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MESSAGĦ MILL-PRESIDENT

Għezieġ Membri,
Żgur li hadd ma ġista jinnega li din is-sena kienet mimlija b’attivitajiet soċjali organizzati mill-Union. Kienet sena fejn iċċellobrajni il-hames sena mit-twaqqif tal-Union tagħna. Ta’ union li verament għandha l-interest ewlieni li thares il-professionijiet tan-Nursing u l-Midwifery f’ pajjiżna.
Hames snin li nħarsu lura lejhom b’ sodisfazzjon kbir għax kienu esperjenzi ta’ suċċess, wiehed wara l-iehor. Suċċess li seta’ jseżb biss bil-kollaborazzjoni sħiħa u l-appoġġ kbir tagħkom.
Illum l-MUMN hija stabbilita sew fil-qasam trejdunjoniżtiku kemm fil-kamp lokali kif ukoll dak internazzjonali.
L-MUMN mhux ser toqghod tiptahar u toqghod cċiċċi beqqi u toħlom fuq il-passat sabiħ tagħha, iżda bħalissa għaddjejja ħidma intensiva li ħdan il-Union sabiex il-proċess ta’ avvanz fil-professionijiet ma jieqaf qatt.
Sabex naraw li l-professionijiet tan-Nursing u Midwifery f’pajjiżna ikun fuq l-istess livelli ta’ professionijiet oħra, l-eżekuttiv tal-Union bħalissa għadejj f’negożjati intensivi mal-Gvern biex jiġi formulat ftehim kolletiv ġdidd, bil-għan li jiġu ntrodottu kuncetti ġodda bhal dawk ta’ gradi fuq binarji professjoni jiġifieri speċjaliżazzjoni f’oqsiema speċifiċi.
Barra min hekk qed jiġu konkużi taħdidiet biex tiġi mibdula l-liji li tirregolarizzza l-professionijiet tagħna u b’hekk tkun konformi ma’ professjoniżti oħra fil-qasam tas-sahha.
Proċess iehor li għaddej huwa l-preparamenti biex sentejn oħra issir Konferenza Internazzjonali f’Malta għan-Nurses li jahdmu f’pajjizi tal-Commonwealth u dan seta jsejħ wara li l-MUMN qed tghin fil-organizzazzjoni tal-konferenza ta’ din ix-xorta f’Marzu 2002 f’Ċipur. Dan għax il-Union tiegħek hija membru attiv fl-ICN u CNF, żewġ ghaqdiet ta’ importanza kbira fil-qasam tan-Nursing.
Rudolph Cini
January 2000

To: Presidents/Executive Directors/General Secretaries of National Nurses Associations
From: Mireiile Kingma, Nurse Consultant
Subject: New ICN Strike Policy

Social dialogue is widely recognised as the principal and most effective means of resolving professional and workplace-related problems. When negotiations are unsatisfactory, unsuccessful or refused, national nurses’ associations have had to consider taking strong measures to bring about necessary change. The ICN Board of Directors approved the attached Strike Policy as a guide for possible future industrial action taken by nurses.

**Strike Policy**

**ICN Position:**
The International Council of Nurses (ICN) expects nurses to have equitable remuneration and acceptable working conditions, including a safe environment. As employees nurses have the right to organise, to bargain collectively, and to take strike action. ICN defines a strike as employees’ cessation of work or a refusal to work or to continue to work for the purpose of compelling an employer to agree to conditions of work that could not be achieved through negotiation. Strike action is considered the measure of last resort; to be taken only after all other possible means to conclude an agreement have been explored and utilised. Effective industrial action is compatible with being a health professional so long as essential services are provided. Abandonment of ill patients is inconsistent with the purpose and philosophy of professional nurses and their professional organisations as reflected in ICN's Code of Ethics for Nurses.

