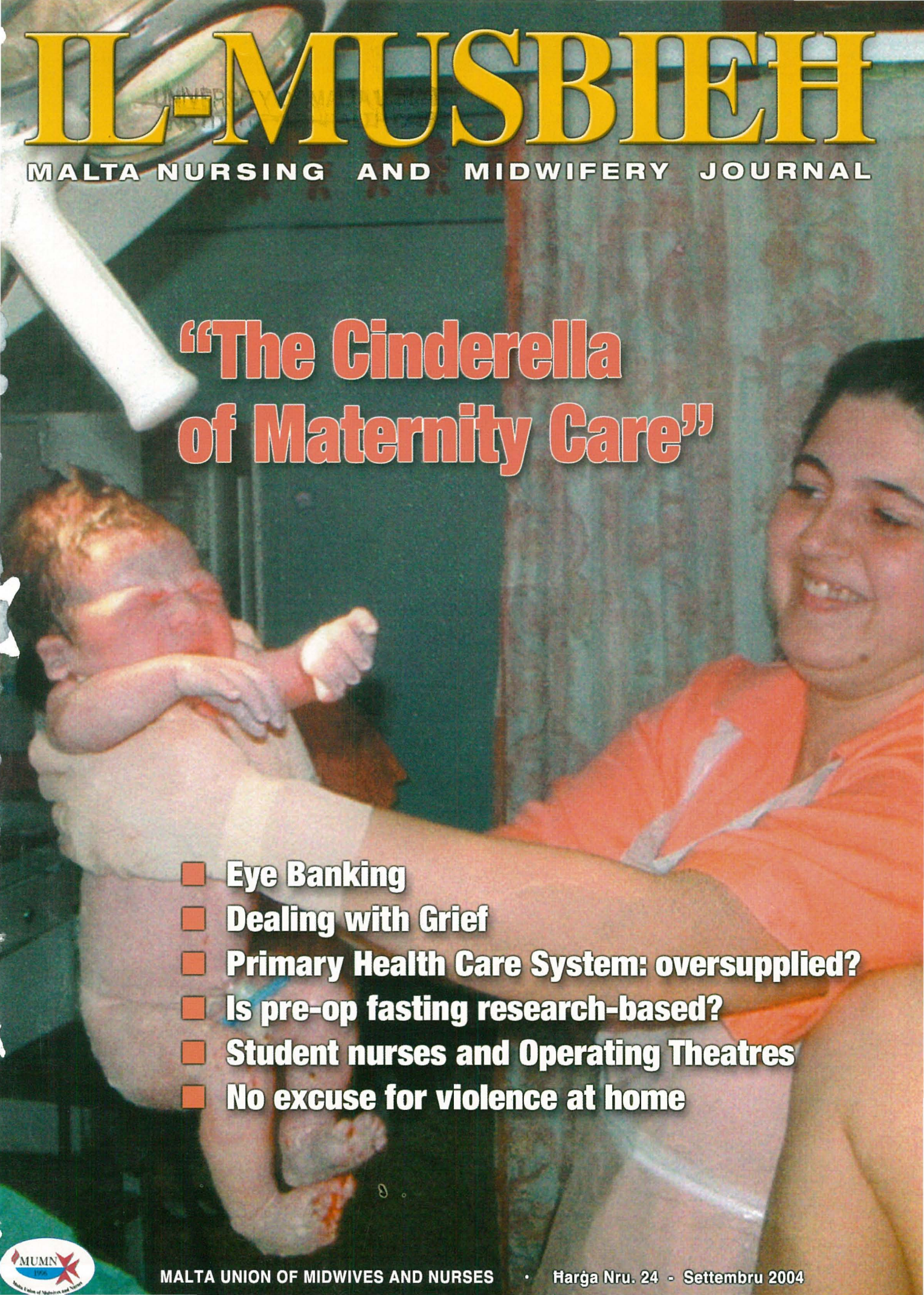
IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL



"The Cinderella of Maternity Care"

- Eye Banking
- Dealing with Grief
- Primary Health Care System: oversupplied?
- Is pre-op fasting research-based?
- Student nurses and Operating Theatres
- No excuse for violence at home

MALTA UNION OF MIDWIVES AND NURSES • Ħarġa Nru. 24 - Settembru 2004

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Nru.: 24 Settembru 2004

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F'Din il-Ħarġa

Editorjal

Is-Sħana tas-Sajf fis-Swali

Dan l-editorjal mhux l-ewwel darba li aċċenna fuq il-kundizzjonijiet fiżiċi xejn sbieħ ta' ċertu swali fl-Isptar San Luqa. Dawn ivarjaw minn infrastruttura antikwata u difettuża, ħmieġ, 'supplies' neqsin minħabba l-'out of stock', ordnijiet riġettati minħaba l-famuża 'no funds available' u nuqqas ta' Saħħa u Sigurta'. Meta mbagħad tinqala' xi waħda naraw lil min ser nagħtu 'charge' (li generalment ikun xi Nurse jew Midwife), barra l-għajjat u r-reċtar.

Illum però ser nittrattaw il-problema ta' kull Sajf: dik tas-sħana tal-istaġun ġewwa s-swali tagħna. Problema li taffetwa lil marid, lilna li naħdmu magħhom u lil qrabathom. Bħall kull problema, anke din qisa ndrat, iżda mhux l-ewwel darba li tisma' li xi pazjent iffirma kontra l-parir mediku għax m' issaportiex is-sħana jew b'konsegwenza t'hekk tkompli taffetwa ħażin il-kundizzjoni ta' xi ħadd f'qiegħ ta' sodda.

Meta naħdmu f'kundizzjonijiet ta' sħana kbira hemm ċans li jsiru aktar żbalji u t-tempra ta' kullħadd titla' b'riżultat li jista' jkun hemm aktar incidenti bejnietna u ma' oħrajn. Sħana li tifgag u xxawtek speċjalment f' ħinijiet twal ta' xogħol, f'kundizzjonijiet t' iffullar inaċċettabbli u b'nuqqas ta' 'staff compliment' minħabba l-vaganzi tas-Sajf.

Le, għal xi wħud mhux dejjem il-pazjent jiġi l-ewwel.

Kemm minna nafu li bir-regolamenti tas-Saħħa u Sigurtà (Health & Safety), jekk it-temperatura interna tagħna fuq il-post tax-xogħol taqbeż t-38°C (100.4°F), ma jistax wieħed jibqa' jaħdem u jiffunzjona tajjeb u għalhekk irid jieqaf jaħdem?

Kemm minna nafu li fi staġun sħun bħal tagħna għandu jiġi offrut ilma tax-xorb frisk (10°C -15°C) (tazza kull 15-20 minuta) u għandu jkun viċin ta' fejn naħdmu b'tali mod li ma jintilifx ħin biex nixorbu f'xi 'staff room'?

Ir-regolamenti jaċċennaw li l-ħwejjeg li jintlibsu fis-Sajf (li aħna s'issa għandna tip wieħed biss), iridu jkunu ħfief u ta'materjal li l-għaraq tagħna jevapora bla xkiel. Dan mhux ovvju? Anke regolamenti tal-EU fuq it-temperatura jitkellmu dwar 'adequate ambient conditions'.

Nagħmlu kemm nagħmlu fannijiet kollu għalxejn. Illum l-arja kkondizzjonata mhix lussu iżda neċessita'. Dejjem b'xi skuża fuq dawn biex ma jinxtrawx u ma jistallawhomx, bl-aktar waħda famuża li m'hemmx 'supply' adekwat ta' elettriku għal xi partijiet tal-Isptar. Allura nsaqsi: għalfejn kull Sajf naraw units ġodda tal-'airconditions' mwaħħlin barra xi uffiċċju ta' xi ħadd 'importanti', ta' xi direttur, ta' xi segretarja, ta' xi ħadd li jaf kif jakkwista wieħed, ta' xi ħadd li għamel xi xenata x'imkien u approvawhom jew ta' xi post fejn individwu fil-privat irregalhom (bħala 'donation') u se jwaħħluhom. Allura hemmhekk hemm elettriku biżżejjed? Dawn huma 'double standards', duru dawra madwarkom u taraw b'għajnejkom minn għandu l-arja kkondizzjonata, fejn il-maġġoranza tagħhom mhux għall-morda, ma tarax, iżda għal min irid jaħdem fil-frisk wara xi 'computer'. Din id-darba ma 'ħallewniex għall-frisk'! Le, għal xi wħud mhux dejjem il-pazjent jiġi l-ewwel.

MESSAGE FROM THE PRESIDENT

Dear Colleague,

It seems that the journal Il-Musbieh *is doing its job and be the perfect link between the operations of our Union and yourself. This achievement is maintained by the hard work that is being carried out by the Committee within the Union responsible for the publication of our journal.*

Il-Musbieh *contains varies articles that proves that the MUMN is not only a Trade Union and is after better conditions of work but also a professional organisation finding ways and means to keep you updated with professional developments.*

Once again I will take advantage of this journal to update you about the work that is being done and the developments in our negotiations with regards improvement in our working conditions. Sometimes discussions take a bit too long but it is because we believe that it's the end product that counts. All issues that we agreed together to negotiate for the benefits of our professions are not discarded even though some are taking longer to achieve but we are seeking the right moment. Sometimes there might be those few who criticises the way we are tackling things and I truly accept criticism as this is healthy as long as it is constructive.

Patience proved beneficial as in the case of the agreement reached between the Health Department and the Union with regards the 46th hour week. This agreement was a breakthrough as this working week is now guaranteed to all nurses even those who shall qualify in the future until a new agreement is reached.

MUMN is currently finalising the agreement regarding incentives for continuing educational programmes for nurses and midwives. I shall take the opportunity to personally thank our Director Nursing Services for his involvement in this issue, as his input was an asset. Discussions are still going on about the sectoral agreement and with regards improvement in salary scales and early retirement and MUMN is adamant with its position that we shall not enter into negotiations for Mater Dei Hospital until we finalise the sectoral agreement.

It is nobody's illusion that nowadays the Health Authorities know our strengths and are more careful when taking decisions that involve our professions, we still have a long way to go but we started. After all our Union was established only eight years ago but nonetheless we established ourselves as the fifth largest union in the Island

This is a challenging moment were talks of reform and change in working practices are the trendy words. The MUMN Council and the Executive Committees are gearing up for this challenging moment and the least we shall ask is that you will continue to support your Union and be prepared to follow any instructions that might be issued.

I conclude by referring to a meeting I attended at the IHC as I was really impressed with the healthy relation that exists between tutors and students. The MUMN Committee representing students is doing a great job for the benefit of our future nurses and midwives. MUMN is now the acronym that is synonymous with the Nursing and Midwifery professions at all stages.

Rudolph Cini
President
mumn@maltanet.net

MUMN EXECUTIVE EDUCATIONAL COMMITTEE

1st Maltese Conference on Neonatal & Paediatric Care

Friday 12th November 2004, Hotel Hilton Malta, St. Julian's

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PROGRAMME

08.00 - 09.00	Registration
09.00 - 09.05	Introduction by Chairperson, *Ms. Helen Borg*
09.05 - 09.15	Opening Speech *Mr. Rudolph Cini*
09.15 - 09.35	Evidence Based Clinical Practice Decisions *Ms. Maria Cutajar*
09.35 - 09.55	Prenatal Environment: Effect on neonatal outcome *Prof. Mark Brincat*
09.55 - 10.15	An Infection Control Overview *Mr. Paul Pace*
10.15 - 10.45	Coffee Break
10.45 - 11.30	Nursing Challenges in the 21st Century *Ms. Suzanne Simmons*
11.30 - 11.50	Paediatric Care in Malta *Dr. Simon Attard Montaldo*
11.50 – 12.10	SCBU Quo Vadis? Ms. *Winnie Buhagiar & Ms. Joanne Micallef*
12.10- 12.30	Nursing in Paediatric – The way Ahead
12.30 - 12.50	Family Centred Care *Ms. Sabina Drago*
12.50 - 13.00	Question Time
13.00 - 14.30	Lunch
14.30 - 14.50	Paediatric Surgery in Malta *Mr. Chris Fearne*
14.50 - 15.10	Promoting Breast Feeding in the NICU *Ms. Helen Borg*
15.10 - 15.30	Paediatric Oncology in Malta *Dr. Victor Calvagna*
15.30 - 15.50	Neonatal Resuscitation. Training for Health Care Professionals *Ms. Anna Cini*
15.50 - 16.10	Closing Speech *Mr. Jesmond Sharples*
16.10 - 17.00	Coffee Break

Registration Forms from:
- ❑ **PAUL PACE** (INF CONTROL)
- ❑ **MARIA CUTAJAR** (LABOUR WARD)
- ❑ **HELEN BORG** (POSTNATAL)
- ❑ **MUMN OFFICE** (B'KARA)

MESSAGE FROM THE SECRETARY GENERAL

As of this year the Union Council has taken the decision to add another edition of "Il-Musbieh" in order to keep our members up to date with all the necessary and relevant information. Over the last year the Union's commitment has become so, that every week we have to deal with new circumstances and situations.

The last edition of "Il-Musbieh" focused on the Commonwealth Conference. The international level of this conference has moved the MUMN forward to a new dimension, especially in the professional and educational aspects of our work.

It is worth noting that with the organisation of such conferences the MUMN has attracted Midwives and Nurses who in the past considered this Union as being just 'an other union'. These new members can now better understand that the MUMN's commitment has always been and continues to be the development of the two professions.

In this edition one can find the publication of the latest agreement, which is divided into three categories. The first point is in relation to the 46.6hrs, the second about the Nursing Compliment in Medical and Surgical wards, and third IV Therapy. The truth is that this agreement has taken longer than expected, but I have no regrets, because I believe that the best acquisitions require time and patience. The secret to this acquisition was that we remained united to the end to ensure the outcome of this agreement, and it is popular opinion, at this moment, that the outcome could not have been better. The most crucial point is in the matter of the 46.6 hrs, where as the agreement stipulates that unless another agreement is reached, this extra duty remains in force, and another agreement can only be met with the approval of the MUMN. So it's a clear fact that MUMN has secured the 46.6hrs for Nurses and Midwives, without us having to work an extra day in a month. This also stands for the nurses who qualified last year, even if at some moment it seemed impossible to acquire.

As regards the Nursing Compliment, the SLH Group Committee will be embarking on a series of discussions with the Management in order to ensure that previously reached agreements are adhered to, as for some reason or other these seem to have been shelved, resulting in our general wards being regularly understaffed. I appeal to Nurses working at SLH, as always, to cooperate with their respective Group Committee in order to ensure the best possible results. I personally know that the Group Committee is always prepared and on the ready, but it is very important that they also have everyone's backing.

It is also very satisfying to note the development of the Florence Nightingale Benevolent Fund (FNBF) where an agreement has been reached with the Richmond Foundation, where the said foundation will render it's services on two levels of counselling to all FNBF members should they need it. Why two levels? One will be in group sessions on a ward basis, while the other will be on a more individual basis. Not long ago it was noted that a good number of nurses, for different and complex reasons, were needing counselling sessions, (even in relation to their private life which in turn effects their work performance), and on this regard we received a number of letters asking the FNBF to start organising these counselling sessions. Even though the heart of our profession is caring for our patients, we in turn are not finding the care we need, when we need it. Again the MUMN had to get in and intervene in a very sensitive matter, but we are convinced that all will prevail in the interest of the FNBF benefactors.

Even though many may think that the MUMN's main function is purely trade unionism, today's message was an opportunity to shed some light on another aspect of our Union, which even though it has nothing to do with trade unionism, it bears a lot of weight on our professions and the work we do. This, in turn, affects the quality of care we give to our patients. There are many similar activities in the pipeline, and in every edition of "Il-Musbieh" I intend to share with you all the relevant information, so that you are all kept informed with what goes on in our Union.
Regards, Your friend,

Colin

Secretary General

mumn@maltanet.net

COUNCIL FOR NURSES AND MIDWIVES

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REVISION OF THE REGISTERS OF NURSES AND MIDWIVES

In accordance with paragraph 22 of Health Care Profession Act, the Council for Nurses and Midwives will soon publish its' registers. It is in the interest of all Registered Nurses and licensed Midwives to verify that their personal particulars as recorded in each respective registers are correct.

