A HISTORICAL SURVEY
OF THE LEGISLATION
THAT REGULATES
NURSE REGISTRATION
IN MALTA

by

Lawrence Bonavia

A thesis submitted in partial fulfilment
of the requirements for the degree of

Masters (Honours) in Nursing and
Midwifery Studies

University of Malta

2007
Declaration

I hereby declare that I have carried out this research study and this is entirely my work.

Lawrence Bonavia
UNIVERSITY OF MALTA

ABSTRACT

A historical survey of the Legislation that regulates Nurse Registration in Malta

by Lawrence Bonavia

This thesis aims at presenting a detailed historical-legal narrative on the transformation of the legislation that regulates nurse registration in Malta. This was primarily done by evaluating the various laws that were enacted over the years and the amendments made to such laws. It was done to analyse how nursing regulation has changed over the years and what might have influenced such changes.

The philosophical background to this study is Foucault’s power/knowledge theory which briefly states that power is related to knowledge. So as to relate the study with this philosophy I tried to relate local advancements in nurse education with the changing legal status of nursing and nurses. It is indicated that as nurse education progressed so did the legal status of nursing but there is still more that has to be done. This is in the light that nursing has traditionally been a female based profession under the influence and control of a male dominated profession, medicine.
Up until 1964, the various regulations that were made to regulate nursing seem to have been strongly influenced by the circumstantial needs of the various conquerors of Malta. A prime mover could have been the war experiences that necessitated the provision of state of the art nursing services to the war casualties. Other legislative changes can be attributed to other factors such as the changing political climate in Malta and finally Malta's entry into the European Union. One can notice that with every significant political event that has happened since 1936, the legislation that regulates nurse registration has been amended or changed. The last significant change being in 2003 when the Health Care Professions Act was enacted. In this dissertation, various other historical facts are presented.

The dissertation concludes with various recommendations that can help to increase the knowledge base of nursing as a profession, the knowledge of individual nurse practitioners and the knowledge of the general public about nursing. This is important so that the discourses about nursing will change thus it will affect how nurses and nursing are viewed by the public in general. A change which might mean greater power to the nursing profession because it is more knowledgeable and thus have greater credibility in the eyes of the general public.
# TABLE OF CONTENTS

**Table of Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgments</td>
<td>iii</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>v</td>
</tr>
<tr>
<td>Chapter 1 - Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Problem</td>
<td>2</td>
</tr>
<tr>
<td>Background</td>
<td>3</td>
</tr>
<tr>
<td>Justification</td>
<td>3</td>
</tr>
<tr>
<td>Method</td>
<td>4</td>
</tr>
<tr>
<td>Questions that have to be answered</td>
<td>5</td>
</tr>
<tr>
<td>Study structure</td>
<td>6</td>
</tr>
<tr>
<td>Conclusion</td>
<td>7</td>
</tr>
<tr>
<td>Chapter 2 - Literature Review</td>
<td>8</td>
</tr>
<tr>
<td>Power</td>
<td>8</td>
</tr>
<tr>
<td>Knowledge</td>
<td>10</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>11</td>
</tr>
<tr>
<td>Power/conflict</td>
<td>15</td>
</tr>
<tr>
<td>Nursing</td>
<td>17</td>
</tr>
<tr>
<td>Professions</td>
<td>20</td>
</tr>
<tr>
<td>Professional regulation</td>
<td>23</td>
</tr>
<tr>
<td>Feminism</td>
<td>25</td>
</tr>
<tr>
<td>Conclusion</td>
<td>26</td>
</tr>
<tr>
<td>Chapter 3 - Methods and Procedure</td>
<td>29</td>
</tr>
<tr>
<td>Definition</td>
<td>31</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>31</td>
</tr>
<tr>
<td>Time scale and plan of work</td>
<td>33</td>
</tr>
<tr>
<td>Reference Material</td>
<td>34</td>
</tr>
<tr>
<td>Criticism of the data</td>
<td>36</td>
</tr>
<tr>
<td>Interpreting and relating the findings</td>
<td>38</td>
</tr>
<tr>
<td>Research Journal</td>
<td>39</td>
</tr>
<tr>
<td>Limitations</td>
<td>40</td>
</tr>
<tr>
<td>Chapter 4 - Historical Review</td>
<td>42</td>
</tr>
<tr>
<td>The period of the Knight Hospitallers</td>
<td>43</td>
</tr>
<tr>
<td>The Early British period</td>
<td>48</td>
</tr>
<tr>
<td>European Union</td>
<td>51</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>56</td>
</tr>
<tr>
<td>The United States of America (U.S.A.)</td>
<td>59</td>
</tr>
<tr>
<td>New Zealand</td>
<td>60</td>
</tr>
<tr>
<td>Conclusion</td>
<td>60</td>
</tr>
<tr>
<td>Chapter 5 - Nurse Registration legislation in Malta</td>
<td>62</td>
</tr>
</tbody>
</table>
The early 20th century .................................................................................................. 63  
World War I ............................................................................................................. 69  
Post-World War II .................................................................................................. 76  
Post independence ................................................................................................ 81  
The Republic ......................................................................................................... 85  
The Health Care Professions Act ......................................................................... 94

**Chapter 6 - Discussion** ......................................................................................... 101  
The beginnings ...................................................................................................... 102  
Regulation ............................................................................................................. 103  
Political involvement ......................................................................................... 105  
Problems ................................................................................................................ 110  
Mobility ................................................................................................................... 111  
Ensuring competence ......................................................................................... 114  
Education .............................................................................................................. 117  
Other initiatives ................................................................................................... 120  
Archives ................................................................................................................ 121  
Conclusion ............................................................................................................ 122

**Chapter 7 - Conclusion and recommendations** .............................................. 124  
Recommendations for practice ........................................................................... 124  
Recommendations for education .......................................................................... 125  
Recommendations for research ........................................................................... 126  
Concluding remarks ............................................................................................. 126

**References** ...................................................................................................... 129
ACKNOWLEDGMENTS

The author wishes to thank heartily Dr. R. Mangion BA (Communication Stds. & Literature), MA (history), LL.D., D. Phil (Oxon), my supervisor, for his impeccable assistance, support, and professional guidance.

Over the course of working on this dissertation, I have incurred many debts. I am at a loss of words so as to be able to thank all those who provided institutional, financial, intellectual and emotional support, nonetheless I want to acknowledge my gratitude to all those who helped make this dissertation possible. I wish to thank all those who historically participated in the development of nursing for if it was not for them I would have been at a loss. I would also like to thank the library staff at the various libraries and archives from which I have sought material.

I am also in debt with the staff at various depositories who helped me in the documentary search. Staff without whose help I would have been at a loss. I would also like to thank Magistrate Dr. J. Cassar who helped me in a number of ways. Heartfelt thanks also go to the Hon. Mario Galea, who helped me in making the necessary contacts at the House of Representatives and also helped me find some of the necessary material.
I would like to thank also my colleagues in the MSc course, all those involved in the running of the course, my work colleagues for bearing my regular absences from work and the Department for sponsoring my attendance to the course.

Finally I would like to thank my wife Claire and my sons Andrea, Luigi and Giovanni Luca for their constant support.
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGMO</td>
<td>Chief Government Medical Officer</td>
</tr>
<tr>
<td>DCG</td>
<td>Debates of the Council of Government</td>
</tr>
<tr>
<td>DHR</td>
<td>Debates of the House of Representatives</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>GN</td>
<td>Government Notice</td>
</tr>
<tr>
<td>MCG</td>
<td>Maltese Council of Government</td>
</tr>
<tr>
<td>MGG</td>
<td>Malta Government Gazette</td>
</tr>
<tr>
<td>MGG Supp</td>
<td>Malta Government Gazette Supplement</td>
</tr>
<tr>
<td>UKCC</td>
<td>United Kingdom Central Council for Nursing, Midwifery and</td>
</tr>
<tr>
<td></td>
<td>Health Visiting</td>
</tr>
</tbody>
</table>
CHAPTER 1 –

INTRODUCTION

The development of technologies and practices for the care of the sick moved with the establishment of hospitals as part of pious Christian practice in the 4th century (Nelson, 1995). According to Cassar (1964), the first hospital founded in Malta was the Santo Spirito Hospital and the presence of nurses at this hospital is reported in the manuscript records of the apostolic visit of Monsignor Tommaso Gargallo in 1599.

Reforms in the medical, social, and economic sectors as well as in nursing itself certainly left a mark on nursing and how nurses came to be viewed by other professions and society. Nursing has moved from a profession for destitute women to a profession with a university-based education. Given that nursing is a female oriented profession, escalation in its standing could also be ascribed to the recognition of the contribution of females to society in general. Another factor could also be the influx of male nurses into the profession thus eliminating the view that nursing is solely a profession for females, and making it appear in a different light in the eyes of society at large thus helping
it to gain more credibility. Another contributing factor might be the increase of nurses working in an autonomous setting which depicts them more as professional practitioners independent from doctors rather than being their handmaidens.

Problem
The main purpose of this historical enquiry is to document the progress made over the years in legislation governing nurse registration in Malta. This study will be mainly based on a survey of the various amendments made by the local legislature with relevant reference to discourses made during the debates when legalisations and relevant amendments were enacted.

The Health Care Professions Act of 2003 today regulates Nurse Registration in Malta. This has replaced the Medical and Kindred Professions Ordinance of 1901, an Ordinance that was amended a large number of times in line with the signs of progress that nursing and Malta has endured during the last hundred years.
Background
The author has been interested in the development of nursing in Malta for a long time. He was mainly motivated from his past involvement in the Nursing and Midwifery Board, now replaced by the Council for Nurses and Midwives. This involvement made the author more conscious of the laws that regulate nursing and developments in them during the period that he was a member on this regulatory body.

In the course of his membership of this board, the author noticed that the relevant enactments that regulate nurse registration in Malta are quite complex. Following these instincts, the author discussed his interest with various people and finally with his supervisor. Here he confirmed that the history of nursing in Malta is very complex and very little has been written about it. Thus, this dissertation will be focusing on milestones in the annals of nursing in Malta, focusing on the issues surrounding this evolutionary process in legislative terms. I hope that this study will lay a foundation for further research and writings about the history of nursing in Malta.

Justification
The author feels that this study is justified for a variety of reasons. First, no local similar studies were identified, so this study can help in shedding light on
the local developments in nursing and be the basis for further more elaborated research. Another reason is that nursing in Malta is more closely related to the State than the private sector because it is regulated by the State and by a Council set up by primary legislation as well as the major part of the nurses in Malta are State employees.

An understanding of nursing history may provide insights that can contribute to effective approaches to the understanding of current professional issues. The history of nursing will be seen against a wider historical background. The author hopes that this piece of research will help to fill a void that exists owing to a lack of local research on the subject matter. It is also hoped that this study will help others to gain understanding and some insight into the history of nursing in Malta.

Method
This study will concentrate on the reading and treatment of legislation and some of the reports of parliamentary debates that were held when such legislative changes were being discussed. Therefore, this is what is known as a documentary analysis. According to Burns and Grove (1999), this method is good for nurses to examine phenomena in both the recent and the more distant past.
For the purposes of this study, the chronological rather than the thematic approach will be adopted. This has been adopted to help the reader to understand the sequence of events more. Reference is also made to the local legislative system. Influences outside the legislative processes are also pinpointed. This also helped the researcher to evaluate historical events. This evaluation was done both through the main text and in the discussion part.

Questions that have to be answered
The main aim of this study is to analyse facts that have led to subsequent changes in legislation concerning Nurse Registration. The facts stem from the reasons mentioned during the said debates, from the political climate of the time and from the legislative amendments. The main aim of this historical research is not to test theories but to try to derive facts stemming out of this analysis. Therefore, the main objectives of this study are to answer questions such as:

- When was the first enactment regulating nurse registration locally enacted?
- When were amendments to such legislation enacted?
What views did the various members of the Legislature express during the debates?

Study structure
First, there is the introductory chapter, which is followed by the literature review. In the literature review, the development of nursing and how the definition of nursing evolved from the times of Florence Nightingale will be outlined. Chapter 2 will also include the philosophical background to this research study and an overview of the sociology of professions and other issues related to this dissertation. Chapter 3 is concerned with the methods and procedures used.

Chapter 4 will be a historical review on various matters that are directly related to nurse regulation. First, a brief history of local regulation of medicine and allied professions than the developments within the European Union and the United Kingdom will be explained because they are relevant to this study.

The next chapter is the findings chapter, which will give a historical survey of the relevant Legislation from the beginning of the twentieth century and any important events that might have left an impact on such legislation. Then there is the discussion chapter and finally the concluding chapter. In the first of these chapters, the findings will be discussed and in the final chapter, a list
of recommendations will be made. The final part of this study will be composed of the reference list.

**Conclusion**

Nurses have always been an integral part of health care systems. Therefore, such a historical study may also be a contribution towards research about Maltese health care in general and its development thought the last century. These developments may be partly attributed to the social, economic, and political developments in Malta. It may also be a reflection of the development that nursing has undergone, both at national and at international level.
CHAPTER 2 - LITERATURE REVIEW

To aim of this literature review is to explain the theoretical framework for this dissertation. For the purposes of this dissertation various philosophical backgrounds could have been used. It was decided to use Foucault’s theory because I think that nursing developed as a profession mainly because of how the members of this profession developed into knowledgeable doers. Therefore an overview of Foucault’s theory and various other theories that are considered to have an impact on this study will be given. A brief outline of how nursing evolved throughout the years together with various definitions of the concept of “nursing” will follow.

Power
Sociologists usually define power as the ability to impose one's will on others, even if those others resist it in some way or another (Giddens, 1993). This imposition need not involve coercion, which is force or threat of force. Most of the traditional ideas of power originated with Francis Bacon who said that
knowledge is power. Bacon argued that the only knowledge of importance to
man was empirically rooted in the natural world, and that a clear system of
scientific inquiry would assure man’s mastery over the world (Giddens, 1993).

On the contrary, Foucault asserts a new model of the relations of power and
knowledge that he called “power/knowledge”.

According to French and Raven (1968) the various types of power are: reward
power, coercive power, referent power, legitimate power, and expert power.

Foucault (1980) differentiated between sovereign and disciplinary power. He
said that power is obtained through panoptic surveillance, normalising
judgement, homogenisation, individualisation, and knowledge, all of which
define the truth.

Foucault emphasises the subtle nature of power as being distinct from violence
or force. For Foucault, power is inextricably connected with knowledge in
that “power produces knowledge; .............. that power and knowledge
imply one another.” (Foucault, 1977: p.77). Thus “power” in the sociological
sense subsumes both physical and political power. In some ways one can say
that it closely resembles what is commonly referred to as influence.
Knowledge

Nursing has mainly evolved into a distinct discipline through the development of clinical knowledge and skills, the application of knowledge from other disciplines and nursing specific research and enquiry. Nursing involves various ways of knowing and Carper (1978) suggested that there are four types of knowledge in nursing: empirics, ethics, aesthetics and personal knowledge. According to Foucault (1982) knowledge production centres on two key questions: who we are? and how we live? That is, who are we as a profession and how should we act to be seen as a profession distinct from others.

According to Meleis (1997), the professional’s knowledge base includes some knowledge that is shared with other people, but also includes discipline specific knowledge about the particular conditions or problems, which constitute the discipline’s phenomena of concern and the particular interventions that can be used to overcome them. This is the profession’s particular domain – the profession’s particular expertise, or what they know about it. Identifying and defining nursing specific knowledge is important to make it distinct from other professions and give it credibility.
Theoretical framework
Michel Foucault, a Frenchman, was born on October 15th 1926 and died on June 26th 1984. Foucault is known for his critique of various social institutions, most notably psychiatry, medicine, and the prison system, and for his theories on the history of sexuality. In his book, the birth of a clinic, Foucault (1973) argues that there exists a relationship between certain medical discourses and the exercise of power in society. His general theories concerning power and the relationship between power and knowledge, as well as his ideas concerning 'discourse' in relation to the history of Western thought, have been widely discussed and applied (Best & Kellner, 1991).

Foucault has demystified power. Foucault’s analysis states that power is situated among a great number of social practices and situations. Foucault believed that power is fluid and flows from discourse and is usually done by using systems of talk that are limited by the particulars of the discipline they inhabit (Foucault, 1980). Foucault’s idea of discourse shows historical specific relationships between disciplines (bodies of knowledge) and disciplinary practices (forms of social control and social possibilities) (Foucault, 1995). Thus, he interprets the changes in the nature of power and knowledge.

He believes that humans are conditioned by discourse that is, how we talk, how we formulate knowledge, and where we look up to for knowledge. Such
discourses are at times interpreted in legislation (Best and Kellner, 1991) and it is only through the understanding of such discourses that nursing can challenge it status quo.