During a strike, the principles to be upheld include:
- The minimum level of disruption to the general public;
- The delivery of essential nursing services to a reduced patient population;
- Crisis intervention by nurses for the preservation of life;
- Ongoing nursing care to assure the survival of those unable to care for themselves;
- Nursing care required for therapeutic services without which life would be jeopardised;
- Nursing involvement necessary for urgent diagnostic procedures required to obtain information on potentially life-threatening conditions;
- Compliance with national/regional legislation as to procedure for implementation of strike action.
Nurses' right to take industrial action in the case of a breakdown of negotiations may only be curtailed if independent and impartial machinery such as mediation, conciliation and arbitration is established. National nurses' associations are responsible social partners and must develop training programmes that adequately prepare their representatives, nursing leaders and nurse employees in the practice of the various methods of negotiation as a means for resolving their employment concerns - i.e. conciliation, arbitration, collective bargaining - as appropriate in each country/province.

ICN provides technical support to NNAs addressing labour issues. National nurses' associations, as professional associations and/or trade unions, are affected by health sector strike action. They must therefore develop proactive policies and contingency processes as well as structures to guide their members' professional attitude and behaviour in such situations. Evaluations of strike actions (including the responsibility of main stakeholders) must be undertaken so that lessons learned may improve future negotiations. Furthermore, counselling services need to be available to address any strikerelated post-traumatic stress among the nurses involved.

ICN and NNAs recognise the potential strength of interdisciplinary partnerships within the health and social sectors during negotiations with public and private employers.

ICN and NNAs oppose the deliberate use of strike breakers, a practice that weakens the pressure for credible social dialogue.

**Background**

The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering. In certain cases, nurses may find themselves in situations where strike action is necessary to ensure the future delivery of quality care by qualified personnel.

While social dialogue is widely recognised as the principal and most effective means of resolving professional and workplace-related problems, frustrated employees may take industrial action in cases where the option of employer/employee negotiation has been unsatisfactory, unsuccessful or refused. Where deficiencies in the quality of working life and the economic rewards of nurses have become so serious as to affect the long-range prospects for maintaining high standards of nursing care, nurses may choose to take industrial action to bring about needed changes. In extreme situations, strikes have occurred and on occasion have resulted in wide public and intraprofessional debate.

Strike action maintaining essential services has been used successfully by professional trade unions in the past to initiate social dialogue, improve the
quality of care provided as well as the working conditions of nurses/health workers. A range of strike action is possible. "Selective strikes" have provided the necessary impact to advance negotiations while generating less disruption to patient care. In certain cases, token strikes (e.g. one hour demonstrations) may generate the impetus to initiate social dialogue. As an initial or complementary measure, strike action may include the cancellation of all elective interventions, a work-to-rule policy and/or the withdrawal of services involving non-nursing duties, e.g. domestic, clerical, portering, catering.

The negotiation and strike process needs to be evaluated in terms of its implementation and results, including the impact on stakeholders and social outcomes. Support required for the parties involved in each step of the action taken must be identified and provided (e.g. financial, emotional).

If strike action is taken, national/provincial legislation may determine the conditions under which such measures are implemented. Essential services are often based on evening/night shifts and weekend staffing ratios and protocols, commonly accepted levels of service.

Adopted in 1999
Related ICN Position:

Socio-economic Welfare of nurses

Footnotes and References


2 Workplace-related demonstration, manifestation or strike.

3 ILO Convention 151 Labour Relations (Public Service).

4 ICN Position Statement on Socio-economic Welfare of Nurses.

5 Individuals hired specifically to replace striking employees with a view to weakening the strike action.

6 ICN Code for Nurses.

7 A selective strike - where nurses from a determined number of hospitals/health services or departments within health care facilities stop working.

The International Council of Nurses is a federation of more than 120 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.
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Last June, more than 4600 nurses from every region of the world gathered in Copenhagen - Denmark to participate during the International Council of Nurses (ICN) 22nd Quadrennial Congress. The theme for the congress was Nursing - A New Era For Action. Proudly, the MUMN represented Malta for the first time as an ICN member country during this amazing and unforgettable Congress. As well this year, the MUMN attended the Council of National Representatives (CNR) business sessions that involves the decision making body of the ICN. It is good to know that the ICN has 124 member countries on 5 continents. The ICN works mainly focus on 3 directions that are to bring nursing together world wide, to advance nursing and nurses worldwide and to influence health policy. In fact, the ICN is recognized as a valued partner on a global level by governments and international agencies such as the WHO, UNESCO, UNICEF, World Medical Association, International Pharmaceutical Federation and International Labour Organization.