Nurses/Midwives are urged to fill a confirmation form, which may be obtained from the Council for Nurses and Midwifery Registrar office at 181, Melita Street, Valletta.
Alternatively these forms can be downloaded from Council for Nurses and Midwives website:

http://www.health.gov.mt/statutory_bodies/nmb.htm.

Please note:
Registered Nurses and licensed Midwives should notify immediately The Registrar of Council for Nurses and Midwives, of any changes/corrections in the information supplied.

TRUE OR FALSE QUESTION!

(Part 1)

■ **Mary Ann Bugeja,** BSc (Hons) Nursing, Dip. Gerontology.
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The aim of this article is to analyse if the public and health authorities are correct in their perception of over supply of nurses in this sector. However, as an introduction the author is asking you this question:

" In Our Primary Health Care System there is an over supply of Nurses". Before giving me your response, I would like you to read this article (Part 1 and Part 2 in the December issue) in order to be in a better position to answer this question! Hence, this article will highlight the current raising demands, the provisions of Primary Health Care (PHC) services and the resources required to ensure an equilibrium in the principle of supply and demand chain.

What forces are influencing the health demands increase and health inequalities?

During my nursing academic course, I have learned that it is important for any policy maker or manager to analyse proactively how the organisation will be influenced by internal and external forces to ensure success. The same principle applies to our Health Care System to ensure sustainability of the service and the Maltese health care needs are met. Personally feels that the following are the main forces:

✦ **Life expectancy increases and fertility rates fall** - Like in any European Region countries, Malta is faced with increasing health needs arising from the ageing of the populations as life expectancy increases and fertility rates fall. For instance, the proportion of people aged 60+ in Malta will be 23.8% by the year 2025 (Troisi, 1988). The increase in those aged 65+ will be the tenth highest (7.6%) in Europe. The rapid growth in rates and proportions of 'old old' generation (over 75 years) is bringing about various social, economic, medical and political strains on our country's resource allocation.

✦ **Modernisation** - Health inequalities are an endemic characteristic of modern, industrialised societies such as in the western European countries, where the gap between rich and poor appears to have widening as the number of socially marginalised groups living in poverty is increasing. Another strain as a result of modernisation is the changing role of women in the family.

✦ **Changes in Health care needs** - Also the changing patterns of disease such as increase in mental health problems or sexuality health problems, health services in all countries are coming under increasing pressure as governments struggle to contain costs and manager public expectations.

✦ **New philosophy of care delivery** - New Acute teaching Hospital - Mater Dei Hospital strategic directions are to address and cater for the acute medical and health needs of the Maltese population. With the introduction of new services at Mater Dei Hospital based on Day Care/ Short Stay this will include the Day Surgery Unit which is estimated to cater a turnover of about 80-90 patients a day. Having Mater Dei Hospital without an adequate backup from the Primary Health Care service delivery system can only leads to failure. This concept can only be achieved if there will be the required support of services from the PHC.

What are the effects of these demands on the PHC system?

Given these common pressures, it is possible to identify a number of trends in health care across the European Region, namely: -

1) A shift in the focus of care from the hospital to the community and primary care;
2) The changes from primary medical care to primary health care;
3) Increasing emphasis on health promotion, illness prevention and health education;
4) Decentralisation, with increasing local responsibility for decision-making;
5) Greater participation by individuals, families and communities in their own health care and public health programs;
6) A recognition that intersectoral partnerships are essential to tackling the determinants of ill health;
7) The search for methods of prioritising that are evidence-based, open and fair.

The Maltese Health Care system has to bind by these trends as well, however in the actual fact these changes are not taking place due to various reasons such as the curtailed opening hours of some health centres because of shortage in the number of doctors working with the government and lack of staff development and training programs. Health service in Malta can be considered as an essentially hospital-based with a weak supporting primary care structure. If our PHC system is not moving a parallel policy direction, according to the development plan eg. the Mater Dei Hospital new philosophy and pressing needs for change, we are ending up in a national catastrophe. For Mater Dei Hospital to function successfully there is the need to develop Primary/ Community based services.

What reforms are required within the Primary Health Care Services Delivery System to meet the Maltese health care needs?

PHC services can be provided at four different levels within the Maltese Community, namely: -

1) Health Centres;
2) *Bereġ* and Local Council;
3) Home-Based Care;
4) School and Work Place;

1) Health Centers Services

At present there are 9 Health Centres that are covering all localities. In the Health Centres, nurses' work in closer collaboration with the medical profession, in most cases they practice solely under the direction of the medical doctor, in as much that most services cease to be delivered if the medical doctor is not on premises. In fact due to shortage of doctors in the Health Centers there were shortening of services.

The role of the health centres needs to be expanded to strengthen the

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programs of health education and health promotion, and to provide more specialist services within the community such as Continence, Diabetic and Mental Health Clinics led by Clinical Nurse Specialists. Such specialist services should be located in the locality that they serve and provide the base from which multidisciplinary team deliver the bulk of services for a particular community. The PHC services should be strengthened in ways that will allow for the development of sound doctor/nurse-patient relationships and continuity of care, and will evolve from one exclusively providing care and cure to clients/patients at time of illness to one of advising, counselling, educating and coordinating all such activities that will help people adopt lifestyles conducive to better/optimum health and better quality of life. Shifting the focus of the health services from being service oriented to being more health oriented.

✦ Adding health to life-further reduce disease and disability, and improving the quality of life by promoting healthy lifestyles and focusing on the vulnerability of society.

✦ Adding life to years – empowering people to achieve, and use their full physical, mental and social potential.

Also, more public education is required to encourage the public to attend the Health Centres that serves his/her locality of residence via media and health care professionals themselves thus reducing the excess pressure on SLH (Independent, 2003). Another recommendation is to make full use of B'Kara Health Centre, especially now that Mater Dei Hospital is due to be opened thus reducing the influx of patients to Mater Dei Hospital – Nurse Practitioners will help in this. B'Kara Health Centre can support the Mater Dei Hospital in various ways, for instance can provide pre and post operative support service, such as the physical psychological preparation of the patient prior admission or can co-ordinate the nursing home visits post discharge after hospitalisation.

2) Local *Bereġ* and Council Services -

Dr Busuttil confirms that the 55 district health clinics, known as the *Bereġ* closing them would increase the load on the health centres (The Times, 2001). However, a change the role/ usage of *Bereġ* is required to serve not only for limited medical services but also in a collaboration with Local Councils will serve as a Teaching/ Referral Centre in the community co-ordinated by the Family Health Nurse (FHN).

One recent development, which should not be overlooked, is the emergence of Local Councils, which will increasingly become more socially accountable. Encouraging their involvement, and that of the local communities, in health matters should become a major objective of health policy planners in the future. In addition the FHN will act as a 'gatekeeper' to health services thus appropriate and accessible referrals are made easily via networking and links. This will relieve the occupancy of acute care beds.

3) Home-Based Care Services

Governments should be careful not to repeat the past experience of a number of countries who, following the Welfare State Ideology which they adopted in all their social policy plans and programs, considered institutionalisation as the best principal societal response to their dependent elderly citizens. For instance creating another giant older persons institution like St Vincent De Paul Residence (1100 bed capacity) at St Luke's Hospital (after transferring to Mater Dei Hospital) with the intend of reducing the number of bed blockers at the acute hospital. Such as strategy resulted in emarginating the older persons from community at large and usually entailed a surrender of personal independence. To counteract this, the need is felt for a radical change of perspective, replacing the policy of segregation with a strategy of integration enabling the elderly to participate in society to the greatest extent possible and not to be seen as a burden to society.

Guided by the awareness that the family environment is the one best suited to the life style of the elderly, and at the same time recognising the fact that the family's traditional role of care giver to the elderly is being subjected to various economic, social and psychological strains, it is necessary for governments to initiate policies and programs which support, protect and strengthen the family so as to enable it to continue responding to the need of its elderly members. On the other hand, the continued involvement of the elderly within their families should be more than encouraged. Institutional care should only be considered as a last resort since it is not only emotionally undesirable, but has a negative effect upon personal development such as decline in the intellectual skills. Government should try to support and strengthen the family's traditional role simultaneously must provide community and home-based care services for those older persons who cannot rely on themselves or on their families. Any citizen in spite of disabilities and needs of care should be free to continue living in his/her own home, rather than being admitted to a nursing home.

Older persons can be seen as the focus for this service as there is an increase demands for nursing homes, partly because SLH/Mater Dei wants to be able to discharge the patient. In Denmark, the establishment of home care service has made it possible to offer the elderly, the sick and dying persons home nursing service and other assistance in their homes 24 hours a day. This system has led to a transfer of several complex tasks from hospital sector to the health clinics. This has resulted in an increased number of people with somatic disease and people with great needs of care in the health clinics. Furthermore, in recent years a number of clients have been discharged from psychiatric hospitals to further treatment by the home nursing services as they have the right to live and work as far as possible in the community. Also, as far as care of terminally ill patients is concerned, the development of the home care service has made it possible to offer these patients a dignified end of life within their familiar and homely environment.

In order to help the older persons to live their lives as full as possible in their own surroundings and at the same time, act as a very effective support to whole family there is the need to extend nursing service on a 24 hours basis by the co-ordination of Family Health Nurse working in link with the Private General Practitioners and other health professionals such as Social Worker of the Area. This system can be the mechanism where both private and public sector would communicate and work in harmony –"co-operating rather than competing". Currently, the only community nursing service is provided by MMDNA but not on 24 hours basis together with an extended network of services especially for the older persons including: home help, meals on wheals, day centers, Telecare, neighbourhood scheme and others.

Also, another essential element for the strengthening of primary health care is the development of multidisciplinary rehabilitation services not only at the Health Clinics but also at their own home. This encourages early discharge from acute hospital, for instance a client recovering from an acute phase of stroke.

4) School and Work Place

The school health service is an integral part of the child community service designed to meet the health needs of the school age children. At the moment school nurses' primary role is to assist the doctor during the physical examination of the children or leading the immunisations programs in the schools. However, the role of school nurse can be much developed such as that of health educator and promoter. The school nurse can formulate and implement health promotion and prevention programs according the students' needs such as about sexually transmitted diseases, nutrition and smoking. An example of proactive program that school nurse can implement is on prevention of sexual assault among female secondary school students.

As a result of the recent Industrial Health and Safety law the presence of the Occupational Health Nurses in our workplace is being emphasised. In fact due to society, economies, work life and work are undergoing changes that is having a global impact on the work of Occupational Health Nurse. These changes will require new ways of working methods, performances, monitoring and evaluation of impacts. These developments are necessitating changes and adequate training of nurses in this specialist field in order for instance to prevent and reduce occupational health accidents.

The second part of this article will focus on required resources and cost-benefit analysis of the proposed Primary Health Care delivery System.

NB. The term nurse reflects as well midwife but it also depends according to working practice

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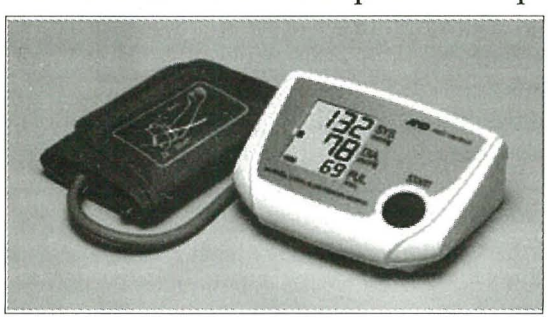

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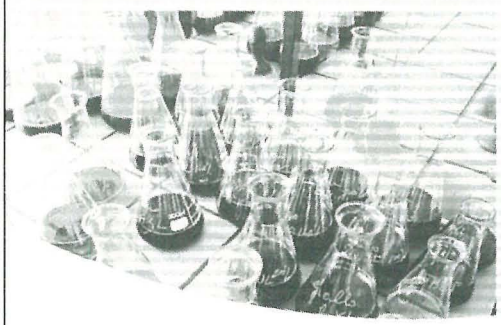

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How Nurses and Midwives Deal with Grief

■ Antoinette Martin
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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 machine like-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 that 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?

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, recognising 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 optimise 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 rationalisation.

Practice of seeking supervision or counselling for workplace or occupational stress is increasingly seen in many organisations 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

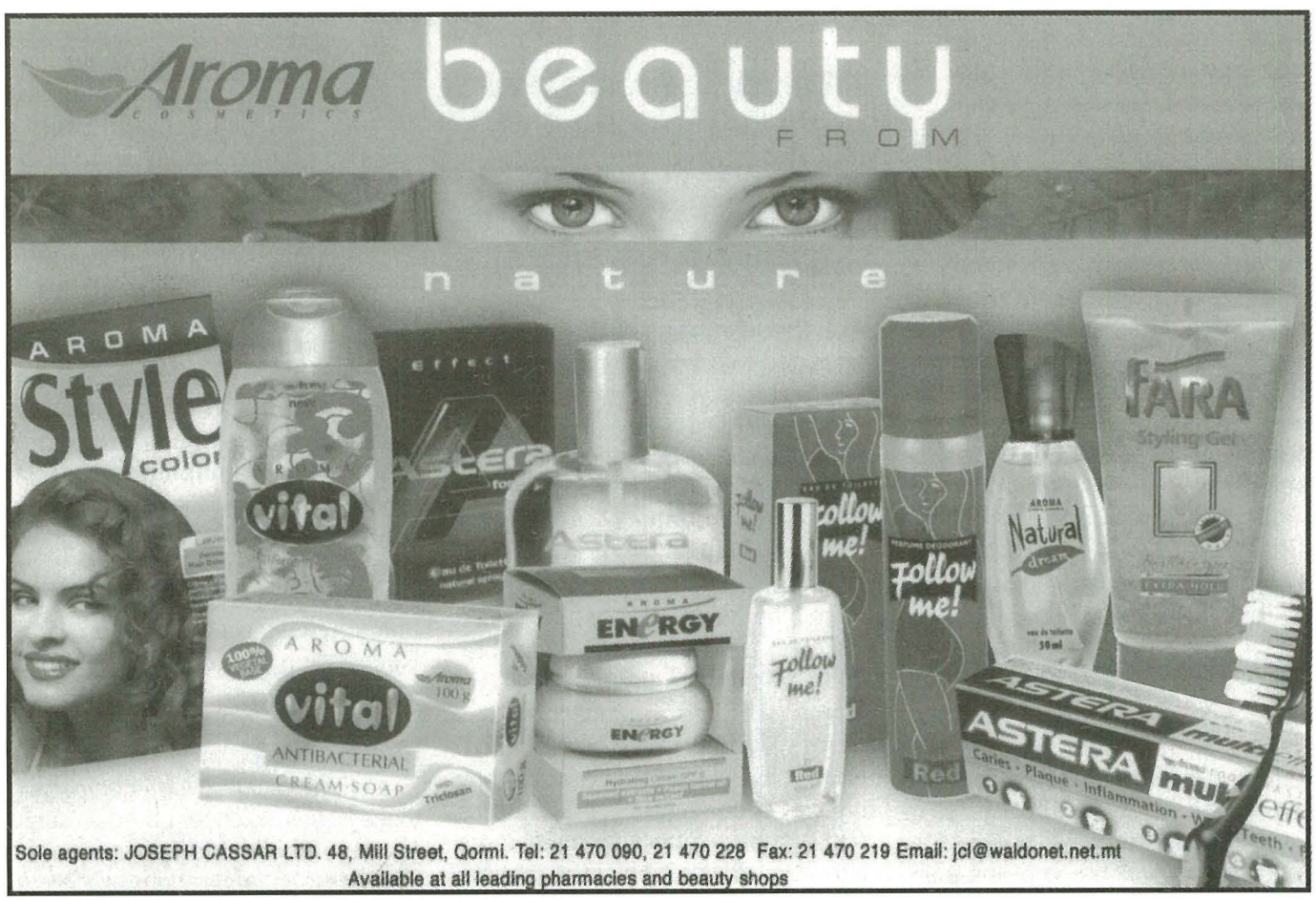
The support the caregiver receives from others may be a critical element in preventing burnout. In order to prevent overload and self-destruction, support is needed to sustain the multiple expectations of working with grieving patients and their families. Various ways can be suggested to cope with grief. 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.