Power is a relationship between different forces. The operation of power is defined by the ways in which one force may effect, or be affected by another force. Discursive practices first create the realities and the subjects of which they speak and than, through ‘dividing practices’, subjects are categorised, divided and confined according to their perceived differences from others (Foucault, 1977). In this way, not only individuals are divided into categories, but are also encouraged to identify themselves in the same way. Foucault claims belief systems gain momentum (and hence power) as more people come to accept the particular views associated with that belief system as common knowledge (Ransom, 1997). Moreover, “all ideas are historically variable, but....... Some concepts and ideas have come to be so widely accepted that they are taken as true.” (Smith 1998: P. 288). Allen (1999) who stated that having knowledge is having the privilege that one can make statements that cannot be challenged for they are assumed to be a reflection of the truth corroborated this.

Foucault is also concerned with the historical process of how do human beings construct themselves as subjects. According to Allen (1999), there is a
reciprocal, mutually reinforcing relationship between the circulation of knowledge and subsequently the control of conduct. Thus power and knowledge are reciprocally related, the greater the knowledge the greater the power one has and the greater the power the more knowledge one can obtain or is perceived to have. This could be a reason why certain professions tend to use a lot of professional jargon so that people from outside the profession will not understand their discourses thus retaining some form of control over their clients. This subtle form of power lacks rigidity, and other discourses can contest it. Thus, discourses of power may lead to discourses of resistance.

Foucault outlines a form of covert power that works through people rather than only on them (Ransom, 1997). Foucault (1980; p.122) said that

"Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowance for the concept’s complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it."

Foucault (1980, p.25) said that in Western societies since the Middle Ages, "the exercise of power has always been formulated in terms of law". This helps to give sole and absolute power to those who are knowledgeable in a certain field. Having specialist knowledge in a unique discourse allows a
doctor to have unique power and control. The doctor has power to diagnose a condition, and because the person belongs to this specialist discourse, his word is considered authoritative and "true." Hence, they have absolute power.

In other areas, power can be less tangible. If one makes a statement and it is taken for granted that it is true, this statement becomes the accepted reality, and thus it becomes a form of knowledge thus leading to a discourse. An example of such a power can be seen in the media. A number of statements or images portrayed by the media are taken as a true reflection of society. Thus, the reality and the discourse become what the media tries to portray or portrays to the watching public at that particular instance in time. Thus, this statement becomes power when those who believe it transmit it to others as a reflection of reality.

Habermas (1987) in The Philosophical Discourse of Modernity criticises Foucault’s theory of power as over generalising and universalising and as reductionistic and contradictory in its role as a concept of empirical analysis. According to Habermas (1987), Foucault faces two problematic areas of self-referentiality: epistemology (through the concepts of truth, knowledge, and objectivity) and value claims (not value free) he also criticised Foucault for not giving a good basis for a social critique of power (Ransom, 1997). This was
also the argument brought by Purvis and Hunt (1993), where they argued that Foucault’s work lacks depth and so is not a true reflection of how power acts.

Marxists criticise Foucault for excluding class-related power. According to Johnson (1972), from the Marxist perspective, professions form an institutionalised form of client control. Abbott and Wallace (1990) stated that clients are often distanced from their advisers by social class, ethnicity, and educational background or by gender, and Foucault is criticised that he only considers knowledge as the limiting factor. Other writers criticise Foucault for the constraints of language, also because he does not take in consideration feminist issues (Best & Kellner, 1991).

I tend to see Foucault’s concept of power as something that empowers the individuals or individual groups within society. The fact that he creates a revolutionary concept of power, power that is widespread and multidimensional, makes it easier for individuals to utilise it in a multiplicity of ways. It also leaves space for a number of variables, thus all influencing variables can be taken into account.

**Power/conflict**

Foucault (1980) said that modernity proposes an opposition between power and truth. Organisations are microcosms of conflict in society, there are
conflicts between different genders, religions, classes etc. "Typically, conflicts are based upon differences in interest and values, when the interests of one party come up against the different interests of another." (Huczynski & Buchanan, 2001: p. 770). Best and Keller (1991) said that such conflicts might also arise from different interpretations of the truth. Foucault emphasises the issue of resistance and claims that "as soon as there is a power relation there is possibly resistance" (Foucault, 1990: p. 123). This is because "power is only exercised over free subjects and only insofar as they are free." (Foucault, 1982: p. 221).

Free subjects are thinkers and they can air their views, so at one moment in time there can be a multiplicity of discourses in existence thus leading to resistance that is only made possible by power. Power whose strength and form may differ between individuals or groups in society. In line with his, Foucault (1986: p. 46) calls upon us to "separate out, from the contingency that has made us what we are, the possibility of no longer, being, doing or thinking what we are, do or think". This could be enhanced by encouraging others to take up the 'critical ontology of self':

"the work of an intellectual is not to shape others' political will; it is, through the analyses that he carries out in his own field, to question over and over again what is postulated as self-evident, to disturb people's mental habits, the way they do and think things, to dissipate what is familiar and accepted, to re-examine rules and institutions...." (Foucault, 1990: p. 265).
This can be done by identifying the power effects of various discourses (Foucault, 1973 & Foucault, 1977). Foucault (1986: p. 343) goes on to state that

"my point is not that everything is bad, but that everything is dangerous, which is not exactly the same thing as bad. If everything is dangerous, than we always have something to do. So my position leads not to apathy but to hyper- and pessimistic activism".

Such activism might give rise to resistance and subsequently change.

Nursing
The general upheaval in the early 19th century, which emanated partly from the French revolution that condemned slavery and partly from the industrialisation and urbanisation of English society, led to the prohibition of the exploitation of servants (Abbott & Wallace, 1990). Due to this, household duties and the caring activities previously carried out by servants were devolved onto nurses (Denny, 1997). At present nursing is one of the leading sought-after professions in the healthcare field for the reason than nearly everyone who profits from any heath care service will appropriate from the services provided by a nurse (Rider Ellis & Love Hartley, 2004).

Over the years, in modern society, nursing evolved, as have many other professions that contribute to better care delivery. This is attested by various
definitions of nursing that have been published throughout the years. This evolution of nursing is an ongoing process, since compared to the established professions; nursing is a relatively new profession (Rider Ellis & Love Hartley, 2004). Owing to this continuous evolution, it may be too restrictive on the development of the profession to have a rigid definition. Another reason, which makes it difficult to accept a strict definition of nursing, is that nursing is very diverse. In 1999, the UKCC stated that a definition of nursing would be too restrictive for the profession because of the ongoing development of nursing. Rider Ellis and Love Hartley (2004) also said that it is difficult because there are many overlaps between nursing and other health care professions.

In 1859, Florence Nightingale said that the very elements of “Nursing” are unknown. She clarified that she used the word “Nursing” for want of a better word and that “nature alone cures.... and what nursing has to do.... is to put the patient in the best condition for nature to act upon him.” This might also be true down to this very day because different people have different concepts of who is the nurse and what does nursing entail. This may be partly because not all “nursing” is prescribed, administered, and evaluated by qualified nurses and nursing is practised in different settings.
Nightingale's focus on the promotion of health and healing as distinct from the
cure of illness, and the triad of the person, health and the environment, remain
central to modern definitions of nursing. One of the most cited wider
definitions of the nurse is that given by Henderson (1966, p.15) where she
stated that:

"The unique function of the nurse is to assist the individual, sick
or well, in the performance of those activities contributing to
health or its recovery (or to peaceful death) that he would
perform unaided if he had the necessary strength, will or
knowledge. And to do so in such a way as to help him gain
independence as rapidly as possible".

From this definition one can deduce that Henderson saw the professional
nurse, as being there to help the client, not the doctor, therefore the nurse is
accountable towards the client. One can also note that according to
Henderson, the contribution of nursing is not only towards the sick but also
towards those who are well. One can also say that this is an expansion on
Nightingale's definition for the main concepts are similar to those mentioned
by Nightingale.

The International Council of Nurses (2002, p.2) declared that:

"Nursing encompasses autonomous and collaborative care of
individuals of all ages, families, groups and communities, sick or
well, and in all settings. Nursing includes the promotion of
health, prevention of illness, and the care of ill, disabled and
dying people. Advocacy, promotion of a safe environment,
research, participation in shaping health policy and in patient
and health systems management, and education are also key nursing roles.”

In this definition, one can notice that apart from the points mentioned in Henderson’s definition, there is emphasis on the nursing care that is to be provided to people coming from different settings and age groups.

The American Nurses’ Association followed this up. In 2003, in its Social Policy Statement it declared that:

Nursing is the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individuals, families, groups, communities and population.” (ANA, 2003 p.6)

This declaration is clearly influenced considerably by the definition given by the International Council of Nurses in 2002.

Professions
When searching sociology literature one meets various theories of professions. Professions as they are understood today emerged from medieval universities with the creation of the traditional professions of medicine, law, and clergy (Abbott & Wallace, 1990). Today, the number of recognised professions is on the increase and they are regulated by the state since their members can potentially cause harm to their clients. They are regulated because they are authorised to practice independently and are expected to set standards and to
ensure that their members are competent in their area of practice (Giddens, 1993). This is what may be seen as the contract that such professions have with society, they are trusted with self-regulation but are expected to ensure that their members give a service that is up to standard and knowledge based (Rider Ellis & Love Hartley, 2004).

Various theorists have proposed a number of criteria for professions and professionalisation. One criterion being that there is knowledge of the history of the profession that is transmitted to those entering the profession (Burns & Grove, 1999). Professionals are assumed a homogeneous group that uniformly adopts professional values and therefore its members can be defined in part through their common interest in autonomy. To claim to be a profession is to suggest independence, autonomy, control over work and work practices, and a good knowledge base (Abbott & Wallace, 1990).

The definition of professions as developed by Friedson (1986) requires the monopolisation of knowledge by the professionals otherwise; the profession will lack professional authority and the right to be classified as such. This inequality in the ownership of knowledge puts the privileged professionals in a state where they can dictate what is good or what is not good for the client, and disempowered the clients by leaving them no choice but to accede to professional judgement. This can be a reflection of paternalistic society,
whereas the father (professional) decides what is good or bad and the mother (other workers) help in the carrying out of the orders to be able to cater for the children (the clients). This can be a description of what was the situation in nursing is; the father being the doctor, the mother being the nurse and the children being the clients. Whereas the father had absolute control on all, the mother had slight control on the children but she had to follow the orders imparted by the father whilst the children are there as passive recipients of orders and parental love.

This model of practice based on professional authority has become obsolete because the professional solutions based on the professional’s “extraordinary knowledge” more than often have created unanticipated consequences and sometimes have created even worse problems from those they intended to solve (Schon, 1983, 1987). This could be because as Foucault said, it could give rise to resistance. Thus, Schon (1983) said that the emerging social tendency is that of a partnership between the individual and the professional. This is made clearer by Schon (1987) when she advocates that the public expects more personal, direct and immediate involvement in the solution of it’s’ problems because the public has lost its’ confidence in professionals to solve their problems. This could be partly attributed to the public’s greater access to knowledge that traditionally was only accessible to the members of the traditional professions. This widespread access to knowledge and greater
education of the public has helped to create a knowledgeable society and subsequently a questioning one.

Professionalisation might give rise to newer challenges. Salvage (1985) argued that if nursing becomes professionalised it might lead to nurses identifying more with doctors and thus create barriers with lower workers such as auxiliaries and with relatives of patients. This might impede the nurses from working in teams whose sole aim is that of meeting the needs of the clients. According to Abbott and Wallace (1990), this move into professionalism has also given rise to discourses that impose certain standards that were created by the male dominated traditional professions.

Professional regulation
Nursing is regulated because it is one of the health professions that can pose risk of harm to the public if practiced by someone who is unprepared and incompetent. Regulation is done through various acts of the legislature and it puts certain demands on the regulatory bodies. In 2005, the ICN together with WHO declared that the core principles behind professional regulation include accountability, collaboration, competence, effectiveness, efficiency and affordability, equity, flexibility, public participation, relevance, responsiveness, self-regulation, transparency and universality.
As part of the ICN process of helping national associations examine and develop their regulatory practices, Affara and Styles (1992) have developed a useful publication titled Nursing Regulation Guidebook: From Principle to Power. In this guidebook a list of standards are set and they propose that regulatory bodies must ensure that only individuals meeting such standards are allowed to practice as a nurse. The reason for this is that the public may not have sufficient information and experience to identify an unqualified health care provider and is vulnerable to unsafe and incompetent practitioners. Therefore, registration helps to bring about legal recognition of the nurse as a professional and would help to distinguish between trained nurses and impostors.

There is increasing pressure on regulatory bodies to demonstrate accountability to government and the public that they are fulfilling their mandate. Nurses’ regulatory bodies must concern themselves with ensuring that nurses are competent and safe practitioners. The ICN (2001) declared that nursing legislation must authorise the regulatory body to setup a scope of practice, standards of education, standards of ethical and competent practice and systems of accountability. This is needed to protect the public from unsafe and incompetent care, and to promote the highest attainable level of good quality care. According to Abbott and Wallace (1990), critics of self-
regulation say that the professions cannot be necessarily relied upon to police themselves effectively or to act in the public interest.

Certain aspects of globalisation have intensified the scrutiny of professional regulation, both at national and international levels. This is mainly because of the increasing mobility of professionals, growing trade in health services, ongoing health sector reforms, and a greater public interest in the quality of health care services. According to Styles and Affara (1999), the globalisation of registration is posing various challenges to State regulation of nursing. According to these, regulation is also taking a negative connotation because it is now being associated with central control, unreasonable bureaucracy, and restraint in international trade and worker mobility. This stems from the fact that a lack of uniformity in nurse regulation and standards is costly because it limits professional mobility.

Feminism
Historically nursing has been a female dominated profession. Throughout history, the traditionally male dominated profession of medicine has influenced the perception of how society viewed nurses and nursing. Hospitals became hierarchical systems with the doctors being at the top followed by nurses in descending levels of importance. Abbott and Wallace
(1990) state that since medicine is traditionally male dominated the female profession of nursing has been subordinated. The repercussions of this are all still felt today by nurses, other health care workers, and patients. Hospitals developed into job specific gender specific environments with male doctors and female nurses. This environment might have influenced negatively the advancement of nursing as a profession and the political involvement of nurses. Ford and Walsh (1994) state that nurses were subordinated to male dominance both by the virtue of being female in a patriarchal society and by being seen as assistants to the male dominated medical profession.

Females have been traditionally discriminated in various sectors. There is reciprocity between variables in the external work setting and the internal feeling of self-esteem, personal beliefs, and values that affect work. Behaviours that make women appear to be ‘good girls’ are often rewarded in private and public spheres but lead to negative behaviours such as silencing and devaluing each other. This was also in nursing for nurses were traditionally trained to be quiescent and submissive to doctors (Slater, 1990).

Conclusion
This journey along some of Foucault’s works helped me to learn to appreciate history more and see history in a different perspective. At first, Foucault is
difficult to understand but when taken seriously and one gets involved into his
spirit and thought he is understood more easily. This journey along Foucault's
work also helped me to appreciate the changes in the discourses used in
different definitions of nursing as they progressed through the years.

What is stated clearly in these works is that power only occurs when one
desires or attempts to direct the behaviour of another. Of course, this
encompasses most of our interactions. However, it also requires us to examine
the individual relationship. The parent/child relation, the pedagogical relation,
the teacher/student relation are all relations of power. They can be negative,
i.e., repressive, oppressive, or limiting in unacceptable ways, and they can be
positive, i.e., creative productive, etc. In fact, they can be both.

Power, like freedom is something that manifests itself in practices; it is neither
metaphysical nor ontological. It is a function of human interaction. Foucault
also showed that even in situations where the relation is extremely one sided,
or unbalanced, the other always has the possibility of resisting and changing
the shape of the power relations. Such relations remain fluid, they are not
fixed or unchanging, and those in unbalanced power relations need ways to
come to know that they can resist, that they can change the relationship. Such
changes never come without a cost, and this is the element of danger involved,
but again danger is something that changes its value, its value tends to change

27
from something that is always pejorative, to something that needs to be evaluated on a case-by-case basis.
CHAPTER 3 - METHODS
AND PROCEDURE

The purpose of this chapter is to give a description of the methodology adopted and the process that was adopted for the purposes of data gathering during the conduct of this research project. This task was no easy undertaking since the history of nursing is *prime facia* influenced by a number of variables. Such variables are also influenced by the adopted approach that could have been historical, professional, sociological, feministic, and postmodernist or a combination of all or some of them (McDowell, 2002). Another complicating issue was the interchangeable use of certain terms, such as historical research, historiography, historical sociology, and historical comparative research (Polit & Beck, 2004). After reading the research methods available, it was decided that historical methodology would be used.

