħal donnu jitħawwad. Sfortunatament, fl-Isptar San Luqa tant hemm apatija u telqa li ħadd mill-awtorità konċernata m'għadu jinħasad u għaldaqstant ma jsir xejn biex jinbidlu l-affarijiet, anzi nippruvaw ngħattu x-xemx bl-għarbiel. L-aktar ħaġa li tolqtok u li tidher sewwa, hija t-telqa fil-manutenzjoni ta' l-istruttura ta' l-isptar u anke f'dak kollu li jinsab fih. Dan meta suppost kellu jsir 'refurbishment' fis-swali kollha... saru ta' ftit swali u ġibnihom fuq it-televiżjoni però l-oħrajn...suffetti se jaqgħu, żebgħa migrufa u ilha li waslet għal żebgħa oħra, ċaċċiż maqlugħ, pultruni mqattgħin, kanen tal-ilma jixpakkaw u drains jinstaddu il-ħin kollu...Għaliex qed inħallu dak li diġa għandna jaqa' biċċa biċċa !? Fuq kollox, il-pazjenti, f'dan l-isptar qed nieħdu ħsiebhom bħalissa, u fl-ebda sptar ieħor. Meta jkun lest imbagħad, (jekk il-Bambin irid) nitkellmu aħjar.

Bħalissa, kull min jaħdem fl-isptarijiet kellu jmur għall-'lecture' dwar d-'Data Protection Act'. Prosit u ħaga tajba ħafna li l-impjegati kollha jkunu nfurmati tajjeb b'dawn il-liġijiet, però, dak kollu li qed isir huwa farsa. Dak li qed jingħad huwa storja tal-fantasija. Kif tista żżomm il-kunfidenzjalità meta l-pazjenti qegħdin saħansitra fil-korsiji (kuruturi)? Mhux biss m'hemmx kunfidenzjalità, imma saħansitra neħħejnilhom id-dinjità tagħhom ta' "**UMANI**", lil dawk li aħna lkoll suppost qed nieħdu ħsieb u nipprotegu. Din ċ-ċirkostanza l-awtorità qatt ma tgħat kasha. Tant hu hekk li kif issemmiha, l-awtorità twieġeb li bħal dawn iż-żmienijiet is-sitwazzjoni dejjem hekk qiegħda: Skond l-istaġuni! Daqqa minħabba l-kesħa u daqqa minħabba s-sħana. Anżi dejjem qalet li din dejjem kienet sitwazzjoni ta' emerġenza u ta' ftit zmien.

X'taħsbu? Mhux aħjar naħdmu bis-serjetà u nkunu kompatibbli ma dak li ngħidu? Mhux aħjar darb'għal dejjem insolvu din l-imbierka problema tal-iffullar, ningħaqdu id f'id u nsolvuha ta' veru.

Kull min hu nteressat li jikkontribwixxi xi artiklu, ritratt, aħbar, avviż, rapport, studju jew riklam huwa mħeġġeġ jagħmel kuntatt ma' membri ta' 'Il-Musbieħ' Group Committee:

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Dear colleagues,

The Nursing and Midwifery professions are facing a continuous challenge and change throughout the world. I have to admit though that in Malta our professions are facing challenges of huge dimensions and sometimes frustrating situations.
Sometimes Nurses and Midwives themselves are so disturbed with these changes that we lose control on what our role is and we get tempted to perform other professions' tasks. What makes matters worst is that we are performing tasks that are supposed to be carried out by other professions but are considered as time consuming and sometimes dirty. This has been happening for quite a long time now and everyone is made to believe that these tasks which we are now calling extended roles are in fact our roles. So this is becoming a vicious circle and I appeal to all that we must beware. Let's all perform the tasks we have been trained to perform and lets do them right. We must never consider ourselves as assistants to other professions but we are professionals in our own right, second to none. Respect is gained if we have pride in our role and believe in ourselves and continue to advance academically to demonstrate competence.
We are also facing challenges with the coming event of EU membership. Nursing and Midwifery in Malta has been undergoing adaptations for this new era in our country. There was also a change in legislative measures related to our professions, we now have the Nursing and Midwifery Council instead of the Nursing and Midwifery Board. This Council was recently composed and I am proud to say that all seven elected members were nominated and supported by MUMN. Personally and on behalf of the MUMN Council I congratulate once again all the members of this newly composed Council which I am sure they all have our professions at heart.
The momentum of change is also felt within the structures of MUMN. Our Union is constantly evolving and finding avenues that nourishes and strengthens the concept of unity. I am pleased to say that our family is once again extending its' arm and we now have also the students joining forces. MUMN now represents Nurses and Midwives at all stages. This is a great achievement and we must treasure this unity and keep working together for the advancement of our professions.
Last month I attended the Commonwealth Nurses' Federation - European Region Conference held here in Malta. I felt really proud being a Nurse but most of all of being Maltese. This was the first time that a conference of such calibre for the Nursing profession was entirely organised by us Maltese. We proved that when we work hard and together as a team we can deliver the best.
Topics discussed were entirely nursing related issues and to say the least I was very much impressed with the presentations I had the opportunity to follow.
Maltese Nurses and Midwives must do some self-reflection and understand more the importance to keep to the roots of our professions and strive to change any misconceptions both from our pier professionals and from the public in general. This can only be achieved if we believe in our potential.

Rudolph Cini'

The Challenge: A Community Health Care Based System. Why?

The Health Care System's current emphasis on physical health as the main component of quality of life has in part created an artificial and dysfunctional way of examining what needs attention (Bennet.J, Flaherty M. 2003). In Malta we surely need a system that is not only focused on physical health; we need a system where nurses and midwives can dedicate their time to the concern of the whole family. In the 21st century it is this kind of care that will be providing health care to all.

We already enjoy a health care system that is one of the best as rated by the World Health Organisation, but still, our community service is *underdeveloped*! This has as already been declared in previous articles and also accepted and declared by the health care authorities. It's a challenge to all organisations (governmental or non-governmental) that have a share in the decision-making processes and is to be taken as an opportunity. Two of the most beautiful words in the English language, "nursing" and "home", when put together in the term "nursing home" have become a symbol of fear, isolation, and suffering in the minds of many middle-aged and older persons (Bennet.J, Flaherty. M 2003). The challenge is obvious but the advantages should supersede. Giving up this challenge means that this country will have to face the consequences of the ever-growing population. This is no joke; the financial implications will be on the whole country to carry. If I can in a humble way offer my advice to the government, it would surely be that the government should include the opinion of health care experts when discussing the issue of pension's sustainability. All stakeholders should advice to reach the solution that best fits our boots! The challenge offering this opportunity goes beyond such an argument as it is clearly a part responsibility of a health and social policy issue, and like all health care issues it carries the responsibility of offering a service of the best quality possible.

However, lower satisfaction has been noted among patients who wanted a home visit and were offered either telephone advice or appointment at a primary care centre (Hopton et al 1996). This home care service should be a service that involves skill mix, where as already mentioned in the previous articles the family health care nurse is to have the important function of coordinating the professional work to be done. It was another winter that proved the country that our general hospital gets the full responsibility for the social cases. This is happening when developed countries found or are trying to find the means of sifting responsibilities of this type of health care away from the hospital settings. This is why all stakeholders should be involved in the reforms like that of the pension's reforms, as this is also a cost effective intended issue that concerns the same individuals.

If Community Based Health Care is proved to be cost effective, why not get it involved in the national plan and maybe ending up with safeguarding our pension scheme? Interesting to note is what is happening in the United Kingdom - we should keep close look at the new concept of creating *age concerned groups*. This type of care is hoped to extend to other towns in the United Kingdom in the nearby future, as it is one of the most effective systems in health care. It already proved to; prevent health problems by early intervention, improves communication, improve patient care, provide source of information and also provide a useful and appropriate efficient and cost-effective resource for older people. Nurses and midwives have much to offer to the improvement of the efficient and effective national growth and ignoring this only leads to a faulty way of implementing policies! Nurses are in a prime position to promote health and this is especially true in the primary care setting (Whitehead 2000). My sincere advice to my colleagues is to get involved in the national issues. Nurses and Midwives are a force that can contribute to the well being of our country and we should take all challenges as opportunities. The Community Health Care Reform can reach a win/win situation where the government, nurses/midwives, and other health care professionals goals are reached. Though on second thought, one should believe that both are the same; that of conserving our high level of health care service for the benefit of the patient, and at the same time to giving this high quality service in the most cost effective way possible! One can do this by trying to increase a maximum level of accountability, responsibility and discipline among staff. So far so good but the concern remains; will all this by itself reach the objectives set in this challenge?!

"...Other factors, such as aging of the populations and concern for those with chronic and terminal illness, place growing demands on health and social services." "In 1978 ICN declared its support for primary health care and its intent to co-operate at national and international level with governmental and non-governmental organisations in making primary health care an effective reality to meet the health needs of populations." ICN position paper Nurses and primary health care-adopted in 2000. So it becomes inevitable that this challenge still remains and is a reality. We ought to face it and turn it into an opportunity so that this country will finally start to shift the responsibility of social cases to an non-institutional type of health care. It does not mean that if we did not have it done up till now, we give up! Quoting Sir Winston Churchill *Success is the ability to go from failure to failure without losing the enthusiasm*, we need to move and pick this challenge, especially when we know that our past in health care professional services is a chain of uninterrupted successes. If we want our health care services to remain of the same high standard, if we want our country to reach the growing demands on health and social productive life and most of all keep giving good health care services to all, then we need to change.

Other reasons why to take this challenge is purely of environmental importance, both for the patient and the professional giving the care. The

difference between hospital and community may be explained by suggesting that the 'false' and 'temporary' environment of the hospital setting imposes a change in the normal dynamics of the relationships that is not vigorously imposed in the community settings (Carr.S 2001). This shows another important reason; if the nurses and midwives offering the community service are also trained in health protection and promotion, this brings the client to obviously be more willing to talk about his/her family and personal problems. This can render the service to shift more to a community-based health care; it will also result in fewer admissions to hospitals. Elevating the quality of life of the client and that of the people in general, as education through this type of communication and prevention will surely contribute to decrease the liability to illness can reduce such admissions. This is when the best results of the cost effectiveness will be felt and aids to the country's economical growth. More productive healthy people, in a small country totally reliable on its human resources only mean a better living for all.

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care (Alma Ata 1978). This is another obvious reason why a community health care reform should be the target of all countries opting to offer a system of care that is not only based on the geographical perception, but on the humanitarian principle to reach out for the holistic needs of the whole population. Not only the physical needs of the population are met with such a system but even spiritual needs can be assisted to. A caring nurse/patient relationship is paramount when providing spiritual care (Narayanasmy 1996). Primary care is first contact, continuous, comprehensive and coordinated care provided to populations undifferentiated by gender, disease or organ disease (Starfield 1994).

In the four countries of the UK, they are already taking the changes in technology as an ongoing reform, a challenge, but most of all an opportunity to direct them towards the Community Health Care Reforms. I already wrote various articles on this subject, and my intent is to keep persisting on it, because if we take a passive attitude, the challenge will just pass by and we will be loosing precious time and a precious opportunity! Already the discussion is now shifting to another level; that of creating teams of professionals to organise a gate keeping system. To what extent are the challenges of a Primary Health Care Reforms to serve as a useful tool for this purpose? Here in Malta with the Mater Dei Hospital already build, the least of what we want is to migrate the overcrowding that we presently have at St Luke's Hospital which means shifting the current problems to the newly build hospital. Le Grand (2002) proposes that the gate keeping role should be not be seen as an obstructive role which denies patients the service they want but should be seen as a prioritisation mechanism which enables those patients who need to be seen quickly. The question comes naturally; **why are we waiting so much?**

Andy Warhol, an American painter, motion-picture director, producer, publisher and leader of pop art movement stated: *they say that time changes things, but you actually have to change them yourself.* With such words in mind we shall pick this challenge to move forward and face this necessary and inevitable change. A country like ours cannot afford to remain passive when the World around us is constantly changing technologically and, moreover, developed countries are on all scopes and dimensions to pick up new challenges. We cannot stare at the situation of the changing truth happening in community health care. The 26th United States President Theodore Roosevelt, in his famous speech "Citizenship in the Republic" held at the Sorbonne, Paris on the 23 rd of April 1910 stated: *It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, and comes up short again and again, because there is no effort without error and shortcoming; but who does actually strive to do deeds; who knows the great enthusiasms, the great devotions; who spends himself in a worthy cause; who at best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat.* It may sound rhetoric, but it surely fits in describing people that are in a position that can bring about the needed change in our health care services. Those people are nobody but us. We have to take this challenge and shift our health care services to be based on a Community Care Oriented System.

