

Nursing in Malta (1964-1996): A Narrative of Delayed Professionalisation

A thesis submitted to the University of Manchester for the Degree of
Doctor of Philosophy
in the Faculty of Biology, Medicine and Health.

2017

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To
Jesmond

for being there...

always

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ABSTRACT

This study aimed at describing how the nursing profession in Malta changed between 1964 and 1996 emerging as a profession a result of circumstances and changes within and without. Change appears to have been imposed from outside the profession but Maltese nurses did not react to changes whether it was to their benefit or not. Meanwhile, the cumulative effect of various factors such as demographical changes, educational status and political decisions initiated the process of professionalisation of nursing in Malta.

Source materials included archival sources and oral history interviews with twenty four interviewees consisting of nurses and other persons who were influential during the time, including politicians. These were analysed in order to produce a narrative of professionalisation of nursing in Malta. This is the first indepth study on the subject.

The chosen period under study begins in 1964, the year Malta gained independence and ends in 1996, the year when the post of Nursing Director was established, thus allowing nurses a relative autonomy. Nurses were initially led by the Sisters of Charity who supervised them. Changes in the demographics of nursing, the type of preparation needed for it and the management system together with political decisions that often followed similar ones taken abroad, affected Maltese nurses. The official opening of the St Luke's School for Nurses and the introduction of nurse education at tertiary level were significant markers in the process of professionalisation. The thesis presents an insight into how Maltese nurses did not show much eagerness to reach professionalisation but were still propelled towards it by changes occurring extrinsically and then intrinsically. This is perhaps unique since nurses in other countries had nurse leaders who actively worked to reach professionalisation.

DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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LIST OF ABBREVIATIONS

CGMO	Chief Government Medical Officer
HA	Hospital Attendant
MGG	Malta Government Gazette
MLP	Malta Labour Party
NAM	National Archives of Malta
NATO	North Atlantic Treaty Organisation
NO	Nursing Officer
NSO	National Statistics Office
PN	<i>Partit Nazzjonalista</i> (Nationalist Party)
PNO	Principal Nursing Officer
SEN	State Enrolled Nurse
SNO	Senior Nursing Officer
SRN	State Registered Nurse
SSEN	Senior State Enrolled Nurse
STOM	Sunday Times of Malta
TMI	The Malta Independent
TOM	Times of Malta
UK	United Kingdom

ACKNOWLEDGEMENTS

I should first wish to thank my supervisors Prof Christine Hallett and Dr Jane Brooks, without whose constant support I would not have persisted in pursuing this research. My gratitude and thanks also go to my colleagues who supported me when I felt discouraged. I would also like to thank all the staff at the National Archives (Malta) for their expertly assistance and their professional help in my research. Thanks are also due to the librarians at the Malta National Library. I should like to thank all the interviewees participating in this study who willingly gave their time and support in my collection of their oral testimonies.

I should like to thank Miss Mary Borg, the late Prof Donia Baldacchino, Mr Anthony Cordina and the Sisters of Charity for their donations of original documents and copies that greatly enriched my sources of data. My gratitude also goes to my husband Jesmond, whose assistance in all that was necessary and never failing support encouraged me to go on. His love and practical assistance were greatly appreciated. My thanks also go to my children Ian, Edel and Andrew for their love and understanding especially during times of distress. I would also like to thank Bill and Jackie Yates, dear family friends, for offering me accommodation on every trip to Chester during the last six years, and to Miss Barbara Burkey and Miss Mina Mills for hosting me in Bromborough and Nethybridge, Inverness-shire respectively. I would also like to thank my dear parents and all my family for listening, encouraging and supporting me with their prayers. I am sure that without these wonderful people this project would have remained a dream.

Chapter 1

BACKGROUND TO THE STUDY

1.0 Introduction

Malta became an Independent State in 1964.¹ That year was to lead to many changes for the island and its inhabitants. The change towards political autonomy and the full responsibility of administration was a leap into the unknown as the island had been ruled by the Phoenicians, Carthaginians, Romans, Arabs, Normans,² the King of Spain, the Knights Hospitallers of St. John of Jerusalem,³ the French, and the British.⁴ The quest for autonomy had been a long one and many were not confident that Malta could be independent.⁵ A failed attempt to be truly independent during the 15th century may have shown the Maltese that they could not be alone and would always depend on other countries for supplies and economic activity.⁶ Malta had been proclaimed a State in 1962, but by 1964 it was still highly dependent on the British Services for income as reimbursement for its use as a Naval Base.⁷ There was an inter dependence between the United Kingdom (UK) and Malta, as the UK sought to maintain a military presence in Malta while agreeing on a financial settlements that would support Malta's economy until all

¹ Henry Frendo, *Maltese Political Development 1798-1964: A Documentary History* (Malta: Frendo; 1993), 905.

² Andrew P. Vella, *Storja ta' Malta*. Vol I (Malta: *Klabb Kotba Maltin* (KKM) ; 1974), 74.

³ Andrew P. Vella, *Storja ta' Malta*. Vol II (Malta: KKM, 1979); 3.

⁴ Frendo, *Maltese Political Development*, 7.

⁵ Henry Frendo, *The Origins of Maltese Statehood: A Case Study of Decolonisation in the Mediterranean* (Malta: Publishers Enterprises Group (PEG), 1999), 256. Results of a referendum regarding independence showed that there were 42% who voted for it while 35% voted against. There were 14% who abstained or invalidated their vote.

⁶ Vella, *Storja ta' Malta*. Vol I, 130. The Maltese seem to have accepted all dominions without much protest although there was a time of unrest during the early 1400s where they protested against a feudal lord of Sicily. However, as a consequence of these protests contact with Sicily was stopped and the island was on the brink of famine. The Maltese gathered money to pay the feudal lord so as to release their Island and be able to govern it themselves within the kingdom of Sicily.

⁷ Joseph M. Pirota, *L-Istorja tal-Kostituzzjoni f'Malta (1942-2004)* (Malta: Pubblikazzjoni Indipendenza (PIN); 2005), 194.

military services were removed.⁸ According to Herbert Ganado, a lawyer, political party leader and opinion writer, the transition period between being a colony and reaching independence was marked by an infrastructural upheaval to accommodate industrial investment and development, the tourism industry and a larger University where more students could be accommodated to learn to become Malta's leaders in all spheres, once the British retired.⁹

The constitution was one granted by the UK Parliament.¹⁰ Newly arising circumstances brought about changes in all aspects of Maltese socioeconomic affairs. Referring to post colonial times, Kevin Aquilina, Dean of the Faculty of Law at the University of Malta, stated that:

The vast majority of the laws enacted during this period of Maltese legislative history are English Law inspired. In this respect; legal coloniality (that is, the enduring vestiges of English law colonialism) in post colonial Malta is preserved.¹¹

In Malta, changes often followed those occurring in Britain. Nursing was no exception as changes occurring in nursing in Britain were also adopted in Malta later on and with some differences. There were also significant differences in factors affecting professionalisation in both countries such as the presence of identifiable nursing leaders who fought for registration, educational change and professional status.¹² These had been present in Britain but were lacking in Malta. In 1964, Harold Wilensky compared the way global nursing had moved towards professionalisation with that of other professions. According to Wilensky, the process that

⁸ Simon C. Smith, Dependence and Independence: Malta and the End of Empire. *Journal of Maltese History*. 1 (2008), 44. Available at: <http://www.um.edu.mt/arts/history/jmh/docs/2008/jmh-0101-04.pdf> [Accessed 15 April 2016]. Smith, Professor at the Department of History, University of Hull quotes a 1958 memorandum by Colonial Secretary Lennox Boyd indicating that it would be 'impracticable for Malta to become independent while its economy was almost wholly dependent on the UK and while Britain had defense commitments on the island (TNA. CAB134/2234, MM (58) 3, 'Future constitutional arrangements for Malta': memorandum by Lennox-Boyd, 12 Nov. 1958.) The fact that Malta did achieve independence within six years of this memorandum is therefore a feat even if the transition was to be a gradual one.

⁹ Herbert Ganado, *Rajt Malta Tinbidel* Vol. IV (Malta: *Il-Hajja*; 1977), 137.

¹⁰ John J. Cremona, *Recollections of Constitution Making* (Malta: PEG; 1994), 48.

¹¹ Kevin Aquilina, Rethinking Maltese Legal Hybridity: A Chimeric Illusion or a Health Grafted European Law Mixture? *Journal of Civil Law Studies*, 2011 (4) 2:277.