A historical analysis of the various amendments made to the Medical and Kindred Professions' Ordinance (1901) and other related Acts will be taken up. This historical analysis will be mainly based on a documented analysis. Such an approach required me to carefully and thoroughly examine a number
of past documents that relate to the topic in question. The purpose was to gain a clearer understanding of the impact of the past on present and future events (Lewenson, 2004) as related to local Nurse Registration Legislation.

Prior to this analysis of the relevant legislation, a historical research on local nursing practice and education areas that have left a mark on nursing and its progress was carried out. Research is also made on various European Union Directives and Recommendations that influenced nurse education and nursing practice in Malta.

All nurse registration laws and any other amendments made to such laws were outlined. Some debates that were held in connection with the discussion of this legislation and amendments, as well as any other relevant information that shed light on the reasons leading to the formation of such legislation or amendments were also used. The great majority of the materials of this study are found in various local depositories for historical documents. Such an approach helps one to answer questions like: Where have we come from? Who are we? Where are we going? (Rees & Howells, 1999).

This approach helps us to describe and interpret past events (Polit & Beck, 2004). It also helps the reader of such research studies to understand more the present state of affairs by shedding more light on the influence that the past has on present behaviours and practices (Winkler & McCuen, 1989).
Historical research also helps to increase appreciation and understanding of contemporary issues (Berg, 2004). Therefore, historical research might also help us to plan.

Definition
Historical analysis is a type of qualitative research (Brockopp & Hastings-Tolma, 2003) that examines past events (Burns & Grove, 1999) and attempts to fashion a descriptive written account of the past (Berg, 2004) it is also known as historiography (Berg, 2004). In the relevant literature one can find various definitions of historical research, such as that proposed by Polit and Beck (2004, p. 720) 'the systematic collection, critical evaluation, and interpretation of historical events' and that by Cohen and Manion (1989 p.48) that states that historical research is:

"the systematic and objective location, evaluation and synthesis of evidence in order to establish facts and draw conclusions about past events. It is an act of reconstruction undertaken in a spirit of critical inquiry designed to achieve a faithful representation of a previous age."

Ethical considerations
The first steps done to carry out this research were applying for the approval of the study by the Board of Studies, than by the Institute of Health Care and the
University of Malta Research Ethics Boards. The research proposal was submitted on 1st June 2005 and acceptance was confirmed by e-mail on 19th of July 2005. Since only publicly available documents were used, this study was pursuant to the provisions of the Data Protection Act and no further approval was needed.

An ethical obligation outlined by Polit and Beck (2004) was to be truthful. They also said that in historical research, both the hypotheses and research questions, if they exist, are not tested statistically, but attempts are made to try to explain and interpret the conditions, events, or phenomena under investigation. Brockopp & Hastings-Tolma (2003) stated that truthfulness could be guaranteed if personal biases are set aside and a factual report is made. Apart from being an ethical obligation, truthfulness is also a legal obligation and because of Chapter 113 of the laws of Malta, that is The House of Representatives (Privileges and Powers) Ordinance, I had to be more careful about what to write about certain debates. This is especially so because some people can be identified for they have been mentioned either by their names or by their responsibilities.

Given that public documents were used, no permission to gain access was needed as with confidential information because most of the documents used are over 50 years old or their contents are not sensitive. An important ethical
consideration in documentary analysis is good handling and good care of original documents (Sweeney, 2005). Proper handling and care are important for such documents may be unique and therefore if they are damaged they are irreplaceable.

**Time scale and plan of work**

To collect all the data that is directly related with this study, months and years were needed, but since this is a study with a specific submission date, it was time restricted. When formal approval of the research proposal was received data collection and information gathering was immediately commenced. This was done in the light that no permits to gain access to material were necessary for already mentioned reasons.

As already stated the amount of material gathered was restricted mainly because the time to carry out the study was limited and to be able to find all relevant sources of information analyse and interpret them a longer period was necessary. This is one of the limitations of this study for if time permitted one could have looked at more information sources for it to be more exhaustive.
Reference Material

After developing the research questions, that is the questions that the researcher intended to answer with this study, the next step was to determine what other sources of data for the purposes of the study exist and are available (Burns & Grove, 1999; Polit & Beck, 2004). Checking about the availability of material did this, for the lack of such material would have posed a great limitation to this study. As already stated no local studies about the history of nursing were located.

There are four main types of historical evidence: primary sources, secondary sources, running records, and recollections. Academic historians rely mostly on primary sources, which are also called archival data because they are kept in museums, archives, libraries, or private collections. Emphasis is given to the written word on paper, although modern historiography can involve any medium. Secondary sources are the work of other historians writing history. Running records are documentaries maintained by private or non-profit organisations. Recollections are autobiographies, memoirs, or oral histories.

Original documents are known as primary sources (Brockopp & Hastings-Tolma, 2003). These documents include both published printed, non-printed, and unpublished material. This material is most likely to shed true light on the information that the researcher seeks (Burns & Grove, 1999). By its very nature a primary source is unique and is not reproduced or published.
Polit and Beck (2004) state that a historical researcher needs to develop considerable effort to identify and evaluate data sources. Before beginning to write, an initial search in various databases was conducted. These databases included CINAHL, MEDLINE, and various catalogues, both electronic and manual that are found at the University of Malta Library (including OPAC), EBSCO, National Archives catalogue, European Union Databases, and the internet. An important thing was that certain sources exposed the research to various other sources.

Primary documents are usually authored by people directly involved in the events (Polit & Beck, 2004). The main documents used during this study were; Ordinances, Laws, Legal Notices, Minutes of Parliamentary debates, and official Publications such as the Government gazette. The main depositories where these materials were found are; The library of the House of representatives, the Melitensia, the Bibliotheca in Valletta, the Floriana Public Library and its Melitensia section, the Public Library at Victoria Gozo, the Santo Spirito – National Archives and the archives of the Medical and Health department. Information was also sought from informa library at Hamrun. Most of the material found in such libraries could only be utilised on site. Therefore, a substantial amount of time was consumed carrying out library work. According to Winkler & McCuen (1989), a researcher might need
much more time than originally envisaged to trace historical material. This was also true in this case.

Historical material may be difficult to obtain (Polit & Beck, 2004). A lot of historic material owned and concerning nursing leaders and institutions involved in nursing is being discarded for not much intrinsic value is seen in them (Burns & Grove, 1999). This also applies for Malta. This lack of primary material can be one of the limitations for such a study. Therefore it was important to make thorough searches, for most of the people who were directly involved in the enactment of such laws are dead and therefore it was difficult to gather further information. During this phase and other phases of this research project meetings with various people who are interested in the subject were held and the topic was discussed with them.

Criticism of the data
Criticism of the data necessitates a comprehensive review of the gathered material (Brockopp & Hastings-Tolma, 2003). This is an arduous task requiring a sense of scepticism about the documents in question. Christy (1975) cited in (Brockopp & Hastings-Tolma, 2003) described the analytic process of document review as a two-pronged activity. It is composed of external criticism and internal criticism. External criticism helps to determine
the validity by determining the authenticity of the documents used, whilst internal criticism helps to determine the reliability by correctly interpreting the contents of a document (Polit & Beck, 2004). There can also be potential problems of errors associated with transcriptions or typed versions of the historical documents (Winkler & McCuen, 1989).

For internal criticism, the researcher must determine biases of the author (Burns & Grove, 1999). This refers to the evaluation of the worth of the evidence (Polit & Beck, 2004). It is important to examine the writings for bias. When the author tried to analyse newspaper reports the author kept in mind the publishers of the particular newspaper and the political/professional allegiances. To verify the accuracy of a statement the researcher should preferably have two independent sources that provide the same information (Winkler & McCuen, 1989). The researcher should also make sure that he understands the statements made by the writer because words and their meanings change across time and cultures. During the conduct of this study at times, various documents had to be read a number of times to be able to understand what was being said.

According to Sweeney (2005), if a document exists it does not necessarily mean that the event described actually occurred. Most of these were not an issue for this study because this documentary analysis was based mainly on
primary sources. The minutes of the parliamentary debates of every sitting are approved in the next sitting after any corrections are made. This means that the minutes are a true reflection of what was actually discussed. This also applies to legal publications for these are also original and they are scrutinised well.

Interpreting and relating the findings.
According to Matejski (1979) cited in Brockopp & Hastings-Tolma (2003) this is the final step in historical research. This activity is undoubtedly the most difficult and requires synthesis and resynthesis of the available material to arrive at an appropriate interpretation. The academic nurse historian needs to sift through the data and ultimately relate the content to a larger theory or model (Winkler & McCuen, 1989). For the purposes of this study, the material found was related with Foucault's power/knowledge theory.

In such a study, the researcher might fall into the trap of seeing one cause whilst there can be many causes for such a decision (Winkler & McCuen, 1989). During the write up it was deemed important to reason according to the reasoning of the days in which the discussions and legislative changes took place and not according to the reasoning of today. It was also important not to be carried away by the study and try to reach hasty conclusions. Winkler &
McCuen, (1989) said that a researcher might be so willing to find reasoning behind certain actions that he may try to attribute certain decisions on unrelated facts or occurrences.

According to Berg (2004), it is important to distinguish nostalgia from historical research. One should be careful so as not to confuse historical analysis with a literature review (Polit & Beck, 2004). Historical research reports do not follow the traditional formalised style characteristic of much research (Burns & Grove, 1999). These studies are designed to attract the interest of the reader by writing a narrative account that is flowing, revealing, vibrant and alive (Berg, 2004).

Research Journal
Keeping a research journal or notebook is very important (Polit & Beck, 2004). This is used to keep a record of field notes, ideas, contacts, material, documents, references etc (Burns & Grove, 1999). During the conduct of this research a journal was kept. In this, dates and the places where ideas came from were noted to keep track of time and place. Reactions and hunches to certain findings were also noted. These, especially immediate reactions whilst reading the material for the first time were deemed important. Therefore, such initial reactions might have helped to shed light on why certain changes were
done in a particular period. It served as a map of the research journey. Such a journal contributes to the reliability, validity, and integrity of the inquiry (Burns & Grove, 1999).

Here a note of any personal biases was also kept. Such biases may pose a limitation to such a study. Any other ideas and thoughts were written. Such ideas came from various sources; these included the supervisor and other people who were interested in the subject.

Limitations

During the conduct of this research project, various hurdles that limit this research study were encountered. One of the main limitations was the lack of related research material available locally. Locally there are just two medical historians who have published related research and both of them with special emphasis on medicine. This represents a gap in the literature that the researcher tried to fill up with related material from other countries.

Due to various factors, one of that was the long search for material, getting me seated and starting to write was a difficult task in itself. On a considerable number of instances, writing had to be postponed until a reasonable amount of material was available. Some of the material had to be read a number of times for it to be understood well. All chapters were rewritten and revised a number
of times until this final piece of work was finished. At times work had to be postponed a number of times for reasons that were beyond control.

Another hurdle was about its format; since this is the first historical research study at the Institute of Health Care there were no similar projects to which one can refer. This necessitated a search for dissertations from other faculties to be able to plan this piece of work better. Another limitation was the fact that a long period had to be covered. Another hurdle was the lack of an organised depository for nursing related historical documents and other related material both at the Medical and Health Department's archives and the national archives. In a substantial amount of instances, it was difficult to find certain documents that had been mentioned in related studies such as annual reports and correspondence. This meant that in a number of instances it took much longer than envisaged to find the material or it was not found at all.

Another constraint was that most material and documents could not be photocopied therefore they had to be read onsite. This also necessitated the spending of more time than envisaged in various libraries or archives. Another limitation is personal bias of the author. Such biases even though the author tried to eliminate them as much as possible, might have influenced this study mainly in the discussion part.
CHAPTER 4 – HISTORICAL REVIEW

Here, a departure is made by giving a historical outline of the laws that regulated medicine and the allied professions in Malta prior to the twentieth century. The reason is that the nurse registration concept is one that started to be implemented in the first half of the 20th century and this period will be dealt with in the findings chapter. In this chapter, an overview will also be made on how nursing has evolved throughout the years in the United Kingdom and the European Union, which has surely influenced recent nursing and related legislation in the Maltese islands.

After the loss of Rhodes in 1522, the Knights of the Order of St. John were left without a home. In 1530, the Order accepted Charles V's offer to create their new base on Malta. They remained here until 1798 when they were ousted by the Napoleonic forces. The French forces occupied Malta until the arrival of a British fleet to blockade the island and they defeated the French in 1800. In 1814, by the provisions of the Treaty of Paris Malta became a British protectorate.
Information about nursing in Malta, before the arrival of the Order of St. John of Jerusalem is scarce. Information about the social, political, and religious aspects of life in Malta during those times, especially during the early middle ages is almost non-existent. One of the earliest hospitals in Malta was that of Santo Spirito in Rabat. In 1494, in this hospital, among the employees we find the spitalieri, who worked as male nurses or attendants and who were later on replaced by female attendants called garzuna and servitici (Cassar, 1964). Vassallo (1890) refers to a bando issued in 1521 by the Universita for the protection of the Health of the Maltese islands. This bando, which could have been one of the first local sanitary Laws, was published to regularise the port quarantine service.

The period of the Knight Hospitaliers
According to Paul Cassar (1964), medicine in Malta has been regulated since the time of the Knights of St. John. Savona Ventura (2004) when he said that various regulations governing medical, surgical, apothecary and midwifery practices were incorporated in the Legal Code of Grandmaster Antonio Manoel de Vilhena confirmed this statement. This legal code was published in 1724 (Benvenuta, 1724) and renewed in the Municipal Code of Emanuel de Rohan de Polduc published in 1784 (Mallia, 1784). The Municipal Code was a landmark in Maltese Legislative history because it was an orderly synthesis
of all the municipal laws enacted by the knights (Savona Ventura, 2002). The
code remained in force with minor amendments in the nineteenth century
under British rule until the police laws were published in 1854 (Savona
Ventura, 2005). The police laws relating to the practice of medicine and allied
professions were eventually substituted by the Sanitary Laws promulgated
between 1900 and 1908.

The first hospital of the Knights was an infirmary built in Vittoriosa in 1552
followed by a second one in 1553 (Savona Ventura, 2004). In 1575, we see
the opening of the Sacra Infermeria in Valletta. These hospitals catered for
male patients only and only males provided service. These carers were known
as servjenti whilst the real nurses were the knights themselves (Cassar, 1964).
According to Article 24 of the Capital Ordinance of the Order of St. John that
was published on the 1st of June 1631, each knight had the obligation to serve
patients personally (Savona Ventura, 2004).

These regulations, which were revised in 1725, stated that the work of the
Knights was limited solely to the distribution of food according to the
instructions given by the doctors (Cassar, 1964). The 1725 regulations also
specified the work that had to be done on a regular basis by the
servants/guardians. They had to make the beds every evening and change the
bed linen as necessary and they had to ensure that the bed curtains were kept
clean. The beds and linen of contagious patients had to be burnt and the servants/guardians were responsible for the silverware (Cassar, 1964).

Due to the provisions of the Order’s statute of 1588, all the hospital workers fell under the responsibility of the infirmatur. The infirmatur was a professed knight who had the authority to employ and discharge infirmary employees and ensure that they abide by the regulations and punish them if they broke any regulation (Savona Ventura, 2004). In 1765, the Venerable commission was set up to investigate the finances of the infirmary. They reported that the attendants maltreated their patients unless they were bribed by bread or money (Cassar, 1964). This led to a recommendation that was implemented in later years, to increase the number of attendants and their salaries.

In 1625, we see the opening of the women’s hospital in Valletta. The main employees there, apart from a male employee who was employed for the anointing with mercury, were females who as a punishment for certain offences were sentenced to give service in the hospital (Cassar, 1964). The Municipal Code of 1784 stipulated that women who were found guilty of selling or ransoming gold or silver objects they had procured, were given sentences of serving in the women’s hospital, chained at their feet, or condemned to serve in the women’s hospital for incurable diseases, for periods of between two to four years (Mallia, 1784). Similar penalties were given to
those women who were accused of perjury or of inciting young women to a boisterous life. Women who were found guilty of criminal acts were never sentenced to serve at the Santo Spirito Hospital, where the attendants were somewhat better. By 1765, the Bali Sigismondo Piccolamini, who was the President of the Casetta delle Donne, came up with the idea of training the maid-nurses of the Sacra Infermeria to work as barberotti (Savona Ventura, 2004).

In his writings, Howard describes the late 18th Century in a very denigrating way, but this was a time when the Order of St. John was declining (Cassar, 1964). He wrote that the attendants and the nursing conditions in the Order’s Hospital were appalling. He said that the dirtiest people who were dressed in tatters, and acted in an unkind and inhuman manner served the patients. Once he found eight or nine of them making fun of a delirious moribund patient and that the Governor told him that he had only 22 servants working in the hospital, most of who were either in debt, criminals or escapees seeking refuge.