It is a challenge where we shall find the opportunity to create a cost effective system, an environmental change system, a different spiritual attitude approach system, a system based on new technology and therefore a higher quality health care service system. A system even better than the one we actually owe. The ultimate winner and achiever in a community care service based health care system will surely be the patient, and moreover the general public. Even if to implement this type of system we have to pass through certain victories and defeats, let us not be among those cold and timid who never knew victory nor defeat!

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References:

Alma Ata Declaration.
International Conference on Primary Care USSR, Para IV.
6-12 September 1978.

Bennet A. Jill, PHD, RN, CNS and Flaherty-Robb K. Marna RN, MSN.
Issues Affecting the Health of Older Citizens: Meeting the challenge.
Online Journal of Issues in Nursing Vol 8. No2 Manuscript 1.
Articles published May31, 2003.

Carr. M Susan, PHD, MSC, BA, RGN, RHV, RNT, HVT, PGCE (2001).
Community nursing: does the title fit the talents?
Online Journal October 2001, vol 15, issue10.

Hopton J, Hog R, McKee I. (1996).
'Patient' accounts of calling the doctors out-of-homes; qualitative study in one general practice,
BMJ, 313; 7063; 991-4.

International Council of Nurses.
Nurses and Primary health Care, Position Paper adopted in 2000.
Geneve.

Le Grand J. (2002).
'Further tales from the British National Health Service'.
Health Affairs, 21; 3: 116-128.

Naraysanamy, A. (1996)
Spiritual Care of Chronically Ill Patients,"
British Journal of Nursing, 5; 7: 411-416.

Starfield B. (1994).
Is Primary Care Essential?

Whitehead D. (2000)
'What is the role of health promotion in nursing?'
Professional Nurse, 15; 4: 257-259.

Nurse-to-patient ratios affect hospital patient mortality

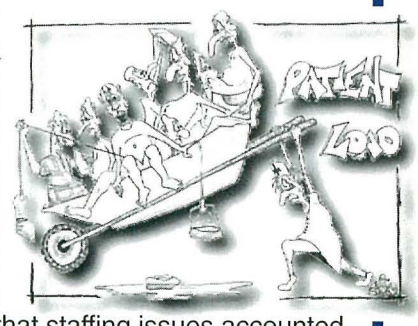
Evidence makes the case for better nursing staffing levels in hospitals, by linking workload and nurses' job satisfaction to patients' out comes. A study involving 168 hospitals, 232,300 surgical patients and 10,184 nurses showed that surgical patients' risk of dying increased in proportion to nurses' workload. In addition, nurses in hospitals with high patient-to-nurse rations were significantly more likely to have job dissatisfaction and burnout.

The study showed that when a nurse's caseload increased by even a single patient over the average 4:1 ratio, the risk of a surgical patient dying within 30 days increased by seven percent. This risk doubled if the average patient load was increased from four to six patients. When the load increased from four to eight patients, risk of patient death rose to 31%.

(Source: www.jama.ama-assn.org)

Overwork contributes to a growing number of medication errors

According to data collected by the US Pharmacopeia's s (USP) Center for the Advancement of Patient Safety, increased nursing workloads and short staffing contributed to a greater proportion of medication errors in the last three years. The study indicated that distractions were the leading contributing factor, accounting for 46% of errors in 2001. The recently released analysis of 2001 errors showed workload increases contributed to 24% of medication errors reported, up from 15% in 1999. Insufficient staffing contributed to 14% of the errors reported in 2001, jumping from just 3% in 1999. The proportion of errors involving inexperienced staff showed a modest gain of 17% in 2001, rising from 13% in 1999. The study concluded that staffing issues accounted for 36% of all contributing factors in 2001.



(Source. Zurlinden, J, (2003), Nursing Spectrum, 12, 2PA: 14.)

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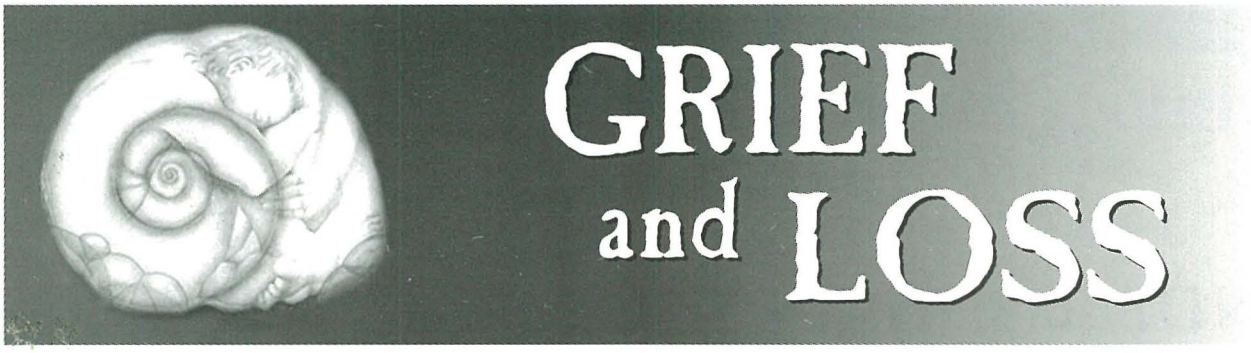


Everyone will experience sadness or grief at some time in his or her lives, although we all think of grief being connected only to a loss of life. If a marriage or relationship ends, if one loses a job, health or any part of the body, then sadness and grief are normal human reactions.

The impacts of such losses are seldom recognized. These may include loss of a valued role in life, in family and in the community and/or the workplace; changes in physical appearance for instance after surgery, loss of independence, income decline, and self-esteem. Grief is unpredictable: it comes in waves and leaves people out of control.

Grief is a process that always occurs after loss. It has stages that overlap: there is often an initial period of numbness lasting from several hours to a couple of weeks, which may take the form of difficulty in accepting what's happened. This then gives way to a mixture of sadness, anger, bewilderment, hopelessness and yearning.

Nurses and midwives carry a special responsibility and an unusually high likelihood of having to function in these extremely stressful circumstances for long periods of time. They work with patients as they grieve their losses that come with their illnesses, and address grieving issues with their patients' loved ones on a daily basis. They are also often present at the patient's death and offer support to the family immediately after death. Many nurses and midwives are reluctant to admit that they are affected. They do not realize how important it is to talk about their feelings and in fact prefer to keep a stiff upper lip. Clearly nurses and midwives are expected to handle grief and the "I must seem untouched and strong" culture that is forced on us makes us believe it and remain untreated. We have been conditioned into believing that we should be able to cope on our own and that asking for help is a weakness.

But before we deal with the emotional and physical hazards of nursing and midwifery associated with long-term exposure to grief, we are going to try to understand the process of grief and how we can help when faced with someone who is grieving. By finding out more about the grieving process we can all help others who are going through this difficult experience.

PROCESS OF GRIEVING

Grief is a process of experiencing the psychological, social and physical reactions to one's perception of loss. It is a natural and expected reaction to all kinds of losses. Grief is a wound that needs attention in order to heal Thus it is useful to consider the process in terms of stages of grieving. The achievement of these stages is the essence of the process of grief, and lead to growth and greater psychological strength.

Many theories about the grief process have been developed. One of the earliest developments in this field came from the renowned psychiatrist

Elizabeth Kubler-Ross. Her theories, developed from her work with dying patients, have provided ground information for physicians, nurses, social workers and pastoral care givers. Kubler-Ross established the five stages of grief. Each and every stage of grief must be passed through and experienced before healing takes place. Dr. Kubler-Ross made it clear that the stages are not usually experienced in order and that one may pass through each stage more than once and that one may be in more than one stage at a time. However, no two people grief alike, each person's grief is unique. The five stages are:

1. **Shock and Denial.** These are often the initial responses to loss. It is a normal reaction to rationalize overwhelming emotions. It is a defence mechanism that buffers the immediate shock. This is a temporary response that carries us through the first wave of pain. The reality of loss has not yet been accepted and the person feels stunned and bewildered as if everything is "unreal".
2. **Anger.** As the masking effects of denial and shock begin to wear, reality and its pain re-emerge. The intense emotion is redirected and expressed instead as anger. We feel guilty for being angry, and this result in more anger. The grief stricken person often lashes out at family, friends, themselves, God, their caregivers or the world in general.
3. **Bargaining.** The normal reaction to feelings of helplessness and vulnerability is often a need to regain control. If only we had sought medical attention sooner. If we got a second opinion from another doctor. If we took care of our health more. In this stage the grieving person asks for a deal or reward from God. Comments like "I'll go to church everyday, if only I'll live" are common. This is a weaker line of defence to protect us from the painful reality.
4. **Depression.** This occurs as a reaction to the changes in the way of life created by the loss. The grieving person feels intensely sad, hopeless, drained and helpless. This is a reaction to practical implications relating to the loss. Sadness and regret predominate. We worry about others that depend on us, how we wished to have spent more time with them, how much we are putting burden and weight on our loved ones with our loss. Simple clarification and reassurance, and also a bit of helpful cooperation and a few kind words may ease this phase.
5. **Acceptance.** Reaching this stage of grieving is a gift not afforded to everyone. Acceptance comes when the changes brought upon a person by the loss are stabilized into a new lifestyle. This phase is marked by withdrawal and calm. One learns to live with the loss. It becomes part of who one is forever. This is where growth comes in. Grief can cause a person to prioritize things in life. None of this growth makes it good and worthwhile that one suffered a loss; but it is the positive outcome from such experiences.

FACTORS THAT INFLUENCE GRIEF

The factors that influence an individual's grief experience are as varied as each individual. Rando (1984) identifies three categories of factors that influence the grief process of all individuals. These factors are:

1. **Physiological factors**: these influence functions such as sleep patterns, physical health and diet. Grief takes a physical toll on individuals who have health alterations prior to the start of grief. They often find themselves more fatigue and less

energetic. Grief also can affect eating habits and sleeping patterns, causing either a marked increase or decrease in both.

2. **Social factors**: factors, which greatly influence the grief process, are educational background, support network, as well as an individual's religious, and cultural background.

3. **Psychological factors**: Gender, past experience with grief, personality, meaning of loss and mental health status all impact the grief process. Men and women grieve in different ways. Women tend to have a more affective component to their grief, while men tend to become more involved in activities such as work as a means of addressing their grief. Cultural influences tend to influence the grief response of each other. For instance, cultural influences state that it is permissible for women to show emotion, while men (as boys) are taught that boys do not cry. Another gender difference is that women are more likely that their male counterparts to seek out support to assist them with their grief.

Also past losses will greatly influence how an individual copes with the current loss, as past losses are remembered and resurface with each subsequent loss (Rando, 1984).

How can we as Nurses and Midwives help those who are grieving?

The first problem encountered by nurses and midwives when faced with grief is "what is the right thing to say, in order to help someone who is grieving?" Although, they want to comfort and help the grieving person, the stress and anxiety of the encounter sometimes makes it difficult to know what is actually helpful. Often, the phrase that is meant to help actually can produce more pain and distress.

STRATEGIES

Information and suggestions to help with the grieving process in general are:

- Grief is an emotion and needs to be felt; it cannot be worked out in the head.
- Only the individual can decide what is right for him/her during this time.
- Grief takes up a lot of emotional and physical energy.
- Grief is a life-changing experience and it takes time and patience to adjust.
- Lack of concentration, difficulty in sleeping, forgetfulness, and confusion is normal.
- Tears are not a sign of weakness: they are an emotional first aid.

Ways of helping the grieving person include:

- **By being there:** do not offer solutions just be there and listen. Many grieving individuals simply need a safe place to explore their many reactions to their loss.
- **By listening in an accepting and non-judgmental way:** many difficult thoughts and emotions may be expressed; accept them whatever they are. Listen without giving advice, and resist telling your own stories. Simply ask the person how he/she is and listen as they share their grief and problems.
- **By showing that you are listening and that you understand something of what they going through:** be attentive, recognize how they are feeling, sometimes touch can be appropriate. For many nurses and midwives feel it is natural to put an arm around a person who is crying over their loss. In the great majority of cases this gives a sense of acceptance and sympathy, enabling the person to get closer to the 'letting go" kind of weeping. However, in some people body contact has the reverse effect. They stiffen and become insecure. They may think that the contact is a sign to stop crying. So it may be a good idea to ask if it will be all right to take their hand or put an arm around their shoulder.
- **By encouraging them to talk about their loss:** mention and ask about their loss. Sharing one's own stories and memories can assist people who are grieving as they struggle to understand their loss.
- **By tolerating silences:** silences are useful thinking time.
- **By being familiar with your own feelings about loss and grief:** know your own fears and difficult feelings.
- **By offering reassurance:** about the normality and duration of grief, and about the future.
- **By not taking anger personally:** it is an attempt to get rid of the anger by projecting it onto someone else. Part of the anger, which is expressed by the grieving person, is"holding on to" anger. As long as someone like nurses and midwives are blamed, the grieving person shifts the pain caused by the loss. If one is angry enough, there's no room to feel the sorrow.
- **By recognizing that your feelings may reflect how they feel:** feelings of helplessness, hopelessness, frustration or anger may be what the other person is feeling.
- **By accepting that you cannot make them feel better:** nothing one can say can remove grief, however, you are still doing something useful, even if it does not feel like it.