¹² Sioban Nelson, Reading Nursing History, *Nursing Inquiry* 1997 (4) 229-234. Nelson identifies factors that contributed to the rise of nursing as a profession and in the perception of society that could identify with it and accept it as a necessary, desirable occupation.

occupations aspiring to professional status actually adopt is a contributing factor in the process of professionalisation.¹³ In Malta, nursing may have been affected by factors that resulted in a unique process of achieving a place on the continuum of professionalism.¹⁴ This thesis explores the ways nursing in Malta changed between 1964 and 1996 and possible contributing factors leading to these changes including organisational changes, social changes, political influence, the introduction of medical technology and education in Malta. The period under study begins in 1964, a year that can be said to be a virtual new beginning for all civil servants including nurses. This was because there was a transfer of authority from the British to the Maltese. In 1996, there was the appointment of the first Director of Nursing in Malta, a move towards the recognition of autonomy of the profession of nursing.

During the period under study, changes occurred in the number of nurses in employment, entrance requirements, course content and delivery, regulation, grades in nursing and quality of education. Discussion of these changes and how they may have contributed to or hindered professionalisation will form a part of this thesis arguing that while Maltese nurses as individuals or as a collective entity do not seem to have consciously contributed much to the changes, the response to the changing circumstances eventually led to a more knowledgeable body that could aspire to professional status. The significance of the heretofore practically unknown state of independence of the Maltese people and therefore to Maltese nurses is explored as a determining factor in their inclination to accept the conditions imposed upon them by those in authority.

¹³ Harold L. Wilensky, *The Professionalisation of Everyone?* *American Journal of Sociology*, 1964, (70) 2:143.

¹⁴ Margaret A. Moloney, *Professionalisation of Nursing: Current Issues and Trends*. 2nd edition Philadelphia: J.B. Lippincott & Company; 1992), 18. Moloney suggested that there exists a continuum of professionalism based on how much an occupation aspiring to professionalism can be viewed as possessing and demonstrating a series of attributes that define a profession.

This chapter introduces the setting of the study and the research questions it intends to answer. Chapter Two describes the methods used to achieve the aims of this study together with a discussion of the appropriateness of each method, challenges and benefits. The changes that occurred within the nursing work force between 1964 and 1996 are described and discussed in Chapter Three, while Chapter Four explores the transformation of the nursing elite. Chapter Five highlights the factors that may have acted as barriers to professional development. Education as one particularly significant factor affecting professional development is described and discussed in Chapter Six; that is followed by a description of how nursing in Malta was raised to a tertiary level of education, in Chapter Seven. An overall discussion and conclusion is presented in Chapter Eight in which the nature of the changes within Maltese nursing are presented as a narrative of delayed professionalisation.

1.1 Malta

Malta is the largest of an archipelago situated in the Mediterranean Sea between Libya and Italy. It has a very long history of civilisation and is the site of the oldest free standing building in the world that dates back to 5800 BC.¹⁵ The population of Malta and its sister island Gozo has grown from 321,250 in 1964¹⁶ to the current figure of around 430,000.¹⁷ Malta measures 14.5 km across and 27 km in length.¹⁸ According to Jeffrey Richards, these factors fit it into the United Nation's definition of a micro-state.¹⁹ Having gained independence in 1964 and become a

¹⁵ Karen Tate, *Sacred Places of Goddess* (San Francisco, USA: Consortium of Collective Consciousness; 2006), 204.

¹⁶ Data from World Bank. Available at:

https://www.google.com.mt/publicdata/explore?ds=d5bncppjof8f9_&met_y=sp_pop_totl&idim=country:MLT:LUX:MDV&hl=en&dl=en [Accessed 15 April 2016].

¹⁷ Malta Population available at <http://www.tradingeconomics.com/malta/population> based on 2015 Census. [Accessed 19 April 2015].

¹⁸ National Statistics Office (NSO), November 2014 available at www.nso.gov.mt/ [Accessed 16 April 2016].

¹⁹ Jeffrey Richards, Politics in Small Independent Communities: Conflict or Consensus? *The Journal of Commonwealth & Comparative Politics*, 1982 (20) 2:155.

republic in 1974²⁰ Malta now forms part of the British Commonwealth, and has been a full European Union member state since 2004. Although it had never been allowed membership in the North Atlantic Treaty Organisation (NATO) the latter had a headquarters in Malta until 1971.²¹

The era of the British Rule in Malta began in 1800 when the Maltese asked for the protection of Britain as they struggled to oust the French rule of Napoleon Bonaparte.²² The treaty of Paris established Malta's position as a possession of Britain.²³ After Malta gained its independence in 1964 Britain maintained a military presence that ended in 1979.²⁴ Malta therefore formed part of the British Empire during Victorian times when industrialisation, the slow emergence of the emancipation of women, modernisation of medicine and the need for social welfare gradually changed the organisation of society.²⁵ In a quest for independence, political parties were formed that, although holding different beliefs, all aimed at gaining a Constitution under which the Maltese could take control of their own affairs.²⁶ Ganado stated that there was little strife in Malta's gaining independence.²⁷ However, the political struggle was long and harsh; abated during the times of both World Wars but continuing in spite of such tactics as revocation and suspension of the Constitution.²⁸

²⁰ Mark Harwood, *Malta in the European Union* (Abingdon, Oxon: Routledge; 2016), 47.

²¹ John Manduca, *The Flavour of the Mintoff Era* (Malta: Manduca; 2008), 23.

²² Frendo, *Maltese Political Development*, 64.

²³ Joseph Attard, *Britain and Malta: The Story of an Era*. (Malta: PEG; 1988), 6.

²⁴ Edgar Mizzi, *Malta in the Making: An Eyewitness Account* (Malta: Mizzi; 1995), 313.

²⁵ Henry Frendo, *Storja ta' Malta*. Vol III (Malta: KKM; 2004), 59-142.

²⁶ Frendo, *The Origins of Maltese Statehood*, 60.

²⁷ Ganado, *Rajt Malta Tinbidel* Vol IV, 429.

²⁸ Frendo, *Maltese Political Development*, 813; Mizzi, *Malta in the Making 1962-1987*, 16.

After the Second World War the Maltese people made further attempts at requesting independence which was achieved in 1964.²⁹ Until then, the economy of Malta depended mainly on the activity in the port, namely the naval presence of the ruling country that brought in financial benefits according to the intensity of its activity.³⁰ There was a heavy dependence on the British services, not only for actual employment but also for money received as payment for land use, housing, utilities and supply of work that was not of the military kind such as domestic assistance. After Independence, the challenge was to transform the economy from a defence oriented one to a service providing one.³¹ According to Richards, the economic challenge of diversifying industry was more accentuated by the small size of the local market and the difficulty in penetrating foreign markets due to the size of the produce as well as the physical boundaries of the island.³² Moreover the demographic changes due to emigration of potential contributors to the economy, lack of opportunity for education, division of labour and specialisation compounded the problem. John Dowdall stated that Malta has no natural resources.³³ Its prosperity depends on the work of its people.

1.2 The Maltese

Genetically, the nearest people to the Maltese are the Sicilians.³⁴ One possible explanation for this is that the earliest Maltese settlers are believed to have come from Sicily.³⁵ The close

²⁹ Joseph M. Pirotta, *Fortress Colony: The Final Act 1945-1964*. Vol. 1 (Malta: Studia Editions; 1987), xix; Frendo, *Maltese Political Development*, 905.

³⁰ Ganado, *Rajt Malta Tinbidel Vol IV*, 11.

³¹ Michael Briguglio, Malta's Labour Party and the Politics of Hegemony. *Socialism and Democracy*, 2010 (24) 2: 213.

³² Richards, *Politics in Small Independent Communities*, 158.

³³ John Dowdall, The Political Economy of Malta. *The Round Table: The Commonwealth Journal of International Affairs*, 1972 (62) 248:467.

³⁴ Stephanie Bezzina Wettinger, Joseph Borg, Alex Felice, Clint Mizzi & Scott Wilcockson, The Hidden History of the Maltese Genome, *Think: Ideas, Malta, Research, People, University*, 2016, 16:23. Popular belief, sustained by political influential persons such as Sir Gerald Strickland, had regarded the Phoenicians as the

proximity to Sicily and the traditional social relationship with Italy makes this a plausible explanation. Having been under the rule of different conquerors, the Maltese have become cosmopolitan, renowned for their hospitality.³⁶ The Maltese have kept their own language although Italian was the language used in official affairs for a long time.³⁷ Together with the language, Malta's religious beliefs contributed greatly to Maltese society's homogeneity.³⁸ Since early Christendom, the Christian faith has been present in Malta and most Maltese people still confess to the Roman Catholic Church.³⁹ This religious belief has been so entrenched in Maltese culture that it survived centuries of Islamic conquerors (870-1090) and a long period of colonisation by a people professing Anglicanism (1800-1964).⁴⁰ Dennis Austin an emeritus professor of Government in Manchester University; contended that although they have close ties with the British, the Maltese are very different being Catholic and Mediterranean such that they cannot 'belong' to British history.⁴¹ When it became a colony Malta had been an effective theocracy for more than 250 years, under the rule of the Knights Hospitallers of the Order of St. John of Jerusalem,⁴² and this distinguished it from other colonies.⁴³ The deep religiosity of the

ancestors of the Maltese: Carmel Cassar, *Malta : Language, Literacy and Identity in a Mediterranean Island Society*, *National Identities*, 2001 (3) 3:270.