Since the era of worldwide changes are having an impact on the profession of nurses and midwives, our Union should think holistically and act by viewing the whole picture. These changes should be seen as challenge or opportunity rather than threat. Examples of these worldwide changes mainly are: the world wide health care sector reforms that are resulting in increased professional accountability and participation; increasing use of technology such as through telehealth and telemedicine; increasing ethical issues; increasing awareness of gender issues in health care and new health problems such as HIV/ AIDS. As professionals, we should lead these changes rather than resist them. During the ICN Congress, Dr Bertrand Piccard (the first round the world balloonist) stated that part of the science of life is based on drifting with the wind and accept the unknown rather than fight against it. Therefore, there is the need to think positively and creatively, learn new skills and set new goals to influence change correspondingly.

At the ICN Congress, nurses shared their knowledge and experience in more than 700 concurrent sessions with colleagues. Other highlights of the Congress included 90 symposia given by international health care experts and more than 650 posters were presented whereby two of the posters were presented by Maltese colleagues namely, Ms. Rose Spiteri and Ms. Donia Baldacchino.

This experience helped the MUMN to achieve two important elements. The first one is that nurses representing different countries have common needs/challenges and goals. Such as: the impact of the demographical changes on the health care services; the nursing shortage; the improvement of the socio-economic welfare of nurses and the recognition of nursing specializations. Secondarily, through sharing of knowledge and experiences our Union can learn from other countries as well can teach other countries even though we are small. For instance, during a CNR session, Malta was mentioned by Ms. Judith Oulton (ICN - Chief Executive Officer) as an example where joint venture strategy was attained by the ICN, PSI and MUMN to solve Mount Carmel Hospital industrial dispute related to staff deployment exercise.

To conclude, the MUMN congratulates to the new elected 24th ICN President - Ms. Christine Hancock a high success and achievement for the benefit of the world wide nursing.

More relevant information can be attained from the ICN website - www.icn.ch

Mary Ann Bugeja
FINANCIAL SECRETARY - MUMN
Kelmtejn mis-Segretarju Ġenerali

Bdejna nirrankaw ghall-hames snin oħra. Ahna bhala Ufficjali u Attivisti tal-Union ma ghandna nkunu kuntenti qatt, ghalix dejjem hemm x’takwista aktar u x’rirranga.

L-akbar tlett sfdi li nara llum quddiem kull Midwife u Nurse huma dawn:-

1. Li nżommu u nippriżervaw dak li f’dawn il-hames snin akkwistajna u rbaħna;

2. Li jkollna support staff adekwat f’ kull hin u livell;

3. Li niżviluppaw u ninfiltraw b’pass imgħaqġel fil-qasam ta’ l-ispecialisations u l-’conversion courses’;


Ma nistax ma nsemmix l-interess qawwi li din il-Union qed ikollha minn associations u unions tan-Nurses u Midwives barranin. Hafna qed isaqsu għall-informazzjoni fuq l-landament tal-professionijiet f’pajjiżna u saħansitra hemm talbiet sabiex jigu organizzati konferenzi hawn Malta. Dan juri li l-MUMN mhux biss qed tikber f’pajjiżna iżda qed ikollha wkoll għarfien internazzjonali b’mod konsistenti.


Nixtieq nawgura Milied hieni u Sena Ġdida mimlija b’dak kollu li tixtiequ, lilkom u ’l dawk viċin tagħkom.

Colin Galea
During our discussions in Brussels we tackled one of the main concerns for Nurses and Midwives and a concern which also affects directly mainly all workers on our Island. This is with what regards to chapter 2 regarding freedom of movement of workers in the member states of the European Union.