However, whenever in doubt as to what to say or what impact your words may have on the grieving person, don't say anything. The golden rule in expressing sympathy is observance in silence. Remember that silence is golden, or divine if you prefer. Instead you can use the nonverbal language. Holding hand, shaking hand, giving a hug or a smile with eye contact "speak" adequately about what you want to express.

WHAT TO SAY:

I am sorry.
Please tell me what you are feeling.
I am here and I want to listen.
I am sad for you.
How are you coping with all this?
Take all the time you need to grieve.
Thank you for sharing your feelings.

WHAT NOT TO SAY:

I understand exactly how you feel.
You'll feel worse before you feel better.
You have your whole life ahead of you.
Death was a blessing.
It was God's will.
It is time to put it behind you now.
Be strong!

We want to be effective in whatever we do. So when we express sympathy, we want to see immediate results. This builds up pressure on the grieving person. It is as if we are saying, "I've sat here for the last thirty minutes, now you should feel better". Don't expect anything.

HOW NURSES AND MIDWIVES DEAL WITH GRIEF

As stated in the previous article, nurses and midwives deal with grief every day. Professional objectivity does not make them immune to the suffering of their patients or to those who grieve for them. All of us are expected to handle damaging amounts of distress, and this can lead to inadequate provisions of staff that have been over-exposed to long periods of stress. However, some employers neglect this aspect of staff-care and wonder why all the sick-time is going on and the morale low. Disciplinary matters, overwork, too much exposure to misery can all add up. The employee is often seen as machinelike—devoid of human emotions and unaffected by human experiences. This kind of work experience fosters an environment in which the open expression of feelings is taboo. A conflict therefore emerges between the needs of the grieving person and the goals of the workplace. This can cause a lack of vitality and can put a strain on relationships and health.

Moreover in some situations, the grief-stricken patient or relative experience intense emotion, which can easily give rise to verbal or physical violence, directed to staff. Getting angry or blaming the nurse/midwife is an unfortunate but common occurrence when a patient/relative is suffering from a highly charged and confusion situation. This can be an exaggerated version of the common human tendency to blame others.

SERVICES NEEDED FOR HELPING STAFF

Prevention In exceptional circumstances of extreme or prolonged exposure to highly charged, dangerous or upsetting occurrences, there can be a risk to the well being of the staff. When staff are exposed to a traumatic event and there is some doubt as to their well being, it can be very useful one would offer them a de-briefing session, just to find out if they are ok. The aim of this session is to find out if further help is needed. Different things upset different people and many staff is affected. Visible signs are jumpiness, irritability, shaking, excessive sick-time, eye contact avoidance, substance use, isolation or simply the "sense" that something is wrong with this person.

Are these nurses and midwives equipped with skills to assist patients and their relatives in dealing with loss and grief? Did we ever try to find other variables why complaints about less caring nurses and midwives are still very prevalent? Are these patients and families simply unfortunate in their encounters or are there other variables at work? While uncaring actions are not excusable, these health care professionals are working without any education in loss along without a range of supportive techniques. Uncaring behaviour may also be a component of job stress and burnout. Identifying causes, for example, recognizing areas that are understaffed, identifying the need for additional education or realignment of areas, aid staff to achieve high quality and sympathetic care. The intent of health care is to optimize the outcome for each patient and their family. Support groups can aid on the delivery of healthcare during and after loss. Empowering and giving continued support to nurses, midwives, patients and families with loss can be instrumental, as road to recovery after loss is long and lonely and dealing with it together is usually the better way.

Trauma Counselling It is important that when nurses and midwives come in contact with a serious trauma it is important that help is offered immediately. Serious trauma, a series of smaller traumatic events or prolonged exposure to stress that is left for too long can develop into Post Traumatic Stress Disorder. Isolation, flashbacks, deterioration in working and personal relationships, too much time off and "jumpiness" are all features to watch out for.

It is imperative that these caregivers recognize themselves as humans and acknowledge the emotional reactions that traumatic events elicit on them. Recognition of their vulnerability to tragedy is a key element in a way that losses they face everyday are handled. To cope with the anxiety and stress that occurs when confronting these issues, defences based on denial is often manifested by repression, displacement and rationalization.

Practice of seeking supervision or counselling for workplace or occupational stress is increasingly seen in many organizations as an extension of professionalism. Many professionals should use such facilities as ongoing means of stress prevention rather than waiting for stress to build up.

Support The support the caregiver receives from others may be a critical element in preventing burnout. In order to prevent overload and self-destruction, support is needed to sustain the multiple expectations of working with grieving patients and their families. Various ways can be suggested to cope with grief. Sharing feelings with other professionals or receiving social support from others, is a useful intervention. Nurses and midwives, like other workers, spend almost 50% of their time in their place of work. The relationships that develop between co-workers generate an intensity and life of their own. Colleagues working together can develop an emotional dependence upon each other. Talking daily to each other, working as a team, encouraging creativity and motivating each other, result into a support system that enhances their productivity.

Each nurse and midwife brings his or her own personal history and each will focus on his or her subjective sense of the personal impact of grief. However, they are likely to have similar feelings about their losses including; sadness, anxiety, fear, anger, depression and loss of confidence. Some may develop physical symptoms. These may include headaches and gastrointestinal disturbances, loss of appetite, fatigue and insomnia.

Although the psychological processes of denial and repression protect people from emotional pain and appear useful in allowing the person to grieve in manageable doses, when feelings of grief are not permitted to be expressed, they are likely to reappear at a later date.

Nurses who conceal job-related stress exhibit reactions such as physical and emotional distancing from patients, families, and other staff and feelings of inadequacy, anger, frustration and impatience set in. Encouraging open expression of grief can help these professionals deal with their own feelings and attitudes. Each caregiver should be assisted in finding a tolerable level of feelings evoked by his work and to view this level of tolerance as a human limit rather than a personal inadequacy.

Loss in an integral fact of life. Grief is the outcome of loss and must be experienced by the individual so that he or she can heal. Grief is an interpersonal problem; its resolution is dependent upon the nature of the social structure and context. Identifying the grief reaction, accepting a wide range of behaviours associated with grief, examining one's motives for working with grieving patients and their families, and accepting one's human tolerance all appear to be important in preventing unresolved grief. Developing patterns of open communication can prevent nurses and midwives' maladaptive reactions and help them become more emotionally supported.

Antoinette Martin, Midwifery Management
antoinette.martin@gov.mt

MUMN 1996
Malta Union of Midwives and Nurses

MUMN IS HOLDING TWO SEPARATE PROGRAMMES FOR THE INTERNATIONAL DAY OF MIDWIVES & NURSES

INTERNATIONAL DAY OF MIDWIVES – 5TH MAY 2004

MUMN TOGETHER WITH THE MIDWIVES ASSOCIATION ARE ORGANISING A SEMINAR AT THE VIVALDI HOTEL - PACEVILLE.
THE THEME FOR THIS YEAR IS ~

'MIDWIVES – A VOICE FOR HEALTH FAMILIES'

FOR MORE DETAILS CONTACT MARIA CUTAJAR OR HELEN ANN BORG or MUMN on 21448542

Prices vary from Lm5 to Lm8 according to orders of lunch

INTERNATIONAL NURSES DAY – 12TH MAY 2004

9am-11am: FORUM – VICTORIA HOTEL – '*PARTNERSHIP IN NURSING*'
Amongst Guest Speakers – Rudolph Cini, Helen Muscat, Jesmond Sharples

12pm-3pm: VOLUNTARY WORK AT THE DAR TAL-PROVIDENZA, SIGGIEWI

7.30pm: THANKSGIVING MASS AT THE SEMINARY CONCELEBRATED BY FR. IVAN SCICLUNA SN B.Sc.
A special token will be given for the occasion.

8.30pm: PASTA/PIZZA NIGHT AT IL-VEDUTA RESTAURANT, SAQQAJJA, RABAT

ALL THIS FOR THE PRICE OF Lm5!

FOR MORE DETAILS CONTACT SIMON VELLA (M3), PAUL PACE (ICU), MARVIC AQUILINA (M5), DORIS DEBONO (QHC), RITA COSTA (SVPR), STEPHEN DEMICOLI (MCH) RITA BRIFFA (CHC) LORA PULLICINO (P/N) or MUMN OFFICE on 21448542

ALL MIDWIVES & NURSES ARE ENCOURAGED TO CELEBRATE THESE INTERNATIONAL DAYS, DEDICATED TO US, TOGETHER.

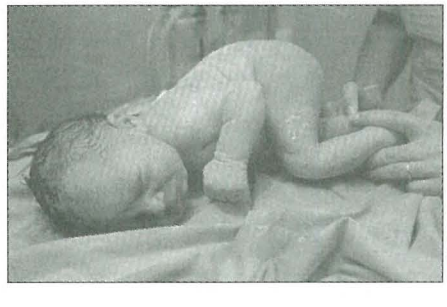
Natural pregnancy, labour and delivery

Everyone knows that in the old days, when the birth rate was much higher than it is today, mothers used to deliver at home. Hospital, in those days was unheard of. They used to go to hospital only when things went wrong. A village midwife used to go to help the mothers deliver in their homes. Monitoring was non-existing and doctors used to come to their home when problems arise during the delivery. Maternal and fetal morbidity and mortality were high in those days. We used to hear of diseases such puerperal sepsis due to lack of sterility in the nature of their work.

By time, experience and studies things have changed. Nowadays birth is more associated with hospitals or clinics. Birth is monitored through out, so much so that I sometimes wonder if the mother has any say at all in delivering her baby. The first time the mother steps into the antenatal clinic for her booking visit, she is asked multiple questions (some may be personal) so as we at the hospital know her history. We can all understand that it is vital to know the clients' history as this may indicate diversion from the normal for this pregnancy, however all this information is written on a co-operation card for all the hospital to see. Mothers are advised to keep this card with them wherever they go, however little do we realize how much harm this can do if the card falls into the wrong hands.

All throughout the pregnancy, personal data and information is exposed to any doctor of the firm. Again this is understandable, as the entire firm should know about the client. But I ask, "Is it possible for this mother to establish a relationship with only one or two people? Can she trust the system and confide in her carer, when every time she comes to the visit she finds a new face?" Pregnancy, labour and delivery is the most intimate and unique part of life between a couple. Are we destroying that, due to our system and everyday humdrum at our clinics.

I do agree that nowadays with modern, advanced technology, the midwives and doctors alike know what is really happening during labour. We have gone above those days where morbidity and mortality were high. However, I feel that now we have gone overboard. Before continuos fetal monitoring was implemented, the mother in labour was allowed mobility. It is a well-known fact that mobility is a natural method of pain relief and aids the progress of labor. Nowadays, the mothers are hardly allowed to move in case we loose the trace of the fetal heart for some seconds. Documentation is of the utmost importance in everything we are doing. I fully understand that but are we allowing the mother to go about delivering naturally or are we imposing our technologies to cover our own backs?



There are loads of methods of pain relief during labour but most of our mothers go for medicalised pain relief. Is this due to lack of information, or is it due to how we are presenting these methods. Thinking ten years back, epidural analgesia during labour was hardly ever used. Nowadays it has become a most pushed forward option and sometimes I wonder whether we women are loosing the skill of giving birth and delivering children or whether we *do* have the choice of delivering our baby as we would like to. I feel that women are loosing the control and freedom that they most treasure. We are loosing the ability as old as age itself.

When you listen to comments like "my mother" or "my patients", I wonder if these couples who come to labour ward for delivery are individual and unique, or have become part of the system of giving birth. Are we allowing our clients to talk and express their wishes? Are we able to listen to what the mother is really saying when we present the consent form on admission? Do we understand what the mothers are asking for? Are we offering the mother all the options i.e. positions during labour, natural pain relief, and supporting the mother throughout? Are we assertive enough to know what the mother is really saying during labour – body language?

The tradition that anybody who comes to hospital has now become a patient under our 'rule' must be overruled. Our clients are not patients! Our clients are normal healthy beings who come to deliver a normal healthy baby. They are neither ours, nor part of a system. We cannot enforce on them anything they do not want to be done, as after all its' their body and they have the right to decide. They are not and never were our patients and our mothers.

Maria Cassar
Deputy Midwifery Officer
Labour Ward
daffodill@onvol.net

Newsletter of the European Forum of Nursing and Midwifery Association and WHO

This data collected by the World Health Organisation clearly shows that in 2001 Malta has 374.78 Nurses per capita 100,000, making Malta 3rd from last of having the least number of Nurses per capita in Europe.
The only countries that registered a less number in 2001 are Andorra and Turkey.