³⁵ Vella, *Storja Ta' Malta*. Vol I, 11.

³⁶ Information Division, Malta. *Malta Handbook* (Malta: Information Division, 1981), 4.

³⁷ Henry Frendo, *Party Politics in a Fortress Colony: The Maltese Experience* (Malta: Midsea; 1991), 208.

³⁸ Richards, *Politics in Small Independent Communities*, 162.

³⁹ Joseph Bezzina, *L-Istorja tal-Knisja f'Malta* (Malta: PIN; 2002), 9.

⁴⁰ Mario Vassallo, *From Lordship to Stewardship: Religion and Social Change* (The Hague: Mouton Publishers; 1979), 17. Although it is believed that Christianity has been practiced continuously in Malta since the arrival of St. Paul in 60 AD, during and after the Arab invasion in 870 there might even have been a desertion of the island as there is a void of information regarding such practice supported by the lack of architectural remains pertaining to the era: Vella, *Storja Ta' Malta*. Vol I, 63; Bezzina, *L-Istorja tal-Knisja f'Malta*. 56; Charles Dalli, *Iż-Żmien Nofsani Malti* (Malta: PIN; 2002), 33. Records of a few families making up the Maltese diocese in 1240 suggest that a Christian tradition may have persisted even though the population was very small: Vella, *Storja ta' Malta*. Vol I, 100.

⁴¹ Dennis Austin, Britain, Europe – And Some Malta, *The Round Table: The Commonwealth Journal of International Affairs*, 1970 (60) 240: 401.

⁴² The Knights Hospitallers of St. John were founded in the 12th century as an Order of Hospitallers to take care of the many pilgrims visiting the Holy Land in their pastoral and physical needs. Later on they took on the role of military defendants of the pilgrims who were in danger of being robbed. As a military order they were involved in the fight against the Saracens who eventually overcame them and they were given the island of

people during the 18th century may have contributed to the acceptance by the coloniser that these traditions were sacrosanct if the country was to be run smoothly and therefore the Maltese could carry on in their ways and accommodate the coloniser as necessary. However, this same religiosity may have contributed to the people's acceptance that this 'oppressed' state was their destiny. Paolo Freire refers to religious colonised people explaining that they have: 'a false view of God, to whom they fatalistically transfer the responsibility of their oppressed state.'⁴⁴ The succession of rules governing the Maltese rendered them incapable of perceiving that the island could stand on its own economically⁴⁵ to the extent that there were politicians who suggested Malta's integration with the UK.⁴⁶

1.3 The Maltese as a Colonised people

The Maltese always seemed to need to be led by a foreign people.⁴⁷ This is presumably because Malta had little resources on which to rely and a population that is larger than that which is

Malta as a fief from the King of Spain, Charles V. In Malta they built a large hospital called the *Infermeria* that was to become world renowned for its novel ways of caring for the sick: Thomas Freller, *Malta: The Order of St. John* (Malta: Midsea Books; 2010), 20.

⁴³ Jon P. Mitchell, *An Island in Between: Malta, Identity and Anthropology*, *South European Society and Politics* 1998 (3) 1:143.

⁴⁴ Paolo Freire, *The Politics of Education: Culture, Power and Liberation* (Westport, USA: Bergin & Garvey; 1985), 132.

⁴⁵ Dennis Austin, *Malta and the End of the Empire* (Malta: Frank Cass Publishers; 1971), 32; Joseph M. Pirotta, *Fortress Colony: The Final Act 1945-1964*. Vol. 2 (Malta: Studia Editions; 1987), 27.

⁴⁶ Simon C. Smith, *Integration and Disintegration: The Attempted Incorporation of Malta into the United Kingdom in the 1950s*. *The Journal of Imperial and Commonwealth History* 2007 (35) 1:59.

⁴⁷ The Maltese people had been governed by one people after another; relying on these people to make infrastructural developments, stimulate and run the economy by their activity and provide security. In order to overcome the French, the Maltese requested assistance from the British to achieve freedom. They then needed protection which the British granted. Malta became a British colony under the Treaty of Amiens: Frendo, *The Origins of Maltese Statehood*, 23. Edward W. Said stated that notions that 'certain territories and people require and beseech domination' actuated colonialism with their associated ideas of dependency: Edward Said, *Culture and Imperialism* (New York: Vintage Books; 1994), 9. In the case of Malta, the islanders beseeched the British for help but this was not a far away island or one where western civilization had not yet been introduced. It was also dissimilar to other colonised countries such as India that Penelope Tuson described as being a far away source of economic prosperity: Penelope Tuson, *The Queen's Daughters: An Anthology of Victorian Feminist Writings on India 1857-1900* (Berkshire, UK: Ithaca Press; 1996), 2.

expected to be well sustained by the output of the island.⁴⁸ According to Austin this perception of Malta as being unable to move towards full independence was attributed to Malta's vulnerability, political and economical.⁴⁹ There seems to have been acceptance by the Maltese that the situation had always been like that and it could hardly change. This may have resulted from a sustained social memory, a phenomenon that could, according to John Tosh: 'serve to sustain a sense of oppression, exclusion and or adversary.'⁵⁰ Said contended that colonisation implied a mindset of the coloniser that 'allowed decent men and women to accept the notion that distant territories and their native people should be subjugated' implying the notion of a quasi 'obligation to rule subordinate, inferior or less advanced' people.⁵¹ In establishing empires, the dominant countries encountered little resistance, this process was described by Dirk Moses as the absorption of the majority (the colonised) by the ruling minority (the coloniser).⁵² This may be partially true for the Maltese who absorbed 'Britishness' to some degree but proved difficult to govern,⁵³ and did not afford unconditional assent to the ruling powers.⁵⁴

According to Carmel Borg and Peter Mayo: 'One of the legacies of colonialism is a preference on the part of the colonised, for all that is foreign (that is White and coming from the West).'⁵⁵ This may explain how the Maltese adopted imported traditions such as culinary traditions where the Mediterranean diet was partially substituted by the British one.⁵⁶ According to Uhuru Hotep,

⁴⁸ Brian W. Beeley & William A. Charlton, *Maltese Patterns of Dependence: An Historical Perspective*; *Scottish Geographical Magazine*, 1994, (110) 113.

⁴⁹ Dennis Austin; *Malta Today Asks – Under Which King, Bezonian?* In *The Round Table: The Commonwealth Journal of International Affairs* 1996 (85) 339:334.

⁵⁰ John Tosh, *The Pursuit of History* (5th Edition) (Oxon: Routledge; 2010), 5.

⁵¹ Said, *Culture and Imperialism* 10.

⁵² Dirk Moses, (ed) *Empire, Colony, Genocide: Conquest, Occupation and Subaltern Resistance* (Oxford, UK: Bergahn Books; 2008), 9.

⁵³ Austin, *Britain, Europe – And some Malta*, 401.

⁵⁴ Anon, *Independent Malta*, *The Round Table: The Commonwealth Journal of International Affairs*, 1964 (55) 217: 40.

⁵⁵ Carmel Borg & Peter Mayo, *Learning and Social Difference: Challenges for Public Education and Critical Pedagogy* (New York: Routledge; 2016), 122.

⁵⁶ Matty Cremona, *The Way We Ate: Memories of Maltese Meals* (Malta: Midsea Books; 2011), 24.

the colonised mind associates authority to these traditions rather than accepting them as another way of doing things.⁵⁷ The colonised accept inferiority to their coloniser that: ‘will ultimately warp their self-image, subvert their self-esteem, undermine their self worth, stifle their self motivation and dim their prospects for high level achievement.’ Robert Young asserted that upon colonisation a situation of ambivalence arises where the people admire and hate the coloniser resulting in simultaneous imitation and hostility of those in power.⁵⁸ Mayo and Borg contended that as a result of colonisation in Malta there was limited economic growth and transformation.⁵⁹ They also asserted that colonisation fostered a passive mentality in the Maltese population. This may have contributed to a general lack of motivation to instigate change.