In 1797, there was a revision of the regulations of the Sacra Infermeria (Savona Ventura, 2004). These concerned the role of the guardians or nursing attendants, and those of the servants whose work consisted only of domestic work in the wards and other hospital departments, like the kitchen, food stores,
and the washerwomen. The guardians were divided into two categories depending on the number of years of service. The young ones had the right to an increase in salary after ten years of service and to be promoted to the older grade when a vacancy arises and then only after the approval by the hospital authorities. The guardians worked in shifts on a week on week off basis. They were not paid for their week off, nor were they allowed any rations but if they fell ill during their working week, needing to be admitted into the infirmary then they received their full salary without rations, and having to pay for the food. Besides nursing work, the attendants were responsible for keeping the ward discipline, by seeing that women who had no access to the wards reserved for dying patients did not enter these wards. In addition, that food is not brought in for patients from outside while ensuring that patients did not exchange their food. The attendants themselves were not allowed to sell their own food rations to the sick, or to take it out of the infirmary. They could not accept presents from patients. They were trusted with the silver plates, sheets and clothing and had to make sure that the oil provided for the ward lamps was used appropriately. Finally, they had to perfume the ward with rosemary every morning and evening. Those who did not obey these regulations were punished by being locked in irons or dismissed.
The Early British period

The British took over the Maltese islands in 1814 by virtue of the treaty of Paris. The early British period was a period of autocratic rule due to the Governors' assumption of wide political powers against the expectations and the wishes of the Maltese. This was mainly because the British were invited by the Maltese to come to Malta. During this period, thorough reforms in the legislative system of the islands were made.

During the early British period, health regulatory responsibilities fell on the Head of Government, than Ordinance VIII and Government notice 102 of 1885 provided for the setup of the post of Chief Government Medical Officer (CGMO) who later on became responsible for the Medical Board and other Boards that followed (Cassar, 1964). The regulation of the medical and sanitary services was entrusted to the executive police. This remained so until 1901 when the Medical and Kindred Professions Ordinance was enacted. Prior to this, most of the developments were driven by situations of epidemic emergencies. Important notices were implemented during the plague epidemic of 1813 and during various cholera epidemics. On the 10th of September 1813, a Government Notice to re-organise the medical services was published and it was later amended by Government Notice published on 23rd of October of the same year coming into force on 27th October 1813.
The pharmaceutical profession started to be regulated by a Proclamation issued in January 1814 (MCG, 1814) and in 1816; we see the establishment by Government notice of the Committee of Charitable Institutions. Down to 1821, with exception to two years under the French, it was the duty of the Protomedicus to assess professional competence (Savona Ventura, 2005). From than onwards these responsibilities were transferred to the Comptroller of Charitable Institutions and than to the Medical Board (Cassar, 1964). During the French period, these executive duties were transferred to the Health Committee responsible to the Commission of Government (Savona Ventura, 2005).

Originally the CGMO was vested with the powers previously appertaining to the Chief Police Physician thus he acted as the Governor’s principle advisor on matters concerning health and was directly accountable to him. Government Notice 102 of 1885 also appointed the CGMO as the President of the Medical Board (MGG, 1885b). Apart from various other duties, this board examined the applications for the conferment of warrants to practice as physician, surgeon, accoucheur, apothecary, midwife, or phlebotomist. The CGMO was also vested with the power to determine and revise the fees to be charged by physicians, surgeons, and phlebotomists. The post of CGMO was abolished in 1993 when legal amendments were made for the creation of the Post of Director General (Health) (Savona Ventura, 2005).
In 1850, the central hospital in Floriana was inaugurated in the building that is today being used as the Police General Headquarters. It remained in operation until all services were transferred to St. Luke’s hospital. In 1851, the instructions for the guidance of the officers and servants of the Government and of Charitable Institution of the Islands of Malta and Gozo were issued (Borg, 1998).

An important thing to note here is that the researcher encountered the term ‘nurse’ for the first time in an official document in a letter sent by the Comptroller of Charitable Institutions Mr. F. V. Inglott in 1860 (Letters to Government, 1860). In April 1882, Dr. T. Bonnici, the Resident Junior Surgeon at the central hospital organised the first training course for nurses (Savona Ventura, 2005). According to Savona Ventura (2005), the first trained nurses arrived in Malta in July 1885. These were members of the Order of the Sisters of Charity and were trained at the Santo Spirito Hospital in Rome (Bonnici, 2002). One of their roles was to teach the nurses on how to attend to the patients (Cassar, 1964). In June 1875 a Government notice set up the Public Health Department and in August 1899 we see the publication of a Government Notice that brought into effect regulations that regulated the practice of midwifery (MCG, 1899).
European Union

According to Wallace (2000), European Union legislation consists of treaties, directives, regulations, and decisions. According to the provisions of ACT V of 2003 of the Maltese Parliament, as amended by Act III of 2006, which is known as the European Union Act, the Treaty and existing and future acts adopted by the European Union became binding on Malta. This was as from the first day of May 2004 and they became part of domestic law.

One of the main principles behind the European Union is the freedom of movement. This principle is encouraged and guaranteed by various recommendations and directives issued by the European Union. Mr Frits Bolkestein, Internal Market Commissioner stated that,

"the free movement of qualified persons contributes to the development of the knowledge based economy, the flexibility of labour markets and improved public services. The purpose of this proposal is to ensure a clearer and simpler system for the benefit of the workers concerned and to step up our efforts to create in Europe by 2010, the world's most dynamic and competitive economy" (EU Commission 2001, p. 5).

Although this principle is to be supported, one cannot allow this principle to take precedence over public protection. In the European Union, the profession of nurse responsible for general care is covered by the system of mandatory and automatic recognition of diplomas and degrees. Draft directives on the content of general nurse training were presented to the European Parliament in 1969 (Keighley 2003). The directive was finally published in 1977, which is
eight years after the first draft was presented to the European Parliament. Thus, the main directives that regulate nursing locally are 77/452/EEC, 77/453/EEC. These specify minimum requirements of 2300 hours of theoretical and 2300 hours practical training in programmes leading to the initial qualifications of nurses and midwives. Additionally, a minimum age of 18 for the entry into nursing and midwifery programmes is specified.

Directives 81/1057/EEC, 89/594/EEC, 90/658/EEC 2001/19/CE amended the 1977 regulations and the Act of the Accession of Malta into the European Union. This means the treaty of accession that the Maltese Government signed with the European Union prior to Malta’s entry as a member on 1st May 2004. Directive 77/452/EEC is concerned with the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of this right of establishment and freedom to provide services. Directive 77/453/EEC concerns the co-ordination of provisions laid down by Law, Regulation, or Administrative Action in respect of the activities of nurses responsible for general care.

Than in 1981 directive 81/1057/EEC was published which supplemented directives 75/362/EEC, 77/452/EEC, 78/686/EEC and 78/1026/EEC. These directives treated the mutual recognition of diplomas, certificates and other
evidence of the formal qualifications of doctors, nurses responsible for general care, dental practitioners, and veterinary surgeons respectively, with regard to acquired rights. These together with directive 80/154/EEC were amended by directive 89/594/EEC that was later amended by directive 2001/19/EC.

This Directive applies to all nationals of Member States wishing to practise a regulated profession in a Member State other than that in which they obtained their professional qualifications. Here it is important to note that these general directives only apply to general care nurses thus branch nurses and specialist nurses are not regulated by such directives and their regulation remains totally the prerogative of the individual states. Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications is another important directive together with directives 85/432/EEC, 85/433/EEC, 89/48/EEC, 92/51/EEC, 93/16/EEC, and 1999/42/EC.

Whilst general care nurses are recognised under the sectoral directive, branch nurses are recognised under 92/51/EEC. All the qualifications that do not fall within the provisions of the sectoral nurse directives are at the level of the second horizontal directive 92/51/EEC, with the exception of the qualified nurse (teaching tasks)/nurse teacher and qualified nurse (management tasks)
who are trained at University level. Post-basic specialisations are recognised under directives 92/51/EEC and 89/48/EEC.

The 1992 directive will come into affect in all member states on 20th October 2007. This directive has proposed a number of changes when compared with the existing rules, these changes include greater liberalisation in the provision of services, more automatic recognition of qualifications and increased flexibility in the procedures for updating the Directive. Article 15 of this Directive aims to facilitate the recognition of professional qualifications throughout the European Union based on common educational platforms. This will help to bring harmony in the nurse education systems in the European Union states.

The concept of common platform is defined in Article 15(1) as

"a collection of criteria on professional qualifications able to bridge the substantial differences between the training conditions in the different Member States. These criteria must be established in such a manner that Member State A, which may have higher training requirements than the training provided in Member State B, would not be justified in requiring a professional from Member State B to take a test or undergo further training because, in compliance with the criteria of the platform, this professional will already have compensated for the differences in question in advance"

The procedure for adopting the common platform is set out in Article 15(2) of the Directive. Up until now, these platforms are purely voluntary, thus member states are not legally bound to abide wholly with these
recommendations. This means that the professional associations or the regulatory bodies concerned are in no way required either to establish a platform or to present it to the Commission with a view to transforming it into a Community act that is binding upon the Member States. On the other hand, a fully qualified professional who does not satisfy the criteria of the platform would continue to benefit from the rules on recognition, but could be required to comply with compensatory education/training measures.

The enactment of Directive 77/454/EEC led to the establishment by the EU of the Advisory Committee on the Training of Nurses (ACTN). This was the only committee that the EU Commission was legally obliged to consult with about matters relating to the training of nurses (Keighley 2003). Since then the ACTN has ceased to function, thus all decisions were left solely in the hands of the European Commission. Mead (2003) expressed concern regarding the absence of advisory committees and the potential for the absence of an official voice of the professions at European Commission level. Decision 77/455/EEC amended decision 75/365/EEC on the setting up of a Committee of Senior Officials on Public Health. In 1971, national nursing associations across Europe established the Comite Permanante Nursing (PCN) a Europe-wide standing committee of nurses. The PCN achieved recognition as the official liaison committee for nursing within the EU (Keighley 2003).
Other agreements that have an impact on nurse education include the Bologna declaration of 1989 and the treaty of Lisbon of 1997. The Bologna declaration is concerned with the harmonisation of the architecture of the European higher education system (Mead, 2003). The principles involved include the adoption of a system of easily readable and comparable degrees, the adoption of a system based on two main cycles of education whereby access to a postgraduate programme is dependant on successful completion of an undergraduate programme lasting at least three years and the establishment of a shared system of educational credits.

The main principles behind the treaty of Lisbon are the recognition of qualifications granted in one country by another country and the fair and efficient review of applications received. Recognition can only be refused if the qualification is substantially different from that of the host country. The EU Health Policy Forum (2003) recommends that there should be a strong legal basis for the recognition of professional qualifications and lifelong learning should be used to facilitate mobility of Health Care Professionals.

United Kingdom
According to Masterson (2004), civilian nurse registration in the U.K. started in 1919 seventeen years after the enactment of the Registration of Midwives
Act of 1902. Nurse registration came into effect by the provisions of The Nurses Act 1918, which established the General Nursing Council for England and Wales (Abbott & Wallace, 1990). Prior to this, in 1916, a College of Nursing was set up to represent the interests of nurses (Masterson, 2004). The College maintained its own register, which excluded male nurses and mental nurses.

According to the provisions of the Nurses Act, the General Nursing Council for England and Wales in conjunction with the General Nursing Councils of Scotland and Ireland, established at the same time, had clearly prescribed duties (Abbott & Wallace, 1990). These councils were expected to compile and maintain a register of qualified nurses, and to act as the disciplinary authority of the profession (Masterson, 2004). The Councils also had the duties and responsibilities for the training, examination, and registration of nurses and the approval of training schools for maintaining a Register of Nurses for England and Wales, Scotland and Ireland (Abbott & Wallace, 1990). Originally there was the main General Register with supplementary ‘Mental’, ‘Male’, ‘Fever’ and ‘Sick Children’s’ parts of the Register.

The 1943 Nurses Act made it compulsory that to practice nursing in the United Kingdom one has be a State Registered Nurse (SRN) (Masterson, 2004). In Scotland, the term originally used was Registered General Nurse (RGN). In
1943, another type of nurse appeared the Assistant Nurse, later known as the State Enrolled Nurse (SEN) (Abbott & Wallace, 1990). The GNC became automatically responsible for keeping the Roll, set the syllabus for the examinations, and approved the schools of enrolled nurse training within hospitals.

The National Boards for Nursing, Midwifery and Health Visiting of England, Scotland, Wales and Northern Ireland were established in 1980 by the provisions of the Nurses, Midwives and Health Visitors Act 1979 (Masterson, 2004). Their main functions were to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses (Abbott & Wallace, 1990). The General Nursing Council for England and Wales was one of the nine bodies replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the National Boards in 1983. The provisions made by the Nurses, Midwives, and Health Visitors Act 1979 set up this council. The core functions of the UKCC were to maintain a register of UK nurses, midwives and health visitors, provide guidance to registrants, and handle professional misconduct complaints (Abbott & Wallace, 1990).

In 1992, the UKCC published The Scope of Professional Practice (1992) which emphasizes the nurse's professional accountability and places decisions
about boundaries of practice in the hands of the individual practitioner. The structure of the UKCC and National Boards survived with minor modifications up to April 2002, when the UKCC ceased to exist and its functions were taken over by the newly established Nursing and Midwifery Council (NMC) (Abbott & Wallace, 1990). The English National Board was also abolished and its quality assurance function was taken on board by the NMC.

The United States of America (U.S.A.)

According to Birnbach (1985), events in Great Britain enlightened American Nurse Leaders and guided their struggle for registration and licensure. Baer (1985), stated that in the late 1800’s, in the U.S. there were three major approaches to try to organise nursing: these were the original Nightingale model, that kept nursing separate from hospital and medical domination but supervised by the Boards of Lady Managers; the Linda Richards model which was initiated at Boston City Hospital, this subjected nursing to medical control and the professional model, espoused by Isabel Hampton, which sought self-regulation for nursing. Although the registration movement in the United States began 16 years after the British movement, American nurses were successful in achieving their goals well in advance of their British counterparts (Birnbach, 1985).
Since its inception, one of New York State Nurses Association’s principal goals has always been to protect nursing practice through legislative advocacy. The Association’s first initiative was to elevate the standards of the nursing profession through the creation of the Nurse Practice Act of 1903. This law permitted registration of qualified nurses and created the title of “RN.” The Nurse Practice Act was revised in 1938, and it became the first state law in the nation to mandate licensure for “all who nurse for hire.” Another revision, signed into law in 1972, revised the legal definition of nursing. New York was the first state to recognise nursing as a distinct and independent health profession.

New Zealand
The first Register of Nurses in the world was set up in New Zealand. This was set up in 1901 and the first nurse to have her name on that register was Ellen Dougherty (Wood, 2001).

Conclusion
Thus in this chapter various salient historical features that are relevant to this study were outlined. The reason for this being that the reader of this historical piece of work will be able to relate the historical situation in Malta with other
happenings both locally and in other countries, both within and outside the European Union. Here the author also tried to outline some of the factors that he thought left their mark on nursing and nurse education in Malta.
CHAPTER 5 – NURSE REGISTRATION LEGISLATION IN MALTA

The aim of this review is to give a historical outline of the laws that regulated medicine and its allied professions in Malta during the twentieth century up until this day. During the presentation of the findings important events that occurred whilst such legislation was being enacted especially those that might have influenced such legislation will also be included.

Ordinance XIV of 1900 created the Council of Health. This was replaced by Ordinance XXX of 1937, which also provided for the setup of the Medical and Health department. Emergency Ordinance 1 of 1959 provided for the setup of the Medical Council. Subsequent legislation provided for the setup of the Pharmacy Board in 1968, the Nursing and Midwifery Board in 1973 and the Board of Professions Supplementary to Medicine in 1983. Finally, in 2003 we see the enactment of the Health Care Professions Act.
The early 20th century

The active constitution at this time was the 1887 Knutsford Constitution that was based on the United Kingdom Colonial Laws Validity Act (1865) (Cremona, 1997). This constitution gave the last say to the elected majority to decide on questions of finance and on other questions of public concern involving expenditure (Cremona, 1997). Due to the provisions set by this Constitution, the Governor retained the power of veto and the Council of Government, which was elected for three-year tenure, was composed of the Governor as President and nineteen other members, thirteen of whom formed the elected majority.