Countries	1989	1999	2001
Albania	...	377.36	390.94
Andorra	...	294.28	308.68
Armenia	708.37	460.85	384.69
Austria	397.58	570.47	...
Azerbaijan	1,010.39	758.69	738.14
Belarus	827.04	1,218.89	1,235.54
Belgium	...	...	...
Bosnia and Herzegovina	471.88	397.22	444.85
Bulgaria	756.69	683.22	450.14
Croatia	498.90	476.70	499.95
Czech Republic	866.50	892.29	949.48
Denmark	841.78	943.35	961.58
Estonia	729.53	646.02	623.34
Finland	1,828.60	2,171.83	2,171.10
France	537.60	650.00	668.61
Georgia	1,067.92	579.00	422.67
Germany	...	951.43	954.78
Greece	203.50	...	...
Hungary	305.89	367.97	...
Iceland	760.19	869.18	...
Ireland	...	1,637.75	...
Israel	594.02	599.05	590.60
Italy	296.15	...	...
Kazakhstan	884.65	613.05	593.09
Kyrgyzstan	876.09	755.52	683.94
Latvia	...	526.63	507.60
Lithuania	1,099.46	835.65	798.18
Luxembourg	...	749.13	767.54
Malta	407.76	...	374.78
Monaco	1,046.43	...	...
Netherlands	808.15	1,320.98	1,328.21
Norway	...	1,898.29	2,067.54
Poland	501.43	...	...
Portugal	276.18	375.30	...
Republic of Moldova	975.20	806.74	629.21
Romania	367.50	404.03	403.05
Russian Federation	992.34	817.55	792.97
San Marino	515.40	...	...
Serbia and Montenegro	...	448.53	...
Spain	404.22	353.81	...
Sweden	...	842.82	...
Switzerland	...	...	...
Tajikistan	802.04	485.34	425.92
The former Yugoslav Republic of Macedonia	512.93	522.97	518.21
Turkey	158.70	240.26	240.62
Turkmenistan	811.65	...	...
Ukraine	1,159.07	795.43	768.41
United Kingdom of Great Britain and Northern Ireland	497.20	...	...

Nurses (PP) per 100,000 - Both Sexes

SCHERING

Yasmin®

Drospirenone/Ethinylestradiol

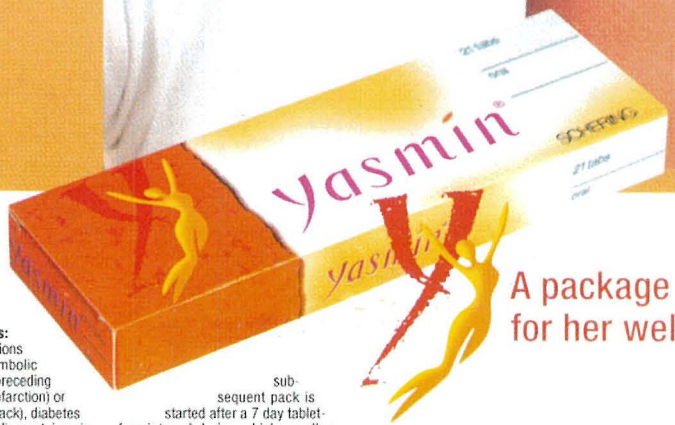
Reliable contraception with

stable body weight[1)]

relief of premenstrual symtoms and menstrual pain[2,3)]

beautiful skin[4)]

A package of benefits for her well-being



A package of benefits for her well-being

Yasmin Prescribing Information **Indication:** hormonal oral contraception **Composition:** – Active ingredients: one light yellow filmcoated tablet contains 0.03 mg Ethinylestradiol and 3 mg Drospirenone – Pharmacologically inactive ingredients: lactose monohydrate, maize starch, Povidon K25, magnesium stearate, Hypromellose, Macrogol 600, talc, titanium dioxide, iron oxide hydrate. **Contraindications:** Yasmin is contraindicated, if one of the following conditions is present: preceding or existing venous thromboembolic events (VTE, deep venous thrombosis, lung embolism), preceding or existing arterial occlusions (myocardial or cerebral infarction) or their precursors (angina pectoris, transient ischemic attack), diabetes mellitus with vascular damage, severe hypertension, dyslipoproteinemia, inherited or acquired disposition for venous or arterial thrombosis, e.g. APC-resistance, antithrombin-III-deficiency, protein-S-deficiency, protein-C-deficiency, hyperhomocysteinemia, antiphospholipid-antibodies, preceding or existing severe liver disease, until liver-specific functional parameters have returned to normal, severe renal insufficiency or acute renal failure, preceding or existing benign or malignant liver tumors, suspected or established malignant diseases of the genital organs and of the breast, if hormone dependent, vaginal bleeding of unclear origin, migraine with focal neurological symptoms, increased sensitivity against the active or inactive ingredients of Yasmin. Should one of these conditions appear for the first time under medication with Yasmin, the intake of Yasmin had to be stopped and the prescribing physician has to be notified. **Side effects:** occasionally cycle disturbances, breakthrough bleeding, breast tenderness, headache, depressive mood, migraine, nausea, discharge, vaginal mycosis, rarely libido changes, hyper- or hypotension, vomiting, acne, eczema, pruritus, vaginits, edema, weight changes, single cases of asthma, lactation, hypacusis and thromboembolism have been described. **Dosage and regimen:** one tablet is to be taken daily at about the same time for 21 consecutive days, following the order shown on the blister pack. Each subsequent pack is started after a 7 day tablet-free interval during which usually a withdrawal bleed occurs. **Interactions with other medicinal products:** contraceptive failure and breakthrough bleeding have been described for the concomitant use of hydantoin, barbiturates, primidone, carbamazepine and rifampicin. Such interactions are also suspected for oxcarbacepin, topiramate, felbamate, ritonavir, griseofulvin and St. John's wort. Contraceptive failure has also been described for concomitant use of antibiotics, such as ampicillin and tetracyclin. **Warnings:** If any of the conditions/risk factors mentioned below is present, the benefits of combined oral contraceptive use has to be weighed against the possible risk for each individual woman. In the event of aggravation or first appearance of any of these conditions or risk factors, the woman should contact her physician: Vascular disorders with or without indication of arterial or venous thrombosis. The risk is increased for individuals with a respective family history, advanced age, smoking, overweight, lipid metabolism disorders, hypertension, diabetes, immobilization, valvular disorders, atrial fibrillation, systemic lupus erythematosus, hemolytic-uremic syndrome, chronic inflammatory bowel disease, migraine. Tumors: the risk of having breast cancer is slightly elevated for women taking combined oral contraceptives. Breast cancer is rare in woman under 40 years of age, and the excess risk potentially caused by hormone intake gradually disappears during the course of the 10 years after cessation of combined oral contraceptive use. Experiences from clinical studies do not provide evidence of a causal relation between the use of combined oral contraceptives and an increased incidence of breast cancer. An increased risk of cervical in long-term users of COCs has been reported in some epidemiological studies. Annual routine checks by a physician are recommended. **Special precautions:** Contraceptive safety is impaired if one or more tablets have been missed. In this case the physician has to be informed. Yasmin is not indicated during pregnancy. Should a woman become pregnant while taking Yasmin, the use has to be terminated immediately. In case of concomitant use of potassium sparing preparations the serum potassium level should be controlled. Should vomiting and/or severe diarrhea occur within 3–4 hours after the intake of Yasmin, a new pill has to be taken. If more than 12 hours have elapsed until the new pill is taken, medical advice has to be sought. **References** 1) Foidart J-M, Wuttke W, Bouw GM et al.: Eur J Contracept Reprod Health Care 2000; 5: 124–134. 2) Parsey KS, Pong A: Contraception 2000; 61: 105–111. 3) Freeman E, Kroll R, Rapkin A et al.: J Clin Psychiatr, submitted. 4) Data on file

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from our diary...

mid-djarju tagħna...

1. MUMN proudly presents its first elected Student's Group Committee Chaired by Nadia Attard (front row, 3rd from right)

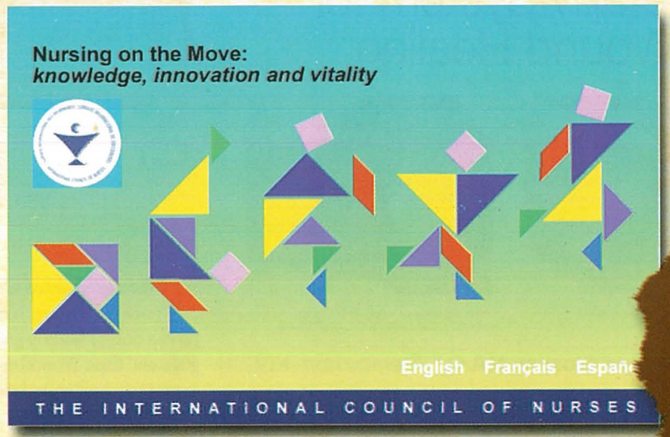
2. The 6th Annual Activists Meeting organised last November with the theme of the Family Health Nurse/Midwife.

3. The first activity organised by the Florence Nightingale MUMN Benevolent Fund to honour those Nurses and Midwives who retired from work by rewarding them with a memorable token as a sign of recognition and appreciation for their long dedicated work towards our patients. This activity would be held annually. In the photo the FNBF Group Committee is seen with the retired Nurses and Midwives.

4. During the annual Christmas Dinner Dance organised by the Entertainment & Cultural Group Committee, the Paul Bezzina Shield was rewarded to the Pensioners Group Committee as the committee who struggled most for the interests of its members. Runners-up were Mount Carmel Group Committee. Well Done.

5. The first group attending the new SEN-SRN Conversion Course after an important agreement reached on the format of this course between the Directorate Nursing Services and MUMN. The third group has already kicked-off in this new format (36 Enrolled Nurses in each course).

6. An important seminar organised by the Education Executive Committee regarding Breast Feeding. This seminar, besides Midwives, also attracted several other professionals who participated together towards this objective.



ICN 23rd Quadrennial Congress 2005

Dear Colleagues, The International Council of Nurses is pleased to send you the link to the Call for Abstracts for its' 23rd Quadrennial Congress, 21-27 May 2005 Taipei, Taiwan, inviting the submission of abstracts for the Congress.

We look forward to seeing you in Taiwan. Further inforamtion visit: **www.icn.ch**

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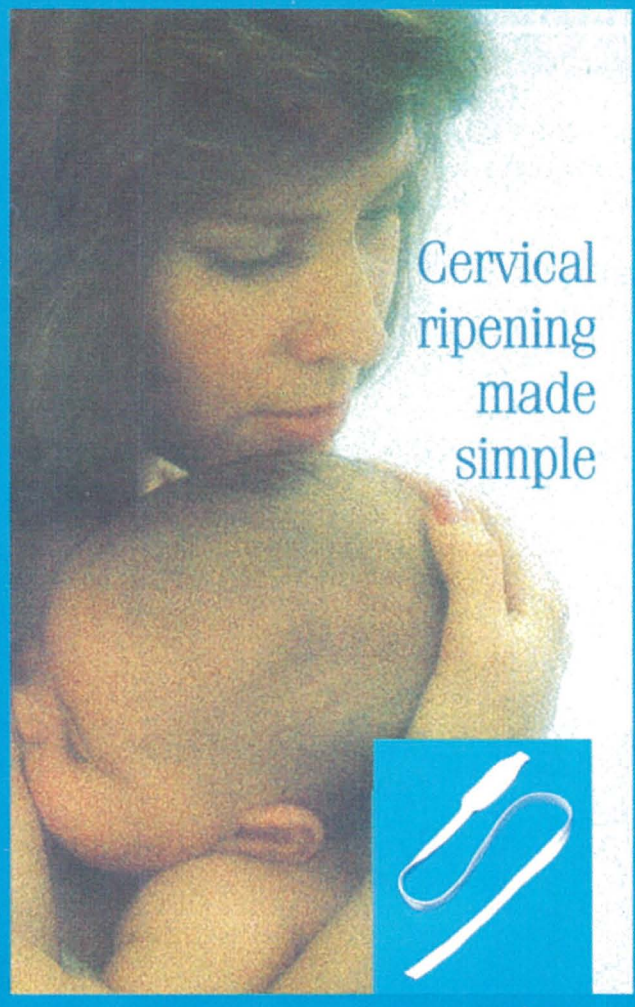
* Controlled delivery of dinoprostone to stimulate cervical ripening[5].
* High treatment success[6,8-10].
* Simple to insert, with high patient acceptability[5].
* Easy retrieval of pessary with minimal patient discomfort[5].
* Low incidence of uterine hyperstimulation or fetal distress[5,6,8-10].
* Retrieval system gives effective control of cervical ripening and induction[5].