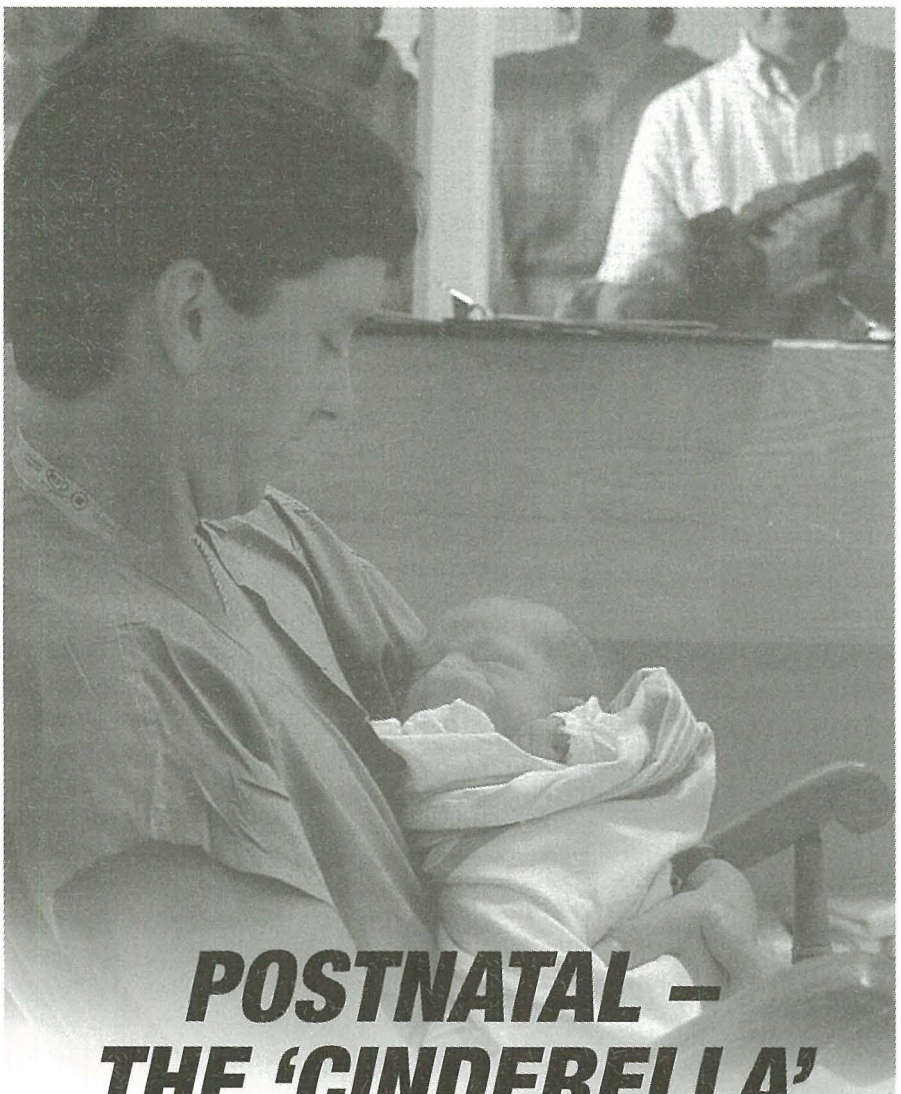
Each nurse and midwife brings his or her own personal history and each will focus on his or her subjective sense of the personal impact of grief. However, they are likely to have similar feelings about their losses including; sadness, anxiety, fear, anger, depression and loss of confidence. Some may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





POSTNATAL – THE 'CINDERELLA' OF MATERNITY CARE

Ms. Helen Borg
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Postnatal care has been described as the 'Cinderella' of maternity care as importance given to this area is considerably less than other areas of maternity services. Research alone highlights this by being mainly confined to specific issues such as breastfeeding and postnatal depression; unlike research in antenatal and intra-partum care which covers a broad angle (Royal College of Midwives, 1987). Postnatal care has become routine focusing on pathological problems that can occur after birth. Although it is important to detect and treat such problems, which can actually be, life threatening this should not be done at the expense of the new family's psychosocial needs. Long-term morbidity from what is considered, as minor but normal complaints following childbirth should also be given more emphasis as many women believe these are incurable and do not seek assistance. Glazener et al (1995) looked at a number of symptoms such as haemorrhoids, perineal pain, backache, stress incontinence and fatigue and discovered that a staggering 76% still experienced symptoms 8 weeks after birth.

DEVELOPMENT OF POSTNATAL CARE

When women gave birth to their babies at home their supporting family treated them as a VIP. Meals were served on special plates and new mothers were expected to do nothing else than care for the new baby. Relatives and housework cared for older children and meals were the family's responsibility. Although perinatal mortality and morbidity were higher adaptation to motherhood seemed smoother.

Since childbirth entered the hospital the whole experience became medicalised and impersonal. Over the years shortages in midwives on postnatal wards has led to doctors predominating over care and thus care has become centred on physiological adaptation.

The actual hospital stay has become shorter and shorter. In the UK it is commonplace for mothers and babies to be discharged within 6-8 hours of birth. It is true that scientific evidence shows that morbidity is less and uterine involution is faster when a woman is active but are women ready to go home and cope alone. Extended families are becoming rarer, single parents are increasing and it quite possible a mother can be discharged to little help and support (Ockenden, 2000).

THE NEW MOTHER

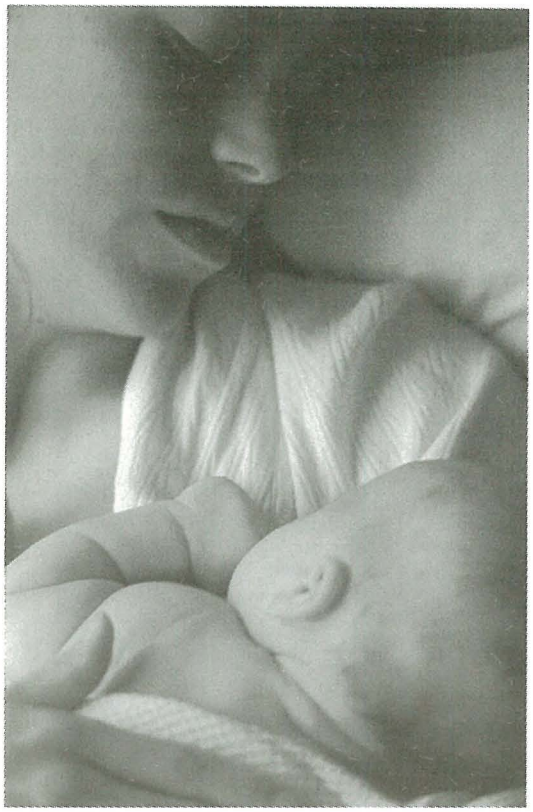
After a normal vaginal birth a woman has to cope with a number of physical discomforts. There is loss of lochia, perineal pain, after pains when the uterus contracts, possibly pain on micturition and commonly large tender breasts and sore, cracked nipples. Around 25% of mothers also have to overcome the major surgery of a Caesarean section. On top of all this is fatigue. After 2-3 days of lack of sleep and especially lack of deep sleep the ability to perform simple tasks is impaired. The mother is on call 24 hours a day, 7 days a week. She has to learn to respond to her baby's cues and interpret his needs as well as learn baby care. For a first time mother this complete lack of freedom and the new intense responsibility can become rather overwhelming (Larkin & Butler, 2000).

ENHANCING POSTNATAL CARE

Midwives and health professionals involved in postnatal care must continuously bear in mind that motherhood demands physiological, psychological and social role adjustments. Education, support and practical help are vital elements within care. Antenatal education should paint a realistic picture of the early days and move away from the image of the wonderfully happy, perfectly groomed mother that is portrayed in advertising. Education should focus on flexibility, teaching women to adapt themselves to evolve the day around the baby's demands and not to expect a young baby to be part of a structured routine-like day.

Support from family is becoming less of a reality today. Close family members may themselves be working and unable to care for the new family. The new mother often finds security from her partner, as the responsibility of the baby is equally his. However, inclusion of his role is not always facilitated with some maternity units only allowing him access for short visiting times.

In many cultures motherhood is made special through certain rituals such as seclusion for a period of time, being totally waited on by the surrounding community and being given positive recognition of a new status. These rituals promote mental health. In cultures where new mothers are not celebrated and revered postnatal depression becomes an issue. Women need to be pampered following birth. This highly emotive period affected by sudden changes in hormone levels and fatigue has the potential to lead to chronic depression. Depression of any intensity will impair the relationship between mother and baby (Singh, 2001).



COMMUNITY CARE

Sending mothers home soon after childbirth is not a bad thing as most women seem to want this. However, community midwifery must be good. Ideally mothers should be visited daily for the first 10-14 days and each visit should be allocated adequate time. Supporting women in their own environment, providing good consistent advice helps to increase a mother's confidence and enhances her experience.

Community care has the potential to provide holistic, individualised care to mothers and their babies.

Community care has the potential to provide holistic, individualised care to mothers and their babies. Community midwifery based on caseloads provides continuity of care that has frequently been highlighted as a desirable factor in maternity care. Changing Childbirth (1993) identified that women had 3 major requests overall in their care, choice, control and continuity. Shifting care into the home helps empowered parents to achieve this. Good community midwifery for as long as a family requires can be a means of support during the transition to motherhood. Continued midwifery care may help identify morbidity following childbirth and encourage women to seek medical attention.

Breastfeeding is classified by the World Health Organisation as the gold standard for infant feeding therefore there must be focus on its initiation and support. Breastfeeding is not instinctive and with low numbers of breastfeeding mothers in society few women are exposed to this art prior to birth. Therefore, is has become the responsibility of health professionals caring for women after birth to teach and support this natural function. Breastfeeding support is an intensive need during the first 2 weeks and possibly longer and many mothers give-up breastfeeding during this time because of misinformation and lack of support.

CONCLUSION

Postnatal care appears to be in need of updating to suit mothers of today. Creating an atmosphere that celebrates and supports new families, should be given as much importance as medical care. Letting new families have a 'babymoon' helps to complete a positive birth experience.

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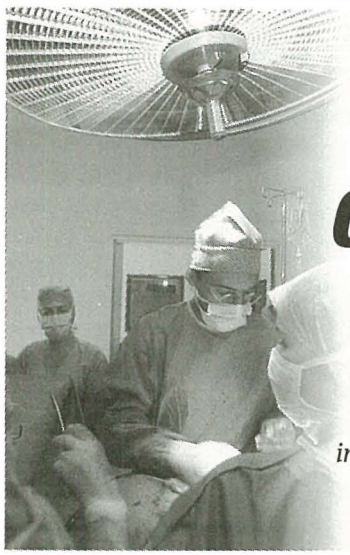

Nursing and Operating Theatres

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"Nursing practice grows more technical and academic with each passing year, but we must remember that nursing is the art of caring" Matthewson (2002).

Nursing is a particular profession, and we nurses should be able to carry out our actions cautiously and well. Back in my time, the mid-eighties nursing was lesser in nursing hierarchies, but in my opinion richer in service. In a previous edition of 'Il- Musbieħ' (No. 20 Pg.14) I put my views on paper on why I believe this to be true ... mainly because of heavy workload and lack of nursing staff. At present, when it comes to learning, luckily enough student nurses can find various courses in the health sector for which, they can apply for and specialise afterwards. The same goes for qualified nurses who want to sit for postgraduate courses. In my opinion one programme lacks its position in this structure, and this is undoubtedly Theatre Nursing.

I started my theatre-nursing journey 4 years ago, after spending 12 years working in the medical field. At first I thought I'd fallen into an alienated capsule, where I felt I was the only one to be micro-chipped in order to fit in place. I had left a medical ward environment, leaving all the commotion behind me, and got into this 'estranged' world of an Operating Theatre. It took me more or less $1^1/_2$ years to feel that I had fit in, for the reason that the environment is totally different from that of any ward. I guess a few of you reading this article would say I was stating the obvious, but it's still an important issue that needs to be addressed. The good thing is that I knew some colleagues there already, so they assisted me into the system very well, a big thanks to them and to various books!!

To keep as brief as possible, I strongly believe that student nurses should have theatre nursing included in their curriculum and are sent to operating theatres more often, working on a full day rota. Unfortunately back in my time, pupil nurses (becoming Enrolled Nurses after a 2 year programme) were not authorised to work in theatres. The directive had shut me out at that time being a pupil nurse myself, from knowing exactly what went on in operating rooms, at the same time I had to comfort patients back in the ward in the preoperative phase and answer all their queries concerning their surgery. But as we know time has changed! I got to know that working in an operating theatre is not as straightforward as everyone presumes, adding that this skill should be well taught, both theoretically and practically at the Institute of Health Care and in Operating Theatres respectively. I note new recruits' trying to fit in, the same way as I did ... especially those newly qualified nurses starting from day one (*tal-post*), in operating theatres with no previous ward experiences / patients contact at all. Nurses need to keep in mind that theatre nurses in general, although in a different way, are dealing with patients too! They should know how to gear themselves when it comes to communicating with patients' prior to and post anaesthesia phase. Walsh & Ford (1995) state that nurses have to listen to their patients and teach them at the same time. This ability is mostly required towards patients awaiting surgery intervention in the anaesthesia room (side room) who are typically anxious on encountering anaesthesia, surgery and the recovery room, where in the latter, patients normally gain adequate level of consciousness before being transferred back to the ward. Walsh & Ford (1995) declare that information-giving and reducing nervousness are essential in nursing. Student nurses are to be primarily taught well on the basics, how to take part in the preparation of both equipment and sets, required for whichever particular surgery, the roles of the circulating and scrub nurse in being responsible for retaining sterility (Snape, 2000), maintaining discipline in the operating room, etc. The same relate to assessing patients in the recovery unit, such as airway patency, stability of blood pressure, level of consciousness (Starrit, Odom 1999), patency of drains and tubes (Grundemann & Fersebner 1995). Of course it is significant, that nursing students are given a rationale on every action carried out. One has to keep in mind the fact that various surgical procedures are also carried out under local and regional anaesthesia, where patients are aware of what's going on around them, therefore nurses need to constantly demonstrate a good communication level towards them with a sense of support. Same goes to those for Elective and Emergency surgery. I note that operating theatre nurses and their fellow students should also be aware of certain risks that exist both towards nursing staff themselves and patients.

I believe that the Anaesthesia department does feel this particular need towards nurses, who assist anaesthetists in performing their duties, mostly known as Anaesthetic Nurses, which I myself make part of. Action taken a few years back by various Anaesthetists in setting up a programme, based on theory and practice, followed by MCQ tests helped

more in ensuring that patient's safety is a certainty. All those who carried out the course, sat for the tests and conceded also obtained a certificate. It is even good to note that this programme has reopened for new staff interested in this particular field. Operating Theatre courses should be carried out to student nurses by the I.H.C. collectively. The course should entail information on what generally goes on in the operating room. There shouldn't be the simplest thought that allocating students in theatres is 'waste of time' either because wards do need more aid or because patients in operating theatres are most of the time unconscious and there's little work for the student to carry out.