In all our meetings this point was discussed and we appreciated the comments shared and although it is most unlikely that migration of Nurses and Midwives will have a negative effect on our professions, no clear and definite answer was given. One has to keep in mind the size of our country, a country that has only 350,000 population. We were informed that in Luxembourg this migration of Nurses and Midwives did not create any problems.

Though at the Director General for social policy for the EU member states they do not deal with ‘problems’ but do answer questions, a common question was that of harmonisation of conditions for workers migrating from one member state to another. This Directorate is striving to see that all migrating workers get the same treatment when social status is concerned.

Back in Malta I happened to attend a meeting at the Foreign Affairs Ministry where the Minister for foreign affairs addressed MEUSAC participants (of which MUMN is a member) and tackled the negotiating position with regards to chapter 2. I have to admit, it was not of a surprise to hear that this issue is particularly sensitive, especially for a country whose gainfully occupied population totals just under 142,000 persons and that on accession, for a period of seven years Malta will put in place safeguard measures. Malta will retain its work permit system for EU nationals but shall issue permits automatically. Once again MUMN was concerned about an issue which the Maltese Government wants to safeguards.

When seven years pass, then Malta has to prepare itself, because directives like 68/360/EEC; 90/365/EEC; 74/194/EEC will have to be part of the regulations to be adopted. These give rights to all member states and vice versa. The EU member states have to abolish restrictions of movement and residence within the community for all Nurses/Midwives and their families. Moreover co-ordination of special measures justified on grounds of public policy, public security and public health, right for residence, application of social security schemes for Nurses/Midwives and their families must be seen to.

With regards to Nurses and Midwives in Malta our Union urges the Division of Health (or the future autonomous body to be responsible), to take the opportunity and create the necessary framework, take note that we are already late, do not wait for any seven years and start creating specialisation fields and standards for our Nurses and Midwives. In this country we need a culture-oriented mentality towards a joint effective effort to obtain the desired results.

My humble advice to all involved is ‘try to see things from the other person’s point of view’. This is the only formula that is needed at this particular time, it can be effective.
“Ghandi Bżonnok!”

Darba fost l-ohrajn, waqt li kont qed indur mal-morda biex inżurhom u nismaghjom, iltqajt ma incident kurjuż ħafna. Forsi tghiduli li qed naggibhom iżżejjed jew qed nagħmilhom bil-kbir. Fil-fatt, meta tara l-incident minn barra u ma tkunx int il-vittma, tahseb li kien xi incident banali.


Aħna rridu nħarsu, l-ewwelnett, lejn id-dinijità tagħna nfuṣna, ta’ shabna kollegi tagħna, u tal-pazjenti. Irridu nħarsu w nghinu lill-pazjenti mhux biss bil-medċina iżda anke bil-kliem u l-imġieba tagħna, fejn inkunu qed innaqsulhom aktar it-tensjoni li jkunu qed igħixu ġewwa l-isptar.


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‘Courses’ specjażalizzati

Barra li l-MUMN toffri assistenza trejdonjonistika issa wkoll qed torganizza ‘courses’ bil-ghan li tkompli tharreg ill-membri taghha. Ghal dan il-ghan filmkien ma l-Agenzija Sedqa organizzat ‘course’ ta’ kif ghandhom jiġju ttratati pazjenti milquta mill-vizzji tax-xorb jew drogi. Dan il-course kien success u diġa hemm diversi talbiet sabiex isir iehor is-sena diehla. kull minn hu interessat ghandu jčempel in-numru l-gdid tal-Union, 448542 u jistaqsi ghas-Sur Joe Zammit, Office Administrator tal-Union.