VAC ATS

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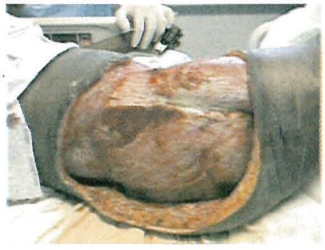

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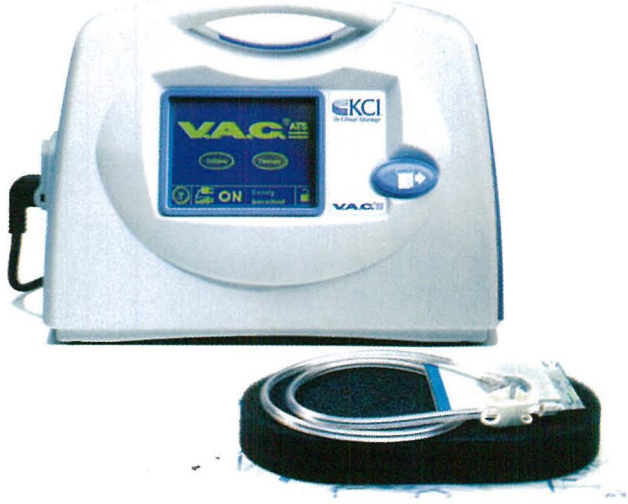
After 20 days of V.A.C.® Therapy wound closed with 100% graft intake.

Vacuum Assisted Closure, V.A.C.® Therapy from KCI, is the most innovative therapy available today for effective wound healing. It is a non-invasive, active wound closure system that uses controlled, localized negative pressure to promote healing in acute and chronic wounds.



"Vacuum Assisted Closure (V.A.C.) is the advanced system for wound healing. It can provide a moist environment and the production of healthy granulation tissue for the application of skin grafts and flaps. Wound exudate is removed in a very effective manner to promote healing and reduce wound infection. The V.A.C. therapy can convert a lengthy and expensive wound healing process into a rapid and cost-effective solution for the majority of wounds."

Mr. F. X. Darmanin – Plastic and Reconstructive Surgeon
St. Luke's Hospital Malta – February 2004

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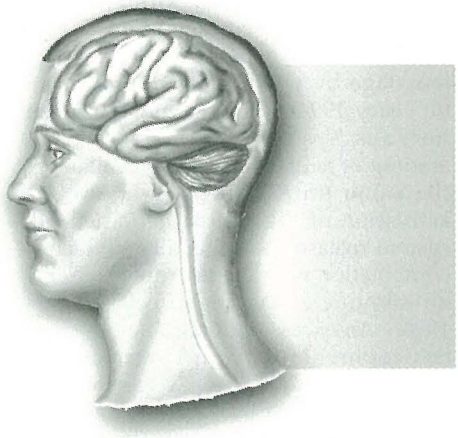
Psychoneuroimmunology-the influence of the mind over the immune system

Reuben Cassar SN BSc
(Nursing) Student



Everyone knows that when the body is under stress, the body's immunity to fight against infection will be lowered. Through research, scientists are finding a strong influence of the mind over the immune system. This is a clear example that if the part of the body fails, the other parts will be unbalanced as compared to the whole body. This gave rise to psychoneuroimmunology. Psychoneuroimmunology is the study of the interaction of behavioural, neural, and endocrine factors and the functioning of the immune system (The American Heritage Dictionary of English language 2000). This area of research is finding evidence that human emotions have a strong effect on the immune system. This was evident during World War 1 as the occurrence of trench mouth (ulcerative gingivitis) was associated with weakened immune system (Sutherland 1990). It showed that every single part of the body that is involved with immunity is connected to the brain either by nervous tissue connection, or by chemical messages. This is further emphasised by Besedovsky, 1991 (cited by Ader 1991) that activation of the immune system is accompanied by changes in hypothalamus, autonomic and endocrine processes.

Although this is a relatively new science, Galen (200 AD) was among the first physicians who recognised the importance of psychological factors in the prognosis of disease. Research is showing that stress influences the normal functioning of the immune response. This is so as stress can temporarily inhibit certain components of the immune system (Tortora 2000). Edlen (1996) referring to Glaser et al (1992) found that stress slowed down the affect of an immune response to a vaccine. Evidence also suggests that stress affect the immune system's ability to defend the body (Taylor, 1999 in Atkinson 2000). Another study indicated that the common belief that one is more likely to catch a cold when is under stress is probably correct (Cohen, Tyrel, and Smith, 1991 cited by Atkinson 2000). Stress, which has both physiological and psychological influence on the mind and body, is the major culprit of diseases such as asthma, depression, cancer and autoimmune disorders.

Not all stress is harmful in actual fact. It helps us to cope with different situations that are brought about in our daily life events. This enables the body to create a balance between health and illness. The body has its own stress adaptation method. Cannon 1929 (in Powell.TJ, 1990) was the first one to call this short-term alarm reaction as the *"flight or* fight *reaction"*. This refers to the complex physiological and biochemical reaction that takes place in our bodies during a stressful situation. This physiological reaction is brought about by three factors mainly the autonomic nervous system, the endocrine system and the skeletal masculature.

In times of stress the sympathetic nervous system releases a hormone which increases arousal when the organism is under threat, enabling the heart to increase its activity. On the contrary the effects of the sympathetic stimulation are reversed by the action of parasympathetic nervous system, which helps to restore the body to a resting state. Their action is involuntarily and is designed to enable the organism to survive.

The endocrine system is intertwined with the autonomic nervous system. The adrenal glands release hormones, namely adrenaline and noradrenaline, which modify the action of the internal organs in response to stressful stimuli. Their release is controlled by the autonomic nervous system. The adrenal cortex produces glucocorticoids, especially cortisol, which promotes the action of the catecholomines, adrenaline and noradrenaline. Similarly cortisol stimulates neurosecretory cells in the hypothalamus to secrete corticotropin-releasing hormone (CHR). On the other hand a low cortisol level together with corticotropin-releasing hormone promotes the release of ACTH from the anterior pituitary. At the same time the blood carries ACTH to the adrenal cortex, where it stimulates glucocorticoids secretion (Tortora 2000). The release of corticosteroids, in response to stress is one underlying biological mechanism, which explains the link between psychological factors and the immune system. Besides cortisol influences carbohydrate and protein metabolism, it has anti-inflammatory and anti-allergic properties (Sutherland 1990). An increase in cortisol levels combined with adrenaline is associated with a decrease in activity of T-cells and B-cells against antigens. This decrease in lymphocyte activity appears to be important in the development and progression of a variety of diseases with lowered immunity such as cancers (Sarafino 1994). This is further emphasised by Kiecolt-Glaser (1986) that in periods of stress enzymes that destroy chemical carcinogens are reduced.

Besides nerves communicate and transfer information by using neurotransmitters. These allow certain neurones to fire in a certain way. Each nerve uses these neurotransmitters to pass signals through the synaptic gap. The existence of a communication system between the immune system and the nervous system was further enhanced by the discovery of nerve endings in the thymus, spleen and bone marrow where activity of the immune system occurs. It was found that lymphocytes besides having receptor sites for neurotransmitters and neuropeptides they also produce and release them. The neuropeptides have significant effect on the body's communication between the brain and the immune system. These chemicals are released into the blood stream in response to stress as well. Perhaps the most widely talked class of neuropeptides has been endorphins.

Neuropeptides, as their name implies, are chemicals that affect both the nervous system as well as the immune system. There is evidence to suggest that they play the key role in the communication system between the nervous system and the immune system as well as the actual mediation of brain states and their effects on immune function. Another important link is the limbic system.

The limbic system is an area in the brain where there is the most concentration of these chemicals. It is one of the key areas in the brain associated with emotion (Tortora 2000). The link becomes clearer in combination with the fact that there are receptors on lymphocytes for all the neuro

transmitters currently known. This suggests a clear connection between mind and body, and a common chemical language by which they communicate (O'Leary 1994). The functioning of the nervous system is affected by the amount of neurotransmitters available at the same time. Research show that activation of the sympathetic nervous system releases noradrenaline, which in combination with the neuropeptides has an immune enhancing effect (O'Leary 1994). An excess of dopamine can cause Schizophrenia while if the amount of dopamine is too low it can lead to Parkinson's disease (Atkinson 2000).

Cytokines have an important function in this intregate mesh. These chemical signals, produced by the immune cells communicate with the brain where in turn they send their own signals, mainly neuropeptides, influencing the activation of the hypothalamus, the pituitary and the adrenals. These are influenced by glucocorticoids secretion. Administration of Cytokines is thought to influence sleep and eating behaviours, fear and mood states (Ader 1991).

On the other hand scientists are finding that excess stress affects health. A correlation exists between stress and disease. The direct effect of stress can cause heart attacks, depression, cancer, asthma and other autoimmune disorders. Sarafino (1994) associated depression and stress with an impaired immune function. Depression is a result of circulating noradrenaline and Serotonin (Groenwald, 1996). Serotonin is a neurotransmitter, which is responsible in controlling mood and induction of sleep (Tortora 2000). This is further emphasised by a study, which showed that family caregivers of patients with Alzheimer's disease reported more days of illness (Kiecolt-Glaser et al 1991 in Sarafino 1994). They had reduced T-lymphocytes and T-helper cells, the body's main immune fighting components (Irwin 2000). Caldwell (1991) found a lowered immunity activity in those patients with depressive disorder when compared with schizophrenic patients. Psychological response to bereavement can show changes in the immune response of a person. Studies showed that persons who undergone bereavement had suppression of lymphocyte responses, as well as a reduction of natural killer cell activity (Irwin 2000). In another study by McDaniel (1992) it was clear that women who lost their husband showed increased plasma cortisol levels which resulted in immunosuppression. A study done on patients suffering from AIDS suggested that less adequate psychological coping skills corresponded to a lessened ability to fight the disease (O'Leary 1994). Because of the influence of the brain on the immune system research is finding that AIDS dementia can be a problem with the immune system.

Asthma can be the direct effect of this bi-directional communication of the brain with the immune system. As Irwin and Anisman (1984) cited by Sutherland (1990) suggested that allergy in asthma can result from an inhibition of Suppressor T-cells. Suppressor cells are responsible for reducing the immune affect (O'Leary 1994). Consequently stressors could exacerbate allergic symptoms by depressing T-cell activity (Sutherland 1990).

The effect of excessive stress can bring about cancer. Malignancy can only develop if there is a dysfunction in the immune function. In times of stress cortisol is released reducing the number of antibodies produced. At the same time neuropeptides, can alter the activity of lymphocytes and natural killer cells. Evidence is showing that depression in cancer can also be linked with a lowered immunity, due to an increase in cortisol level thus resulting in decreased T-cell growth factor. This was confirmed by a study on psychological problems in cancer patients resulted that they had reactive anxiety and depression. Kennedy et al (1988) found that closely related viruses were linked with cancer. Herpes Zoster infection is associated with diminished immunological defences and patients can have also a higher incidence of cancer.

Researchers are finding other links that are related to stress and the immune response. Auto immune disorders such as rheumatoid arthritis, systemic lupus erythematosus and multiple sclerosis are taught to be caused as a result of stress. Certain negative life events have been associated for the onset and development of such disorders (Baker et al 1981). It is believed that autoimmune disorders may be due to reduced activity of Suppressor T-cells and an increase in lymphocytes rather than overstimulation of immune cells (Kohler and Vaughan 1982).

Although psychoneuroimmunology is still in its infancy, it is gaining ground. On going research is being done to go in much deeper insight from what it has been known till now. This is important so that newer medications can be studied and finally tried. Besides this change is bringing with it newer approaches in health care. A multi-sectorial team approach is being used. Nurses together with the multi-sectoral team should work in co-ordination ensuring a better approach in care and cure. To be able to do so nurses must keep abreast with the new developments in medical research such as is the science of psychoneuroimmunology. As Swanson (1993) rightly said that nurses could use the findings of psychoneuroimmunology to formulate interventions that will promote their patients' physical and psychological well being. Care should be geared to try and reverse the negative impact stress can have on the immune system. Today care is not just focusing to treat the disease but it is concentrating more on the physical, emotional, and psychological aspect of the patient.

Getting to know how psychoneuroimmunology works is giving us a deeper insight of the influence the mind has over the immunity system. Thus it will help to treat diseases leading to developments of new treatments for such illnesses based on stimulating all the parts of the immune, neuro or endocrine systems to promote healing.

REFERENCES:

Ader R, Cohen N, and Felten DL (1991) - **Psychoneuroimmunology interactions between the nervous system and the immune system.** The Lancet vol. 345, no 8941, Jan 14, 1991

Atkinson RL (2000). **Hilgard's Introduction to Psychology** (13th edition). Orlando. Harcourt Brace.