When it comes to us, nurses who already work in operating theatres, we should be responsible enough to welcome nursing students first of all, by showing them that they make part of a *professional team* and secondly, show them around and explain what the daily structure consists of, emphasising that *discipline is a main concern.* On each allocation, a qualified theatre nurse(s), should assess students during a four-week allocation in various competencies, as shown here in table I gathered from Walker (1998);

Nursing students in Anaesthesia

- Assisting anaesthetist in anticipating and passing equipment for Endo Tracheal Tube insertion,
- Correct use of airway management devices, such as self inflating bag (Ambu bag), laryngoscopes, ET tube,
- Care of the unconscious patient's airway, holding jaw correctly and administering oxygen via facemask,
- The know how of various electronic instruments, such as pulse oxymeter etc.,
- Running through an intravenous line for blood, blood products and other fluids, and the setting up of a blood warmer and arterial and central venous pressure line,
- Applying ECG monitoring devices and understanding the rationale for this.

Nursing students in the Recovery Unit

- Caring for an unconscious patient with particular emphasis on pressure areas, correct patient position, airway management, oral toilet,
- Caring of patients who require accurate fluid balance records, pain relief, such as P.C.A. monitoring,
- Observes the patient during this time, and be aware of the drugs available and normally used during the recovery phase, methods of administering analgesia and the advantages and disadvantages of each,
- Caring of patients following a spinal or epidural anaesthesia.

Nursing students in the Operating Department

- Demonstrate the principles of aseptic and sterile technique,
- Assist with the care of a patient who has a temperature, patient safety (positioning, padding, transfer, etc.), dignity,
- Demonstrate the correct technique for female / male catheterisation,
- Assist with the care of a patient, undergoing surgical intervention during local and regional anaesthesia,
- Recognise five suture materials used and the choices of the removal of each,
- Assist with the care of surgical wounds and discuss the process of wound healing, choice of wound dressing and the rationale for choice, selection of skin preparation products and wound drainage products, having observed at least one insertion of a wound drainage device,
- Discuss the medical legal aspects of surgery stressing on consent, assault and negligence.

By the end of the allocation, the student nurse should be well informed on each feature listed. Each element is very commonly encountered in every operating theatre locally and abroad. One has to bear in mind that nurses in operating theatres have to assist medical colleagues on a one-to-one basis for longer periods of time than in a ward, and if we have to keep on emphasising that nurses are professionals, then each one of us do recognise that WE cannot fail.

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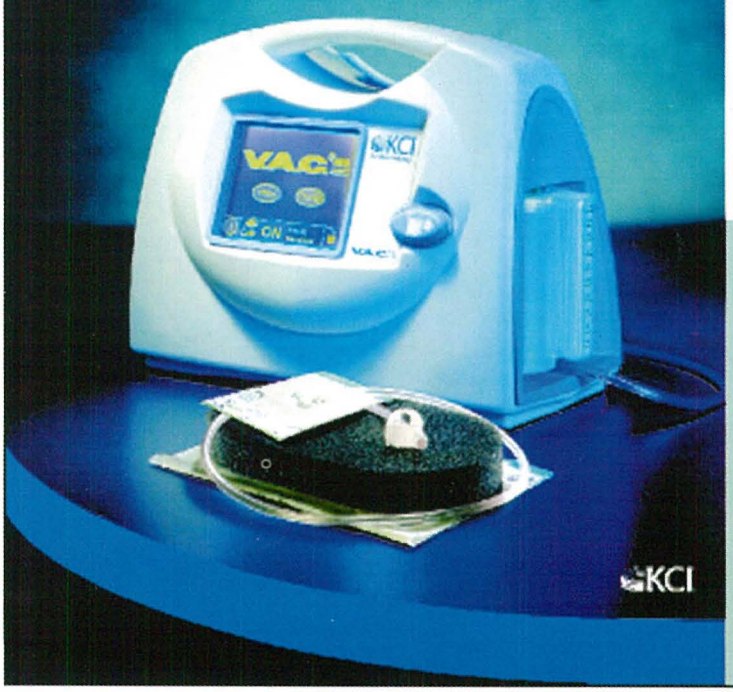

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In the next issue...

1. One item to commemorate The International Day for Nurses, MUMN together with St. James Hospital organised a Seminar, the theme being, Partnership in Nursing.

2. The last but surely not least of the activities was the Mass celebrated at the Seminary to thank our Lord and to pray for all those Nurses who have passed away. The Mass was celebrated by Fr. Ivan Scicluna who is a BSc Nurse and the choire was made up of Nurses too. Well Done!

3. Again this year MUMN organised the 7-a-side summer league where a good number of teams participated. The MUMN President Rudolph Cini and General Secretary Colin Galea share moments of success with the Champions of this year's tournament-the Karen Grech Theatre Team. Well Done too!

4. Doing work in a charitable institution was another part of the celebrations during The International Day for Nurses. Here Nurses are giving a helping hand at the 'Dar tal-Providenza'.

5. To celebrate The International Day of Midwives, MUMN together with the Midwives Association of Malta, organised a Seminar - 'Midwives, a voice for healthy families'. This Seminar was very interesting, well-attended and various Midwifery issues were raised.

6. MUMN as a sign of solidarity protested in front of the Libyan Embassy together with other organisations over the death sentence given by the Libyan Government to a number of Bulgarian Nurses.

7. This larger group of Nurses & Midwives together with the MUMN Council, voluntary dedicated some of their time to help at the 'Dar tal-Providenza' as part of the celebrations to commemorate The International Day for Nurses.

8. MUMN met with the newly appointed President of Malta, H.E. Dr. Edward Fenech Adami to inform him about his patronage regarding the Florence Nightingale Benevolent Fund. MUMN Officials also took this opportunity to discuss other relevant issues.

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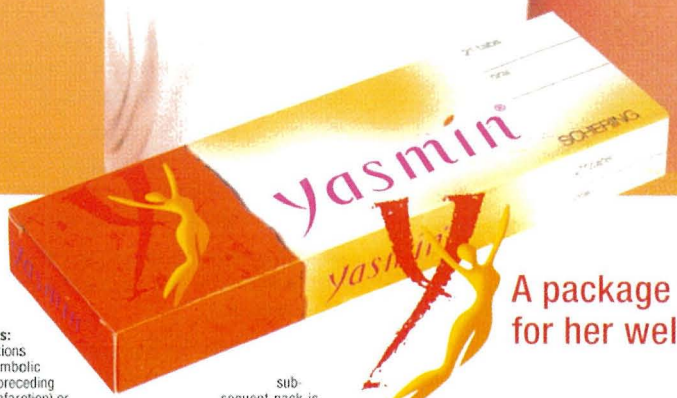
stable body weight[1)]

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 cressation 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 vormiting 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

21.01-322 1021592

DIVIZJONI TAS-SAHHA

Palazzo Castellania, 15, Triq il-Merkanti,
Il-Belt, CMR 02
Malta

HEALTH DIVISION

Palazzo Castellania, 15 Merchants Street,
Valletta CMR 02
Malta

Agreement between the Health Division and the Malta Union of Midwives and Nurses regarding the 46.67hr working week, the Administration of Intravenous Therapy, Care Workers in Mount Carmel Hospital and the Nurse to Patient Ratio.

Today Friday the thirtieth day of July two thousand and four

The Health Division and Malta Union of Midwives and Nurses agreed in principle to:

1. Develop the nurse to patient ratio and new rosters as part of a strategy for future negotiations for the benefit of both parties and particularly for the patient's welfare. Until then it was agreed that further discussions are to be held between the Manager Nursing Services St Luke's Hospital and Malta Union of Midwives and Nurses MUMN Group Committee St Luke's Hospital so that past agreements signed related to the Nursing Complement in the Medical and Surgical Wards would be, as far as possible, honoured for the patient's well-being.

2. While accepting that there would not be any changes in the actual current conditions related to the 46.67 hrs working week (as stipulated in DH circulars DH 89/91 & DH138/91) until another agreement has been reached between the two parties, this working week is to be offered to all nurses who are in employment before the signing date of this agreement.

3. Accept that the 46.67 hr working week as per current working conditions will not be offered to any nurse who is newly recruited as from this date of agreement. Any new recruits shall be offered the option to work a 46.67 hr working week, with new conditions to be negotiated with the respective management of each hospital.

4. Accept that the intravenous therapy administration is part of the nurses' responsibilities, but that this does not exclude that doctors share this responsibility too as part of existing protocols.

5. Courses in intravenous therapy administration for all nurses registered in Malta as first or second level nurses are to be mandatory; administration of such intravenous therapy shall be mandatory for all nurses so trained. These courses are to continue so that all qualified nurses will be certified as competent to administer intravenous therapy. Those nurses who did not have the opportunity to undertake the training and consider themselves as not competent in such skill should refrain from administering intravenous therapy until they receive the appropriate training. Nurses who consider themselves competent to administer intravenous therapy can continue to do so but are still encouraged to attend for formal training.

6. Accept that the present working rosters are reviewed in future negotiations.

7. Accept to discuss with Mount Carmel Hospital and all unions concerned the presence and status of care workers in Mount Carmel Hospital.

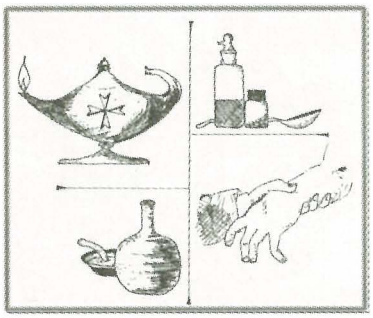
We the undersigned hereby ratify the above statements as declared. The effective date of the agreement is the 1st day of August , 2004

Dr Ray Busuttil
Director General Health

Mr Jesmond Sharples
Director Nursing Services

Mr Rudolph Cini
President MUMN

Date 30/04/2004



Kitba ta' **JOE CAMILLERI**
joseph.f.camilleri@gov.mt

L-ISTORJA TAN-NURSING F'MALTA

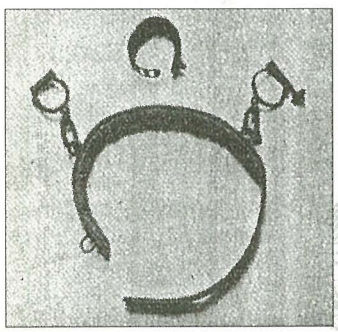
MIS-SITTAX IL-SEKLU SAS-SITTINIJIET

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

IL-KURA TAL-MORDA MENTALI

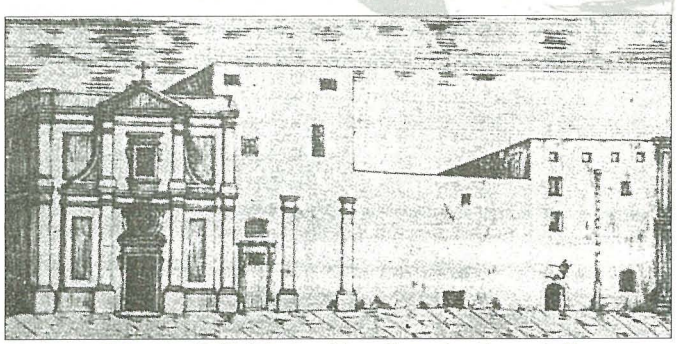
Bħall-ħafna mill-pajjiżi Ewropej, l-istorja tat-trattament tal-pazjenti mentali f'Malta, sa nofs is-seklu dsatax kienet iġġib dieqa tassew. Fi żmien l-Ordni ta' San Ġwann ta' Ġerusalemm pazjenti mentali irġel kienu jdaħħluhom fis-Sacra Infermeria u jieħdu ħsiebhom żewġ attendenti f' 'kamra għall-imġienen'. It-trażżin personali kien il-metodu wżat biex jorbtu l-pazjenti fis-sodda u għalhekk jipprevenu milli jiddisturbaw lil pazjenti oħra.

Meta kienu jkunu vjolenti kienu jmexxuhom għall-parti mill-kantina tal l-isptar u hemm kienu jinżammu maqfula bi ktajjen mal-ħajt. Meta l-pazjenti kienu jkunu ddikjarati bħala nkurabbli jew jitilgħu għal numru kbir, kienu jiġu ttrasferiti għall-Ospizio tal-Furjana. It-trattament li kienu jirċievu hawn kien il-bogħod minn trattament ħanin. Kienu joqogħdu f' post orribli, imlibbsa u mitmugħa ħażin u ħafna drabi msawta bla ħniena għax kienu jaħsbu li huma 'ppossessati mix-xitan'-ideja ħażina li kellhom in-nies ta' bla skola sa nofs is-seklu dsatax. Fl-1725 il-pazjenti nisa kienu kkurati fiż-'żewġ tikmamar għan-nisa mġienen' fl-Isptar tan-Nisa Inkurabbli fil-Belt. Kamra oħra kienet akkwistata minn bini ħdejn il-Muniċipalita' tal-Belt Valletta f'Diċembru tal-1783.



Trażżin mekkaniku; manetti, u marbat tal-qadt

Fi żmien l-okkupazzjoni qasira tal-Franċiżi (1798-1800) il-pazjenti femminili kienu trasferiti għall-Ospizio waqt li l-irġiel, flimkien ma' dawk morda fiżikament ta' l-Infermeria, kienu evakwati għall-isptar il-ġdid tal-pazjenti ċivili li twaqqaf ħdejn il-monasteru ta' Santa Maria Maddalena. Hawnhekk huma tpoġġew fil-ħadid u mrażżna bil-ktajjen, bil-paviment tal-ġebla f'kamrithom 'jittiekel minħabba tkarkir kontinwu bil-ktajjen'. Peress li ma kienx hemm arranġamenti adekwati f'Għawdex, għall-kura tal-pazjenti mentali, dawn kienu jintbagħtu fl-Ospizio ta' Malta. L-akkomodazzjoni kienet ta' livell fqir immens speċjalment għall-pazjenti vjolenti u perikoluži u kienu miżmuma fi kmamar żgħar u mudlama u b'nuqqas ta' ventilazzjoni. Il-gwardjani kienu jsawtu lil dawn il-pazjenti u kienu jaqfluhom għarwenin u jħalluhom jgħaffġu fil-ħmieġ sakemm il-mewt biss teħlishom mit-tbatija u d-degredazzjoni tagħhom.



L-isptar ċivili fejn tpoġġew il-pazjenti mentali waqt il-ħakma Franċiża

L-'observation wards' kien stabbilit fl-1832 u waqqfu fl-1849. Sa dan iż-żmien ma kienx hemm nursing staff imħarreġ kif suppost.

IL-MANIKOMJU TA' FRANCONI- 'TA' FRANKUNI'

Fl-1835 dar kbira fil-Furjana ġiet mibdula għal 'dar ta' l-imġienen'u l-pazjenti kienu jittieħdu hemm mill-Ospizio lejn l-aħħar tal-1837. Il-bini kien residenza ta' Kavallier ta' l-Ordni ta' San Ġwann, Bali Fra Fabrizio Franconi u għalhekk iġib ismu.

Bħala 'Visiting Physician' tal-manikomju ġie appuntant Dr.T.Chetcuti u dan sab li Ta' Frankuni ma kien xejn għajr ħabs. Huwa għalhekk ħeles lill-pazjenti mill-ktajjen, illimita l-użu tas-sekluzjoni u beda juża l-'istraight jacket' f' każijiet ta' pazjenti nervużi u perikoluži. Huwa ma ħalliex lill-attendenti jużaw il-kelma 'imġienen' meta jirreferu jew ikellmu pazjenti u kellu għajnejh bħal ta' seqer fuq l-impjegati tiegħu għal xi trattament ħażin fuq il-morda. Huwa neħħa l-kastigi lill-pazjenti li kienu jidgħu, jisirqu l-ikel, iqattgħu l-ħwejjeġ jew jattakaw lill-oħrajn, u biex jara li is-superviżjoni fuq il-pazjenti issir aħjar, żied in-numru ta' l-attendenti. Fl-1844 meta n-numru ta' pazjenti tela' għal 144, żewġ attendenti rġiel żdiedu mat-total ta' erbgħa attendenti rġiel u nisa. Fl-1850 kien hemm sitt attendenti nisa u sitt attendenti rġiel, immexxija minn 'headkeeper' (li kien ukoll 'storekeeper'). Sa dan iż-żmien ma kienx hemm matron. Meta kienu jsiru r-rounds fid-Diviżjoni Femminili kien ikun akkumpanjat minn attendenta femminili.