The political autonomy gained by Malta through Independence was a relatively new concept for the Maltese who were used to carrying on with their own business complying with political authority according to the circumstances. An anonymous writer writing before Malta gained independence described them as having:

a long experience of knowing when to comply with political authority, and how to circumvent it and carry on in their own sweet way.... For the Maltese, individualists to a man, habitually seeking their ends and finding security in a network of personal relations, whether of kinship, clientage or patronage, the machinery of organized political authority has ever been something to be used, avoided, bamboozled or manipulated as occasion served.... If an administrative regulation can be ignored, it is ignored. If there is something to be made on the side in a government contract it is made. Why not? ... the notion of being responsible for governing themselves is entirely novel.⁶⁰

⁵⁷ Uhuru Hotep, Intellectual Marrons: Architects of African Sovereignty, *The Journal of Pan African Studies*, 2008 (2) 5:5.

⁵⁸ Robert J. C. Young, *Empire, Colony and Postcolony* (Sussex: Wiley and Sons; 2015), 58.

⁵⁹ Borg & Mayo, *Learning and Social Difference*, 117.

⁶⁰ Anon. Independent Malta, 40. It is perhaps quite telling that the author of this article preferred to remain anonymous when describing the Maltese people of 1964 in this way. Popular dissent may have ensued in spite of the possible truth of the description given and the added information that the Maltese may even ignore the authority of the Church if the occasion calls for it. This was evident at the time of writing (1964) when many (33.8%) Maltese had just chosen to vote for the MLP in 1962: Michael J. Schiavone, *L-Elezzjonijiet f'Malta 1849-1992* (Malta: PIN; 1992), 515. This was in spite of the danger of being interdicted from the Church: Joseph M. Pirota, *Fortress Colony: The Final Act 1945-1964*, Vol III, (Malta: Masprint; 2001), 727.

The notion that the success of government was now totally their responsibility was quite alien. According to Jon Mitchell, the ensuing liberation was unsettling as it disrupted Maltese society's perception of its role.⁶¹ Mitigating risks and disruption may also explain why, after Independence, the Maltese continued to run the country on the same models as the British had; continuing with the same constitutional institutions that existed before.⁶² Freire explained this behaviour by stating that upon colonisation, people consider freedom as a fearful thing and therefore find risk taking difficult.⁶³ Malta's historical past contributed to its people's reluctance to really become independent in their actions and taking initiatives unless truly compelled to do so by circumstances.⁶⁴ The Maltese carried on with their own lives irrespective of the authorities, causing minimal agitation,⁶⁵ so that changes were so minimal as to produce a slow evolution rather than revolution. Major changes such as gaining independence came about perhaps more because of the determination of the politicians leading them rather than of their own free will.⁶⁶ Jeremy Boissevain, an anthropologist who studied Maltese society for over fifty years contended that the Maltese have a tendency to act or react to a situation if there is an egoistic motivation. The Maltese are so intensely family centred that they are unwilling: 'to give national interests precedence over private interests.'⁶⁷ Boissevain contended that the Maltese who had been

⁶¹ Jon P. Mitchell, Looking Forward to the Past: National Identity and History in Malta. *Identities: Global Studies in Culture*, 2003 (10) 3:386.

⁶² Aquilina, Rethinking Maltese Legal Hybridity, 277.

⁶³ Paolo Freire, *Pedagogy of the Oppressed* (New York: Herder & Herder; 1970), 46.

⁶⁴ The Maltese would support any proposal that would guarantee employment even if this involved such a change as the political integration with Britain: Joseph M. Pirotta, *Fortress Colony*, Vol II, 27.

⁶⁵ Anon. Independent Malta, 40.

⁶⁶ Frendo described the situation of the Maltese under British Rule as being one whereby the British: 'became themselves their [the Maltese] main providers, to some extent even their captive clients. The urge for freedom therefore could not be quite identified with that for bread.' The actual run to Independence took around two years of decisive action: Frendo, *The Origins of Maltese Statehood*, 27, 35.

⁶⁷ Jeremy Boissevain, On Predicting the Future: Parish Rituals and Patronage in Malta. In: Sandra Wallmann (ed) *Contemporary Futures: Perspectives from Social Anthropology* (London: Routledge; 1992), 75. Frendo described the colonisation process of Malta as coming through 'redemption' as perceived by the Maltese of the time. Ruling the islands had necessitated the nurturing of a class that would appease the government. The most effective of these was that of giving money. Frendo quotes one governor who in 1883 wrote that the secret

subjects of successive domination by others even regarded their monumental heritage as pertaining to others associating them with the Knights, the British, the government.⁶⁸ In an interview he gave to Kurt Sansone, Boissevain referred to: ‘Amoral familism’ describing it as ‘a belief that any behaviour is justified if it furthers the interest of the family.’⁶⁹ Boissevain also described Maltese society as ‘a cowed civil society’⁷⁰ that may have kept the Maltese from moving at a faster pace towards independence and autonomy both politically and socially. Individuals may have failed to perceive protest or a move towards autonomy as being beneficial to them and their families, especially if such moves were somewhat risky as indeed they were for employment and industry. There was a lot of uncertainty and the leap was perhaps achieved through the politicians’ rhetoric that Malta would be able to go on receiving aid even when independence was obtained.⁷¹ In the early 1960s the two main political parties had in a way agreed in principle that independence would be of benefit to Malta. Such an ‘agreement’ was new to Malta.

weapon was: “Appeal... to their personal interests.” The loss of jobs and the introduction of new taxes seem to have been very powerful stimulants for popular manifestations of Nationalism: Frendo, *The Origins of Maltese Statehood*, 25, 39.

⁶⁸ Jeremy Boissevain, *Factions, Friends and Feasts: Anthropological Perspectives on the Mediterranean* (New York: Bergahn Books; 2013), 249.

⁶⁹ Kurt Sansone, All in the Name of the Family, *Malta Today* 8.4.2001, 7.

⁷⁰ Boissevain, *Factions, Friends and Feasts*, 250.

⁷¹ Dom Mintoff from the Malta Labour Party had called for integration with the UK on the premise that the Maltese would then have equivalence in welfare and wages. When this was not granted he immediately called for total independence. Malta’s economical dependence on its activity as a military base made it virtually impossible for it to be totally independent. Mintoff reached out towards Britain’s alien countries such as Russia with the intention of showing that these countries might be ready to substitute the financial support to Malta upon its independence and therefore may have an increased accessibility to the Mediterranean and Africa: Joseph M. Pirota, *Fortress Colony*, Vol. III, 159. The leader of the Nationalist Party, George Borg Olivier was in favour of a dominion status and full membership of the British Commonwealth that would allow the Maltese to govern their own affairs with partial sponsorship from the UK as compensation for the continuing use of Malta as a military base. The gradual retreat of the British forces would allow for a full transition from Colony to Independent statehood: Frendo, *The Origins of Maltese Statehood*, 600.

1.4 A Divided People

The Maltese people are generally a peaceful people.⁷² According to Sansone, in 2001 Boissevain was still of the opinion that there was a division in many aspects of Maltese life which he attributed to the increased tendency of small scale, family societies to view things in black and white which easily leads to antagonism.⁷³ Perhaps the greatest division amongst the Maltese was that along political party lines.⁷⁴ Although Richards attributed this to the small size of the population which did not allow for much diversity,⁷⁵ this political divide developed through the last two centuries when representative government of various forms was granted to the Maltese by their British rulers.⁷⁶ The two main political parties were the Nationalist Party (PN) and the Malta Labour Party (MLP). The PN tended to come from the bourgeoisie and still maintains close ties to the middle class.⁷⁷ It also had close links with Italy.⁷⁸ The MLP originated from a worker base and was traditionally pro British, a stance it later changed into stressing Malta's interests above all else.⁷⁹ Patronage still characterises Maltese society,⁸⁰ and allegiance to the chosen party is not really chosen so much as 'inherited' within the family or ascribed by geographical area. Boissevain stated that 'one is either born into a *partit* [a party], or marries into it.'⁸¹ According to Dominic Fenech, 'allegiance is fundamentally class-based'.⁸² This

⁷² Joseph V. Micallef, Mediterranean Maverick, *The Round Table: The Commonwealth Journal of International Affairs*, 1979 (69) 275:249.

⁷³ Sansone, All in the Name of the Family, 7.

⁷⁴ Mitchell, Looking Forward to the Past, 379.

⁷⁵ Richards, Politics in Small Independent Communities, *The Journal of Commonwealth & Comparative Politics* 1982 (20) 2:159.

⁷⁶ Mitchell, Looking Forward to the Past, 381.

⁷⁷ Dominic Fenech, The 1987 Maltese Election: Between Europe and the Mediterranean. *West European Politics*, 1988 (11) 1:134.