Baker G.H.B and Brewerton (1981). **Rheumatoid arthritis –a psychiatric assessment**. British Medical Journal, 282, 2014.

Caldwell C, Irwin M and Lohr J (1991) in: **http://www.healthy.net/collinge/mindbody.htm** [accessed 28/10/03@10.15p.m]

Edlin G, Galanty E (1996). **Health and Wellness** (5th edition). Boston. Jones and Bartlett.

Galen (200AD) in; **http://www.journeyofhearts.org/jofh/transition/pni_art** [accessed 16/10/03@10.00pm]

Groenwald SL, Frogge MH, Goodman M and Yarbro CH eds (1996)-**Cancer symptom management.** London. Jones and Bartlett.

Irwin M (2000.) in: **http://www.journeyofhearts.org/jofh/transition/pni_art** [accessed 16/10/03@ 10.00p.m]

Kennedy S, Kiecolt-Glaser JK and Glaser R (1988). **Immunological consequences of acute and chronic stressors. Mediating role of interpersonal relationship.** British Journal of Medical Psychology, 61, 71-85.

Kohler PF and Vaughan J (1982). **The autoimmune diseases.** Journal of American Medical Association, 248, 2646-57.

McDaniel (1992) in: **http://www.journeyofhearts.org/jofh/transition/pni_art** [accessed 16/10/03@10.00p.m]

O'Leary A (1994) in: - **http://raptor.slc.edu/synapse/papers/pni/html[accessed** [accessed 29/10/03@10.45pm]

Powell, TJ and Enright JS (1990). **Anxiety and Stress Management**. London. Routledge

Sarafino EP (1994). **Healthy Psychology-Biopsychosocial interactions** (2nd edition). New York. John Wiley and Sons.

Sutherland VJ and Cooper CL (1990). **Understanding Stress-a psychological perspective for health professionals.** London. Chapman and Hall.

Swanson B, Stubbs DC, ZellerJM, Kessler HA and Bieliauskas LA (1993). **Characterising the neuropsychological functioning of person with H.I.V-** Archives of Psychiatric Nursing. Vol V11-2. Philadelphia. W.B.Saunders.

Tortora and Grabowski (2000). **Principles of Anatomy and Physiology** (9th edition). NewYork. John Wiley and Sons.

http://www.naturalhelthcourses.com/reading_room/ancient.wisdom.htm. Stress is not an illness [accessed 15/8/03@ 9.00p.m]

The American Heritage Dictionary of English Language. 4th edition (2000) [online]. Houghton Muflin Company.

Farewell to a long Career

When one of your colleagues whom you have known very well and worked hard with, retires to pension, it will come as a shock to you, even though you may be expecting it. That is what happened to me. We all knew that Ms Mary Anne Agius, Midwifery Officer of Antenatal Ward was coming close to retiring age, however none of us, deep down wanted her to leave.

Ms MA Agius was one of the pioneers. She qualified as a Staff Nurse in 1969 and in 1974 she qualified as a midwife. After she became a midwife, she always worked in Antenatal Ward, climbing up step by step to Midwifery Officer. Her dedication towards the mothers and staff was admirable. She had a strong personality but very calm in decision making.

She acquired many changes to Antenatal ward, though this may seem strange to people who knew her ***only*** these past few years. Throughout the years Ms Agius has taught her staff to work more independently. When she first became a Midwifery Officer the staff under her charge did not carry proper nursing/ midwifery duties. She changed that! Her staff started carrying duties which where previously done by doctors. She brought about the client allocation system. I can guess that in those days, it was not easy. She tried to make the clients' stay as comfortable and homely as possible, since most mothers stay in the ward for long periods of time. Mothers used to adore her and show her respect. She worked in Antenatal ward last on the 14th of January 2004.

I could go on forever writing the biography of Ms Agius. She was one of us and we miss her. All the good work that she has done is reflecting now on Antenatal Ward. Finally came the day when she had to leave. Everybody was in tears during the mass that was organised on her behalf, held on the 25th of January 2004. She blushed when the staff showed their appreciation of her work by small gifts. I personally heard her murmur that she was only doing her duty.

I am sure that the staff in our department will always remember Ms Agius. She was one in a million. I always looked at her as a mother figure, with loads of experience which she always shared with anybody who was interested.

Maria Cassar
Deputy Midwifery Officer, Labour Ward
daffodill@onvol.net

GRUPP PENSJONANTI

Illum il-ġurnata il-grupp tagħna affiljati mal-Alleanza ta' Organizzazjonijiet ta' Pensjonanti, fejn nieħdu sehem fil-laqgħat li jsiru kull xahar. Għal dawn il-laqgħat nattendu għalihom jien u Frans Agius.

Numru minn dan il-grupp iħallas il-miżata tal-*Florence Nightingale Benevolent Fund*. Il-kumitat tal-Fund iddeċieda li jippreżentalna *memento* sabiħ bħala rikonexximent tas-servizz li tajna mal-pazjenti. Dawn il-*mementoes* ġew ippreżentati f'*social* li ġie organizzat minnhom stess.Ta' dan nirringrazzjawhom.

Meta jiena spiċċajt mis-servizz wara 43 sena ippreżentajt 'shield' f'ismi lill-MUMN sabiex ta' kull sena tintrebaħ minn dak il-*group committee* li jkun iddistingwa ruħu bħala dak il-grupp b'ħidma utli ma' tul dik is-sena partikolari. B'sorpriża għall-grupp tagħna, l-iżjed għalija, għas-sena 2003, il-Board għażel il-grupp tagħna bħala rebbieħa tal-**PAUL BEZZINA SHIELD**. Żgur li meta ntroduċejt ix-'shield' qatt ma ġieni f'rasi li xi darba nkun iċ-chairpersom ta' xi grupp. Però nista' ngħid li jien ferħan ħafna.

Lil sħabna pensjonanti irrid narrafhom li l-kumitat qiegħed jipprepara ħarġa oħra għal Għawdex. Din se tkun fis-16 ta' April 2004. Kullħadd għandu jirċievi it-tagħrif id-dar.

Hemm ukoll il-ħsieb li tiġi organizzata xi safra fis-sajf.

N.B. Meta kull *chairperson* tal-gruppi tal-isptarijiet u *units* oħra jkunu jafu b'xi nurses u midwives li jkunu se jispiċċaw mis-servizz jew jirtiraw, iffakruhom fl-għaqda tagħna.

Inselli għalikom

PAUL BEZZINA
Chairperson

Rapport ta' Ħidma
Sotto Kumitat SVPR

Nixtieq ninfurmakhom li bħalissa qed isiru diskussjonijiet bejn l-MUMN SVPR, d-Direttur s-Sur M. Bezzina u s-Sur A Briffa MNS rigward is-sitwazzjoni preżenti fl-SVPR. Fost l-oħrajn qed jiġi diskuss ir-riżultat tal-kwestjonarju li sar mill-MUMN SVPR.

Fil-laqgħa li saret nhar it-23 ta' Jannar 2004, fost ohrajn iddiskutejna il-problema ta' l-għoti tal-V/leave. Bi qbil mad-Direttur s-Sur. M Bezzina u s-Sur A Briffa, bħala miżura temporanja b' seħħ minn nhar it-tnejn 2 ta' Frar 2004 ingħatat il-fakulta' illi l-N.O.'s, A/N.O., Dep.N.O.'s, A/Dep. N.O.'s ser ikunu jistgħu jidħlu jagħmlu l-OT bħala 'bedside nursing' b'ġurnata sabiex intaffu ftit il-problema ta' l-ikkanċellar. Hemm diversi punti li jridu jiġu diskussi fil-laqgħat fil-futur qarib.

Nhar il-25 ta' Jannar 2004 ktibna ittra lid-Direttur s-Sur M. Bezzina fejn għarrafnih dwar is-sitwazzjoni bejn il-'personnel section' f' SVPR u l-istess infermiera.

Nhar it-2 ta' Frar 2004 l-MUMN SVPR ireġistrat tilwima industrijali mad-Dipatiment ta' l-Anzjani. Il-Union għamlet dan wara li d-Dipartiment ta' l-Anzjani injora talba li l-Union għamlet sabiex l-infermiera jingħataw il-kotba tal-V/leave, minkejja li kien diġa' beda Frar. Barra minn hekk l-MUMN tosserva li fid-Dipartiment ta' l-Anzjani qed jiġu ttollerati miżuri li joħolqu biss burokrazija u diffikultajiet meta l-infermiera jkunu jridu jieħdu informazzjoni dwar is-salarju tagħhom u informazzjoni oħra relatata mar-'records' tagħhom.

Fid-19 ta' Jannar 2004 ktibna ittra oħra lid-Direttur s-Sur M. Bezzina, fejn irrimarkajt ċerti problemi li jistgħu jinqalgħu bil-lejl min-naħa tal-'maintenance.' Sfortunatament f'SVPR ma jeżizti l-ebda ħaddiem tal-manutenzjoni ta' l-ilma u d-dawl li jaħdem bil-lejl bil-konsegwenza li qed tkun diffiċli ħafna sabiex jiġi kkontrollat / irranġata ħsara urġenti fir-Residenza matul il-lejl. F'risposta tad-Direttur qalli li tajjeb li tiġi ttrattata f' laqgħa ma' l-amministrazzjoni. Tkellimt mas-Sur J. Rapinett Assistant Direttur SVPR u qalli li ser iressaqha għad-diskussjoni mal-Hospital Management Committee.

Raymond Chetcuti
Chariperson MUMN SVPR.

Gozo Group Committee

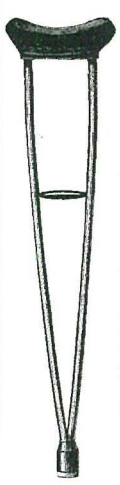
- ✔ The Gozo Group Committee has been meeting on an ad hoc basis and several issues were discussed.
- ✔ The most important issue to date and still pending is the overcrowding of the Female General Ward at G.G.H. which is an acute ward catering for all types of disciplines namely surgical, medical, orthopaedic, gynae and ENT.
- ✔ The problem arising from overcrowding is known to everyone and the main cause of this is the increase in the number of geriatric patients in the acute wards. For this purpose the dire need to increase the staff compliment at Residenza Sant Anna with the already proposed number has been sought with the authorities. Until now we do not have any concrete answer and in the coming weeks action may be taken to enforce our needs in this issue. All this for the benefit of the acutely ill patient.
- ✔ Another issue which although minor caused a problem for some of the Enrolled Nurses was the Progression Report for the progression into Scale 10. This has been resolved.
- ✔ The MUMN has been invited to have a representative on the newly appointed Regional Project Committee for Gozo, by the Ministry for Gozo. This committee has been appointed according to the EU negotiations for Gozo. MUMN appointed Mr. A.Degiorgio (Chairperson Gozo Group Committee) as representative in this committee.

A. Degiorgio
Chairperson Gozo Group Committee

Food for thought...

"Always love your enemies – nothing annoys them so much."

Oscar Wilde

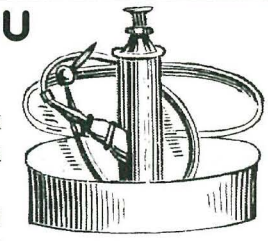


NIĠBDU L-ATTENZJONI LILL KULL MIN GĦANDU GĦAL QALBU L-ISTORJA MEDIKA MALTIJA!

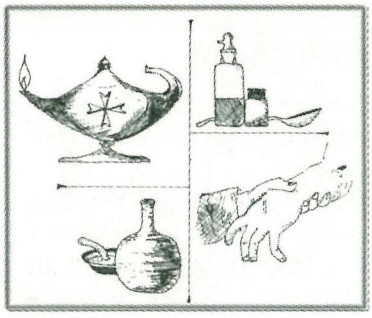
Qiegħed isir kull sforz biex tinħoloq Assoċjazzjoni biex kull min hu nteressat f'dak kollu li għandu x'jaqsam mal-istorja (history) medika Maltija, ikun jista' jiddedika ftit ħin minn tiegħu.

Il-ħsieb hu li dak kollu li għandu x'jaqsam ma' arkivji (karta jew equipmentl) jiġi miġbur (qabel jintilef/jintrema), imfittex, katalogat, imsewwi/imnaddaf u arkivjat f'forma ta' esebizzjoni temporanja (mużew).

Jinħtiegu għalhekk individwi li għandhom għal qalbhom dak kollu li għandu x'jaqsam mal-passat tal-isptarijiet biex anke jieħdu ntervisti minn ex-impjegati li xi darba ħadmu f'xi sptar biex nieħdu kemm jista' jkun rakkonti/esperjenzi minn għandhom biex jiġu preservati.