In the late 1800’s, Malta started to experience a politico-constitutional crisis mainly due to the proposed language question reforms and reforms of the educational system in Malta. This led to the boycott of the Council of Government sittings by the majority of the elected representatives of the Maltese. This, according to Lee (1972) led Sir Joseph Chamberlain, Secretary of State for the Colonies, to state that if the health of the garrison was at stake he was ready to interfere by an Order in Council or in a more drastic manner. This threat materialised in 1903 after the elected members in the Council of Government rejected the educational vote in the estimates because the government denied parents the right to choose between Italian and English language education in the first four years of schooling.
Than by a letter Patent dated 3rd June 1903 the 1887 Constitution was revoked and the Chamberlain Constitution came into force. This led to a reduction in the number of elected members on the Council of Government to a minority thus establishing the constitutional situation of 1849. Here the elected members decided to adopt a policy of systematic abstentionism. The effect of this was that between August 1903 and April 1904 Malta experienced seven general election proclamations. The reason being that on each occasion the number of contesting candidates ended up being the same as to the number of seats and they were elected automatically for them to resign from the post immediately (Cremona, 1997). This reaction shows a great unity between the Maltese. The colonial government’s reaction to this was the postponement of the general election until 1907. After this election, the pre-1903 situation in the Council of Government was reinstalled. This political insecurity could have been the driving force behind the attention given to the medical and social systems of the islands.

On 19th October 1898, the Governor in his speech from the throne on the inauguration of the new Council of Government stated that: “Another important legislative work which will be brought before you will be the Sanitary Ordinance which for convenience and to facilitate the business of the Council will be subdivided into several Ordinances” (DCG, 1898). This materialised by the enactment of four Ordinances, that is the Public Health
Ordinance of 1900, the Medical and Kindred Professions Ordinance of 1901, the Food, Drugs and Drinking Water Ordinance of 1902 and the Prevention of Disease Ordinance of 1908. These Ordinances were to be the basis of the local medical legislation until the publication of the Health Care professions Act of 2003.

In 1900 to bring together the various previous Ordinances, Regulations and Government Notices that had been enacted over the previous century and to amend the laws relating to public health, the Public Heath Ordinance of 1900 was enacted (MGG, 1900). Apart from other things, this bill provided for the re-composition of the Chief Government Medical Officer, the Medical Board that was set up in 1885 and for the introduction of a Council of Health, which replaced the Board of Health. Due to the provisions of this bill, the duties of the Medical Board remained the same as those in Government Notice 102 of 1885.

Ordinance VII of 1908 changed the composition of the Council of Health (MGG, 1908). With this amendment, the members on the Council of Health were reduced to six and the powers that were bestowed on it in 1900 were reduced. The role of the Council of Heath became limited exclusively to regulations intended for the prevention and propagation of infectious diseases.
The draft of the Medical and Kindred Professions Ordinance was given its first reading on 26th May 1899 and it was divided into seven chapters (DCG, 1899). With the enactment of this Ordinance, various provisions concerning the regulation of medical and kindred professions were streamlined thus making them easier to interpret. The first chapter of this draft listed the professions that were meant to be regulated by the proposed law; these were the practice of medicine and surgery, pharmacy, midwifery and dentistry. Here it is important to note that no mention of Nursing is made and prior to the enactment of this ordinance, some of the kindred professions did not fall under any juridical framework. The next four chapters dealt with each different profession separately and chapter six dealt with the trades similar to the sanitary professions. The proposed law laid down the conditions for the granting of a licence, together with the respective powers and duties of each profession.

In June 1899 (DCG, 1899b) it was decided that this draft of the Kindred Professions act was to be discussed in the committee stage, a discussion that never materialised because in October 1899 (DCG, 1899c) a new draft of the Medical and Professions Ordinance (MGG, 1899) was proposed by Dr. A. Naudi, the Crown Advocate. Dr. Naudi said that the new draft incorporated various suggestions made by the representatives of physicians and pharmacists (DCG, 1900). The pharmacist’s representation was consolidated in 1903 due
to the provisions of an ad hoc Ordinance that led to the legal recognition of the Chamber of Apothecaries (MCG, 1903).

This new draft of the Medical and Kindred Professions Ordinance differed from the earlier one by the proposed introduction of Chapter eight in which penal sanctions to ensure that health professionals observe the law were introduced. The insistence for the introduction of these penal sanctions may have been because at that time there was illicit practice of some of the professions regulated by this Ordinance. The Medical and Kindred Professions Ordinance was discussed in the committee stage on 10th January 1900 (DCG, 1900b) and was enacted on 30th May 1900 (MGG, 1900). It was published on 1st August 1901 and it immediately became active by Promulgation X of 1901 (MGG, 1901b). In this ordinance apart from the previously mentioned professions, due to the intervention of Dr. Pullicino, one of the elected members, a chapter dealing with veterinary surgeons was added.

The Medical and Kindred Professions Ordinance was an enabling law for it envisaged for the publication of subsidiary legislation. This subsidiary legislation was to be done by the head of Government who was empowered to issue regulations. The reasons that it was enacted as an enabling law may have been because health care changes so much that amendments to such laws may be needed on a regular basis. During this period in the U.K., there was a
strong lobby towards nurse registration and in New Zealand, there was already a nurse registration Act. These overseas developments could have been another reason why the Medical and Kindred Professions Ordinance was promulgated as an enabling law to leave room for it to embrace other professions such as nursing.

Prior to the first instance that nursing started to be regulated by the provisions of this Ordinance, the Medical and Kindred Professions Ordinance was amended six times. Dr. Alfredo Naudi, the crown advocate, proposed the first amendment to this Ordinance on 7th June 1901 (DCG, 1901). The amended Medical and Kindred Professions Ordinance came into force on 2nd July 1901 (MGG, 1901a). This revoked the original Medical and Kindred Professions Ordinance and all the provisions of the original Medical and Kindred professions Ordinance were transposed into the new law. In this Ordinance, midwives were prohibited from practicing sick nursing. In 1904 a book, by Dr. J.S. Galizia, 'Il ctieb ta l’infermier – lezzjonijiet moghtija lill infermiera ta li Sptar' was published.

Ordinance V of 1906 amended the Medical and Kindred Professions Ordinance again. This amendment made it illegal to practice the professions of Medicine and Apothecary concurrently unless one fell under the exceptions that were mentioned in this Ordinance (MGG, 1906). It also authorised
practising pharmacists who were also qualified as medical practitioners to be able to practice the medical profession but it did not authorise physicians to revert to the pharmaceutical profession (MGG, 1906).

**World War I**

Malta was not directly involved in the First World War. Malta’s indirect involvement started in May 1915 when the first ship with casualties arrived in Malta. In 1917, the Governor issued a declaration praising the Maltese for the important role played during the First World War. Malta became known as the ‘Nurse of the Mediterranean’. In 1917, we also see the appointment of Ms R. Osborne as the Principal Matron (BJN, 1928). Later on in the same year, she relinquished this post upon being transferred to Salonica.

After the First World War, the Maltese requested the British Government to grant a constitution with full political and administrative autonomy. This resulted in political and economic unrest that culminated with the 7th June 1919 riots (Cremona, 1997). After this, we see another suspension of the constitution. A new Constitution came into force in May 1921 due to the provisions of which, the control of the island was divided between the Maltese Government and the Maltese Imperial government (MGG, 1921a). The Maltese Government dealing with purely local affairs whilst the Imperial
Government was responsible for the control of the naval and military services. Thus, the enactment of medical laws and regulations fell under the jurisdiction of the Maltese Government. The Maltese Government was composed of a bicameral legislature, the Senate and the Legislative Assembly. The Senate was composed of seventeen members whilst the Legislative Assembly was composed of thirty-two members. The 1921 Constitution also established seven Ministries, the Executive Council, the Nominal Council, the Privy Council, and the Joint Committee of the Privy Council.

In 1921 the Medical and Kindred Professions Ordinance was amended by means of Ordinance VIII of 1921 (MGG supp, 1921). Due to these amendments, the professionals that became regulated by this ordinance were Physicians, Veterinary Surgeons, Dentists, Apothecarists, Assistant Apothecarists, and Midwives. Dental surgeons were added to the above mentioned professionals by the amendments made in 1932 by Ordinance No. XII (MGG supp, 1932). In October 1923, regulations that concern nursing were published in the Maltese Government Gazette for the first time. In these regulations it was stated that applicants should be fit to practice nursing, they should be able to read in Maltese or any other language and were expected to take a course consisting both of theoretical and practice studies, a course that lasted twelve months (MGC, 1923).
In April 1930, Sir John du Cane laid the foundation stone of St. Luke's hospital. The first patients were admitted in May 1940. The early 1930's were another period of political unrest in Malta, which led to the retraction of the constitution in 1933. This was done under Section 41 (1) of the 1921 constitution as amended in 1930. The situation was further aggravated when the Press law was repealed thus severely curtailing freedom of expression. The Nationalist Cabinet was dismissed after it passed a supplementary vote of 5,000 pounds to increase the teaching of Italian (Cremona, 1997). The Nominated Executive Council was restored in 1936, meaning that responsible Government was withdrawn.

In the 1930's the Medical and Kindred Professions Ordinance was amended nine times. Ordinance XXIII of 1931 stipulated new qualification for those intending to practice the medical profession in Malta (MGG supp, 1931). Ordinance XII of 1932 revised the provisions relating to dentistry (MGG supp, 1932). These provisions were amended again in 1933 (MGG Supp, 1933) and in 1934 (MGG Supp, 1934).

An amendment, which is very significant for this dissertation, is that made due to the provisions of Ordinance VIII of 1936. This law was enacted thirteen years after the first regulations concerning nursing were published in the Government gazette. The Nominative Council approved this Ordinance on 6th
March 1936. This amendment added chapter VIa to the Medical and Kindred Professions Ordinance and it was titled Registered Nurses for the sick (MGG Supp, 1936). It provided for the setup of a register of nurses for the sick and it set the criteria needed for one to be able to be registered as such. With the provisions of Ordinance VIII of 1936, the Medical Board became the regulatory body for nursing. By the provisions of Ordinance VIII of 1936 all those registered as Nurses were to be issued with a certificate of Registration, which was to be signed by the CGMO.

This board also had the powers to approve training schools and courses for nurses and the conditions for the admission to such training courses. The approval of teachers and examiners fell also under the jurisdiction of the Medical Board and it was responsible for the establishing of any fees necessary both for examination and for registration purposes. Ordinance VIII of 1936 also provided for the drawing up of a scheme for the establishment of a nursing school. It also gave the right to those who will be on the register to use the title ‘Registered Nurse’ and practice as such. It also made it unlawful to assume the title of registered nurse unless one is duly registered. Originally, the register for nurses was to be kept in the Medical and Health Department. The title of this general heading was changed in 1968 to “Registered and Enrolled Nurses”. That is when Enrolled Nurses started to be accepted on the Maltese Register for Nurses.
The Medical Board was also responsible for the maintenance of professional standards in nursing. In fact, this Act laid out the procedures for the erasure of names from the register in cases of misconduct or because of infirmity of mind or body. It also stated how licences can be restored to people who are struck off the register and how one can appeal from any Medical Board decision. Ordinance 1 of 1944 when the rules of procedure of the Medical Board were also laid out amended these erasure and revocation proceedings.

In the 1920’s, the Maltese Government had already tried to set up a course leading to a qualification in general nursing (Cassar, 1964). This could not be done because no suitable facilities that could serve as a home for the nursing students, close to the Central Hospital could be found (Savona Ventura, 2005). The objectives of Ordinance VIII of 1936 started to be applied during 1937, when a nursing school was established in Malta on the 22nd August 1937 with the engagement of English trained Nurse Ms L.M. Doherty as senior tutor (Savona Ventura, 2005). According to Bernard (1938) in the following year, the school managed to recruit fifteen students. During the Second World War, the theoretical part of the Nursing Course was suspended and the probationer nurses were employed in the emergency hospitals (Savona Ventura, 2005). According to Gauci (1948), the theoretical training resumed in 1942 and in 1945, six Sisters successfully passed their exams.
Ordinance 1 of 1937 amended the section that dealt solely with nursing. This amendment extended the list of foreign nurses eligible for registration under Article 59 of the Medical and Kindred Professions Ordinance (MGG supp, 1937a). It made it possible that not only those registered in the United Kingdom and His Majesty’s Dominions, but also those registered in any British Protectorate or Protected State or any Territory in respect of which a Mandate on behalf of the League of Nations that has been accepted by His Majesty can apply for registration as nurses in Malta. This amendment also made the proviso that for such candidates to be considered there should be an agreement of reciprocal recognition. Therefore one can say that here the path for the recognition of Maltese Registered Nurses abroad was laid. Act V of 1948 amended this paragraph and it made it obligatory that any foreign Registered Nurse who applied for recognition by the Board had to have been engaged for at least five years in buona fide practice before 1st March 1948 and had to undergo an examination set by the Board.

The provisions of Ordinance XXX of 1937 repealed the Public health Ordinance of 1900 and provided for the establishment of the Medical and Health Department for whom, the Chief Government Medical Officer was designated as head (MGG supp, 1937b). The Chief Government Medical Officer also became head of all the public health care services provided in the Maltese islands. The executive official responsible for health administration
entrusted with the supervision of work of the health personnel and their training was the Senior Health Officer.

In 1939, the Macdonald Constitution which restored the Council of Government and provided for the setup of the Public Service Commission was granted. This coincided with the outbreak of the Second World War. In 1939, we see minor amendments to the Medical and Kindred Professions Ordinance by Ordinances XV, XXX, and XLII of 1939. It is important to note that prior to certain amendments and the inclusion of the roll for hospital attendants, on the 16th October 1940, in the debate of the Council of Government the Chief Government Medical Officer described the different nursing classes as being 1) those belonging to the Order of the Sisters of Charity (some of which received some training abroad), 2) a number of nurses who had undergone between ten to twelve months training and these were described as Hospital Attendants and 3) those who in the future will have training in English hospitals. Eight years after this speech, we see the enactment of Act V of 1948, which provided for the establishment of a roll for Hospital Attendants. In August 1942 due to the provisions of Ordinance XIII of 1942, minor amendments were made to the Medical and kindred Professions Ordinance (MGG supp, 1942). Four other amendments that did not directly affect nursing were Ordinance XIII of 1942, Ordinance 1, Ordinance V, and Ordinance XIII of 1944.
Post-World War II

After the ravages of the war in tandem with the post war restructuring project a substantial amount of social measures started to be introduced. In 1945, the Malta Memorial District Nursing Association (MMDNA) was set up to offer a community nursing service. In 1946, we see the arrival of six nurses from the Queens Institute of District Nursing to help in the setup of the MMDNA (BMJ, 1946). They were also expected to train Maltese girls in the art of community nursing.

In 1946, Ordinance XLII of 1946 amended the Medical and Kindred Professions Ordinance (MGG supp, 1946). This amended Article 44 of the Medical and Kindred Professions Ordinance that dealt with the qualifications necessary for the grant of a midwifery licence. By the provision of Ordinance XLII of 1946, the course in midwifery at the University of Malta was abolished. In 1947, the matron of the Central Hospital, Miss Antoinette Butcher, Sister of Charity was honoured with the M.B.E. (BJN, 1947).

In 1947, the MacMichael constitution was promulgated. Act V and Act XLVII of 1948 amended the Medical and Kindred Professions Ordinance. Due to the changes with the provisions of Act V of 1948, nurses practicing for more than five years were given the opportunity to apply for the general part of the register of nurses for the sick (MGG supp, 1948a). Act V of 1948 introduced a register for hospital attendants. As in the case of the register for nurses, a
roll of hospital attendants had to be formed and kept in the Medical and Health Department. Act V of 1948 also substituted Section 71, which is the section about the training schools for nurses. The responsibility for the approval of schools for nursing was put on the Governor where before it was on the Head of Government. This substitution came a year after sister Aldegonda Farrugia was appointed as head of school for nurses after undergoing one year of training in Kensington College, London was appointed as Nurse Tutor at the St. Luke’s School for Nurses (Gauci, 1949). Gauci (1949) also reported that after the appointment of Sister Aldegonda, the nurse education system in Malta was revised to align it with the UK model. Therefore, the Ordinance was amended to make provisions so that the courses provided will be in line with those provided in the United Kingdom. This change in education led to a better level of trained nurses, which in 1952 started to be recognised by the General Nursing Council of England and Wales (Galea, 1954). During this period, another book, *Manwal ghall-Infemieri*, written by Dr. J. Morana, was published.

Act XLVII of 1948 amended the requirements for the prescription of certain medicines (MGG supp, 1948b). In 1948, we see the introduction of another part to the Medical and Kindred Professions Ordinance. This was part VII B that regarded masseurs and physiotherapists. This was done by Act IX of 1949 (MGG supp, 1949) and it laid down the provisions for entry into the
In 1951 Ms Mabel Lawson, Deputy Chief Nursing Officer of the English Ministry of Health was in Malta to give talks about the nurse training and the nursing services in the United Kingdom (BJN, 1951).