⁷⁸ Mitchell, Looking Forward to the Past, 381.

⁷⁹ Mitchell, Looking Forward to the Past, 382.

⁸⁰ Briguglio, Malta's Labour Party and the Politics of Hegemony, 214.

⁸¹ Boissevain, *Factions, Friends and Feasts*, 32.

⁸² Fenech, The 1987 Maltese Election, 134.

resulted in a political allegiance being the basis of social networking.⁸³ Opposing factions were made up of acquainted or even closely related persons since this was a close-knit society.⁸⁴ Due to Malta's size, networking is still very dominant today, and kinship brings together people who interact within different circles in what Richards called 'an overlapping and coincidence of roles'.⁸⁵ Economic, political and legal decisions were therefore affected by the same circle of people or their close acquaintances and overseeing their implementation was relatively more practical than in larger societies. Richards described larger societies as having developed systems whereby state power could be alienated from the personal authority of individual rulers.⁸⁶

As in similar small states, sections of the Maltese society were so close to the Maltese state that the difference between them could hardly be perceived. Party membership could be an instrument for advancing individual and family interests.⁸⁷ The single transferable vote election system led politicians into entering clientelist relationships with their constituents.⁸⁸ Mitchell contended that this leads to a corrupt bureaucracy.⁸⁹ The government's ubiquity encouraged individuals to ask for favours but also to criticise. Such criticism was often taken as a personal affront and the reaction tended to be emotionally charged resulting in deep enmities and personal rivalries.⁹⁰ James Craig went as far as saying that: 'Mintoff's government is not noted for its

⁸³ Mitchell, *Looking Forward to the Past*, 383.

⁸⁴ Austin; *Malta today asks – under which king, Bezonian?* 336.

⁸⁵ Richards, *Politics in Small Independent Communities*, 158.

⁸⁶ Richards; *Politics in Small Independent Communities*, 159.

⁸⁷ John C. Lane, *The Election of Women under Proportional Representation: The Case of Malta, Democratisation*, 1995 (2) 2:154.

⁸⁸ The single transferable vote electoral system is one that results in proportional representation. A person's vote can be transferred to a second or further competing candidate (according to the voter's stated order of preference) if the candidate of first choice is eliminated during a succession of counts or has more votes than are needed for election. Candidates therefore have an interest in gaining first votes but also in gaining second and third preferences.

⁸⁹ Mitchell, *An Island in Between*, 145.

⁹⁰ Richards, *Politics in Small Independent Communities*, 159.

tolerant attitude towards perceived opponents... any criticism of them is regarded in MLP circles as heresy' quoting Mintoff, who said that: 'Those who are not with us are against us.'⁹¹ Boissevain expressed concern at his observation that the Maltese exhibited party political antagonism.⁹² According to Mitchell this antagonism seems to be accepted by the Maltese as being inevitable.⁹³ Godfrey Grima, a Maltese journalist for the Financial Times said that in Malta tolerance: 'is a sin rather than a virtue so those who dare express dissension may suffer the consequences.'⁹⁴ In 1991, Oliver Friggieri, a Maltese writer and philosopher opined that the Maltese react to the divide by fostering a sense of preservation rather than one of criticism.⁹⁵ Friggieri described Maltese society as one where the institutions treat the citizens in a condescending way not really tolerating free speech such that the Maltese often have to live a dualism between what they really think and what they say and do. In this way, according to Friggieri, a society is created that is quiet and seemingly conforming.

This may have been mirrored in the nursing profession in Malta where nurses did not act upon what they thought but allowed themselves to be led in a way that undermined the process of professionalisation. They may have realised that their position was not so secure even though their services were much needed for society. The action taken by the government of locking doctors out of its hospitals when they went out on strike,⁹⁶ could have had repercussions on the way nurses acted. If the government had not hesitated to dispose of the doctors there was no way of knowing whether it would do the same to nurses. In typical Maltese reasoning they may have decided that they would not allow the livelihood of their family to be jeopardized. The

⁹¹ James A. Craig, Malta: Mintoff's Election Victory, *West European Politics* 2007 (5) 3:319.

⁹² Boissevain, *Factions, Friends and Feasts*, 249.

⁹³ Mitchell, *An Island in Between*, 144.

⁹⁴ Godfrey Grima, Forward to Oliver Friggieri, *Fil-Gżira Taparsi Jikbru l-Fjuri*, (Malta: Grima Printing & Publishing Industries; 1991), ix. Author's translation from original in Maltese.

⁹⁵ Oliver Friggieri, *Fil-Gżira Taparsi Jikbru l-Fjuri*, (Malta: Grima Printing & Publishing Industries; 1991), xiv.

⁹⁶ Lino J. German, *Landmarks in Medical Unionism in Malta (1937-1987)* (Malta: Allied Publications; 2007), 80.

Maltese doctors may have afforded to live on private practice and/or take their expertise elsewhere in the world,⁹⁷ but nurses could not hope to do the same.

Through the application of a hermeneutic approach, this work underlines the beliefs of nurses and the wider Maltese population that protesting may not yield positive results to the individual. The effects of a close knit society where government is ubiquitous as a result of the small population and the relatively large number of people holding positions of power may lead the Maltese to be less outspoken. In keeping with a hermeneutic approach, understanding and interpreting language that may be somewhat ambiguous this work seeks to interpret actions and reactions of the Maltese that may have hampered professionalization. The Maltese way of thinking may have been isolated and unique leading to a *modus operandi* that could only hope to affect top-down change rather than in the opposite way. Since many nurses were women this may have been even more accentuated.

1.5 Women in Malta

The fact that it is a traditionally female dominated profession may have kept nursing in Malta away from the limelight, a phenomenon which Christopher Maggs also recorded as having been a feature in nursing everywhere.⁹⁸ Maltese society of the early 1960s considered the position of women as being that of home makers and the increasing trend of seeking employment outside the home or family concern was considered to be improper.⁹⁹ Callus stated that before Independence young women who managed to finish secondary school sought employment as clerks in the civil

⁹⁷ Many Maltese doctors managed to secure employment abroad.

⁹⁸ Christopher Maggs, A History of Nursing: A History of Caring? *Journal of Advanced Nursing*. 1991 (23) 2:631.

⁹⁹ Vassallo, *From Lordship to Stewardship*, 121.

service, bank employees or nurses with about 60 women entering a two year college training course to become teachers annually.¹⁰⁰

In a 1965 newspaper report on nursing, Robins wrote that nursing is a

profession open to educated girls which unfortunately is looked upon as little higher in the social scale than a housemaid; an SRN is still regarded as a nobody in the social scale... not yet fully recognized as one of the careers for a 'nice' girl to aspire to.¹⁰¹

According to the opinion writer Marie Benoit, in the 1960s even those girls who could take up higher education did not generally do so as the most a girl could achieve was a good office job that would allow her to save her money until she got married.¹⁰² Until recently women in Malta felt obliged to forfeit their careers in order to take up what they felt were their responsibilities to take care of their children and elderly relations.¹⁰³ By 2001 female participation in labour supply by Maltese women of working age in Malta was only 35 percent.¹⁰⁴ In the 1960s, Maltese women were still culturally constrained to choose to stay at home rather than seeking employment.¹⁰⁵ The reluctance of Maltese women to enter into employment is not officially documented but it may have affected recruitment into nursing in terms of quantity as well as in educational background. Moreover, there was also the marriage bar, a legislation through which women in government employment had to resign from work upon getting married.¹⁰⁶ This legislation practically precluded Maltese women from nursing and teaching as the latter was only available within government settings. Opportunities in private enterprises in these areas were

¹⁰⁰ Angela Callus, *Ghadma Minn Ghadmi*, (Malta: Ministry of Social Policy; 1992), 52.

¹⁰¹ Sue Robins, A Nurse's Status *Times of Malta*, 2.5.1965, 12.

¹⁰² Marie Benoit, In Love with Life, *The Malta Independent on Sunday*, 22.1.2011, 8.

¹⁰³ Christine Farrugia, Factors motivating women in Malta to work. *European Working Conditions Observatory* (2008). Available at: <http://www.eurofound.europa.eu/observatories/eurwork/articles/factors-motivating-women-in-malta-to-work> [Accessed 11 June 2016].

¹⁰⁴ David Millard & Louise Ackers, The gender challenge in research funding – assessing the European national scenes Malta' (May 2008). Available at: http://ec.europa.eu/research/science-society/document_library/pdf_06/malta-research-funding_en.pdf [Accessed 12 June 2016].

¹⁰⁵ Valerie Vasinich, Generational Habitus of Youth During the 'Swinging' Sixties: A Case Study in Malta, *Journal of Maltese History*, 2012 (3) 1:37.