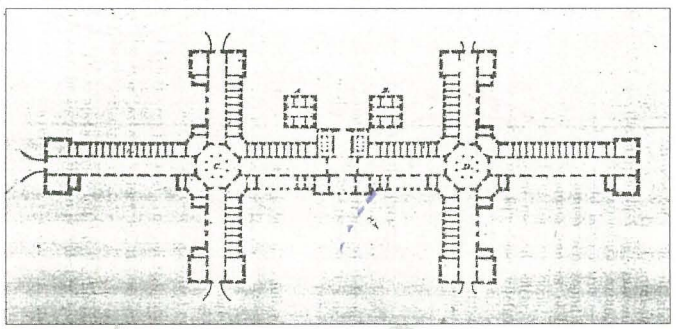
Fi Frar tal-1853, waħda mill-attendenti kienet għalqet erbgħa u sittin sena u l-abbiltajiet mentali tagħha kienu tant fqar li ma 'setgħetx tagħti l-attenzjoni tagħha lil pazjenti, u mhux l-ewwel darba li kienet tinsa tagħti l-pinnoli u kienet tidher għajjiena ħafna tgħix fost dawk il-morda'. Din id-deskrizzjoni patetika ma kienitx biżżejjed biex il-Kummissarju tal-Istituzzjoni Karitattevoli jħenn għaliha, għax ma kienitx laħqet l-età tal-irtirar. Dawn il-ħaddiema kienu jibqgħu fis-servizz anke sal-età ta' tnejn u sebgħin jew tmenin sena.

Għalkemm Dr. Chetcuti kellu intenzjonijiet tajbin u li jirriformaw, il-manikomju ma serviex għal dak li kien maħsub. L-iffullar farrak l-arranġamenti tan-nursing u l-amministrazzjoni. L-istat patetiku tal-manikomju ġie deskritt mill-Kontrollur tal-Istituzzjonijiet Karitattevoli fl-1859 meta n-numru tal-pazjenti kien madwar mitejn; '...il-pavimenti dejjem imxarrba bl-ilma u l-pazjenti jorqdu fuqu. Fi spazju ta' ħmistax-il pied b'disgħa piedi jorqdu bejn 14 u 16-il pazjent b' fetha żgħira biss għall-ventilazzjoni. Fid-Divizjoni tan-Nisa il-bini kien għar minn dak tal-irġiel. Hemmhekk peress li ma kienx hemm Matron, l-Attendenti Nisa tas-Swali kienu jkunu dejjem weħedhom u kemm kienu bla qalb dawn is-sefturi kien jidher sew u ma tistax tispjegah.

Il-pazjenti li kienu bil-'period' kienu jitħallew jitmegħku fi ħmieġhom u fil-'period' tagħhom stess sakemm jieqaf il-'period'. Il-pazjenti kienu obbligati li jpoġġu fl-art fix-xitwa u s-sajf. L-apparenza tal-kok u l-ħwejjeġ tal-kċina kienu biżżejjed biex

jikkonvinċuk li l-ikel kien tajjeb biss biex jintemgħu l-annimali. L-inbid li setgħu jixorbu l-pazjenti u ż-żejt għall-lampi kienu b' mod kostanti jinsterqu bi kwantitajiet kbar mill-attendenti...Dixxiplina ma teżistix, ir-ribelljoni ħakmet kullimkien u l-attendenti kienu jbeżżgħu mhux biss lil pazjenti imma wkoll lill-uffiċjali. Fi ftit kliem, b' mod ġenerali il-post kien pandemonju perfett.' Fl-aħħar tal-1859, sar attentat, biex issir riforma fl-amministrazzjoni tal-manikomju, grazzi għat-tħabrik tal-Kontrollur il-ġdid tal-Istituzzjonijiet Karitattevoli, Sir F.V.Inglott, li kien determinat li jibdel il-manikomju minn 'orrur' għal 'sptar ta' diżordni mentali'.

IL-MANIKOMJU TA' Ħ 'ATTARD



Il-pjanti oriġinali ta' l-Isptar ta' Ħ'Attard

Fis-16 ta' Lulju 1861 infethet din l-istituzzjoni u laqgħet fiha 248 pazjent ta' Villa Franconi. Għalkemm dan il-bini kellu difetti srtutturali u sistemi li spiċċaw, l-atmosfera ordinata u organizzata impressjonat lil dawk li żaruna minn barra.

It-tmexxija tal-isptar ma kienitx miexja ħarir daqs kemm wieħed kien jaħseb. Kien hemm diffikultajiet rigward l-akkomodazzjoni u l-arranġamenti tan-'nursing' li damu għal madwar nofs seklu sakemm saru attentati determinati biex jissolvew mill-gvern.

Għal-ħafna snin wara li nfetaħ il-manikomju, l-attendenti kienu joħolqu nkwiet kostanti għax kienu indixxiplinati u bla rispett lejn l-awtoritajiet. F' ħafna okkażjonijiet is-Supretendent Mediku kellu jirraporta lill-Kontrollur tal-Istituzzjonijiet Karitattevoli dwar numru ta' attendenti li kienu jitkellmu bil-goff u jitraskuraw lill-pazjenti. Waqt li jkunu fuq xogħolhom ħafna mill-attendenti nisa kienu jimxu ħafjin u mlibbsa bl-irqajja.

Sptar ieħor mentali gie miftuħ fl-1934 għal 200 pazjent f' Għajnsielem, Għawdex fil-Fortizza ta' Chambrai li ġiet restawrata. Ix-xogħol biex jinġiebu numru adekwat ta' attendenti biex jieħdu ħsieb popolazzjoni ta' pazjenti dejjem qed tikber kien iebes u jaħlik.

Fl-1876 kien hemm 189 pazjent u n-numru ta' attendenti rġiel kien għadu disgħa, li whud minnhom kellhom xogħol ieħor barra li jieħdu ħsieb il-pazjenti fis-swali. Wieħed mill-attendenti kien ukoll mastrudaxxa tal-isptar, tnejn oħra kienu purtinar u bajjad, waqt li ieħor kien impjegat fid-dispenserija u l-kamra tal-insiġ.

Fin-naħa tan-nisa kien hemm tmien attendenti nisa, żewġ servjenti u tlett sorijiet. Kienet użanza li jimpjegaw tfajliet mill-orfanatrofji tan-nisa. F'Mejju 1882 ingħataw uniformijiet lill-attendenti nisa 'biex jintgħarfu mill-pazjenti, miżura li ntroduċewha fl-Isptar Ċentrali. L-attendenti rġiel kellhom uniformi mill-bidu tal-manikomju.

Kien hemm żmien meta ħamsa w sebgħin pazjent raġel f' Ward 4 kienu jieħdu ħsiebhom tlett attendenti biss (1880) u erbgħa u sittin pazjenti nisa b'attendenta waħdda (1883) f' Ward 3.

Dan ma kienx rakkomandabbli għaliex ir-ratio ta' attendenti għall-pazjenti fil-wards kienet wieħed għal kull 25 pazjent, meta suppost kien attendent wieħed għal kull 17-il pazjent.

Ma kienx ta' sorpriża li l-pazjenti kienu jattakkaw lil xulxin u lill-attendenti u minħabba f' ħekk, kontra qalbu, is-Supretendent Mediku obbliga li jintużaw trażżin mekkaniku u seklużjoni f' każijiet fejn dawn il-miżuri setgħu jiġu ordnati skond n-numru ta' attendenti.

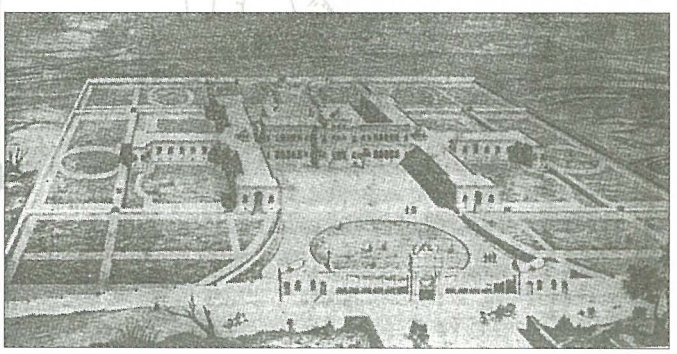
Sal-1884 in-numru ta'attendenti rġiel kien għaxra meta l-popolazzjoni tal-pazjenti rġiel telgħet għal 218. Dan ġieghel lil Dr.F.Xuereb biex jordna ż-żieda fin-numru tal-istaff maskili b' wieħed. Il-Kontrollur tal-Istituzzjonijiet Karitattevoli ma kienx se jilqa' din it-talba iżda ġimgħa wara, Dr. Xuereb kien aggredit serjament minn pazjent kriminali, u għalhekk il-Kontrollur kellu jibdel fhemtu.

F' Diċembru tal-1884 sar attentat mill-istess Kontrollur biex Iħajjar lill-attendenti biex jieklu flimkien mal-pazjenti, pjan li qatt ma rnexxa. Huwa nteressanti li l-impjegati kollha kienu jfittxulhom qabel ma jħallu l-manikomju meta jispiċċaw xogħol.

F' Jannar 1887, kien hemm tlettax-il attendent biex jieħu ħsieb 236 pazjent iżda minn fosthom kien hemm il-purtinar u l-barbier li ma kienux jagħmlu xogħol fis-swali. Fi Frar tal-1888 kien hemm tmintax-il impjegat raġel ma 230 pazjent 200 pazjenta ma sittax-il impjegata taħt it-tmexxija ta' sitt Sorijiet tal-Karità.

Problemi oħrajn kienu wkoll ta' edukazzjoni. L-attendenti kienu prinċiparjament ġejjin mill-villaġġi u ħafna minnhom kienu illitterati. Il-livell edukattiv tal-istaff tan-nursing kien għalhekk fqir ħafna sal-1889, tant li s-Supetendent Mediku kellu jimpjega bħala attendent wieħed bajjâd li kien kapaċi jaqra u jikteb bit-Taljan u 'kien jaf l-ewwel regoli fl-aritmetika'. F'din is-sena kien hemm biss attendent wieħed li ' kien jaf bl-Ingliż'. Kien diffiċli li jinstabu attendenti li kienu kapaċi jaqraw u jiktbu isimhom u n-numri u anke sa l-aħħar tal-1890, is-Supretendent Mediku qal li ħafna mill-attendenti tiegħu kienu njoranti fir-regola tan-nursing l-aktar elementari u 'kultant żmien kienu msejħa jagħmlu xogħol li ma kienux jifhmu'. Dan kien japplika kemm għan-nursing ġenerali u anke għal dak mentali. Dr. F. Xuereb ipprova jirranġa dawn id-defiċjenzi billi jagħti 'course' ta' lezzjonijiet lil attendenti fuq il-kura tal-'imġienen'; imma kien biss lejn il-bidu tas-seklu l-ieħor li s-sitwazzjoni tan-nursing bdiet tirranġa fir-rigward ta' 'standards' edukattivi u żieda fl-istaff. Għaldaqstant, ħafna mill-attendenti xorta baqgħu illiterati u mhux mgħallma sal-1932, tant u hekk li kien intenzjonat li jingħataw 'course' fuq struzzjonijiet u jippreparawlhom ktieb utli bil-Malti; iżda kważi għaddew għoxrin sena sakemm ktejjeb fuq in-nursing mentali kien pubblikat għall-ewwel darba fl-1950, fejn kien jinkorpora serje ta' 'lectures' fuq in-nursing mentali li ingħataw lill-attendenti f' Marzu tal-1947.

Viċin l-aħħar tas-seklu dsatax ix-shift ta' bil-lejl kien jibda' fit-8.00 pm u jispiċċa fis-6.00 am tal-għada. Kien isir mill-istess attendenti li kienu diġa għamlu ġurnata xogħol. F'kull diviżjoni kien hemm żewġ attendenti. Wieħed kien stazzjonat fir-Rotunda biex jattendi lil dawk suwiċidali, epilettiċi u pazjenti li għadhom kif jidħlu l-isptar waqt li l-ieħor kien idur is-swali l-oħra u jattendi għal dawk morda fiżikament. L-attendenti kellhom lejl frank full disgħa t' ijiem. Biex jagħmlu viġilanza fuq l-attendenti ta' bil-lejl, introduċew sistema ta' arloġġ għal kull diviżjoni u kienu jsiru wkoll viżiti għall-għarrieda mill-uffiċjal mediku u miċ-'Chief male attendant'.



L-isptar ta' Ħ'Attard fl-1861

Kienet intenzjoni tal-awtoritajiet tal-isptar fl-1861 li jmexxu l-manikomju ta' Ħ' Attard fuq il-prinċipji tas-sistemi li ma jrażżnux, imma dan l-għan ma setax jinkiseb dejjem u trażżin mekkaniku kien xi kultant inevitabbli. Il-manetti baqgħu jintużaw sal-1873 waqt li s-seklużjoni ma baqgħetx tintuża ħafna lejn l-aħħar tas-seklu dsatax.

L-isem tal-manikomju ġie mibdul fit-2 ta' Marzu 1928 għal 'Sptar għall-Mard Mentali'.

(Ikompli għall-ħarġa oħra)

Il-Pesta f'Malta

L-EWWEL PARTI

Amante Darmanin
amante@onvol.com

"Dik il-pesta ċaħdet l-abitazzjoni umana mill-villaġġi, u l-ibliet, u kastelli u l-irħula, sakemm bil-kemm kont issib bnedmin li jabitaw fihom; tant kienet tittieħed li kull min kien imiss mal-marid jew mejjet kien immedjatament jiġi infettat u jmut: u l-bniedem soġħbien u l-konfessur kienu jittieħdu l-qabar flimkien.

... Jien qed nistenna il-mewt sa ma tasal...għalhekk qed nikteb dan; li ma jmurx il-kitba tinqered ma' l-awtur u x-xogħol flimkien mal-ħaddiem, għalhekk ħallejt il-karti biex ix-xogħol jitkompla, forsi xi ħadd jibqa' ħaj, u razza ta' Adam taħrab minn din il-pesta." — — John Clyn, Patri minur tal-kunvent ta' Kilkenny, 1349.

Kuntrarju għal forsi wieħed jaħseb il-pesta għada teżisti sal-lum, għalkemm din m'għadhiex titqies inkontrollabli grażżi għal antibijotiċi. Infatti ħafna pajjiżi bħal Indja u anke l-Istati Uniti, il-pesta hija endemika (tinsab regolari) u ammont ta' nies jimirdu fis-sena.

Il-pesta hija bacterium tat-tip gram-negattiv jissejjaħ Yersinia pestis. Normalment il-mikrobu jattakka lill-bergħud Xenopsylla ċheopsis. Min naħa tiegħu il-bergħud igħix fuq id-demm tal-far l-iswed Ratus ratus. Il-far l-iswed ukoll jimrad bil-pesta u jista' imut. Ġieli jiġri li l-bergħud jattakka xi annimali oħra jew bnedmin wara li l-far imut. (Qiegħed dejjem insemmi l-far u mhux ġurdien għax xjentifikament hemm differenza kbira bejn ġurdien u far u saħansitra anke bejn il-far l-iswed u l-far il-kannella Ratus norvegeticus. Il-far il-kannella ma jġorrx il-pesta) iżda hemm annimali gerriema (rodents) oħra li jistgħu jġorru l-pesta bħall-iskojjatlu (squirrel). Għalhekk il-pesta tista' tissejjaħ ukoll zoonotic (abilità tal-marda li tgħaddi minn annimal ta' speċi għal annimal ta' speċi oħra differenti)

l-pesta tinfirex fi tlett modi:

Il-Pesta Bubonika

Il-bergħud jista' jittrasmetti il-marda jew billi jigdem il-bniedem jew inkella il-ħmieġ tal-bergħud itir fuq xi ġerħa jew qasma li jkollu il-bniedem. F'każijiet rari far marid jista' jigdem persuna u din ukoll timrad u anke jekk il-ħmieġ tal-far jispiċċa f'kuntatt mal-bniedem, tista' tittieħed ukoll. F'kull każ tista' tirriżulta il-pesta bubonika. Bil-pesta bubonika il-marid ikollu nefħa kbira (bubo) fil-groin (l-irqiq ta' bejn iż-żaqq u l-kuxtejn) jew taħt l-apt jew anke fl-għonq. Dan jiġri wara li s-sistema linfatika timrad wara li tipprova tikkombatti il-mikrobu. Dawn il-boċċi jarmu rieħa tinten qawwijja,(għalhekk ngħidu l-espressjoni tinten seba' pesti). Il-vittmi ikollhom deni qawwi, uġiegħ ta' ras, dardir, dellierju u għeja. L-incubation period hija ta' 2-8 ġranet. Mortalita 30-75%.