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Benefits of a Healthy Nursing Workplace

Research findings released in June confirm that Canada's nursing shortage is "at least in part due to a work environment that burns out the experienced and discourages new recruits". The report Commitment and Care: The Benefits of a healthy workplace for nurses, their patients and the system was authored by Dr Andrea Baumann and Dr Linda O'Brien-Pallas. Some recommendation highlights:

- Job satisfaction of nursing staff is a strong determinant of overall client satisfaction. Nurses' job satisfaction can be improved through manageable workloads and opportunities for nurses to balance work and home life.
- Nurses' absentee and disability rate is higher than that of almost any other profession. There is almost a perfect correlation between overtime and sick time.
- Nurses work best and have more loyalty to their employers when their expertise is respected and they are free to practice to the full scope of their education.
- Retaining staff is easier in a less stressful, more supportive workplace. Good relations on the care delivery team benefit patients and may even reduce death rates.
- Minimising staff turnover and letting nurses practice independently within a cooperative setting could go a long way to improving the work atmosphere.
- Nurses and employers need new ways of relating, including frequent, informal communication among hierarchical levels. SEW News

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Joe Camilleri jintervista lil Sr. Aldigonda Farrugia

■ X’kien l-ewwel xoghol tieghet?

L-ewwel xoghol tieghi kien l-Isptr San Luqa fejn niftakar anke l-inawgurazzjoni tieghi. Konna immorru fis-swali biex nghinu f’dak kollu li kien hemm bżonn peress li n-Nursing kien isir mis-sorijiet tal-Karità. Wara ftit mort nistudja Londra ghal sentejn fejn kont studjajt ghal SRN.

■ X’tiftakar mit-tieni gwerra dinjija?

Il-gwerra niftakarha sew u mhux l-ewwel darba li kien ikun hemm ‘air raid’ waqt li ahna konna nibqghu nahdmu. Konna nibżghu iżda ix-xoghol kien jibqa’ għaddej. Ġieli nizzilna fIx-'shelter li kellu St.Lukes’ u maghna konna nniżlu xi morda.

■ X’kienet il-hajja fl-iskola?


Curriculum Vitae ta’ Sister Aldegonda Farrugia, Soru tal-Karità


Spanish Nurses Suffering from Burnout

Public sector nurses are one of the professional groups most likely to be the victims of professional burnout. A recent study undertaken by the Institution of Public Administration has conferred that nurses are the most affected. This condition usually arises from a wide discrepancy between an individual’s professional expectations or ideals and the daily realities of their work life. The specific causes of burnout included:

- Overload of work.
- Constant dealing with illness and death.
- Rotating shifts? night shifts disturbing biological rhythms.
- Fear of contagion or exposure due to poor occupational health and safety measures.
- Frequent use of casual or temporary work contracts.
- Stress dealing with family as well as professional responsibilities.
- Unhealthy work climate, e.g. bureaucracy, lack of autonomy, rigid management hierarchy.
- High technical competence while failing to provide training in psychosocial aspects of providing nursing care.

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What is Constipation?

Constipation is passage of small amounts of hard, dry bowel movements, usually less than three times a week. People who are constipated may find it difficult and painful to have a bowel movement. Other symptoms of constipation include feeling bloated, uncomfortable, and sluggish.

Many people think they are constipated when, in fact, their bowel movements are regular. For example, some believe they are constipated, or irregular, if they do not have a bowel movement every day. However, there is no right number of daily or weekly bowel movements. Normal may be three times a day or three times a week depending on the person. In addition, some people naturally have firmer stools than others.

At one time or another almost everyone gets constipated. Poor diet and lack of exercise are usually the causes. In most cases, constipation is temporary and not serious. Understanding causes, prevention, and treatment will help most people find relief.

What Causes Constipation?

To understand constipation, it helps to know how the colon (large intestine) works. As food moves through it, the colon absorbs water while forming waste products, or stool. Muscle contractions in the colon push the stool toward the rectum. By the time stool reaches the rectum, it is solid because most of the water has been absorbed. The hard and dry stools of constipation occur when the colon absorbs too much water. This happens because the colon's muscle contractions are slow or sluggish, causing the stool to move through the colon too slowly.

Diet

The most common cause of constipation is a diet low in fiber found in vegetables, fruits, and whole grains and high in fats found in cheese, eggs, and meats. People who eat plenty of high-fiber foods are less likely to become constipated.