¹⁰⁶ Tito Boeri & Jan van Ours, *The Economics of Imperfect Labor Markets* (2nd Edition) (Oxfordshire: Princeton University Press; 2013), 105.

few as they were controlled by religious orders.¹⁰⁷ These had few vacancies as they had not yet experienced a substantial decline in vocations. Other western countries including the UK and America had similar legislation. However, it had been repealed in the UK by 1946,¹⁰⁸ while its effects were ended in Montana, USA, in 1964.¹⁰⁹ Malta took longer to legislate against the marriage bar which was lifted in 1980.¹¹⁰ This legislation may have affected general uptake of education by women who did not feel motivated to study if their career progression was bleak. It may also have affected nursing recruitment both in quality and quantity. The seemingly more attractive employment options such as clerical work within the civil service, the administrative section of the shipyards, and textile industry gradually became available to women. However, they were not so readily available during the recession of the 1980s and the resulting unemployment left recruitment into nursing as one of the few options.

Women's contribution to society did not merit much attention from Maltese historians.¹¹¹ This was similar to others such as those in America where Sherma Berger Gluck lamented the virtual

¹⁰⁷ Adrianus Koster, *Clericals Versus Socialists: Towards the 1984 Malta School War* in Eric R. Wolf (ed) *Religious Regimes & State Formation: Perspectives from European Ethnology*. (New York: State University of New York Press; 1991), 109.

¹⁰⁸ Martin Stanley, *Women in the Civil Service – History*, *Civil Servant*. Available at: <http://www.civilservant.org.uk/women-history.html> [Accessed 20 April 2016].

¹⁰⁹ Martha Kohl, "Must a woman . . . give it all up when she marries?": The Debate over Employing Married Women as Teachers, *Women's History Matters*, 2014. Available at: <http://montanawomenshistory.org/must-a-woman-give-it-all-up-when-she-marries-the-debate-over-employing-married-women-as-teachers/> [Accessed: 2 May 2016].

¹¹⁰ Vasinich, *Generational Habitus of Youth During the 'Swinging' Sixties*, 39.

¹¹¹ Although Ganado dedicated some of his work to issues regarding women in Malta, this was mainly on how employment, education and female roles changed over the years in the first half of the 20th century: Herbert Ganado, *Rajt Malta Tinbidel* Vol I, 325; Ganado, *Rajt Malta Tinbidel* Vol II, 391-394. Frendo's work included information of contributions by the few women who managed to be elected since women were given the right to vote in 1947: Henry Frendo, *Maltese Colonial Identity: Latin Mediterranean or British Empire?* In: Victor Mallia-Milanes (ed.), *The British Colonial Experience 1800-1964: The Impact on Maltese Society* (Malta: Mireva; 1988), 190. Pirotta, dedicated a few pages to women at the end of colonialism: Pirotta, *Fortress Colony* Vol. 1,80; Callus described some of the issues affecting women in Malta over the years.: Callus, *Ghadma minn Ghadmi*, 32. Darmanin conducted studies on the opportunities for education of women in Malta: Mary Darmanin, *National Interests and Private Interests in Policy Making*, *International Studies in Sociology of Education*, 1991 (1) 2:59-85.

absence of women in historical writings in 1972.¹¹² In writing about a feminist frame for oral history Kristina Minister asserted that in the US, women's speech has also been devalued for a long time arguing that even after oral history was introduced in the 1940s and given attention to groups who had been relatively silent, women were still not given much attention.¹¹³ At present there is little written evidence regarding the history of nursing in Malta. This scarcity of material pertaining to nursing may be due to nurses having been less vociferous in the past which in itself may have hindered the process of professionalisation.

1.6 Professionalisation

Margaret Moloney described professionalisation as 'a dynamic process whereby many occupations can be observed to change certain crucial characteristics in the direction of "profession."' ¹¹⁴ According to Allan Bullock and Stephen Trombley professionalisation occurs 'when any trade or occupation transforms itself through the development of formal qualification based upon education, apprenticeship, and examinations, the emergence of regulatory bodies with powers to admit and discipline members, and some degree of monopoly rights.'¹¹⁵ These perspectives point to an internal direction within an occupation towards professionalisation as a result of changes in its characteristics brought about by education, regulation and autonomy. Literature places a sound knowledge base as the foundation on which professionalisation can occur.¹¹⁶ Describing the characteristics of a profession Moloney insisted that intellectual

¹¹² Sherna Berger Gluck & Daphne Patai (eds.) *Women's Words: The Feminist Practice of Oral History*. (London: Routledge; 1991), 1.

¹¹³ Kristina Minister, A Feminist Frame for the Oral History Interview. In: Sherna Berger Gluck & Daphne Patai (eds.) *Women's Words*, 28.

¹¹⁴ Margaret M. Moloney, *Professionalization of Nursing: Current Issues and Trends*. 2nd edition (Philadelphia: J.B. Lippincott Company; 1992), 8.

¹¹⁵ Allan Bullock & Stephen Trombley (eds.) *The Norton Dictionary of Modern Thought*. (London: W.W. Norton & Co.; 1999), 689.

¹¹⁶ Mike Saks, Defining a Profession: The Role of Knowledge and Expertise. *Professions and Professionalism*. 2010 (2) 2:1-10. Saks refers to multiple literary sources that assert that knowledge is the basis of professionalisation even if not solely determining.

endeavour is the primary criterion followed by internal organization and motivation by altruism. These criteria can be used to find out how far an occupation has moved towards professionalisation that is a continuing process.¹¹⁷

Ronald Pavalko used eight dimensions to construct an occupation-profession model to identify whether an occupation has reached professionalisation.¹¹⁸ These dimensions include: theory, relevance to social values, training period, motivation, commitment, autonomous control, sense of community and code of ethics. Moloney stated that there are five stages to professionalisation namely: the creation of a full time occupation, the formation of training schools, the creation of a professional association, the enactment of state licence law and the development and creation of a code of ethics.¹¹⁹ These occupation-profession dimensions and stages of professionalisation can be used to discuss how far nursing has moved towards professionalisation but several factors can act as barriers. Moloney provides a framework that is easy to follow in order to identify how and to what extent has professionalisation of nursing occurred. This framework is used in this work to describe how far nursing in Malta had moved towards professionalization between 1964 and 1996. It is also used to identify areas that may have contributed to a delay in professionalisation. Moloney's suggestion that there is a continuum of professionalisation in nursing seems to be appropriate to assist in understanding how nursing in Malta changed during the period under study; moving forward and sometimes backward in professionalisation.

¹¹⁷ Moloney, *Professionalization of Nursing*, 18.

¹¹⁸ Ronald M. Pavalko, *Sociology of Occupations and Professions*. (Itasca, Illinois: F.E. Peacock Publishers; 1971), 26.

¹¹⁹ Moloney, *Professionalization of Nursing*, 17.

In a concept analysis of professionalism in nursing Fataneh Ghadirian, Mahveh salsali and Mohammed Ali Cheraghi described where and how professional nursing can be identified.¹²⁰

This work was the result of an extensive study of the literature published in English between 1980 and 2011. Ghadirian et al included a description of the cognitive, affective and psychomotor dimensions that could serve to describe the concept of nursing professionalism that may be affected by interdisciplinary, socio cultural and temporal factors.¹²¹

This evolutionary concept analysis is referred to in this work when describing factors that may have delayed professionalisation of nursing in Malta. These include factors relating to demography of the nursing workforce, experience, education and the image of nursing.¹²² These antecedents and the consequences and related aspects of professionalisation in nursing put forward by Ghadirian et al also serve as a guide to describing the nursing profession in Malta between 1964 and 1996. Comparing data emerging from this study to Ghadirian et al's descriptions provides possible explanations for the delay in reaching Moloney's stages in professionalisation.

Moloney's and Ghadirian et al's works are also used in this work to discuss barriers to professionalisation in nursing. These barriers can be within nursing as well as without. Moloney laments the presence of disunity and divisiveness within nursing mostly about its competencies and purpose as one such barrier while also citing a lack of prepared leaders as hindering the process of professionalisation.¹²³ Moloney's list also included educational factors, lack of

¹²⁰Fataneh Ghadirian, Mahvash Salsali & Mohammed Ali Cheraghi, Nursing Professionalism: An Evolutionary Concept Analysis. *Iranian Journal of Nursing and Midwifery Research*, 2014 (19) 1:1

¹²¹ Ghadirian, Salsali & Cheraghi, Nursing Professionalism, 2.

¹²² Ghadirian, Salsali & Cheraghi, Nursing Professionalism, 2.