KULL MIN JIXTIEQ JIXTIEQ LI MA NKOMPLU NITILFU XEJN MINN DAK LI ĦALLEW TA' QABILNA IĊEMPEL LIL ALEX MANCHE' FUQ 25951211, 21678038, 79678038



Kitba ta' JOE CAMILLERI

L-ISTORJA TAN-NURSING F'MALTA

MIS-SITTAX IL-SEKLU SAS-SITTINIJIET

.....Ġabra ta' storja riċerkata dwar l-evoluzzjoni tan-Nursing f'Malta mill-eqdem żminijiet sa era aktar moderna. Harsa analitika dwar kif in-Nursing stabilixxa ruħu fil-ħajja medika Maltija ta' Gżiritna.....

IT-TIENI GWERRA DINJIJA

Flimkien mar-Renju Unit, Malta daħlet fit-Tieni Gwerra Dinjija fit-3 ta' Settembru 1939 u bejn l-1940 u l-1944 ġew feruti 3780 li 1846 kienu gravi.

Skema biex jiġi mwaqqaf l-Emergency Medical Service fl-1935 waqt il-konflitt Italo-Abbisinjan għenet lid-Dipartiment tal-Medical and Health biex jipprovdi minn 1200 sa 1500 sodda għall-vittmi tal-gwerra u saħansitra Ċentri tal-Ewwel Għajnuna u dekontaminazzjoni.

Barra li kien hemm sptarijiet li diġa kienu jeżistu, oħrajn kienu ppreparati fil-Mellieħa, ż-Żurrieq u ż-Żejtun waqt li Ċentri għar-refuġjati f' postijiet oħra kellhom jintużaw għat-trattament tal-morda u l-feruti u każi ta' maternità. Sezzjoni fl-Isptar Ċentrali fil-Furjana, li dak iż-żmien kien l-uniku sptar ġenerali f'Malta, ġie mibdul fi sptar t'emerġenza. Swali t'Emerġenza ġew imwaqqfa fl-Isptar San Vinċenz di Paoli u postijiet oħra għall-kura tal-anzjani u l-morda kroniċi li ma setgħux jieħdu ħsiebhom fid-djar minħabba tħarbit fil-ħajja tal-familja tagħhom. L-isptar ta' San Vinċenz di Paoli ma setax jiffunzjona għal tul ta' żmien għaliex kien viċin wisq tal-mitjar ta' Ħal Luqa u kellu jiġi evakwat kompletament fil-bidu tal-1941. Is-sotterran tal-Isptar San Luqa, li kien għadu qed jinbena, ġie wżat bħala sptar ta' isolazzjoni u mard kontaġġjuż għal dawk il-każi li kellhom jiġu evakwati mill-Isolation Hospital ta' Manoel Island. L-isptar ta' Santu Spirtu tar-Rabat kien mibdul għall-'clearing station' għall-feruti minn dak id-distrett.

Kulleġġi, skejjel, orfanatrofji u kunventi ġew mibdula fi sptarijiet temporanji, apparat tal-X-Ray u apparat ieħor ġie mogħti mill-British Red Cross u l-Order of St. John War Organisation.

L-Istitut V. Bugeja

L-Iskola Teknika ta' Bugeja fil-Ħamrun ġiet mgħammra b'150 sodda; parti mill-Isptar tal-Blue Sisters, il-Kunvent tas-Sacred Heart f'San Ġiljan u l-Iskola Mater Boni Consilii ta' Raħal Ġdid kienu wkoll mibdula fi sptarijiet. Il-pazjenti ta' Raħal Ġdid kienu ittrasferiti lejn il-Kulleġġ ta' San Alwiġi f'Birkirkara li wkoll kien mibdul fi sptar minħabba li kien viċin wisq tad-Dockyard. Sptar tal-Maternità li seta' jilqa' mal-mitt pazjenta ġie mwaqqaf f'Ġunju tal-1940 fl-Orfanatrofju ta' Adelaide Cini ġewwa l-Ħamrun. 'Shelter' fil-blat ġie mħaffer fl-aħħar tal-1941 biex jieħu prattikament il-pazjenti kollha. Dan kien mgħammar b''Operating Theatre' taħt l-art u Labour Ward komplut bl-ilma u l-elettriku. Anke kmamar tal-Maternita` ġew imħaffra f'shelters fil-blat f' ħafna villaġġi, għall-ommijiet li kienu se jixtru u li ma ridux imorru sptar. Dan il-pjan irnexxa tajjeb ħafna u ma kienx hemm każi ta' infezzjonijiet.

L-isptarijiet kollha kienu milquta u saritilhom ħsara minħabba l-bumbardamenti mill-ajru f' xi żmien jew ieħor. L-Isptar ta' San Bartilmew u dak Ċentrali kellhom ħsara estensiva fl-1941 u fl-1942, tant li ċ-Ċentrali kellu jiġi evakwat temporanjament. F'April tal-1941 xi pazjenti ġew feruti serjament fl-Isptar Mentali waqt li tnejn kienu nqatlu. L-Isptar Bugeja u l-Isptar Cini kienu milquta f' Settembru tal-1941. Anke l-Isptar tal-Blue Sisters kien se jlaqqatha, flimkien ma l-Isptar ta' Santu Spirtu u l-Connought.

L-Isptar San Luqa li kien milqut fl-ewwel ġurnata tal-gwerra mal-Italja, meta kien għadu vojt, ġarrab ħsara kbira u kien hemm mhux biss il-midruba, iżda anke miet impjegat. F' Birkirkara ġewwa l-iskola tal-Gvern (S.Francis Hospital) ġew trasferiti xi pazjenti wkoll. L-Isptar Mentali reġa' laqqatha fl-1942 fejn erba' pazjenti mietu filwaqt li Soru tal-Karità u żewġ attendenti nisa tal-Isptar tilfu ħajjithom waqt li kienu qed iġorru pazjenti għax-shelters ta' taħt l-art. Fl-istess sena anke l-Isptar tal-Maternità ta' Cini reġa' laqqatha fejn il-kwartieri tan-nurses iġġarrfu. L-Isptar tal-Furjana (King George V) ġie meqrud fl-1942. Għalkemm kien hemm waqfien temporanju minħabba l-attakki, is-servizzi tal-isptarijiet qatt ma ġew interrotti. L-aktar tipi ta' korrimenti kienu feriti tal-muskoli u ksur fl-għadam u ġogi minħabba ġebel li kien jaqa' u splinters tal-bombi u l-effetti tal-blast tal-bombi.

L-isforzi tal-ħaddiema professjonali u dawk pajżana tal-'Emergency Medical Services' ġabu rikonoxximent mill-pubbliku, u mhux biss taċ-Chief Government Medical

Officer iżda miż-żewġ gvernaturi tal-gwerra, Sir William Dobbie u Lord Gort, " għall-fortitudni li ntweriet waqt id-diffikultajiet u r-rebħa fuq il-kundizzjonijiet diffiċli tal-bumbardamenti u assedju" u "għar-rieda soda u sabar tal-ħaddiema ta' dawk l-isptarijiet u d-distretti li ġarrbu qerda kbira. Ħafna minnhom għexu u ħadmu taħt kundizzjonijiet ta' tbatija kbira u periklu u komplew jaħdmu mingħajr ma ċedew jew gemgmu." Bħala rikonoxximent tax-xogħol li għandu x'jaqsam man-nursing fi żmien il-gwerra, Ms. Margaret Ferro li kienet Nursing Member fil-Voluntary Aid Detachment, ġiet onorata bħala Associate of the Royal Red Cross (ARRC) fl-1942. Fl-1943 is-Sur Vincent Grech ingħata ġieħ, fil-British Empire Medal (BEM) bħala Wardmaster tal-Isptar tal-Lebruż.

"Għas-servizz ta' l-oħrajn"

Ir-rekord sabiħ fi żmien il-gwerra tal-Medical & Health Department huwa kollu mertu tad-dedikkazzjoni u ħila kbira tal-kirurgi Maltin taħt it-tmexxija ta' Prof. P. P. Debono, tobba, nurses, servjenti, xufiera tal-ambulanza, uffiċjali u skwadra ta' salvataġġ. Waħda mill-problemi serji li kienu jiltaqgħu magħha dawn in-nies kienet in-neċessità ta' 'black-out' meta jidlam.

Rakkont interessanti u ta' kuraġġ kien meta fil-Kottonera, is-Sur T. Fenech li kien nurse kapaċi mmens u li kien qiegħed fuq waħda mill-ambulanzi, niżel ċatt fuq żaqqu u flimkien ma' oħrajn tħabtu kemm felħu biex ineħħu biċċa njama kbira biex ikunu jistgħu jeħilsu raġel li nqabad taħtha. Nurses oħra, fosthom Miss Ċensina Baldacchino u Miss Dolly Barber ġewwa l-Isla; Miss J. Mizzi Agius, Miss C. Borg, Miss G. Borg u Miss R. Boffa ġewwa Bormla u l-Birgu, komplew jaħdmu sa kemm eżawraw ruħhom.

Rakkont f' "An Island Beleaguered" ta' F.S DeDomenico fl-1946 jispjega sitwazzjoni tipika għal dak iż-żmien fl-Isptar Bugeja tal-Ħamrun meta hu stess mar iżur qariba tiegħu..."Għall-ikel, dik il-ġurnata, ingħatat 'corned beef' u fażola! Waqt li kienet qed tiekol b'nofs qalb, hija qaltli "Ara!" waqt li żammet f' idejha biċċa ħobż kannella biex naraha, "Dawn jippretendu li niekol din!" Din kienet l-istess tip ta' ħobż li kien jingħata lill-popolazzjoni, taħwira kannella li tqallak, tqila daqs iċ-ċomb, li waqt iż-żmien ta' paċi ż-żwiemel kienu jxommuha bi stmerrija, u li issa l-Gvern qed jgħid li hi 'tajba'. "Ma tantx tidher li tħajrek" jien weġibtha b' simpatija u żidt ngħid, "Imma ma tistax tiddobba xi ħaġa aħjar?" "Iva. Roby (binha), iġibli termos kafè u ħalib. Alla biss jaf minn fejn iġib il-ħalib. Tant hu skars illum il-ġurnata. Iżda l-inkwiet hu li meta nqum mir-raqda ma nsibx it-termos, taf int m' għandhomx dawl hawnhekk!" Bla dawl fis-swali tal-feruti u pazjenti li kienu 'shell-shocked' ħlief għall-'flash tal-azzarini, 'flares' tal-għadu u tfaqqigħ ta' bombi, waqt li dawk li jaraw it-'talkies' fil-Picture Houses mhux talli ma jgawdux minn programmi ta' kulljum iżda jpoġġu taħt fannijiet tal-elettriku is-serata kollha. Inkredibbli, iżda veru!"

Mill-ktieb *"The Illustrious Blitz" ta' Charles J.Boffa, Squadron Leader S.G.Coulson, MBE tal-RAF kien kiteb hekk, "Fl-1941, kont qed inservi mal-Fleet Air Arm bħala surġent fuq l-HMS Illustrious, u kont wieħed mill-ħafna midruba...Qattajt ħafna xhur fl-Isptar tal-Imtarfa...ir-rispett kbir tiegħi imur lejn it-tobba, nursing sisters u nurses Maltin li ħadu ħsiebi u l- isfortunati l-oħra..."*

IL-KURA TA L-ANZJANI U L-INFIRMI

L-ewwel dar tal-gvern għax-xjuħ u l-infirmi, nisa u rġiel kienet fl-1729 meta xi partijiet tal-'polverista' tal-Ordni ta' San Ġwann fil-Furjana ġew mibdula f' 'dar tal-fqar' (poor house).

Il-Gran Mastru Fra Antonio Manoel de Vilhena waqqaf id-'Dar tal-Karita`' (Casa di Carità) fis-16 ta' Diċembru 1732 fil-viċinanzi tal-bini l-ieħor.

Il-ħaddiema kienu jikkonsistu f' kirurgu, kaptan, kappillan, skrivan u gwardjan.

Fl-1854 il-gvern beda jikkontempla li jibni post adekwat biex jibdel il-Casa di Carità. Ms. Florence Nightingale u Dr. J. Sutherland ġew ikkonsultati rigward il-pjanti tal-post. F'ittra bid-data tat-23 ta' Mejju 1862 indirizzata lill-On. F. V. Inglott, hija kitbet hekk: 'Il-pjanti tant huma tajba (ħafna aħjar minn kull sptar tal-irġiel u n-nisa li jien qatt rajt) li d-diffikultà hija kif se nsib xi żball.

Il-kundizzjonijiet fl-Ospizio sa dan it-tant kienu ħżiena mmens fl-1885. Meta l-Eċċellenza Tiegħu il-Gvernatur, Sir J. A. Lintorn Simmons żar l-istituzzjoni f' din is-sena huwa sab il-post 'maħmuġ u mnitten'; u qal li 'huwa skandlu għaż-żminijiet li ngħixu fihom'. Fil-fatt il-'Poor House' il-ġdida tlestiet fl-1892 u fl-1940 ssemmiet l-'Isptar San Vinċenz de Paoli'.