As already stated, in 1952 it was reported that the General Nursing Council for England and Wales had accepted for admission to the general part of the register persons trained under certain aspects in Malta and who were registered by the Medical Board for Malta (The General Nursing Council for England and Wales, 1952). This happened a few months before the first group of 23 graduates locally trained Registered Nurses were presented with their certificates by Lady Creasy in 1953. The Nursing Council of England and Wales recognised all these nurses. Reciprocal recognition with the boards of Queensland and Victoria in Australia was reached in 1955 (Times of Malta, 1955). With the provisions of Act XXII of 1957, it also became not lawful to practice the profession of nurse for the sick unless duly registered under this part.

This was followed by a period of political unrest, which resulted with the Governor, Sir Robert Laycock suspending the constitution, and Malta was relegated again to the status of a Crown Colony. During this Period of political instability Emergency Ordinances 6 (MGG, 1958a) and 15 (MGG, 1958b) of 1958 were enacted to amend the Medical and Kindred Professions
Ordinance. The most important was Emergency Ordinance 15 of 1958, which divested the Council of Government from its powers in the Sanitary Ordinances.

In 1959, we see further reforms due to the provisions of two other Emergency Ordinances. Emergency Ordinances I and II of 1959 brought on further reforms to the medical institutions in the Maltese Islands (MGG, 1959a, MGG, 1959b). Emergency Ordinance I of 1959 brought into effect the suggestions of the Medical Services Commission of 1956 by amending the Public Health Ordinance of 1937. The Medical Board was abolished and the Medical Council, the Advisory and Executive Board, the Hospital Management Committee and the General Services Board were created (MGG, 1959a). The Advisory and Executive Board was responsible for any transfers or promotions within the Medical and Health Department and the appointment of selection committees for new posts within the department.

Emergency Ordinance II of 1959 amended the Medical and Kindred Professions Ordinance of 1901. Ordinance II of 1959 shifted the responsibilities of professional regulation of Nursing from the Medical Board on to the Advisory and Executive Board. Emergency Ordinance II of 1959 removed the powers of the Board to make registration fees; it also regulated the procedure for the deletion and restoration of names in the register. The
state of emergency was ended when an interim government was installed. The Governor and a nominated council administered this interim government. The Medical and Kindred Professions Ordinance was also amended by Ordinance III of 1959 (MGG, 1959c) and Ordinances XXVII and XXX of 1961. In 1961, we see two further amendments to the Medical and Kindred Professions Ordinance. Ordinances XXVII and XXX of 1961 did these amendments. The amendments made by these ordinances affected only the medical profession.

In 1959, a constitution that provided for the formation of an Executive Council where the Governor was granted general power to legislate by Ordinance was granted (Cremona, 1997). During this period the Blood commission that was set up to draft a report and make proposals for a new constitution. This led to the promulgation of the Blood Constitution, which came into force on 24th October 1961. The Malta Labour Party, the Nationalist Party, and the Democratic National Party denounced this constitution. Apart from granting full legislative and executive powers to the local government, the diarchy was abolished. This constitution transferred many legislative powers concerning public health from the Governor to the Minister of Health. In 1962, due to the provisions of Ordinance XXV, the Minister of Health was empowered to issue certain regulations in terms of sanitary Ordinances (MGG, 1962a).
The 1962 election was won by the Nationalist Party with the main aim of acquiring independence from Great Britain. This was attained on the 21st of September 1964 when the Malta Independence Act enacted by the United Kingdom Parliament came into force. The medical and Kindred Professions Ordinance of 1961 was amended by Act III of 1962 (MGG, 1962b) and Act V of 1962 (MGG, 1962c). Legal Notice 4 of 1963 passed on the responsibilities from the Head of Government onto the Minister responsible for Health (MGG, 1963).

Post independence
Independence signified the end of direct British influence on Maltese legislation and the legislative powers fell on the Maltese Legislature. The first post independence amendment to the Medical and Kindred Professions Ordinance was by Legal Notice 46 of 1965. This was done to re-designate various new offices and governmental institutions that were created by the Malta Independence Order of 1964 (MGG, 1965). The Nationalist party was re-elected in 1966 for another five-year period (Schiavone, 1992). During this five-year period the Medical and Kindred professions Ordinance of 1901 was amended six times. On 5th June 1965, Lady Dorman officially inaugurated the School for Nurses (Malta Review, 1965). The nursing courses that were offered in this school continued to be recognised by the General Nursing
Council of England and Wales until 1977. This reciprocal recognition stopped because of the doctor's trade unionist activities (Savona Ventura, 2005). This recognition was reactivated in 2004 after Malta's entry into the European Union.

Amendments done by Acts V, XI, and XXVII of 1967 did not have any effects on the Nursing profession. The most significant amendment to the Medical and Kindred professions Ordinance during this period was by Act XXII of 1968 (MGG, 1968). This Act transferred the powers of making fees from the regulatory boards on to the Minister of Health upon consultation with the various boards, namely the Medical Council, the Pharmacy Board and the Advisory and Executive Board.

Act XXII of 1968 made further provisions concerning nurses. It also created a new class of Nurses, which were called Enrolled Nurses. Article 16 appointed the Advisory and Executive board as the keeper of the register and roll of nurses, instead of the Medical Council. Such a register had to distinguish between registered general nurses and registered specialised nurses. The Advisory and Executive Board was given the task of approving training schools for registered and enrolled nurses and the possibility of recognition was extended to the whole of the British Commonwealth.
As stated earlier on, the conditions for Enrolment were introduced by Act No XXII of 1968. This made provisions for those who were enrolled in the United Kingdom to be eligible for enrolment in Malta. Another provision made by this amendment was that those who were enrolled as Hospital Attendants on 1st March 1968 and were performing such duties were automatically Enrolled as Nurses as were those who on 1st March 1968 were undergoing the course to obtain the qualification as a hospital attendant, if on termination they qualified as hospital attendants. This act made it illegal to use the titles and/or practice as a registered nurse or enrolled nurse unless registered or enrolled with the board. It also remained illegal to wear uniforms or badges that resemble those of nurses as approved by the Board. It also provided that enrolled nurses are to work under the supervision of either a registered nurse or a medical practitioner. Act No. XXII of 1968 also introduced a paragraph into the main law that defined the contents of the register and the roll of nurses. This remained so until the Health Care Professions Act of 2003 finally repealed it. The amendments made by Act XXIII of 1968 provided for the set-up of the Pharmacy board under which the responsibility of the practising of apothecary and apothecary assistants fell. Act No. XXVI of 1969 reintroduced the principle that those applying for registration or enrolment had to show that they have been practicing for at least three years prior to 1st April 1948 and that on the 1st of January 1949
were in possession of a certificate issued by the Advisory and Executive Board or if they did not possess a certificate they had been working for at least 10 years prior to 1st April 1948.

In July 1971, we see a change in government; this is when the Labour party under the leadership of Dominic Mintoff won the general elections (Schiavone, 1992). In 1973, Act XVIII (MGG supp, 1973a) amended the provisions dealing with midwives and nurses. Act XIX of 1973 paragraph 4 made provisions for the establishment of the Nursing and Midwifery Board (MGG supp, 1973b). It was composed of nine nominated members, including the chairperson and six elected members. This board had an advisory role and was vested with various duties, which included the grant of licences to midwives, the registration, or enrolment of nurses, the keeping of the necessary registers and the maintenance of professional discipline. It also had the responsibility to advise the Minister of Health in matters concerning the courses of studies and the training of midwives and nurses. This remained so until it was repealed by the introduction of the Health Care Professions Act when the council for Nurses and Midwives was set up.

Act LVIII of 1974 amended the responsibilities of the Nursing and Midwifery Board. According to article 34 of this Act:
“The duties of the Nursing and Midwifery Board shall be - (a) to advise and make recommendations to the President of Malta concerning the grant of licences to midwives; (b) to advise and make recommendations to the Minister concerning the registration or enrolment, as the case may be, of nurses; (c) to advise and make recommendations to the Minister concerning the courses of studies and training and the relative examinations which may be prescribed as a condition of admission to the register of midwives and to the register or roll of nurses, as the case may be; (d) to keep a register of midwives, a register of nurses, a roll of nurses and a roll of hospital attendants; (e) to prescribe and maintain professional and ethical standards for midwives, registered nurses, enrolled nurses and hospital attendants; and (f) to advise the Minister on any matter including legislation, affecting the practice and service of midwives, nurses and hospital attendants, which matter the Minister may refer to the said Board.”

The Republic
In December 1974, Malta became a Republic. This brought various constitutional changes. Whilst the 1964 constitution was a monarchical one, due to the new constitution the head of state became the President of the Republic (Cremona, 1997). This necessitated an amendment in the Medical and Kindred Professions Ordinance of 1901 to bring them in line with the provisions of the new constitution. These amendments were done with the provisions Legal Notice 148 of 1975. In 1975, we see three minor amendments to the Medical and Kindred provisions ordinance. These were made by the provisions of Acts XXI, XLV, and LVI of 1975. Craig
Hospital, which is now known as the Gozo General Hospital, was opened in May 1975.

In 1976, the Labour Party was returned to government (Schiavone, 1997). In his opening speech of the legislature, the President of the Republic Sir Anthony Mamo announced that the Government was planning to introduce a new health care scheme to ensure free medical services for all (DHR, 1976). The amendments made by Act XX of 1976 made it obligatory that for a foreign registered person to be recognised there must be full reciprocity between these islands and his area of registration. In 1977, we see a minor amendment made by the provision of Act XI of 1977 that shifted the responsibilities from the Minister of Heath on to the Minister of responsible for Public Health (MGG supp, 1977a).

In 1977, we see the flare-up of the doctor's dispute with the labour government. Due to the shortage of junior doctors, the labour government amended the Medical and Kindred Professions Ordinance of 1901 by Act XVII of 1977 (MGG supp, 1977b). After this bill became law, the Medical Association of Malta (MAM) ordered its members to take partial industrial action. This led to the eventual lockout of those who did not agree to work as instructed by the Chief Government Medical Officer for according to the
Prime Minister they were not expected to earn salaries while no providing vital medical services (DHR, 1977).

In June, we see the publication of ACT XX of 1977, which passed on the function of the granting of licences to doctors from the Medical Council on to the Minister responsible for Public Health (MGG, 1977c). The minister was also given more responsibility with stricter control over private medical practice. Due to these amendments, medical practitioners who on May 31st were employed in government service were barred from working in private hospitals unless they were authorised by the Minister responsible for public health. This dispute was taken to court and both the Court of First Instance and the Constitutional Court ruled against the medical association of Malta thus justifying the amendments made by Act XX of 1977. An effect of this dispute was the suspension of the recognition of Malta medical degrees by the British General Medical Council.

In November 1979, we see the inauguration of the new children’s hospital at Pieta, known as Karin Grech Hospital. The Medical and Kindred Professions Ordinance was amended four times between 1980 and 1982. This was done by Act XXV of 1980 (MGG supp., 1980), Act XLIX of 1981 (MGG supp, 1981), Acts IX and XVI of 1982 (MGG supp, 1982). Act XLIX of 1981 made it obligatory that for someone to seek registration the person must be a citizen
of Malta, whilst before it was open to all British subjects. On the 24th of August 1982, we saw the publication of the Elections for the Nursing and Midwifery Board Regulations Order. Act VIII of 1983 constituted the Board for the professions supplementary to medicine (MGG supp, 1983a). Thus after 1983, the Medical Council became responsible only for the control of the professions of Medicine, Dentistry, and Veterinary Surgery.

Act XVI of 1983 (MGG supp, 1983b) made amendments to the same ordinance that made it unlawful for a person registered under a special part to work as a registered nurse outside the speciality to which he or she is registered. If such a person works outside the area of special registration, he/she is to work as an Enrolled Nurse. This section now provided also for a special part for Enrolled Nurses apart from the Special Register for Registered Nurses. This meant that now even Enrolled Nurses could register under a special part. It also made it illegal for any Enrolled Nurses registered under a special part to work outside that speciality. In 1985, we see a number of amendments made to the Medical and Kindred Professions Ordinance by the provisions made by Act V of 1985 (MGG supp, 1985). An important provision made by this Act was related to the empowering of the Minister of Public Health on the control of the manufacture, exportation, distribution, and sale of psychotropic substances. Act XVII of 1986 amended these provisions (MGG supp, 1986). With Act V of 1985, the need for reciprocal recognition
was waived off and it became obligatory that for one to be Registered or Enrolled as a nurse in Malta, the conditions of training for Registration or Enrolment were to be equivalent to those prescribed by the Medical and Kindred Professions ordinance and the Nursing and Midwifery Board. On the 16th of September 1986, the Training School of Registered Nurses and Enrolled Nurses Regulations were published. In 1986, the nurse-training curriculum was changed from a block system to a modular one; these changes were made under the headship of Sr. Federica Galea.

In May 1987, the Nationalist party returned to government (Schiavone, 1992). By an agreement between the government and the Medical Association of Malta a settlement to the doctors' dispute was reached. Act XIX of 1987 implemented this settlement (MGG supp, 1987). This repealed the restrictive licence requirements on private hospitals and clinics and it gave responsibility to the Medical Council to advise the President of the Republic on the granting of licences to practice the medical profession in Malta.

Another Act that has a direct influence on nurse Registration is the Education Act of 1988, the reason for this being that this Act provides for the set-up of the recognised educational institutions that now are responsible for the local training of nurses. Statute 13 of this act provides for the set-up of the Institute of Health Care according to which the aims are:
“(a) to provide degree and diploma courses in Health Care Sciences (such as in Nursing, Medical Technology, Speech Therapy) and allied areas, subject to the statutes and regulations of the University;

(b) to certify courses in Health Care provided by other Institutions if the standards attained are acceptable to it;

(c) to conduct research of both mono-disciplinary and a multi-disciplinary kind, with a focus on health care”.

Nurse Education started to be given at university; this led to a shift from vocational training of nurses to graduate training. This was augmented by the setting up of the first-degree course and later, in 1990, with diploma courses in Nursing. The person who was entrusted with the implementation of these educational changes was Ms. Barbara Burkey

Than on the 18th of September 1997, the Diploma in Nursing or Diploma in Midwifery Regulations was published. Later on in the same year, which is on 3rd November 1992 the Bachelor of Science (Honours) in Nursing/Midwifery Studies Regulations, were published. In 1994 we saw the publication of the Diploma in Psychiatric Nursing Regulations thus providing the legal framework for the provision for the courses leading to a diploma in Psychiatric Nursing and a conversion programme of a diploma to degree in mental health Nursing. In 1994, on the 1st of November, the Procedure of the Nursing and Midwifery Board for the erasure of names from the Register were published.
In May 1997, the Maltese Code of Ethics for Nurses and Midwives was published. The forward of the publication was by Dr. Soler the chairperson of the Nursing and Midwifery Board. Amongst other things, this code stated that amongst the professional responsibilities of the nurse, the nurse should seek to maintain professional integrity to uphold both self-integrity and that of the profession (Nursing and Midwifery Board, 1997). This code of ethics also put a responsibility on individual registered nurses that they should they to maintain professional knowledge and competence especially in the area in which they are practicing. It also made it obligatory for nurses to participate in activities that help to raise the profile of the profession and in research activities. This code of ethics also made it clear that nurses have various obligations toward society. One of the main obligations is to help maintain public trust and confidence in the profession. This strive to maintain trust should not be just during the performance of professional activities but all the time.

In 1998, Ms. Nicholina Farrugia was appointed as the first Director of Nursing for the Maltese Islands (DNS, 1998). On 16th November 1998 the Post-Qualification Diploma in Health Science and Degree of Master of Health Science Course Regulations were added and in December 1998 the Institute of Health Care Certificate in Nursing Practice Course Regulations were published (U.O.M., 1992). In 1998, The Enrolled Nurse to Registered Nurse
Conversion programme started (DNS, 1998). The new Diploma in Nursing and Diploma in Midwifery Course Regulations were published on the 15\textsuperscript{th} of June 1999.

In December 1999, we witness the setup of the Foundation for Medical Sciences and Services (FMSS). The first hospital to be run by this foundation was Zammit Clapp Hospital, which was reopened on 26\textsuperscript{th} September 1991 as an acute geriatric short stay rehabilitation facility.