Septisimja

Is-septisimja tiġi kawżata wara li l-mikrobu jidħol dirett fid-demm. Ħafna drabi il-pesta bubonika tispiċċa f'septisimja jekk ma jkunx hemm fejqan. Il-ġilda ikollha dwawar ħomor, vjola jew suwed (petechiae) u għalhekk il-marda kienet tissejjaħ il-mewt is-sewda. Ġieli il-ġisem kollu jispiċċa vjola (**disseminated intravascular coagulation).** L-incubation period hija 2-8 ġranet. Mortalita kważi 100%.

Il-mixja tal-pesta

Il-Pesta Pulmonika *(pneumonic)*

Din tittieħed wara li l-mikrobu jidħol fil-pulmun ġeneralment minn solgħa jew għatis ta' bniedem ieħor infettat, ġieli anke min nifs biss. Il-vittma ikollu qtugħ ta' nifs, jisgħol u jagħtas, jew jobżoq d-demm. L-incubation period hija 1-3 ġranet. Mortalita 90-95%. Jekk tiġi trattata l-marda, il-mortalita taqa' għal 5-10%. Din il-forma ta' pesta tittieħed ħafna.

Matul iż-żminijiet kien hemm diversi pesti u 'il quddiem ħa naraw dawk li-laqtu l-Malta. Hekk insibu li l-pesta kienet pandemika (madwar id-dinja) fis-sena 542 A.D, u kull fejn dehret ħalliet ħerba sħiħa. Tant li ġieli ma kienx ikun hemm min jibqa' ħaj biex jidfen il-mejtin. Barra minn hekk kien jaħkem biża kbir u f'ħafna drabi il-ġenituri abbandunaw lil uliedhom u viċi versa. L-aktar li baqgħet tissemma kienet il-mewt is-sewda, li f'erba' snin biss qerdet madwar 25 milljun fl-Ewropa kollha.

Il-mewt is-sewda 1346-1350

Kittieba ta' dak iż-żmien jirrakkontaw kif wieħed minn kull għaxra biss salvaw, fil-waqt li oħrajn igħidu li qerdet nofs l-Ewropa. Biss illum qgħedin inkunu iktar konservattivi u nqiesu li mietu madwar terz jew kwart tal-popolazzjoni ta' l-Ewropa, li xorta huwa ammont kbir. Fl-1347 il-popolazzjoni fl-Ewropa kienet ta' 75 milljun. Sal-1352 il-popolazzjoni kienet niżlet għal 50 miljun.

Il-pesta x'aktarx bdiet miċ-Ċina fl-1334, epidemija li qatlet tnejn minn kull tlieta jew ħames miljuni. Minn hemm infirxet għall-Indja u l-

Persja. F'Babilonja (Iraq) ġew irrekordjati 480 000 mwiet u dan nafuh fiċ-ċert għax is-sultan kien jingħata munita tad-deheb għal kull mewt. Il-Pesta kienet qed timxi mar-rotot tal-kummerċ ta' dak iż-żmien sakemm waslet fir-Russja fl-1345-46. Xi merkanti Taljani kienu qed jieħdu refuġju fil-belt ta' Caffa jew Kaffa (illum Feodosija) fuq il-Baħar l-Iswed. It-Tartari assedjaw lil Caffa fl-1345-46. Waqt dan l-assedju it-Tartari qabdithom il-pesta u meta raw hekk dawn bdew jisparaw l-iġsma infettati għal fuq is-swar (Għalhekk din kienet l-ewwel forma ta' gwerra bijoloġika). Minn hemm it-Taljani li kienu minn Ġenova, wara li ħarbu, ġarrew il-marda lejn Kostantinopli fl-1347 u wara lejn l-Italja (Ġenova u Venezja) minn fejn infirxet għal kullimkien.

Skont Gabriele de' Mussis li kiteb fuq il-pesta u miet fl-1356, f'Ġenova, kwazi wieħed minn kull sebgħa biss baqa' ħaj, fil-waqt li f'Venezja mietu 70%. Sa Ġunju ta' l-1348 waslet sal-Bavarja (Ġermanja) u fl-Awstrija f' Novembru. Vjenna u l-Ġermanja ta' fuq ġew affettwati s-sena ta' wara. Il-flotta Taljana wasslet il-pesta ukoll lejn il-Punent ta' l-Ewropa. Fi Franza il-pesta waslet fir-Rebbiegħa ta' l-1348 u sa Ġunju waslet Pariġi. Fl-Ingilterra waslet fis-Sajf ta' l-1348 u sal-Ħarifa waslet Londra. Il-Pesta baqgħet tiela' lejn it-tramuntana sakemm infirxet għad-Danimarka, Svezja, Polonja, Finlandja, u fl-aħħar Greenland.

It-twemmien ta' dak iż-żmien

Ħadd ma kien jobsor li l-pesta kienet ġejja minn mikrobu jew li tinġarr mill-firien u l-briegħed, anke jekk kienu jsibu ħafna firien mejta. Ix-xjenza kienet għada lura. Kważi kulħadd kien jaħseb li dan kien kastig minn Alla tal-mod laxk li kienu qed igħixu.

Iżda fiżikament x'kien qed jikkawza l-pesta? Kienu jaħsbu li hemm korruzzjoni ta' l-arja. Peress li l-arja kienet titqies bħala element (tlett elementi oħra kienu l-ilma, l-art u n-nar). Kienu jaħsbu li fwar ħażin kien qed jikkawza l-ħerba kollha. Dan il-fwar ħażin kien jitla' fil-wiċċ ta' l-art wara li jsir xi terrimot. Il-pjaneti wkoll kellhom ħtija, speċjalment Saturnu u Ġove u anke Marte. Kienu jaħsbu li meta dawn jikkonjugaw (jiġu fi pjan wieħed) dawn b'xi mod jaffettwaw id-dinja u għalhekk il-fwar u r-riħ ikomplu jwasslu l-pesta ma' kullimkien. Wara kollox mhux għalhekk kienu jintnu l-mejta? Din kienet il-konklużżjoni li l-fakulta medika ta' Parigi waslet għaliha fl-1348. Dan it-twemmin baqa' jseħħ kważi sa l-aħħar tas-seklu dsatax sakemm Semmelweis u Pasteur biddlu l-fehma tax-xjenzati.

Oħrajn waħħlu fil-Llud u qalu li dawn kienu qed jivvalenaw il-bjar.

Rimedju għal-pesta

Peress li kienu jaħsbu li l-pesta kienet arja ħażina, allura jekk tinħasel, kont qed tiftaħ il-pori u tidħol l-arja ħażina. Kien għalhekk li ħafna drabi it-tobba kienu jirrakomandaw biex in-nies ma jinħaslux tul l-imxija tal-pesta kollha. Kienu jirrikomandaw li tiftaħ ċerti twieqi filwaqt li tagħlaq oħrajn skont ir-riħ. Kienu jużaw ċertu fwejjaħ imdendla ma' għonqhom (posies) jew fi mnifsejhom biex ma jħallux l-arja ħazina tidħol. Metodu tajjeb kien tal-ħasil tal-idejn bil-ħall. Il-birra wkoll kienu jirrakomandawha. Dan kienu jagħmluh għax kull ħaġa qarsa kienu jqisuha tajba għal kontra l-pesta. Rakkomandazzjoni oħra kienet biex il-marid iġgħeluh jirremetti ħalli jneħħi l-valenu tal-pesta.

Rimedju ieħor kien tal-fsada (tat-tneħħija tad-demm-"blood letting"). Peress li l-arja ħazina tkun daħlet fid-demm u vvalenatu kienu jagħmlu qatgħa fit-tarf tar-riġel jew l-id l-eqreb lejn in-nefħa (bubo).Il-fsada riedet issir malajr sabiex il-valenu ma kienx jilħaq jinfirex u jekk wieħed ma jiekolx sakemm jagħmel il-fsada kien ikun aħjar. M'għandniex xi ngħidu, dan kien idagħjjef aktar lill-marid.

Id-djar ta' l-impestati kienu jiffumugawhom billi jqabbdu taħlita ta' ħwawar u valeni. Ħafna mill-ħwejjeġ kienu jiġu maħruqa. Il-mejta kienu ġeneralment jiġu midfuna u jitfgħu il-ġir fuqhom (metodu li għadu jintusa sal-lum). Ħafna djar kienu jiġu imbarrati bin-nies b'kollox sakemm tgħaddi l-pesta. Iżda malli l-pesta kienet iżżid fil-qilla tagħha kien ikun hemm ħafna katavri fit-toroq mingħajr ma jiġu midfuna.

(Titkompla fil-ħarġa li jmiss)

The S.L.H. Group Committee

Summary of meetings that MUMN SLH Group Committee is holding to improve matters at SLH:

1. Meeting with Mr. Mark Scicluna regarding sick leave certification
2. Meeting with Mr. Tonio Mallia regarding the hospital beds and out-of-stock items
3. Meeting with Mr. Martin Farrugia regarding the staff quarters and canteen.

Geoffrey Axiak
Assistant Secretary
MUMN SLH Group Committee

The MUMN Educational Executive Committee would like to thank all those who participated in the 5th CNF Conference.

The Committee is also informing all Nurses and Midwifes regarding the Survey being carried out on life-long learning that is being done with the collaboration of the Directorate Nursing Services.

Paul Pace
Chairperson Educational Executive Committee

The Florence Nightingale Benevolent Fund and Richmond Foundation on De-Stress Group Programme

■ Ms Doris Gauci
Chief Executive

A career in Health Care is very satisfying, but is also very stressful. Situations that you encounter in your average working day, could be considered to be highly stressful and traumatic such as assisting a child or adolescent as old as your own, seeing a family member in a distressing situation or being involved in a disaster of large proportions.

How does your job affect your health? By 'health' we are not implying solely physical but also mental health. The experiences we go through everyday, be they at work or in our personal lives, leave their mark on our mental health and well being.

How do you experience the affects of stress? You might not have a good night's sleep, may find that your appetite has increased or decreased and have a lower concentration span. Tension headaches, bowel problems, skin conditions and backaches are some of the physical symptoms that have been linked to stress. Our immune system is also affected making us more vulnerable to illnesses and infections such as influenza.

There are many different ways of controlling and reducing the negative effects of stress. For those members in the Florence Nightingale Benevolent Fund, MUMN representatives have recently signed an agreement with Richmond Foundation for the provision of a De-Stress Group Programme.

Groups of fifteen employees will be offered three sessions with a psychologist where, as a group, they will be able to discuss how stress influences their lives and how they can reduce stress levels in order to maintain a good quality of life.

Further information about this innovative service will be provided by Ms Doris Gauci, Richmond Foundation's Chief Executive, at a Seminar being organised by MUMN, on 6th October 2004.

For further information about Richmond Foundation, you may visit our website at **www.richmond.org.mt** or call 2148 2336 or 2122 4580.

The Florence Nightingale Benevolent Fund Seminar

The FNBF will be organising a **Seminar** on the 6th October 2004 to be held at The Coastline Hotel between 7.30pm and 9.30pm.
The Seminar is going to be on a new service which will be offered to all FNBF members **free of charge**.
The FNBF together with the Richmond Foundation is going to organise a De-Stress Group Programme.
Ms.Doris Gauci Chief Executive of The Richmond Foundation will give further information at the Seminar.
For those non-members and wish to attend, the fee of Lm3 will include coffee break and free transport from Valletta Terminus, which will leave at 6.30pm.
For members the fee is Lm1.50. *(Application form below).*

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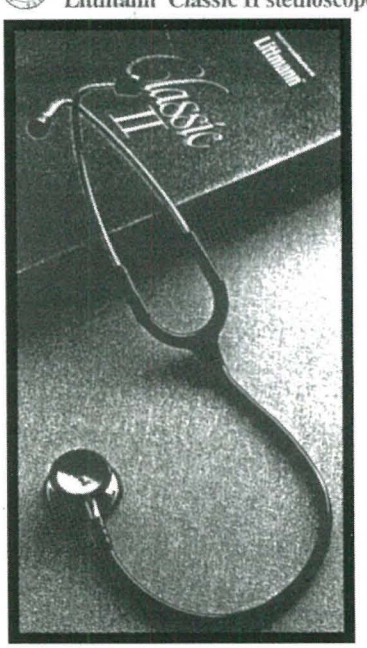

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ĊEMPEL ISSA

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British American Insurance Co (Malta) Ltd hija awtorizzata biex tmexxi Kummerċ fit-Tul ta' l-Assigurazzjoni u hija regolata mill-Awtorità għas-Servizzi Finanzjarji ta' Malta.

Mod aktar efficjenti kif tfaddal flusek!

X'inhuma Endowment Policies?

Endowment policies huma poloz ta' l-assigurazzjoni fuq il-ħajja li jservu ukoll bħala forma ta' kont fejn tfaddal flusek. F'dawn it-tip ta' poloz wieħed jakkumula somma meta tagħlaq il-polza, u titħallas is-somma assigurata f'każ ta' mewt tul il-perijodu tal-kuntratt.

Jeżitu forom differenti ta' endowment policies bl-aktar imfittxiha jkunu dawk imsejha bħala "with profits". F'dawn it-tip ta' poloz wieħed normalment jkun jista jagħmel pagamenti kull sena jew b'mod aktar regolari. Fuq il-pagamenti kollha inti takkumula l-interessi skond kif iddikjarati mill-kumpanija li magħha tkun assigurat. Poloz bħal dawn ta' spiss jintużaw bħala investiment għal futur tat-tfal jew biex wieħed jieħu somma meta jirtira mix-xogħol.

Fejn jigu nvestiti l-pagamenti ta' l-assigurazzjoni fuq il-ħajja?

Il-flus miġbura mill-assigurazzjonijiet fuq il-ħajja jmorru ġo fond imsejjaħ "Life Fund". Il-kumpanija ta' l-assigurazzjoni jkollha kumitat ta' investiment li jieħu ħsieb jinvesti dawn il-flus f'sigurtajiet bħal kontijiet bankarji, proprjetà, stocks tal-gvern u investimenti oħra simili.

Dan il-kumitat jkun magħmul minn professjonisti fil-qasam ta' l-investimenti u jieħdu d-deċiżjonijiet tagħhom skond regolamenti maħruġa mill-awtoritajiet konċernati. L-awtoritajiet lokali għandhom regolamenti stretti ħafna dwar kif jitħaddmu dawn il-flus sabiex jiproteġu lill-klijenti. Skond kif irendu dawn l-investimenti l-kumpanijji ta' l-assigurazzjoni iħabbru l-bonuses kull sena.

X'inhuma l-affarijiet li tfittex meta tixtri endowment policy?

Meta tixtri din it-tip ta polza ta' l-assigurazzjoni fuq il-ħajja mportanti li l-prodott jkun flessibli skond il-bżonnijiet partikolari tiegħek. Fost affarijiet oħra għandek tfittex prodott li joffrilek mod flessibli ta' kif tagħmel il-pagamenti tiegħek.