Fiber - soluble and insoluble - is the part of fruits, vegetables, and grains that the body cannot digest. Soluble fiber dissolves easily in water and takes on a soft, gel-like texture in the intestines. Insoluble fiber passes almost unchanged through the intestines. The bulk and soft texture of fiber helps prevent hard, dry stools that are difficult to pass. The American Dietetic Association recommends an average intake of 20 - 35 grams of fiber daily, however both children and adults eat too many refined and processed foods in which the natural fiber is removed.

Not Enough Liquids

Some gastroenterologists believe that low fluid intake is the major cause of constipation and its related consequences. Liquids like water and juice add fluid to the colon and bulk to stools, making bowel movements softer and easier to pass. People who have problems with constipation should drink enough of these liquids every day, a minimum of 2 litres. Other liquids, like coffee and soft drinks, which contain caffeine, seem to have a dehydration effect.
Lack of Exercise
This can also lead to constipation, and although doctors do not know precisely why, we know it occurs after accidents or during an illness when one must stay in bed and cannot exercise.

Medications
Pain medications (especially narcotics), antacids that contain aluminium, antispasmodics, antidepressants, iron supplements, diuretics, and anticonvulsants for epilepsy can slow passage of bowel movements.

Irritable Bowel Syndrome (IBS)
Some people with IBS, also known as spastic colon, have spasms in the colon that affects bowel movements. Constipation and diarrhoea often alternate, and abdominal cramping, gassiness, and bloating are other common complaints. It often worsens with stress, but there is no specific cause or anything unusual that the doctor can see in the colon.

Other causes of constipation are changes in life or routine like pregnancy, aging and travelling. Abuse of laxatives and ignoring bowel movement urges are also common causes that lead to constipation. Diabetes, under active or overactive thyroid gland, stroke, spinal cord injuries, parkinson’s disease and multiple sclerosis are the most common disorders that have constipation as one of their side-effects.

What Diagnostic Tests are Used?
Most people do not need extensive testing and can be treated with changes in diet and exercise. The tests performed depend on the duration and severity of the constipation, the person’s age, and whether there is blood in the stools, recent changes in bowel movements, or weight loss. A medical history is always taken and a physical examination is performed. If not enough data is collected to confirm cause if constipation, extensive tests are always available; namely Barium Enema x-ray, colorectal transit studies, or better, a sigmoidoscopy or colonoscopy.

Can Constipation Be Serious?
Sometimes constipation can lead to complications, like haemorrhoids that are caused by the straining to have a bowel movement. Anal fissures (tears in the skin around the anus) are caused when hard stools stretch the sphincter muscle. Sometimes straining can be so extensive that a small amount of intestinal lining can prolapse and may lead to secretion of mucus and/or blood from the anus. Usually eliminating the cause is enough to treat the problem, however sometimes the prolapse would need surgical intervention to strengthen and tighten the anal sphincter muscle.

Points to Remember
- The most common causes of constipation are poor diet, low fluid and lack of exercise.
- Additional causes include medications, irritable bowel syndrome, abuse of laxatives and specific diseases.
- A medical history and physical examination may be the only diagnostic tests needed before any treatment.
- In most cases: by eating a well-balanced, high fiber diet that includes beans, bran, whole grains, fresh fruits, and vegetables, drinking plenty of fluids and exercising regularly is enough.
- Set aside time (preferably after breakfast or dinner) for undisturbed visits to the toilet
- Do not ignore the urge to have a bowel movement.
- Understand that normal bowel habits vary.
- Whenever a significant or prolonged change in bowel habits occurs, do a medical check-up.
- Most people with mild constipation do not need laxatives. However, the doctors may recommend laxatives for a limited time for people with chronic constipation.
**Antenatal Care – The Midwives Role?**

A midwife is a person who is qualified to take professional responsibility and to provide care as an autonomous practitioner for the mother during antenatal, intranatal and postnatal periods and for the neonates. ENB cited by Jones (1994).