In 2002, the Nursing Directorate published the Scope of Professional Practice. In its introduction, it outlines the responsibilities of nurses who are registered to practice nursing in Malta. Section 2 of this Scope of Practice gives us a definition of professional nursing practice. It states that:

> “Professional nursing practice is the application of nursing knowledge, skill and judgement to promote, maintain, and restore health, prevent illness and alleviate suffering, and includes:

a) Assessing one’s health status.

b) Planning, providing and evaluating care / treatment and nursing interventions.

c) Counselling, educating and teaching on health issues to enhance one’s health and well being.

d) Carrying out research and implementing research evidence related to health care and nursing care delivery.
e) Participate with and contribute to a collaborative working environment comprising other professionals involved in health care delivery". (Nursing and Midwifery Board, 2002, p.5)

After providing this definition, the scope outlines the basic competencies of the nurse. Here one also finds a list of reserved acts, which is a list of duties that appertain solely to the profession of Nursing, a list that is not exhaustive. It is also made clear that nurses should not assign duties that are theirs to others who do not have the necessary knowledge, skills, and authority to perform them.

On the 21st of February 2002, the Honourable F. Agius asked the Honourable Minister of Health if it is true that a group of Lawyers had been commissioned to evaluate the Medical and Kindred Professions Ordinance. He also asked him about the input by the medical profession and the total costs for this exercise. The answers to these questions were given in sitting number 250 of the ninth legislature where the Honourable Deguara said that a law firm had been commissioned to evaluate the Medical and Kindred Professions Ordinance and various meetings with the Health Care Professionals concerned will be held. He said that the total cost is in the range of LM12, 000. This process led to the enactment of The Health Care Professions Act.
The Health Care Professions Act

In 2003, we see the introduction of the Health Care Professions Act. According to the DGH (2002), this formed part of the legislative changes that were needed in view of Malta's accession into the European Union. According to the Director General, this legislation was written to reflect the exigencies of professional self-regulation and it was written after consultation with the professional associations and trade unions in the health care field (DGH, 2002). In February 2002 a group of EU experts in the field of health professionals regulation, that is the Technical Assistance Information Exchange (TAIEX) made a five-day exploratory visit in Malta (DGH, 2002).

This law was presented by the Hon Minister of Health by motion number twenty-three presented on the 24th of May 2003. The first reading of this legislation was on 26th May 2003 and was approved unanimously. On the 6th of October 2003 the Hon. Helen D'Amato reported to the House that the draft legislation concerning the Health Care professions was approved by the standing Committee responsible for the presentation of draft laws. On the same day, the Deputy Prime Minister seconded by the minister of justice proposed the third reading of the bill, which was later approved unanimously.

The second reading of this draft legislation was on the 22nd September 2003. The second reading was proposed by the Hon Minister of Health and seconded by the Hon. Mario Galea the only nurse who is a member of the House of
Representatives. In his introductory speech, the Hon. Deguara said that the main aim of this legislation is to update regulation and make it more practical and to ensure uniformity between all the Health Care Professions. He also said that such amendments are necessary to put Maltese Health Care Professions in line with European Union directives and regulations.

The Health Care Professions Act came into force in November 2003 after being approved by the House of Representatives on the 6th October; this partially repealed the Medical and Kindred Professions Ordinance and the Department of Health Constitution Ordinance. Through this Act, the Boards that were set up due to the provisions of the Department of Health Constitution Ordinance were dissolved making way for the new councils, namely the Medical Council, the Pharmacy Council, the Council for Nurses and Midwives, and the Council for the Professions Complementary to Medicine. Since its enactment Act III of 2004, Legal Notices 253 and 342 of 2004; Act XIII of 2005; and Legal Notice 376 of 2005 have amended it.

Due to this legislation the Nursing and Midwifery Board was replaced by the Council for Nurses and Midwives and for the first time the majority of members on this Council will be elected members and not members nominated by the Minister of Health or by the President of Malta. Another thing that was introduced thanks to this legislation was the representation of
service users on the respective councils. On each Council there are to be two representatives of the service users, representatives that cannot be health care professionals.

Another innovation is in how investigations are initiated. Whilst in the past there had to be a sworn report for an investigation to be commenced by the board, now the Council can start investigating any breach of regulations or ethics without having a sworn or a written report. For the conduct of such investigation, the Council could also nominate a group of experts so that the investigation would be impartial and it will not take a lot of time from the Council's sittings.

This Act also changed the nomenclature of the locally registered nurses. Whilst with the provisions of the Medical and Kindred Professions Ordinance these were divided into Registered and Enrolled Nurses, with the Provision of the Health Care Professions Act they are divided into First Level and Second Level Nurses. The First Level Nurses being those who before qualified to obtain State Registration, whilst the Second Level nurses were those who were previously called Enrolled as Nurses.

Due to the provisions set by this legislation, unless granted special permission, a professional cannot practice more than one profession that falls under this legislation, and than the professional has to make a choice. Another clause
states that no union official can contest the election to form part of any of these Councils. The Hon. Karl Chircop commented on the fact that the chairperson of these Councils is to be a member of the legal profession. He suggested that these should have at least seven years of experience to be considered for such a post. The Hon Chircop also mentioned the fact that nurses will not be issued a warrant as in the case of other established professions. Here the Honourable Deguara answered that nurses were not issued by such a warrant for it can only be issued to professions that do not work under supervision.

The Honourable Chircop also raised concern about the term ‘proficient in the language’ for he said that unless a Health Care Professional can communicate effectively with the service users it might be detrimental to the service rendered. To this, the Honourable Deguara replied that according to European Union Legislation one cannot impose language barriers for this would interfere with freedom of movement of workers. He also said that the onus for this lies on the employer to see that the Health Care Professionals that are employed is able to communicate effectively and safely. The Hon Silvio Parnis mentioned the fact that now nurses have achieved a certain status because they are being educated at university.

On the 21st of April 2004, that is in sitting 118 of the Tenth Legislature we saw the debate on the Law that was intended to amend various laws. The Deputy
Prime Minister proposed this and in his introductory speech, he said that part of this act is to amend the Health Care Professions act. The reason given was that certain provisions had to be introduced into Maltese Law. These were mainly the recognition of certain foreign qualifications and titles and the provision that in case of a breach of regulations by someone who is registered in Malta the respective Council will have the power to inform the other regulatory bodies within the European Union. This amendment was criticised by the Honourable C. Mangion because it amended about 24 laws at the same time and therefore there was not enough time for debate. The Honourable Dr. L. Deguara added that the amendment that gave the right to the councils to share information with other councils in the European Union was done to protect the public from people who were struck off the registers in their country of origin and would apply to practice in Malta. In fact, this amendment gives the respective Councils power "to forward to any Member State concerned all information regarding measures taken in respect of healthcare professional as well as regarding any criminal penalty imposed on such professionals".

This act also amended the registration process for people who are already registered within the European Union but who obtained their qualification from outside the European Union. Whist before they were registered automatically now it had to be assured that their training is similar to that
given in Malta. In the same debate, the Honourable Dr. M. Farrugia commented on the fact that up until this day there are certain recognised professions which are discriminated against for they are not issued by a warrant as other professions are.

Act XIII of 2005 was published on 29th July, 2005. It was enacted by the House of Representatives at Sitting No. 292 of 18th July, 2005. This was an act that was enacted so as to amend various laws one of which being the Health Care Professions Act of 2003. The part that deals with these amendments is Part XIX.

On Wednesday 12th April 2004 a bill to amend various bills was proposed. One of the amendments was to the Health Care Professions Act. This was published as a supplement to the government gazette, Nr. 17,574, of 30th April, 2004. This was done so as to amend the third schedule of the Health Care Professions Act. This has no affect on Nursing because it just updates the list of the professions considered to be Complimentary to Medicine.

Legal notice 342 was published as a supplement to the government gazette, Nr. 17,611, of 22nd June, 2004. This also did not have an effect on Nursing because it was an amendment to the Fourth Schedule and it was amended to include the Maltese Association of Specialists in Psychiatry and the Malta College of Dental Surgeons. Legal notice 376 of 2005 also had no affect on
nursing because it just updated the list of the professions considered to be Complimentary to Medicine. This was published as a supplement to the government gazette, Nr. 17,842, of 15th. November, 2005.
CHAPTER 6 - DISCUSSION

In a system with a curative bias nurses have always been subordinated and undervalued as carers, and oppressed as women (Carpenter, 1995). In today's world, nurses are encouraged to change this relationship from a subservient one to that of a peer professional. In the last few decades, the applied knowledge domain of nursing has changed from medical knowledge to nursing knowledge. The International Council of Nurses (2002) in a position statement declared that today's health care is dependent on a knowledgeable workforce. Therefore, nurses' information seeking and use should be understood in relation to nurses' professional project. The professionalisation of nursing can be aided by the conduct, dissemination, evaluation, and implementation of nursing knowledge and research.

When compared to the regulation of the established professions of Medicine, Pharmacy, and Midwifery, Nurse Regulation is relatively new. The reason being that whilst the above mentioned professions have been regulated since the publishing of the Legal Code of Grandmaster Antonio Manoel de Vilhena of 1724, nurses only started to be regulated in 1936. Despite this, today the regulation of nursing as compared to the above-mentioned professions is nearly similar.
The beginnings
The legislation that regulates Nurse Registration in the Maltese islands seems to have evolved at a very slow pace. This evolution could be attributed to a wide variety of reasons; these include apparent weaknesses in the system that had to be catered for, advances in nursing and nurse education and the changes in the Maltese political scene. These changes may also be partly attributed to the globalisation of health and the greater availability of Health Care Information. Therefore, one can say that nursing seems to have evolved according to society’s needs.

Nurse Regulation was legalised a number of years after the first short term training course for nurses was conducted in 1882, and the arrival of the first trained nurses in 1885. This regulation was enacted in 1936, eighteen years after similar legislation was enacted in the United Kingdom. The 1936 law provided for the setup of a register for Nurses for the sick. This nomenclature was changed in 1968 when the title was changed to Registered Nurses and this was changed again in 2003 to that of First Level Nurse.

In 2002 with the publication of the Scope of Practice, we see the first local official definition of Nursing. This definition is a reflection of the progress that nursing has made throughout the years, the progress from someone who is just caring for the sick to someone who has a role in both illness and heath.
This definition also reflects the declaration made by the ICN when it issued its definition of Nursing.

**Regulation**

As stated earlier on in this dissertation, the hallmark of any profession is its ability to regulate itself (N.M.B., 1997). This regulation apart from being provided by the legal framework necessitates a commitment from the regulatory bodies, nursing associations and individual nurses. Up until this day apart from the legal framework, nursing in the Maltese islands is regulated also by the Maltese Code of Ethics for Nurses and Midwives (1997) and by The Scope for Professional Practice (2002). Together with these, standards of practice and the mapping out of the competencies of a nurse need to be set up. These are necessary to ensure greater credibility in the profession itself and in individual professionals. It is important for it will contribute towards having more competent and knowledgeable nursing practitioners. Practitioners that will deliver care primarily in the interest of the clients that they serve.

Although nursing is regulated by the same act that regulates the professions of medicine, pharmacy, and midwifery, one can say that in certain provisions, the law discriminates against nursing and nurses. The main reason being that whereas the members appertaining to the above-mentioned professions, apart
from being registered, are issued with a warrant signed by the President of Malta, nurses are not issued with such a warrant. This fact has been criticised a number of times and the excuse that was made by the Minister of Health during a parliamentary debate is that nurses are not autonomous professionals. An excuse which does not hold water for the simple fact that nurses are governed by the same legislation as the above-mentioned professionals and the law in no instance mentions that first level nurses have to work under the supervision of any other profession. The only instance when supervision is mentioned is in the case of second level nurses thus this means that first level nurses are autonomous practitioners as other health care professionals are therefore the non issue of a warrant to first level nurses is discriminatory towards them.

The independence of nursing is also stated in the code of ethics for Maltese Nurses and Midwives, which declares that it acknowledges that nursing and midwifery are independent professions being complementary and not supplementary to other professions and other categories of health care workers (Nursing and Midwifery Board, 1997). Thus here again we do not see a distinction between the two professions, but concerning the issuing of warrants the discrimination is there.
Therefore, legislative changes in this area are necessary. Here one has to be careful that the non granting of a warrant to nurses is not motivated by some other health care profession that is traditionally stronger than nursing. This can be so because some class might use its superior power to exploit classes with less power, and the state is merely the apparatus of power which it uses for exploitation, "a committee for managing the common affairs" of the dominant class (Sabine & Thorson, 1989).

**Political involvement**

If nurses wish to affect outcomes in policy formation, they must be more politically involved. The term politics refers to the "exercise of influence;" however, more than one political level exists in which influence is a factor (Des Jardin, 2001). If nurses do not become politically involved, they will have no power on their future for the discourses that are inherent to nursing will not be heard of and thus not become part of the common language and subsequently gaining power. Such discourses if not made public by the nurses themselves might be appropriated by other Health Care Professions and they will reap benefit from them and not nursing and nurses themselves even though initially they might have appertained to the profession of nursing.
Maybe as nurses, we need to learn to work more together as one whole group. Nurses are relatively a big group so both as a group and as individuals, they can have greater influence than other professional groups if they become politically involved. Many opportunities exist for nurses to become politically involved. They can be involved at community, professional and institutional levels. Nurses can give their invaluable contribution on a number of committees starting from those related to their professional practice and various others where their voice can be heard. Non-traditional approaches, such as professional practitioner visibility, membership on local school boards, and involvement in charitable organizations, are extremely effective methods of influencing public opinion regarding nurses' role at local community and national levels. Here it is important to note that the code of ethics specifies that every nurse must recognise her responsibility to participate in activities that contribute to the ongoing development of their professions (Nursing and Midwifery Board, 1997). Therefore, such participation is obligatory rather than mandatory.

Nurses can also delve into roles that have not been taken up by any other profession or where they can complement the work of other professionals. After all nurses share with other citizens the responsibility for initiating and supporting action designed to maintain and improve the health and social needs of the public (Nursing and Midwifery Board, 1997). It is a well-known
fact that due to a shortage of doctors, some health centres are closing on certain days and nurses are being deployed to other health centres to work there. This may mean that on certain instances or during certain times of the day, some health centres are over staffed with nurses. These nurses can try to go into health promotion by using the health centres to offer classes and other educational opportunities to the community in general. They can also go out of these health centres and offer their expert service outside and thus the nurse will be propagating the image and the reality of a knowledgeable professional thus helping the profession to gain credibility. This will help the public to understand and realise that it is not just the medical profession that is knowledgeable but the nursing profession is knowledgeable too.

All of us can be ambassadors of nursing and all nurses have a duty towards their profession and their professional colleagues. A formal campaign led by the Malta Union for Midwives and Nurses whose aims, amongst others are to be; to enhance the image and reputation of nursing and nurses, to challenge and dispel misconceptions about nursing and nurses, to empower nurses to publicise what they do, to encourage nurses to ‘sell’ nursing to future generations, to raise the public voice and profile of nurses and to encourage more respect for the nursing profession can be launched. Such a campaign should be targeted at all parts of the population.
This campaign can be started after people's perception of nursing are researched so that it will be more effective. This campaign could take the form of what in marketing terms is known as a rebranding exercise. Here one also has to be careful of outside influences. That is from both local and foreign media, since the Maltese tend to see many foreign television stations. Another difficulty is that nursing is so diverse and the numbers are so large when compared to the numbers of other professionals that to reach a consensus of an image might be difficult. That is why a prior concept analysis and the dissemination of the findings of this analysis to the members of the profession are important.

The Scottish Home and Health department (1991) said that every profession involved in Health Care delivery has special skills to offer but at the margins of the field of competence and expertise of each professional group, there are areas where there is some overlap of function. This Department also said that despite these small areas of overlap, the major responsibilities of each professional group are quite clear - with the exception of nursing, where there is a considerable variation in perception. Therefore, unless nurses take it upon themselves to ensure that these perceptions are cleared it will be either other professionals or the media that might fill in this gap.
May 12th, the birthday of Florence Nightingale, is the international nurses’ day. On this day nurses association around the world organise various activities. These activities should be also geared towards the public in general, whose support is needed for the advancement of the nursing profession itself and nurses. This day could be used as a yearly event to launch year long activities concerning the theme chosen for that year by the International Council for Nurses. Such an educational campaign should also be targeted towards other health care professionals, for even these might need to understand more what nursing entails and what the role of the nurse is to be.

The setup of writing groups can also enhance the image of the profession. Such groups can co-ordinate the writing of articles on the printed media and thus show the public that nurses are not just there to obey orders imparted by a doctor but they are knowledgeable themselves too. Such media activities can also help to propagate new ideas or ideas that have been suppressed for a number of years. These ideas can help to give a different and better image of nursing and nurses themselves.

This could be accompanied by a research project to try to assess pre and post intervention views of nursing and if these have changed or not. Such a media campaign would also be beneficial to counterbalance the negative press that nursing sometimes gets, for it is rare that on media we hear the good stories.
about nursing and the achievements that nurses and nursing in general are making.