Importanti ukoll li meta l-kumpanija tagħtik kwotazzjoni tar-rendiment tal-prodott din tkun ibbażata fuq rati ta' bonuses realistiċi. Filwaqt li l-passat mhux garanzija tal-futur wieħed għandu jikkompara l-bonuses kwotati ma' dawk imħallsa fis-snin ta' qabel minn dik l-istess kumpanijja.

L-aħħar u mhux l-anqas importanti li l-kumpanijja ta' l-assigurazzjoni tkun mmexxijja minn nies professjonali. Qabel ma tidħol għal xi forma ta' assigurazzjoni huwa mportanti li tieħu parir mingħand intermedjarju awtorizzat.

Għal aktar informazzjoni dwar dawn it-tip ta' skemi ta' tfaddil (Secure Savings Plan jew Baby Plan) Ċempel issa lill-British American Life fuq

Freephone 80073131

Malcolm Briffa

Product Development Executive, The Global Group

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The Staff Support Group of S.Luke's Hospital

The SLH Staff Support Group is providing a free staff support service that includes counselling. Issues such as occupational stress and burnout, loneliness, social problems, relationship problems, spiritual distress and bereavement and others are just a few examples of whom the Counselling Group can help.

The mission statement is: The staff Support Group serves to promote the holistic well being of all S.Luke's Hospital personnel, by facilitating the provision of free, confidential counselling and educational services to achieve individual and organisational health.

The Councillors are running a service according to requests by staff. The Counselling Services Room is located near the corridor to the Chapel and application forms are retrieved near this room or downloaded from the Intranet and posted in a locked box adjacent to the room.

The Counselling group is at present made up of Fr. Joseph Calleja, Ms. Joan Camilleri, Ms. Mariella Meachen, and Fr. John Vella. Any SLH employee is free to choose anybody from the group when the need arises. Counselling can be a very positive way to enhance one's well being while it reflects the management's commitment to the welfare of staff.

All employees need to rest assured that this service is strictly confidential especially if personalised. Typical counselling includes talking and listening; understanding feelings, non-judging in no circumstances, expressing emotions, support any decisions to be taken (legal, moral or social) and suggesting communication skills.

Future plans of the Staff Support Group include the continuation of such a service to all hospital employees, keeping in mind the changes in trends; organising group sessions for particular sections; holding a 2 hour seminar for Nursing Officers and their Deputies so that awareness would be raised about the role of Staff support Group and how to identify staff that may need referral; future Day Conference for staff with Workshops.

Further information may be sought from the following members of the Group: Fr. J. Vella (1836), Mr. R. Aquilina (1936), Mr. J. Camilleri (1300), Mr. P. Abdilla (1448), Mr. R. Cassar (1187), Ms. M. Vella (22992389), Ms. T. Bugeja (1839).

WELL WOMAN PACKAGE NATIONAL COUNCIL OF WOMEN HEALTH COMMITTEE

(MUMN Affiliate)

On the 40th anniversary celebrations of NCW Malta, the Health Committee, including an MUMN Representative has prepared two Well Woman packages for all MUMN members. The 2 packages are aimed at encouraging the preventive health of women in line with the objectives of ICW and with modern health recommendations.

Package 1 consists of a clinical examination by a qualified gynaecologist, who will also be taking a PAP smear, which will be sent for examination by a qualified pathologist. The package will also include a mammogram, which will be booked at a private radiology clinic.

Package 2 consists of a clinical examination by a qualified gynaecologist, who will also be taking a PAP smear that will be sent for examination by a qualified pathologist. The gynaecologist will also be taking a sample of blood, which will be sent for the examination of blood glucose, serum lipids, liver function, renal function and a complete blood count.

The total cost of either Package 1 or 2, whichever chosen, will be of LM40, and will include the cost of the clinical examination, the laboratory fees (PAP smear and, if package 2 is chosen, the blood analysis) and the mammogram if package 1 is chosen.

Those interested in the package are to book their appointment at Estetika, 66 Dingli Str., Sliema on tel. 21340503/21340509 from Monday to Friday from 9am till 7pm and Saturday from 9am till 4pm. BOOKINGS CAN ONLY BE MADE DURING THE MONTH OF OCTOBER.

Members will be asked to present their MUMN membership card during their visit as proof of membership.

Eye Banking

By Neville Schembri SN, P.Q.Dip., M.Sc (HSM), M.I.M.

Way back in the late months of 2001 things started brewing up to set up a local eye bank to serve the general Maltese public. This article is intended to share with fellow nursing colleagues the basic idea and concept behind eye banking.

What is an eye bank?

In one simple sentence an eye bank obtains, medically evaluates and distributes eyes donated by caring individuals for use in corneal transplantation, research and education. This can be done through the following basic functions:

- Recovery/ preservation of eyes (enucleation).
- Serology testing of donor.
- Exams of eyes and corneas.
- Determination of donor suitability.
- Placement of corneas with transplant surgeons.

Besides the basic functions there are other things that can be done and achieved with such a setup like:

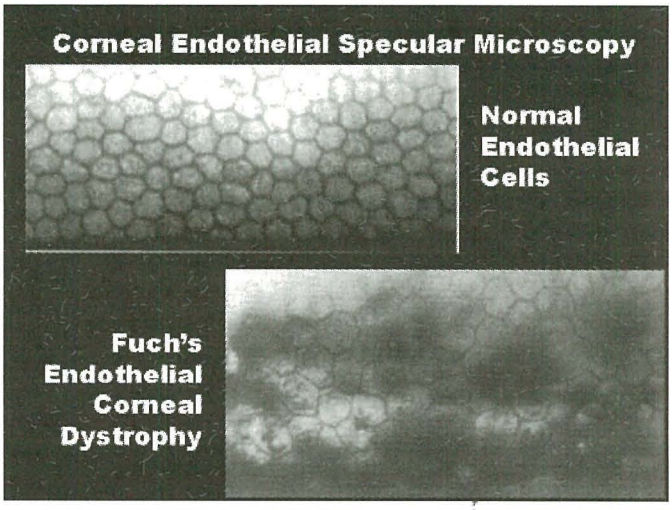
- Reduction in waiting list of patients needing corneal transplantation.
- Improved quality control of transplanted corneas.
- Provision of monitored storage facilities for tissues.
- Serve as a central data collection and retrieval unit on prospective recipients and donors.
- Help in eye donation marketing campaigns.

What is required?

❑ A Specular microscope. This specialised piece of equipment would make it possible to verify that the corneal endothelial cell density is above 2000cells/mm^2 which would make it viable for transplantation. These corneas would be preserved in Optisol at 4°C and have to be transplanted within 3-4 days. This would be tackling the aspect of quality control by ensuring that transplanted tissue is healthy and not using corneas that are deemed for failure due to insufficient cell count.

❑ Electronic donor database, recipient database and tissue quality control database systems. Establishing such database systems is in line with current EU regulations on control of transplant tissue.

❑ Endorsing an active donor promotion together with a recipient and donor support programmes. Theoretically with a proper marketing campaign surplus of tissue should be the order of the day which would later be used when there is a shortage.



❑ Organ culture medium method for corneal storage. This would prolong the lifetime of the endothelial cells to around 28 days and therefore take care of the surplus tissue.

❑ Tissue exchange programmes with established European banks. The cornea is the only piece of ocular tissue used for transplantation in Malta whilst the rest of the lobe following enucleation is discarded. Exchange of such tissue (e.g. sclera) could be arranged with foreign banks in return for other material useful for the local eye bank such as corneas, culture medium etc. The tissue sent abroad can then be used for research on diabetic retinopathy, glaucoma and macular degeneration or scleral transplantation (not performed locally).

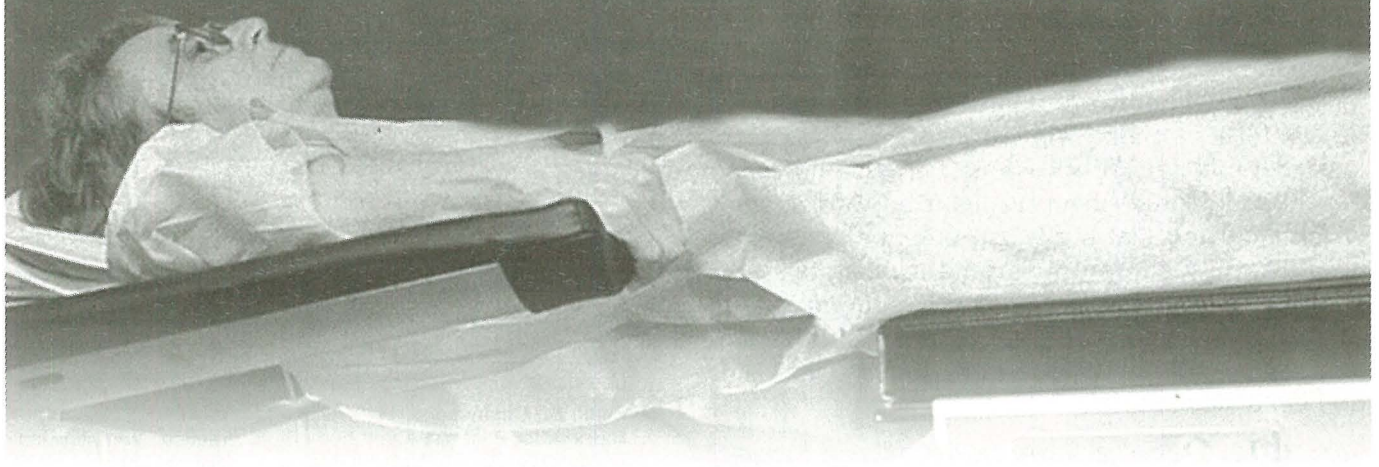
❑ Last but not the least is professional training for eye bank personnel.

"There is no better way to thank God for your sight than to give a helping hand to those in the dark."

Helen Keller (1880-1968)

Nil by mouth: Is our practice, research based or merely a routine?

A Literature Review



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Introduction

I was motivated to write this article about pre-operative fasting, or as it is better known "Nil by mouth" practice, after my father was admitted to hospital for minor surgery which had to be carried out under sedation. He was instructed to stay nil by mouth from midnight, "just in case ....." This is exactly what he did. Nevertheless, the procedure was carried out at 11am of the following morning. By that time, this 76-year-old man had been fasting for eleven hours, feeling weak and shaky, having a dry mouth and difficulty with passing urine. Seeing him in this helpless state, I started thinking that all these undesirable symptoms could have been avoided. Thus I decided to carry out this literature review, which though limited, assisted me in understanding what the best practice is.

He was instructed to stay nil by mouth from midnight, "just in case ....."

Fasting patients before surgery is a well-established practice that prevents the aspiration of gastric contents and reduces the risk of regurgitation and vomiting (Jester and Williams, 1999; Watson and Rinomhota, 2002). Therefore, as Winkley (1998) asserted, pre-operative fasting, with the exception of medical emergencies, is not only a medical necessity, but is, in fact a legal requirement.

Having established that pre-operative fasting is in the best interest of the patients' safety, and is therefore desirable, the debate centres around how long this fast should be for fluids and solid foods. Several authors pointed out that patients are often fasting for longer than necessary before anaesthetic (Chapman, 1996; Jester and Williams, 1999; Winkley, 1998). So much so, there is a blanket "nil by mouth from midnight" policy for patients scheduled for morning surgery, be it at 8am or midday. This does not happen only in Malta, but was found to be a worldwide reality by Pandit and Pandit (1997). Thomas (1987) found that this happened as a precaution against alterations in theatre schedules. However, only six changes were made in the 64 theatre schedules examined by Chapman (1996). Thus, Winkley (1998) suggested increased liaison between theatre and ward staff, to help eradicate uncertainties about alterations of theatre schedules.

Effects of SHORT fasting periods

If the length of fast is inadequately short, a patient may potentially aspirate the contents of their stomach into their lungs, which could lead to aspiration pneumonitis – a life-threatening event (Chapman, 1996; Watson and Rinomhota, 2002). According to Mendelson (1946 cited in Watson and Rinomhota, 2002) the risk factors associated with aspiration pneumonitis increase when the patient has a gastric volume of above 25ml and a gastric pH lower than 2.5. This was substantiated by Roberts and Shirley (1974 cited in Dean and Fawcett, 2002).

Effects of LONG pre-operative fasting periods

Simply prolonging the fasting time does not necessarily produce the desired effect. Studies

carried out by Miller (1983), Hung (1992) and Maltby (1993), amongst others, indicate that an extended fast does not produce an optimum gastric environment. Instead they may precipitate other problems like discomfort, irritability, dehydration, electrolyte imbalance, malnutrition and general malaise (Hung, 1992; Watson and Rinomhota 2002). At worst, prolonged fasting times may contribute to post-surgery morbidity and mortality (Hung, 1992).

Research carried out in Sweden showed that fasting for six to eight hours pre-operatively may reduce the body's ability to cope with stressors such as blood loss and infection (Bird, 2000). This same author described the preliminary results of a Swedish study, which indicated that a glucose drink before surgery spend twenty percent less time in hospital. This substantiates Smith et al's (1997) suggestion that allowing patients to drink up to two hours pre-operatively makes post-operative vomiting less likely and enhances recovery.

What is the optimum fasting time?

Several studies demonstrate that it is safe practice for patients to receive solid food for up to six to eight hours prior to surgery (Chapman, 1996; Hung, 1992; Maltby, 1993) and clear fluids, two to four hours prior to anaesthetic (Maltby, 1993; Phillips, 1993; Splinter, 1991).

A study conducted by Splinter (1991) concluded that healthy adolescents undergoing elective surgery were able to ingest unlimited fluids up to three hours pre-operatively. This decreased thirst and did not effect the gastric contents.

Nurses' practice

Notwithstanding decades of research about the subject of pre-operative fasting, nursing practice continues to be routine. Whilst Dean and Fawcett (2002) identified the inaccessibility of research findings as a barrier to nursing practice. Funk et al (1991), Nolan et al (1998) and Retsas (2000) pointed out that insufficient authority to implement new practices was the major barrier for nurses who persisted with the practice of prolonged pre-operative fasting, despite knowing that this should not be the case.

These barriers could be overcome by teamwork among anaesthetists, surgeons, and theatre and ward nurses. Policies can be formulated, audited regularly and changed according to the needs of the hospital. This is the current practice of the Norfolk and Norwich University Hospital, where a Trust Policy for the Management of Pre-op Fasting was formulated on the evidence mentioned, and audited yearly (Knowles and Hodgson, 2003).

Conclusion

Nursing practice regarding pre-op fasting appears to be based on custom, routine and tradition, in order to accommodate unpredictable changes in theatre lists. It is carried out without thoughtful understanding of the implications that this has.

This practice needs to change. Though it is convenient for nurses to have a routine and uniform standard practice, it is detrimental to patients. Thus it goes against the NMC's (UKCC) Code of Professional Conduct (1992), which states that nurses should "act always in such a manner to promote and safeguard the well-being of patients".

Therefore I suggest that all nurses should keep themselves abreast with current research findings and that a national protocol on the subject in question should be formulated to standardize the pre-operative fasting practice, so that patients can benefit from optimum evidence-based practice.

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You're Needed!

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Every person has a right to live in a safe environment where dignity and respect are not infringed. Violence in the home ruins lives, breaks up families and shatters whole communities. What makes it an even more serious kind of crime is that it is originated by a person who is meant to be close to the victim, and often happens in the home - a place that normally provides safety from the world outside.

Domestic violence is not a private matter, it is a social issue and, as such, it is everybody's duty to report abuse if they come across it. Everyone can make a contribution in winning the battle against victimisation and abuse. We need to move towards zero tolerance to violence, where living free from abuse is acknowledged as a basic human right that we cannot do without.

Domestic violence is about one person exerting control over another. It may include emotional, psychological, sexual and physical abuse, generally against a woman, by a current or former husband, partner or boyfriend. Research conducted by the European Commission indicates that 98% of victims of domestic violence are women. Local research carried out by Appogg confirms that in Malta 96% of service-users are women. 'Appogg' statistics show that the problem is escalating. It is worth noting that domestic violence is dispersed all over the Maltese Islands, and that perpetrators come from every social class.