However, MacDonald (1991) said that there is no doubt that many midwives are under-utilised in relation to their clinical status, experience and competence. Many midwives question their current role. Increasingly, there is an eagerness among midwives to adopt an active stance and reassert their traditional place in obstetric care.

An example is about the care given during the antenatal period. In the UK antenatal care is performed by a range of health professionals, but in many areas up to 70% of this care is given by midwives. Chamberlain (1992).

On reviewing the research about antenatal care, the need for change in our island is more obvious when obstetricians and doctors are the health professionals who provide total antenatal care.

The Royal College of Obstetrics and Gynaecology cited by Ranjan (1993) stated that if the best possible care is to be achieved, there should be a great involvement of consultant Obstetricians in pregnancy and childbirth.

In many studies done, it is found that even though practical guidelines at a local level are not impossible to achieve, the dividing line between obstetrics and midwifery will always be blurred and indistinct.

In other countries, the midwifery staff are fully autonomous in their job, as opposed to the Maltese counterparts. However, according to Tawler & Bramall (1986), the midwives role changed, because they accepted doctors' involvement without protest. Midwives uncomplainingly accepted the subservient role alongside the doctors who supervised their practice.

There is a general assumption that women
benefit from receiving antenatal care, but current service often fail to meet the women's real needs and is a waste of both human and financial resources.

Infact, expectant mothers are becoming more aware of the type and quality of care they need and therefore expect this care during pregnancy, delivery and pureperium. They have high expectations of receiving information, advice and reassurance, but in reality they frequently complain of lack of information, lack of or conflicting advice and anxiety.

Clients should be presented with a better type of midwifery service, than the fragmented type of care they have been given so far. (Ranjan 1993)

The potential for health care workers to make the childbearing experience a positive and enriching time for the women and their families is often not realised.

A factor that inhibits change is that antenatally the health care team is made up of few midwives. This lack of midwifery staff is making it more unlikely that midwives take their role as lead professionals in normal pregnancy.

In a study done by Sikorski et al (1995) on professionals' views on changes in antenatal care, they found that midwives were the group most keen to see change whilst general practitioners were the least.

This is also what has been happening in our island as the General practitioner is the first health care professional, to be in contact with the pregnant women, and also the one who confirms the pregnancy. The latter worsens the situation as the general practitioner is more likely to reduce the primary care role achieved in the provision of antenatal care. Also, he might refer the woman for the hospital booking visit much later in pregnancy, which even if continuity of carer can be provided, this will be restricted.

Team Midwifery is the solution which enhances continuity of carer. Team Midwifery is the only option for those Midwives who feel increasingly powerless and demoralised in their profession because they have found it difficult to provide maternity care that women deserve. (EMG) The Expert Maternity Group (1993).

Team Midwifery was provided on our Island between 1996 till 1999 beside one year of the preliminary study. however this service was stopped suddenly without any valid reason whatsoever.

Women who were chosen were those of the low risk group, and the final decision of whether they were seen by this team was always that of the consultant obstetrician.

The latter happens because there are no protocols available to show exactly what midwives can practice without any obstetric help or interventions. The only protocol available in the maternity units of Karen Grech Hospital, is at the delivery suite, where what is written and what is practised is very different.

If changes in providing care are to be made, they have to be well planned so that when, implementing the necessary change, repercussions on both deliverers and consumers of health care are minimal. The need for change to be planned accurately is that the consequences will ultimately effect all the staff whether interested in change or not.

Luciana Xuereb

Midwife

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It-Tfal, l-Isports u l-Basketball


F’Malta jintlaghub 5 kompetizzjoni lokali- Super Cup, MBA Shield, Louis Borg Cup, K.O. u l-kampjonat- l-ahhar tazza mportanti. Ghalhekk sabiex tara l-eċċitament tal-loghba, waqt il-hin liberu tiegeneh mal-Hadd (sakemm ma tkunx xoghol) wara nofsinhar asal wasla sal- Padiljun Nazzjonali f’Ta Qali (h dejn il- ‘ground’ Nazzjonali) u segwi xi loghba li tkun għaddjejn.