¹²³ Moloney, *Professionalization of Nursing*, 36

autonomy and a continuing lack of power. These barriers may be further compounded by factors that are extrinsic to nursing such as legislation and demography.¹²⁴

1.7 Rationale for The Study

The development of nursing in Malta during the twentieth century, the effects of Malta's achievement of Independence (1964) and resultant self government on the profession of nursing are still largely unknown. No work has been published regarding this aspect and nursing in modern Malta has not been described. In his book, *The Medical History of Malta* Paul Cassar recorded milestones such as the opening of St. Luke's School for Nurses by the Government in 1938. Cassar ended his account in 1959 stating that:

In spite of these efforts to raise the standards of nursing and to encourage girls to take it up as a career, the position remained unsatisfactory; in fact out of over seven hundred men and women nursing in government hospitals only twenty six were State Registered Nurses.¹²⁵

The education of Maltese nurses has generally followed that of the UK since the opening of the School of Nursing. New education methods introduced in nurse education in the UK were introduced in Malta at a later date and were affected by Maltese exigencies of the time which will be discussed later in this thesis. Tertiary level nursing education was introduced in 1988 so that by 2012 Malta had around 500 graduate nurses and 42 post graduates together with eight nurses with a doctoral degree in nursing.¹²⁶ The route to this status has been long and complex but it has not been found to be deserving of much attention. Even less attention has been given to how nurses in Malta have actually carried out their work and how this was affected by the socio political changes and current knowledge in post colonial Malta. Changes in the sphere of

¹²⁴ Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 1.

¹²⁵ Paul Cassar, *Medical History of Malta* (London & Beccles: William Clowes & Sons Ltd; 1965), 404.

¹²⁶ Mario Galea, Press Conference 12.5.2012 *The Independent on Sunday*, 13.5.2012, 2.

Maltese nursing have neither been chronicled nor studied historically. One possible explanation could be Eleanor Krohn Herrmann's assertion that developing countries focus mostly on present and future happenings leaving the past for later, by which time evidence may deteriorate.¹²⁷ The absence of Maltese nurse historians has limited the scope of work in this field. During the period 1960-1996, Malta was striving to gain and maintain Independence while endeavouring to keep pace with global developments, affecting all aspects of life.

The popular image of nursing in Malta is still that of an occupation that is largely subservient to the medical profession and not really one to aspire to. Maltese society in general is hardly aware of the contribution of nursing and therefore possibly cannot regard it as a valuable profession. Studies confirm that nursing is still not amongst Maltese young people's first career choices.¹²⁸ This image amongst the population in general probably extends itself amongst Maltese nurses contributing towards a lack of self-knowledge and identity. Maltese nurses' lack of knowledge of the history of nursing may obscure the profession's perceived identity and contribute towards its slow growth and evolution. According to Sandra Lewenson and Eleanor Krohn Herrmann, 'History teaches us who we are. We, as a [nursing] profession, need to understand this as history offers us an identity that we can use to help us grow and evolve'.¹²⁹ Joan Lynaugh declared that 'History is our source of identity, our cultural DNA' while asserting that: 'history yields self-knowledge'.¹³⁰ Moreover, a lack of knowledge of its history could also inhibit professionalisation of nursing. Nancy Burns and Susan Grove assert that the knowledge of the

¹²⁷ Eleanor Krohn Herrmann, Historical Research in Developing Countries. In: Sandra B. Lewenson & Eleanor Krohn Herrmann (eds.) *Capturing Nursing History* (New York: Springer Publishing Company; 2008), 127.

¹²⁸ Mary Darmanin, The Labour Market of Schooling: Maltese Girls in Education and Economic Planning. *Gender and Education* 1992 (4)1-2:119. Alfred Briffa, School Leavers and Occupational Choice: Is Nursing an Appealing Career? (Unpublished Bachelor's Thesis, University of Malta, 1992), 72.

¹²⁹ Lewenson & Krohn Herrmann, *Capturing Nursing History*, 2.

¹³⁰ Joan Lynaugh, *Editorial Nursing History Reviews* (Pennsylvania: University of Pennsylvania Press; 1996), 1.

history of a profession and its transmission to those entering the profession is one of the criteria for professionalisation.¹³¹ A sound knowledge of the development of nursing as a profession in Malta would contribute towards improving the image of nursing. Lewenson and Krohn Herrmann stated that: ‘Historical research enables nurses to explore their past and thus become critically aware of their professional identity and meaning’.¹³² Historical research could contribute towards asserting the important role of nurses. Nurses do not only make up the largest group of health professions but are also those closest to clients. Patricia D’Antonio asserted that historical reasoning is the foundation of clinical practice and humanistic understanding implying that clinical practice is also affected by nurses’ historical knowledge and reasoning.¹³³ Recording the past and historical research in Malta could contribute to the preservation of evidence, experiential and archival which Susan McGann described as being ‘under constant threat’.¹³⁴ It could also guide policy makers in addressing recruitment and retention strategies.

1.8 Research Questions

The main research question for this study is:

In what way and to what extent did nursing in Malta develop as a profession between 1964 and 1996?

¹³¹ Nancy Burns & Susan K. Grove; *Understanding Nursing Research*. 2nd edition (Philadelphia: W.B. Saunders Company; 1999), 4.

¹³² Lewenson & Krohn Hermann, *Capturing Nursing History*, 2.

¹³³ Patricia D’Antonio, Conceptual and Methodological Issues in Historical Research in Lewenson & Krohn Hermann; *Capturing Nursing History*, 12.

¹³⁴ Susan McGann, ‘Archival Sources for Research into the History of Nursing.’ *Nurse Researcher*, 1997 (5)2:20.

1.9 Aims of the Research

The aims of this study are:

To find out how the composition and organisation of nursing in Malta changed during the period 1964-1996.

To investigate how the management of nursing in Malta changed during the period 1964-1996.

To identify barriers that hindered professionalisation in Malta

To identify major contributing factors to professionalisation in Malta

To investigate how factors such as political expediency, public needs, industrial evolution, emancipation of women, the influence of religious orders, and tertiary education in Malta have impacted on the development of the nursing profession in Malta between 1964 and 1996.

1.10 Objectives of the Study

To reach these aims, the objectives of this study are to:

Review existing reports and documents describing nursing and nurse education in Malta between 1964 and 1996.

Gather information on the perspectives of influential people in the field regarding the development of nursing in Malta.

Gather information from nurses and former nurses on life as a student nurse and as a qualified nurse in Malta's health institutions during the period 1964 -1996.

Analyse the interactions of factors such as political expediency, public needs, industrial evolution, emancipation of women, the influence of religious orders, tertiary education and modernisation of medicine on the nursing profession in Malta.

1.11 Conclusion

Malta is a densely populated island that has been ruled by one dominating people after another. Over the centuries, the Maltese people developed an attitude of tolerance towards the authorities as long as the latter did not threaten the people's livelihood. This coping mechanism led them to be somewhat passive if not reluctant to achieve independence and truly take responsibility for the country's future so that they acted only when they had to. Maltese nurses may have had the same tendency to move along with time and respond to changes coming from outside rather than instigating change themselves. An investigation into factors leading to changes and how they affected nurses and nursing has not yet been carried out. The purpose of this study is to consider these changes in order to trace the process of professionalisation of nursing in Malta.

Chapter 2

METHODOLOGY

2.0 Introduction

This chapter reports on the design and the methodological considerations involved with participants, data collection and analysis in the study of the process of professionalisation of nursing in Malta (1964-1996). Target populations, access and recruitment will be discussed followed by a description of the study design and a discussion of the historical method.

Sources of data collection included oral history interviews with nurses and persons who were influential in nursing – the ‘elite’, and archival sources through which cross reference was carried out to ensure validity.¹ Each of these sources is discussed, including the location and availability of archival source material and the underlying approach to the analysis of those materials, and the issues involved in collecting and analysing the oral histories.

Discussion of the choice of each method according to the appropriateness, strengths and weakness, sampling strategy, ethical considerations will be included. Practical issues encountered in the actual technicalities of searching through archival work, recording oral history and interviewing, and transcribing data, and the analysis of all data will be included.

2.1 Target Populations, Access and Sampling

The population of nurses under study consisted of those working in Malta between 1964 and 1996. Inclusion criteria for the nurses’ sample were that they were registered or enrolled nurses practicing in Malta at any time between 1964 and 1996, and physically able to carry out a conversation in Maltese or English. Members forming part of the elite group included former Ministers of Health, Chief Government Medical Officers, nursing tutors, matrons,

¹ Ann Marie Rafferty, Writing, Researching and Reflexivity in Nursing History, *Nurse Researcher* 1997/98 (5) 2:15.

nursing officers, union leaders, and lecturers of nursing. Some of these worked as nurses and their interviews yielded information about their time as students and as qualified junior nurses.