Young people who are dating or are in intimate relationships may avoid becoming victims of domestic violence by recognising the signs of an unhealthy relationship.

HEALTHY RELATIONSHIP	*UNHEALTHY RELATIONSHIP*
Open and honest communication between partners	There is an imbalance where one partner tries to exercise control and power over the other through threats, emotional and physical abuse.
Both partners are aware that violence is not acceptable	Constantly tracks partner's time and activities.
Both partners share even control over decisions, and power is balanced.	Name-calling, insults, withholds money, even for basic needs, and demands that his partner accounts for all that she spends.
Both partners treat each other with respect even when they are angry or disappointed.	Threatens to isolate partner from family and friends, or even threatens to hurt her, the children or the pets.
Accept that 'no' means no	Forces her to accommodate him against her will, and therefore does not accept 'no'.

For many years, domestic violence has been treated as a taboo subject. No one talked about it, no one admitted to witnessing it, no one did anything to prevent it. Today, we understand the need for it to be placed high on the national agenda.

You too can help by talking about it with friends, colleagues and family. You can teach children how to show disagreement or frustration by using communication not their fist, or by taking time out. The Ministry for the Family and Social Solidarity's Co-ordinated Response Team (Violence Against Women) is appealing for people from different age groups and from all walks of life to learn about domestic violence and help raise awareness by possibly making copies of these information pages and distributing among people in their circle.

In the U.S. and in Europe various campaigns are held to reach different target groups. Sports coaches are raising awareness by talking to sportspeople and to children under their care about the issue. Men's groups are running campaigns showing perpetrators of bullying and abuse as weak individuals who need to learn appropriate life skills. They talk to their sons, nephews and boys in their care about the proper way to treat girls and to use communication skills or take time out when they feel angry or frustrated. Women and children are being encouraged not to tolerate violence, to speak out and to seek help. People who witness violence are told not to turn a blind eye but to report it, even anonymously, to the police. Religious leaders speak out against it and guide victims to seek professional help. Teachers hold discussions in class to help children dispel myths early on in life. Health care professionals keep their eyes open for signs of violence and utilise every opportunity to educate their clients. The Police and the Courts are encouraged to pass on a very clear message that violence is a crime with serious consequences. Young people help out their peers in unhealthy relationships to ask for help before they get caught up in the vicious cycle of abuse. The media, programme presenters, scriptwriters, singers, actors and others in influential positions may seize any appropriate opportunity to pass on the message.

In Malta, support services are available for women, men and children who are suffering abuse in the home. There are also professional therapeutic groups for men or women who manifest abusive attitudes and behaviour.

The main messages are:

THERE'S NO EXCUSE FOR VIOLENCE IN THE HOME

Abuse is never the fault of the victim; it is 100% the responsibility and choice of the abuser

VICTIMS SHOULD SEEK HELP AND NOT SUFFER IN SILENCE

DOMESTIC VIOLENCE CARRIES SERIOUS CONSEQUENCES

WE ALL HAVE A DUTY TO REPORT IT

(this may also be done anonymously)

continued overleaf ☛

You may wish to access the following websites for more information on domestic violence:

www.endabuse.org

http://www.ncwmalta.com/infowomendetail.asp?i=72

http://europa.eu.int/scadplus/leg/en/lvb/l33062.htm

http://toolkit.ncjrs.org

http://www.appogg.gov.mt/services/services_domestic.htm

The link between dating violence and domestic violence

An extract from a newspaper: 'A battered wife told young people to watch out for the danger signs when they are still dating. If a boyfriend starts trying to control his girlfriend on when she can go out and pushes her about or hits her, she should tell him that it must stop. If it does not, the relationship is bound to fail, because contrary to what young women believe, men do not change their behaviour after marriage - it actually gets worse because then they feel they really own their woman.'

- ★ Often dating violence is a precursor to domestic violence.
- ★ Domestic violence is a learned process. often those who engage in abusive behaviour tend to do so from the early dating stages.

they believe that:

- ★ disrespect for women is normal.
- ★ it is acceptable to hurt someone you love.
- ★ A woman is the appropriate victim of violence.
- ★ It is expected as a general rule that a man dominates in a relationship.
- ★ It is acceptable to use abuse to get what you want, or to make what you believe clear or to solve problems.
- ★ after marriage, the abuse tends to increase both in frequency and in severity because the perpetrator feels he has more control, because of stress brought on by marriage itself and because daily stress factors tend to increase. with the arrival of children, the woman's potential for escape or prevention is minimised.

Ejjew nieqfu ftit ...

PRAYER FOR HELPERS OF THE SICK

Lord, You know that it is my duty to assist the sick, grant that I may serve them not only with my hands but also with may heart so that I may love them.

Lord, You had compassion on all human suffering, make my spirit strong, strengthen my arms in caring for the sick, in dressing wounds, in comforting the weak and the dying; keep my soul sensitive to the sorrows of other, let me always have a kind word and manner, and patience in watching.

Lord, You created human nature composed of body and soul, make me respect both the one and the other, teach me to console the downcast spirit, caring for the sick body.

Lord, You said that the care shown to the suffering is shown to You, grant that I may see You in them and them in You.

Lord, You promised that even a glass of water given in Your name would not go unrewarded, conserve the reward wich You alone can give to this my work which I want to accomplish with devotion and love.

And you Mary, consoler of the afflicted and health of the sick, be for me a wise teacher and loving mother.

THE ECHO OF LIFE

A man and his son were walking in the forest. Suddenly the boy trips and feeling a sharp pain, he screams "Ahhhhhhh!"
Surprised he hears a voice coming from the mountain, "Ahhhhh!"
Filled with curiosity, he screams "Who are you?" But the only answer he receives is "Who are you?"
This makes him angry, so he screams "You are a coward!", and the voice answers "You are a coward!".
He looks at his father asking "Dad, what is going on?"
"Son," the man replies. "Pay attention!" Then he screams "I admire you!".
The Voice answers "I admire you".
The father shouts, "You are wonderful!" and the voice answers "You are wonderful!"
The boy is surprised and still can't understand what's going on.
The father explains. "People call this the "ECHO", but truly it is "LIFE". Life always gives you back what you give out!. Life is a mirror of your actions. If you want more love, give more love. If you want more kindness, give more kindness. If you want people to be patient and respectful, give more patience and respect! The rule of nature applies to every aspect of lives".
Life always gives you back what you give out. Your life is not a coincidence, but a mirror of your own doings.

THE MALTESE

A Maltese walks into a Bank in New York City and asks for the loan officer. He tells the loan officer that he is going to Malta on business for two weeks and needs to borrow $5,000.
The Bank officer tells him that the bank will need some form of security for the loan, so the Maltese hands over the keys to a new Ferrari. The car is parked on the street in front of the bank. The Maltese produces the title and everything checks out. The loan officer agrees to accept the car as collateral for the loan.
The bank's President and its officers all enjoy a good laugh at the Maltese for using a $250,000 Ferrari as collateral against a $5,000 loan. An employee of the bank then drives the Ferrari into the bank's underground garage and parks it there. Two weeks later, the Maltese returns, repays the $5,000 and the interest, which comes to $15.41.
The loan officer says, "Sir, we are very happy to have had your business, and this transaction has worked out very nicely, but we are a little puzzled. While you were away, we checked you out and found that you are a multimillionaire. What puzzles us is, why would you bother to borrow $5,000?"
The Maltese replies: "Where else in New York City can I park my car for two weeks for only $15.41 and expect it to be there when I return?"
Ah, the Maltese!

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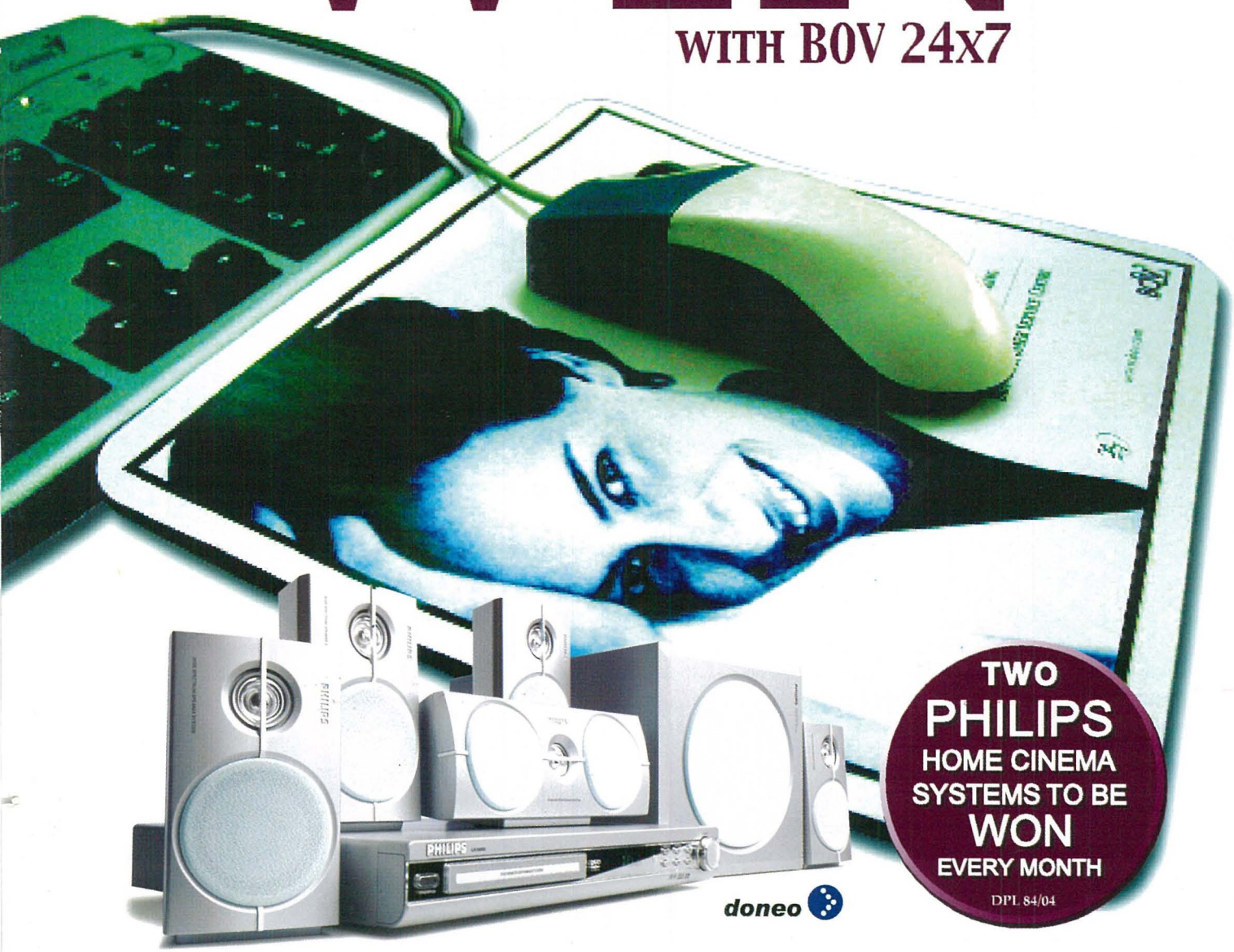

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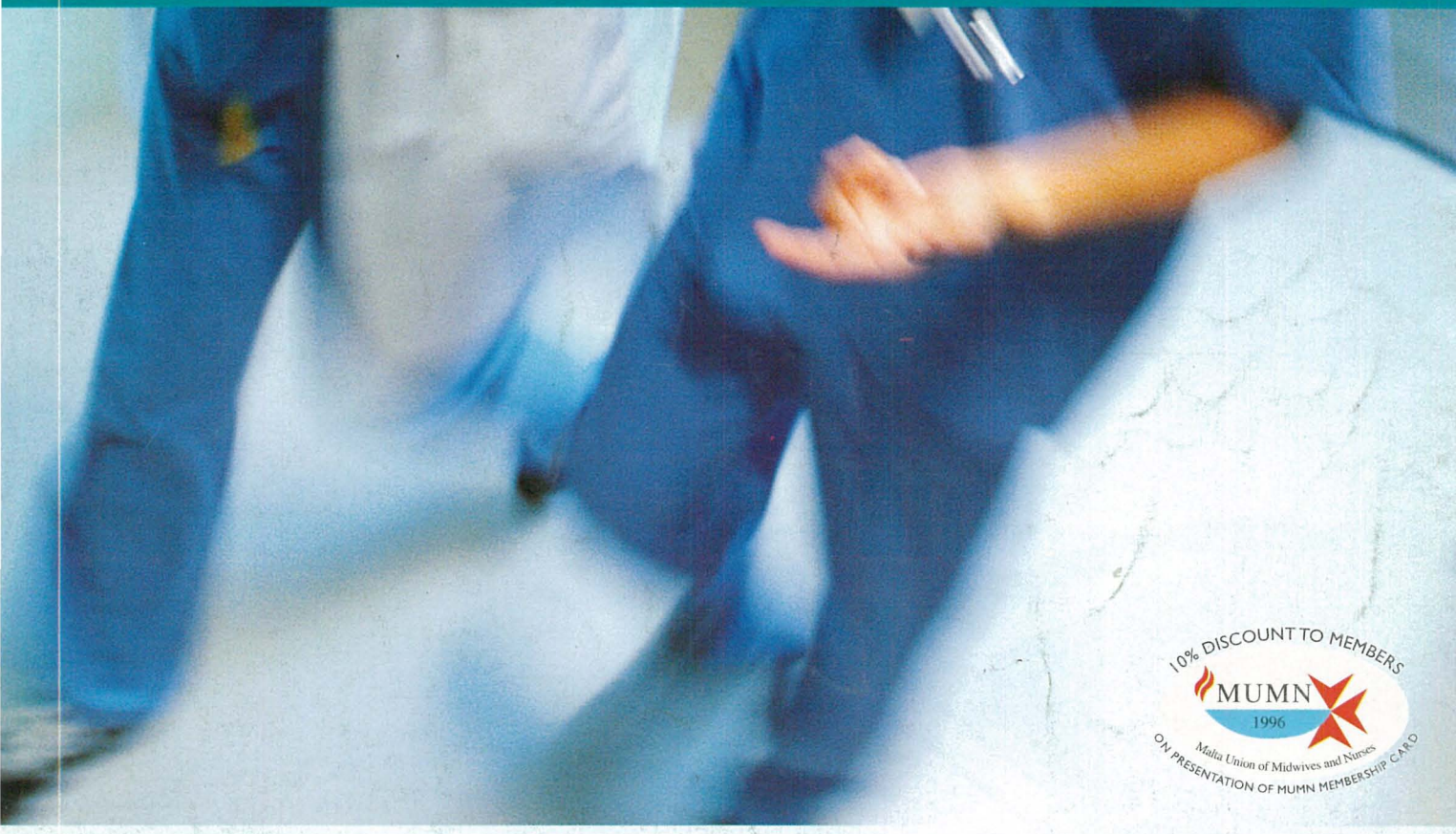

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Now with unique stress-reducing insoles

The secret of our healing soles

Your body has two main balancing points: the heel and the ball of the foot. Your body is in equilibrium when the impact loads, when standing or walking, are evenly shared. This hardly ever happens, though, especially when you're working hard, so your body has to make millions of tiny compensating adjustments all through the day. It's this muscular effort that causes excess stress and fatigue. The stress-reducing insoles in every Scholl professional shoe have two special posture balancers: one directly under the ball of your foot, and one in the heel. These remarkable heart-shaped inserts actually help spread body loads more evenly across the foot, reducing muscle movement, stress and fatigue.

HEART-SHAPED INSERTS, *built into the sole and heel, reduce muscle movements in your legs and hips, helping you sail through the busiest working day.*

Available from all pharmacies

and the Scholl Foothealth Centre, South Street Valletta

Scholl