Jekk ghandek jew taf xi tfal li jixtiequ jilghabu l-basketball (età bejn 8 u 14- il sena) għidilhom li ghada kif twaqqaf skola ‘XL Basketball School’. Is-sessjonijiet isiru kull nhar ta’ Sibt bejn l-8 u l-10 am u nofsinhar gewwa l-Verdala International School-Pembroke. Din l-iskola toffri xejn aktar minn taghlim, divertiment u tahir ġwar il-basketball.

Grazzi ghall-MUMN, fl-okkażjoni tat-5 anniversarju mit-twaqqaf taghha minflok il-prezz ta’ Lm25, it-tfal tal-membri jħallsu Lm20 kull term.

Ghal aktar tagħrif ġempel fuq 419436 jew 09466723.

Doreen Cassar - MIDWIFE
### Nurse Patient Ratios

California passed a law, the first in the USA, requiring minimum hospital staffing standards in 1999. The Department of Health Services is due to declare proposed ratios in September and be implemented by 1 January 2002.

In a landmark labour-management cooperation, Kaiser Permanente, the state's largest healthcare employer, has endorsed the nurse-to-patient ratio plan proposed by a coalition of nurses' unions. The ratio proposed by the California Nurses Association for medical/surgical units is one nurse for every three patients. The Kaiser/union proposal is one to four. Both of these ratios are far lower than those proposed by the hospital industry, i.e. 1 to 10! The negotiation will need to be closely monitored, as the final ratio may become a standard for other countries as well as other states. In 2000 the Victorian Branch of the Australian Nursing Federation (ANF) was due to negotiate another Enterprise Agreement on behalf of the 20,000 equivalent full-time nurses working in the State's public hospitals. The ANF submitted a wage and conditions claim, which emphasised the need to control patient workloads via mandated nurse-to-patient ratios. As a consequence of the nurses' bans, over 1000 beds across the system were closed. The Victorian Government requested arbitation by the Australian Industrial Relations Commission. Hospital management and the ANF agreed to this. The Commissioner subsequently mandated the implementation of nurse/patient ratios from 1 December 2000. Despite its initial concern, the Government provided approximately A$7 million in support of implementation of the agreement, which also included measures to support the recruitment and retention of nurses (e.g. increase in salary, more study leave, increase night duty allowances, increased automatic increment, improved paid maternity/paternity leave, overtime and rostering patterns. Etc.). Anecdotal evidence shows a reduction in staff turnover, reduction in sick leave, increase in nurses' morale, and a potential for a Victorian nursing workforce that is stable and sufficient in numbers.

Examples of the nurse patient ratios applied on dayshifts are:

- **Medical/surgical wards:**
  - Group A hospitals: 1:4+In charge
  - Group B: 1:5+In charge

- **Accident/Emergency:** 1:3 +In charge + Triage

- **Labour Wards:** 1:1

- **Ante/Post natal:** 1:4+In charge

- **Operating Rooms:**
  - General cases: 3 nurses per theatre,
  - Complex cases: 4

- **High Dependency Unit:** 1:2+In charge

- **Palliative Care:** 1:4+In Charge

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God's Mercy
In the beginning God made man;
But man could not live alone
so God made him a mate.
God blessed them both
and saw that their needs were fulfilled.
Mankind was foolish
and sinned against God.
Now man must toil through life;
he must taste the bitterness of life;
he must see his woman suffer to bear his child
and he will suffer with her.
But God was kind in his judgement.
He allowed that the woman would have help in her agony;
that she would have someone beside her to answer to her needs;
someone who would ensure her safety and that of her child;
someone who would ensure the final triumph;
someone who would be the first to witness the miracle of creation;
someone who would be the instrument in God's hands,
who would show His greatness to all the world,
who would praise Him through her work.
Thus was the midwife conceived,
and God was pleased with her
and blessed her.

Jean Vanier
(The Broken Body)
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