Fl-isptar ta' San Ġwann Battista u San Ġiljan f' Għawdex kien hemm ukoll xi fqar invalidi. Fl-1849 tqegħdet l-ewwel ġebla biex jinbena bini ħdejn dak ta' San Ġwann u fl-1851 infetaħ Ospizio ġdid f' Għawdex b' 172 sodda.

L-ewwel istituzzjoni privata li kienet esklussivament għall-kura tal-anzjani u l-infirmi twaqqfet b'inizzjattiva tat-tabib Malti, Dr. Nicolo' Sawra. Għalhekk fir-Rabat ta' Malta inbena l-Isptar San Nikola iżda sar aktar magħruf bħala l-Isptar ta' Sawra immexxi mis-Sorijiet tal-Karita'. Nicola Dingli tas-Siġġiewi u martu Maddalena Cornelio tal-Isla waqqfu sptar żgħir fl-1794 bl-isem ta' l-Isptar Sant' Anna u tmexxa mis-sorijiet tat-Terz Ordni ta' San Franġisk. Fl-1898 kien hemm raġel jaħdem bħala 'infermier' li xogħolu kien ukoll il-ħasil tal-ħwejjeġ.

Meta s-sorijiet tas-Soċjetà tal-Little Sisters of the Poor ġew Malta, fl-1878, fetħu dar għall-anzjani fil-Pietà u fl-1880 marru l-Ħamrun

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Position Statement

Mental Health

ICN Position:

Mental health, a crucial aspect of well being, remains sorely neglected, under resourced and plagued by stigma in most societies. ICN deplores the fact that stigma, discrimination, treatment gaps, and lack of access to services and to continuity of care continue to exist globally.

ICN and national nurses associations (NNAs) are deeply concerned about the quality and continuity of treatment and care for people with mental and behavioural disorders. This concern extends to the needs of their families and communities, and the stigma and discrimination associated with people suffering mental health disorders and their caregivers, including health professionals.

ICN believes efficient, effective mental health services will only be achieved through a coordinated, inter-sectoral, community-based strategy and urges governments to move towards community-based programmes focused on the promotion of mental health, prevention of mental illness, early intervention, and home-based treatment, care and rehabilitation. ICN acknowledges the continued importance of institutional care, based on the condition and need of people living with mental illness, and the need for increased support for informal caregivers.

Greater attention should be paid to the developmental and mental heatth of vulnerable groups (women, young people, elderly, poor, abused, addicted, refugees, etc); to securing sufficient financial and human resources for effective service delivery, and to the education and training of mental health specialists.

ICN calls on governments to:

- Set policy, including legislation, to protect and improve mental health and supply effective, integrated, community-based mental health services.
- Maintain information systems that measure and report on mental health indicators.
- Provide appropriate human resources and technology, including drug therapy.
- Identify and support mental health research priorities.
- Undertake a multi-stakeholder campaign to address stigma in mental health.

ICN calls on the health professions to:

- Combat the stigma and discrimination associated with mental health problems.
- Promote high ethical standards in policy, services and research.
- Promote and disseminate research in the field of mental health.
- Lobby for financiai, human and technological resources, Integrated community-based care and government accountability.

International Council of Nurses

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Further ICN also calls on nurses and NNAs to:

- Work for involvement of nurses in mental health policy development.
- Support integration of mental health into nursing curriculum at basic, post basic and continuing education levels.
- Work with other disciplines and sectors.
- Address recruitment and retention issues.
- Support the continued development of mental health services.

Background

Some 450 million people worldwide suffer from mental disorders and all people are at risk of mental health problems[1]. These can be the result of stressful lifestyles, dysfunctional relationships, civil conflict, violence, physical illness, infection or trauma. Mental health problems are expected to increase globally due to social and economic problems such as unemployment, crime, poverty, racial intolerance, substance abuse, homelessness and abuse.

Stigma and discrimination associated with mental illness have negative consequences on the health and well-being of the patient and family. Stigma is also a barrier to seeking proper care and treatment and to the integration of people with mental illness into the community.

Nurses are concerned with holistic approaches to mental health promotion, prevention, care, treatment and rehabilitation of people living with mental health problems, and support of their families and communities. As well nurses are key in reducing the stigma of mental illness. However, qualified practitioners and leaders in mental health nursing are in short supply due to recruitment and retention problems. Mental health/psychiatric nurses in some countries are not valued and educational programmes in care, management, research, and policy are inadeq uate.

Mentai health problems are common in all health care settings, and physical illness is often accompanied by a mental health problem. Thus all nurses must have knowledge and skills to be able to respond to peopie's mental health needs.

http :/lwww.who.int/whr2001/2001/main/en/chapter4/004a3.htm

Adopted in 1995

Revised in 2002

[1]World Health Organisabon (2001), Mental Health Around The World. World Health Day 2001

Related ICN Positions:

- Nurses and primary health care
- Nursing research
- Nurses and human rights
- Management of nursing and health care services

ICN Publications:

- Mental Health: Tackling the Challenges, ICN Fact Sheet, 2001.

The die is cast!

Dear Colleagues,

I want to use this opportunity to thank all of us who came for the inaugural general meeting held on the 26th January. It was an icebreaker to say the least. For those of us who did not make it for one reason or the other, I encourage us to be more pro-active. With the help of MUMN, we have set the ball rolling and bear in mind that we are working for our common good.

For those of us who were absent, the agenda of the last meeting was basically on our conditions of work. We brainstormed over wide range of issues concerning us, ideas were generated, and opinions were given such as:

- Issues regarding pension. Some of us who would like to work till the time of retirement may not be entitled for pension in the light of our present contract which does not stipulate any retirement benefit for foreign nurses. With this snag at stake, we agreed that we are worried. We have every cause to despair and reason to hope that our dream will be actualised. It is to this end that we are asking the policy makers to find a common ground where this issue may be addressed.
- Also we unanimously agreed that the nature of our contract is a deterrent to capital investment for foreign nurses. The yearly contract does not allow us to borrow money from the bank to buy property for some of us who may want to do so. Different banks feel reluctant to lend money to foreign nurses who have a one year contract because they do not know our fate of repayment should our contract be terminated or elapsed. In view of this, we request that our contract be extended to more years deemed necessary by the government but not yearly like it has been.
- Should foreign nurses who have their children in public schools pay tuition fees, given that we pay national insurance and taxes? This is open for debate.

So, this is to let us know that these were the issues discussed during the previous meeting. Action is being taken to channel our concerns to the appropriate authority for redress. I will put you in the know as soon as there is feedback.

However, it is not uncommon to notice these lapses between employers and employees. But a careful and tactical approach would create a better understanding. As, I said before in my previous write-up, that our cause is just, we pray that those concerned would be more resolute in their approach to address our demands.

Be that as it may, it is also interesting to say that we are making progress. As some of us would have known that, with the help of MUMN, maternity leave can now be granted to foreign nurses when the need for it arises. This was unthinkable few months ago but today we are glad it has become a reality. We should not relent in our effort to achieve our goals.

United We Stand

Nwaokoro Joakin Chidozie (NJC)
Chairperson for Committee of Foreign Nurses.

Students' Sub-Committee

M.U.M.N had wanted to care for nurses in a comprehensive way i.e. from the student life till after the retirement from their profession. For this reason it had the intention of setting up a sub-committee exclusively for students. Such a committee would help fulfill the roles of; offering the support and resources needed to facilitate nursing students' learning experience. Such support is also in the agenda of international nursing associations of which M.U.M.N is affiliated.

On the 9th March 2003, M.U.M.N organised a meeting for student nurses to announce this intention, which was addressed by Dame Betty Kershaw among all others. Following an encouraging response, M.U.M.N set up an *ad-hoc* students' sub-committee, which carried out the necessary groundwork to start things moving in the right direction. It met on a regular basis to identify the needs met by nursing and midwifery students during the beginning of their courses and various problems that might hinder their professional development. This committee also worked on providing the necessary framework for the following committees. In January 2003, M.U.M.N had a meeting with IHC director regarding the students' section, in which both parts agreed on the potential benefits of such a section.

Over January 2004, elections for course representatives were run and the next committee was elected. This newly elected sub-committee is currently working on maximising the benefits for Nursing and Midwifery students in the CNF conference, apart from assisting student members in current issues related to their studies.

The new committee is aiming to increase student memberships as to achieve a wide representation in the IHC. This committee would like to appeal to nurses and midwives as professionals, to empathise with the needs of students and help in providing them with the opportunity of learning as part of the team in the wards, while bearing in mind that they will be their future colleagues.

Stephen Demicoli

Ejjew niegfu ftit

The Golden Box

The story goes that some time ago, a mother punished her five year old daughter for wasting a roll of expensive good wrapping paper. Money was tight and she became even more upset when the child used the gold paper to decorate a box to put under the Christmas tree.

Nevertheless, the little girl brought the gift box to her mother the next morning and said, "This is for you Mama".

The Mother was embarrassed by her earlier overreaction, but her anger flared again, when she opened the box and found it was empty. She spoke to her daughter in a harsh manner, "Don't you know, young lady, when you give someone a present, there's supposed to be something inside the package?"

She had tears in her eyes and said, "Oh mama, it's not empty! I blew kisses into it, until it was full."

The mother was crushed. She fell to her knees and put her arms around the little girl and she begged her for forgiveness for her thoughtless anger.

An accident took the life of the child, only a short time later, and it is told that the mother kept that Gold Box by her bed for all the years of her life. Whenever she was discouraged or faced difficult problems, she would open the box and take out an imaginary kiss and remember the love of the child, who put it there.

In a very real sense, each of us, as human beings, have been given a Golden Box filled with unconditional love and kisses from our children, family, friends, and God. There is no more precious possession anyone could hold.

What goes around comes around

His name was Fleming, and he was a poor Scottish farmer. One day, while trying to make a living for his family, he heard a cry for help coming from a nearby bog. He dropped his tools and ran to the bog. There, mired to his waist in black muck, was a terrified boy, screaming and struggling to free himself. Farmer Fleming saved the lad from what could have been a slow terrifying death.

The next day, a fancy carriage pulled up to the Scotsman's sparse surroundings. An elegantly dressed nobleman stepped out and introduced himself as the father of the boy Farmer Fleming had saved. "I want to repay you", said the nobleman. "You saved my son's life." "No, I cannot accept payment for what I did," the Scottish farmer replied waving off the offer. At that moment, the farmer's own son came to the door of the family hovel. "Is that your son?" the nobleman asked. "Yes", the farmer replied proudly. "I'll make you a deal. Let me provide him with the level of education my own son will enjoy. If the lad is anything like his father, he'll no doubt grow to be a man we both will be proud of." And that he did.

Farmer Fleming's son attended the very best schools and in time, graduated from St. Mary's Hospital Medical School in London, and went on to become known throughout the world as the noted Sir Alexander Fleming, the discoverer of Penicillin.

Years afterwards, the same nobleman's son who was saved from the bog was stricken with pneumonia. What saved his life this time? Penicillin. The name of the nobleman? Lord Randolph Churchill. His son's name? Sir Winston Churchill.

Someone once said: What goes around comes around.
Work like you don't need the money.
Love like you've never been hurt.
Dance like nobody's watching.
Sing like nobody's listening.
Live like it's Heaven on Earth.

"Your present circumstances don't determine where you can go; they merely determine where you start."
- Nido Qubein

"I've missed more than 9000 shots in my career. I've lost almost 300 games. 26 times, I've been trusted to take the game winning shot and missed. I've failed over and over and over again in my life. And that is why I succeed."
- Michael Jordan

"A visionary is one who can find his way by moonlight, and see the dawn before the rest of the world."
- Oscar Wilde

"I live by this credo: Have a little laugh at life and look around you for happiness instead of sadness. Laughter has always brought me out of unhappy situations. Even in your darkest moment, you usually can find something to laugh about if you try hard enough."
- Red Skelton

"In a nutshell, just be good and kind to your children, because not only are they the future of the world, but they are the ones who can eventually sign you into the home."
- Dennis Miller

"My philosophy is that not only are you responsible for your life, but doing the best at this moment puts you in the best place for the next moment."
- Oprah Winfrey

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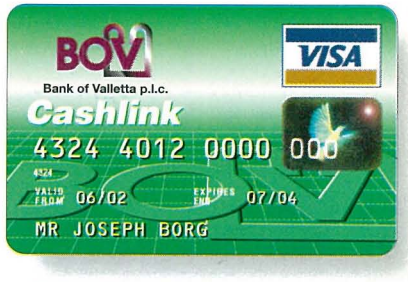

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