Talking about mass media, more nurses should be encouraged to publicise their work. A lot of good research is being done and little of it is published and thus reaching the public. The publication of such research findings, not only in professional publications will also be of benefit both to the researcher and to the profession in general. The publication of a local journal of nursing studies could help to propagate this.

**Problems**

As stated in the literature review since nursing is still maturing and continuously evolving, it is difficult to define it, thus an open definition as the one provided in the scope of practice leaves room for nurses to perform new tasks and assume new responsibilities. The profession's scope of practice encompasses the activities its practitioners are educated and authorized to perform. The overall scope of practice for the profession sets the boundaries of practice for all practitioners. I think that not many practicing nurses know of the existence of the local scope of practice, thus making it more readily available and explaining its scope and expanding further on it would help nurses to clarify their role more.
Since nursing is continually evolving this scope of practice should be updated regularly. The official publication of this scope of practice, at least in the form of a Legal Notice, might also help to give a legal basis to both the definition of nursing and to nursing practice. The scope of practice can also be a tool against which job descriptions of nurses can be measured and built. Another thing would be that it would help the public and other health care professionals to know exactly what the domain of nursing is and thus appreciate more the practice of nursing.

One can also try to envisage how the role of nurses can evolve more. Legal Provisions can be made for the Regulation of Nurse practitioners who as in other countries should be nurses with a master’s level of education. Such nurses have been proven as effective and efficient as doctors at Senior House Officer level (Robinson & Iny, 1999). This might provide an alternative to senior nurses thus avoiding that experienced nurses move away from the clinical field into administrative posts and subsequently losing their expertise from areas where nursing care can be delivered.

Mobility
Another challenge is that being brought over by globalisation and Malta’s entry into the European Union is worker mobility. To help combat this
challenge, the I.C.N. (2002b) recommends for the setup of an ethical framework for nurse recruitment. Such a setup could be beneficial for nurse migration and for the protection of nursing rights throughout the European Union. This is because the problem of potential perils of exploitation and abuse of nurses exists. Other barriers to mobility include language, culture, and traditions. Even the status of the nurse in different countries may encourage or hinder nurse mobility. Thus countries in which the status of nurses is higher than in others may have a greater advantage and thus some countries may experience a nurse drain, especially well qualified and experienced nurses (ICN, 2002b).

This europeanisation might also be a problem because of the different types of terminology used. This might necessitate standardization of certain terminology for even though most of the laws in the different countries give an explanation of the terminology used the layperson is not aware of these different definitions and thus may become confused when making use of services in different countries. This standardisation apart from helping in the mobility of nurses will so help the client to understand better certain terminologies and designations thus he will be a better-informed user of services.
The nurses’ sectoral directives, as stated earlier on, provide for automatic recognition for nurses. One must have a degree or diploma recognised by the sectoral nurses’ directives in order to fall within the scope of these directives, which cover the activities of the general care nurse. Their advantage is that they provide automatic recognition, but the price paid is that they are rather inflexible and rigid. Such rigidity might leave little room for expansion by individual educational institutions thus, it may also be seen as a hindrance to the progress of nursing scholarship. Others may argue that such rigidity may also limit their right for self-regulation of entry into the profession. The need for the demonstration of ongoing competency in all member states is important.

One can set up a European licence where if one is qualified in a certain state it means automatic recognition by others. A concern about this would be the financing and the paying of licences. For if it is a common licence a nurse would only need to pay the licence to a particular regulatory body and not maintain a number of licences. Such fees may also vary because of the different cost of living between member states. Such loss of revenue might have an effect on the functioning of certain regulatory bodies for some of them might depend a lot on the fees that they collect from their licences. A common European licence might help to facilitate worker mobility for one does not have to pass through a lot of bureaucracy to apply for a licence in a state
different form the one she trained it. This will also be of benefit to both the public and the employers because both will know and be sure of the standards of the practitioners through interstate standardisation. In most cases, such career moves can provide opportunities for professional development.

This mobility might lead to a drain of professionals in a state because some professionals tend to be attracted by economic forces. Areas, which offer more to health professionals, may attract more professionals to the detriment of other areas. Other factors that attract health professionals can include opportunities for continuing education and other work and social amenities. The I.C.N. (2001) stated that faced with a growing multicultural patient population, establishing a multicultural provider workforce supports culture-sensitive health care provision.

Ensuring competence
As stated earlier on a framework so that nurse practitioner's competencies are continuously monitored and ensured has to be set up. This is the duty of every registered nurse, because each nurse has the duty to seek to maintain and improve her professional knowledge and competence especially in their field of practice and should take every reasonable opportunity to achieve this (Nursing and Midwifery Board, 1997). A common problem, which is
encountered, is that a nurse could leave professional nursing practice to raise a family or for any other reason and return to nursing many years later, without any requirement to take a refresher course, be re-tested, or in any way demonstrate competence (and safety) to practice. One approach to help in ensuring competence is the use of portfolios, which are a useful mechanism for nurses to plan, evaluate, and document their continuing professional development activities and consequent learning, and help nurses plan for their participation in monitoring and maintaining their continuing competence (Kitson, 1996).

Legal provisions should be set up so that people who are registered and thus legally licensed to practice nursing stay up to date with developments in nursing especially in their field of practice. These regulations are to make it obligatory for people to show that they have attended a specific amount of updating courses or other accredited units related to their work. These educational opportunities are to be accredited and thus approved by the Council for Nurses and Midwives. Here I am proposing that life long registration should be abolished and registration should be renewed every three or four years and this renewal is to be made upon proof of attendance to such courses.
As already stated, the practice of nursing has traditionally been based on the premise that pre-registration education equips the nurse to perform at a certain level, and to engage in a particular range of activities. It is also based on the premise that any widening of that range and enhancement of the nurse's practice requires appropriate competency certification issued by the proper legal body. The reality however is that such practice will continue to be shaped and extended by developments in health care services in general. The best way to ensure optimal care delivery by nurses is for The Council for Nurses and Midwives to establish the listed principles underlying any adjustments to the existing scope of practice. These principles should provide the basis for setting the parameters of the role of the nurse instead of formal certification and/or qualifications. These principles together with the code of practice should safeguard the interests of the client and; moreover allow the nurse to practice as a professional, that is formulate his or her role according to one's own perceived knowledge and experience. This approach to the development of the role of the nurse should provide greater flexibility in practice, which is congruent with the environment within which nursing care is delivered. Above all, the framework of principles and the code of practice established by the Council reflect the personal responsibility and accountability of individual nurses entrusted by the Council to maintain and improve standards of care (Nursing and Midwifery Board, 1997).
People who stop practicing nursing for some time should be put on the dormant part of the register and for them to return to practice they should do a similarly approved back to nursing course. This will help to ensure that all those who are delivering nursing care are truly knowledgeable and competent independent practitioners.

Education

As one can see from the findings and the historical review, nursing has evolved due to the educational evolvement of nurses and has been consolidated by various legal provisions. Some of the legal amendments and changes in designations and roles can be seen to have followed developments in local nurse education. Four years after the appointment of Sister Aldegonda Farrugia in 1947 as the head of school for nurses and the transformation of the courses offered into the British model, nurses qualified in Malta started to be recognised in the Untied Kingdom.

Eight years after the inauguration of the school for nurses, the Nursing and Midwifery Board was created. Than after the move of nurse education into university other significant changes are seen, these include the setup of the Council for Nurses and Midwives, the provision for the independent practice of first level nurses, whereas prior to the Enactment of the Health Care
Professions Act these had to work under the supervision of a doctor, the publishing of the code of ethics and the scope for practice. Thus one here can say that as the educational preparation of nurses improves so does the legal and professional status.

These changes in the education of nurses has helped nursing to start changing from a task oriented approach towards personalised care and helped research, and critical thinking to flourish (Salvage, 1995). This evolution of nursing as a profession can be also described as a process of professional empowerment. The first step to political involvement is empowerment, which is only possible through education (Des Jardin, 2001). Empowerment can be helped through leadership training for nurses at all levels. This can be done by the provision of a formal framework for the provision of continuing education development of all nurses. Sector specific needs analysis research is to be done so that the planning and provision of continuing education is done in line with the findings of such research studies. The greater availability of professional development programmes will help nurses to develop personally and collectively. Such programmes can include professional development, leadership development programmes, skill development, and reflection on practice skills. All these are essential for the person if he/she is to develop his/her knowledge, skills and confidence. After all, continuing education is an essential dimension of human resources development (I.C.N. 2001).
This could also be facilitated by the provision of certain facilities in various areas where such facilities are lacking. Whilst certain hospitals and settings are equipped with libraries and internet connections for nurses so that they will use them for their educational and professional needs, other settings are not equipped with such facilities thus creating discrimination between nurses working in different settings under the realm of the same Director General.

All areas of practice are to be provided with such facilities especially internet facilities so that information can be accessed easily and new trends in care will be taken up immediately. This will help to ensure that information is disseminated to all nurses working supposedly under the same conditions of work and who are expected to perform on the same level. Such discrimination may lead to the development of discourses concerned with Cinderella services or others where certain services are not seen as important as others for no investment is made into these technologies.

Today we are seeing also a number of nurses who possess a master’s degree and nurses who possesses a doctorate working mainly in the local nurse education sector. These nurses can be described as the pioneers of local nurse education achievement. Other nurses are also studying for their PhD and hopefully one day we will have more such qualified nurses.
Other initiatives
The Code of Ethics for Maltese Nurses and Midwives that has been published in 1997 needs also to be revised and updated to the realities of today. A code of ethics should reflect and regulate practice at a particular moment in time, therefore since nursing is dynamic such a code should also be dynamic and it should be continuously updated to be able to reflect and regulate practice better. This argument also holds for all other regulations that are related to nursing and nursing practices including the scope of practice and if drafted and implemented local standards for nursing practice.

Such regulations should take in consideration all different areas of practice and the needs of different nurses for these are to apply for both novice and experienced registered nurses. The main aims of such regulation should be to promote good nursing practice, thus discouraging and hopefully stopping bad practice and when need be intervene to stop unacceptable practices.

Apart from writing and implementing general standards, the council can also set up working groups to write position statements about certain aspects or key words used in such standards. These could take the form of a concept analysis of important themes such as accountability, continuing competence, allocation of knowledge skills and judgement, advocacy, professional relationships, confidentiality, leadership and self-regulation. These guidelines are to be published and made available to each Registered Nurse and their
implementation is to be accompanied by information giving campaigns and an educational campaign. These might help to answer some questions that a lot of nurses pose about what they are supposed and not supposed to do and they may also help to give more credibility to nursing practice, if it is seen by the general public to be credible, well regulated and more knowledge based.

Archives
Initiatives have also to be taken in the preservation of documents that are related directly and indirectly to the history of nursing. During this research I found it difficult to trace certain documents, some of which may be missing and others may not filed in an orderly manner thus difficult to trace. Therefore, the setting up of proper well-maintained Department of Health archive is important. The archives can hold different material in them including written records, photographs, voice records, videos computer records etc.

After all our knowledge of the past is limited to the sources available, thus a lost source may mean a lost link into our past and our understanding of who we are. After all, it is important for us to make it possible for nursing to be a profession with a memory. A memory that should make us proud of who we are and of what we managed to achieve up until now.
Conclusion
Nursing being a predominantly female occupation has been for a long time subjected to the power of the male dominated medical profession. It has been subjected to discourses of dominance by the traditionally male dominated medical profession and discourses about gender and the role of females within society, especially the traditionally patriarchal societies of the west. So to gain credibility as a profession one has to see how it is perceived by either norms or legal coercion. These perceived norms may be attributed to traditional medically (male) dominant and/or discriminatory discourses due to gender biases.

The findings of such studies will help nurses to change discourses so that the truth can change. This search for the truth is the responsibility of the intellectuals and the truth has to be disseminated thus empowering the masses and by helping to create new discourses. Knowledge retention and blocking others from such knowledge is the ultimate exercise of power and this may have been used and maybe is still being used by the traditional professions to suppress the new professions. This dissemination of the truth might mean that the ‘knowledgeable’ few will not have control over the masses.

Here one should remember that nursing has undergone rapid changes and these revolutionary changes are still underway. One should also remember that not all followers will embrace change and it should be ensured that those
who are resisting change are to be catered for and adequately supported. Professionalisation and the move towards science-based nursing can be seen as "counter discourse". This is meant to set up the nurses' own knowledge base, their understanding of the nurse-patient relationship and of nursing practice, against the view of nursing as a profession subordinate to medicine.

Nurses should stop behaving like an oppressed group; nurses should become more proactive and show that they are proactive. One of the major factors that keeps the oppressed from becoming empowered is poor self- and group esteem and identity (Roberts, 2000). The voice of nurses and nursing needs to be heard, heard not just by fellow members of the profession but also by the public in general. After all airing one's own views can be liberating in itself and it gives a sense of power to both the individual and the group.

This demonstrates that Foucault's theory that power and knowledge are closely related is even true for nursing. The acquisition of more knowledge by nurses has led to their legal recognition as independent practitioners, thus consolidating power through legislation. This position of power has put nurses in a better position to acquire knowledge and thus gain more credibility. Credibility that has helped to change discourses about nurses and nursing.
CHAPTER 7 – CONCLUSION AND RECOMMENDATIONS

In this section, I will limit myself to pointing out and listing the various recommendations that arise from this historical study. These will be subdivided into various sections, which are recommendations for; practice, education and research. This is not an exhaustive list for some recommendations have already been made.

**Recommendations for practice**
Stated earlier on information-giving initiatives should be started. These can include various educational programmes aimed both at the public and at members of the nursing profession itself. Nurses should become more politically involved so that their voices are heard more and thus the contribution of nursing would be known more.
The representatives of nurses should take the issue of the warrant more seriously and work for the granting of the warrant to the profession so that members of this profession will gain the same status as the traditionally established professions of medicine, pharmacy, and midwifery. The Code of ethics for nurses and midwives together with the Scope of professional practice should be updated regularly and where need be the Council for Nurses and Midwives is to set up study groups to issue position papers about various issues and concepts.

Recommendations for education
More initiatives are to be taken to ensure that all members of staff have equal access to educational opportunities and resources. This will help so to ensure that the nursing force will be more knowledgeable than it is today since it will be more updated about new trends in nursing. Education in itself is one of the most empowering factors of a profession. If nursing is to move forward, it must be ensured that the members of the profession are knowledgeable and show that they are so.
Recommendations for research

Researching both the publics and nurses' perception of nursing and nurses could help to lay the foundation for the media campaign, which is to be aimed at selling the image of nurses to the public. Further research into local nursing practices and issues is to be encouraged. This could be further enhanced by the publication of local nursing related material so that nurses will have a rational on which to base their practice since they can refer to such publications.

Since Malta is a neophyte in the European Union, more research to see how the different EU directives that are concerned with professional and worker mobility and education affect Maltese nurses. Further research into the history of local nursing and other factors that might have had an influence on nursing are to be encouraged. This could be aided by the setup of an organised nursing or health related archives where related documents can be stored and catalogued.

Concluding remarks

I hope that the reader of this dissertation became more aware of how Nurse Regulation in Malta changed throughout the years. It has changed primarily because nursing is alive, it is still evolving. Things have been changing for the
better but there is still more room for improvement. Lately nursing has achieved the status of an independent profession with the exclusive right to practice unsupervised. However, the relative powerlessness, uncertain professional identity, and lack of recognition for the value of nursing work continue to be realities.

Nursing has been burdened with societal expectations of selflessness and devotion, the status problems of traditional female work, historical domination by physicians and oppression by hospitals, where nurses were kept in training schools long after students preparing for other occupations had moved into colleges and universities. Today we can be proud to say that nurses are not just trained, but they are both trained and educated in the same institutions as other professionals are.

I hope that nursing will have a much brighter future. This depends on many factors. These include the fact that women as workers still have a lot more to gain to be empowered as much as males are and nursing has to stop being marginalised mainly by medicine and in other instances by the establishment. It is important for nursing to given due credit for its contribution towards society, a contribution that is seen and felt by most health service users. The nurses themselves can also aid this by appreciating their history more and thus
understanding the origins of the challenges that they are facing and will have to face in the future.

It is very important to make sure that the voices of nurses are heard so that the discourses that are inherent to the profession will become part of the common language. This together with education is a very important factor that will help nurses to gain power. Power that is based on knowledge as proposed by Foucault.
REFERENCES


Benvenuta, G.A. (1724). Leggi e costituzioni prammaticali. Malta


138


MGG Supp (1934). 25, 8.iii.1934


146


Canada: Graduate School of Nursing and Midwifery.