2.2 Access and Recruitment

Recruitment of nurses for this study was through a call for them placed below an article by the author in the quarterly journal of the Malta Union of Midwives and Nurses (MUMN) called '*Il-Musbieh*' [The Lamp] (Appendix IX) allowing a month's time for response. This journal is distributed by post to all MUMN members. In this way, access to personal data was avoided. Although there was no previous estimation of the preferred sample size, this could not be very large as participants were to be interviewed individually. The purpose of this study was to outline the nature of nursing as it changed over time but also to elicit enough information by delving deeply into nurse preparation for the role and the feasibility of achieving professional status. According to Eve Kosofsky Sedgwick, depth of information is important for historical research.²

There were three responses to the advert and a snowballing process followed whereby nurses invited others to participate while others who met the author offered their participation. The small size of the island, the concentration of nurses in few institutions and the fact that all nurses were mostly trained in one School for Nurses facilitated this method. Request for an interview was also sent to persons who held official positions affecting nursing during the period 1964-1996 and some of the British lecturers who had contributed to the first tertiary level courses in nursing after 1988 (Appendix VI). Some of them still occupy public positions while most of them have their names and addresses in the National Telephone Directory. Access through secretaries was therefore sought. Access for other 'elite' persons was through letters requesting consent after initial contact via contact persons who were mutual

² Eve Kosofsky Sedgwick, *Epistemology of the Closet* (Berkeley: University of California Press; 1990), 29.

acquaintances. Geoffrey Walford recommended using previous links with those in power as a means of access.³

Sensitivity was of paramount importance in the case of elite interviews, because these participants were contacted rather than being a strictly volunteer sample. Only one potential interviewee eventually dropped out of the study citing sickness as a reason for this. Although this interview was deemed to be important as it may have shed more light on decisions taken during the 1980s, it was felt that it would have been ethically wrong to press for it. Louis Cohen, Lawrence Manion and Keith Morrison stated that access to powerful people may be a challenge especially if the research study deals with issues of controversy and those that are contested.⁴ In this study, there may have been issues and decisions made by individuals in authority which may have caused discomfort or unease.

2.3 Sampling

Snowball sampling was utilised to reach potential respondents who were willing to be interviewed but had not responded to the call. Kirby suggested that snowballing is also helpful if a potential participant with significant experiences is mentioned by one interviewee.⁵ Since many respondents had long years of service their experiences provided what Boschma and colleagues referred to as ‘representativeness of the experience.’⁶ Snowball sampling may have introduced some bias in the data generated as those who had kept in contact with each other may have had similar opinions and experiences. According to Hagai Katz snowball sampling may have the disadvantage of resulting in a sample of people who have many links and may be affiliated to a subgroup of the sample that may affect their

³ Geoffrey Walford, *Researching the Powerful*; British Educational Research Association (2011) Available at: http://www.bera.ac.uk/files/2011/06/researching_the_powerful.pdf [Accessed 2 February 2016].

⁴ Louis Cohen, Lawrence Manion & Keith Morrison, *Research Methods in Education*. 6th edition (Oxford: Routledge; 2007), 50.

⁵ Kirby, *The Resurgence of Oral History and the New Issues it Raises*, 48.

⁶ Boschma, Scaia, Bonifacio & Roberts, *Oral History Research*, 85.

opinion and attitude.⁷ This may be true for a sample from small populations such as that of nurses in Malta. However, the close knit Maltese society may in itself have mitigated this since links have to be kept with all irrespective of differing opinions due to interfamily relationships and other interests such as the local band club and parish church. Snowball sampling for this study resulted in the sample being mainly made up of registered nurses. There were only three enrolled nurses and none of these had been a hospital attendant before so there may be missing data regarding this aspect. All elite respondents who agreed to be interviewed were included in the study. The whole sample totalled 24 respondents of whom five were British nurse educators, two were politicians and one senior administrator.

Occupation	Male	Female	Total
Nurse	2	3	5
Nurse & Tutor/Lecturer	0	2	2
Nurse& Tutor & Manager	2	1	3
Nurse & Manager	5	1	6
Lecturer	0	4	4
Administrators (Minister/Administrator)	3	0	3
Consultant on Education	0	1	1
Total	12	12	24
Number of elite interviewees = 4			
Number of interviewees still practicing = 4			

Table 2.1 – Description of Sample of Interviewees

⁷ Hagai Katz, Global Surveys or Multi-National Surveys? On Sampling for Global Surveys (2006). Available at: http://www.global.ucsb.edu/orfaleacenter/conferences/ngoconference/Katz_for-UCSB-data-workshop.pdf [Accessed: 20 July 2012].

The other sixteen participants were nurses who had worked in Malta during the period under study while some of them had also occupied positions of authority in nursing (Table 2.1)

2.4 Design of the Study

This study used a multi-method approach, including documentary and printed materials such as newspapers and official publications; oral histories from nurses who worked in Malta between 1964 and 1996, and interviews of other persons who played a role in the development and implementation of nursing strategies between 1964 and 1996. This is in order to follow Sonya Grypma's suggestion that a historical study should involve at least four different views in order to avoid the problem of being limited in perspective.⁸ Grypma names these views as 'overview', 'ground view', 'rear' or retrospective view and 'world view' that includes values, beliefs and assumptions.

View	Sources
Overview of relevant socio-political events in historical period under study (Bird's eye view)	Published historical works on Malta, the Maltese, colonialism and post colonialism in Malta and elsewhere.
Firsthand accounts (ground view)	Archival documents, documents from private collections, newspaper articles, reports and letters.
Recollections of experiences (Rear view)	Oral history interviews
Understanding of values, beliefs and assumptions (World view)	Published anthropological and sociological works Analysis of interview transcripts.
<i>Source:</i> Sonya J. Grypma, Critical Issues in the Use of Biographic Methods in Nursing History. In: Sandra B Lewenson & Eleonor Krohn Hermann, (eds.) <i>Capturing Nursing History</i> (New York: Springer Publishing Company; 2008), 69.	

Table 2.2 - Views of events needed for improved perspectives (according to Grypma and sources used in this study to find respective view).

⁸ Sonya J. Grypma, Critical Issues in the Use of Biographic Methods in Nursing History. In: Sandra B Lewenson & Eleonor Krohn Hermann, (eds.) *Capturing Nursing History* (New York: Springer Publishing Company; 2008), 69.

2.5 Historical Method

In order to have a guide for the study of nursing in post colonial times an appropriate historical philosophy was sought. Experience in the scientific methods of enquiry led the author to delve into the empirical reconstruction model of historical study in order to ‘let facts speak for themselves’ and to establish the authenticity of sources together with the facts reported by these sources.⁹ This was in search of direct documentary evidence that would help in building up the narrative in an objective way.¹⁰ Adhering to an empirical way of inquiry in seeking documents and appraising them in a scientific way seemed to be the method of choice. However, further study of history methodology led the author to consider construction and deconstruction since these models shed a light on history according to different objectives, epistemologies and ways of presentation.¹¹ Although one cannot move away totally from scientific thinking and working to uncover facts in an empirical way, the course of this study has led into the investigation of frameworks that assist in understanding the story of the profession within different contexts. This is in line with Patricia D’Antonio’s suggestion that historians elicit the interconnections between variables and proceed to interpret these to produce a historical piece of work.¹²

A social and political framework was considered when analysing this model in a constructive approach. A political framework was believed to be appropriate, considering the preoccupation of the Maltese with politics and the Maltese government’s powerful influence in the lives of individuals.¹³ A large number of *Melitensia* books on the immediate pre and

⁹ Keith Jenkins, *The Postmodern History Reader* (London: Routledge; 1997), 20.

¹⁰ Empiricists such as Geoffrey R. Elton and John Bagnell Bury advised on the adherence to strict scientific ways of historical enquiries in order to establish historical facts. Richard Evans, another empiricist, emphasized the need for objectivity by the historian when considering evidence regarding the past. Anna Green, Kathleen Troup, *The Houses of History: A Critical Reader in Twentieth-century History and Theory*. (Manchester: Manchester University Press; 1999), 2-4.

¹¹ Jenkins, *The Postmodern History Reader*, 19.

¹² Patricia D’Antonio, Conceptual and Methodological Issues in Historical Research in Lewenson & Krohn Herrmann. (eds.) *Capturing Nursing History*, 13.

¹³ Dennis Austin, Malta Today Asks - Under which King Bezonian? *The Round Table: The Commonwealth Journal of International Affairs*, 1996 (85) 339:336.

post colonial era in Malta were consulted in order to obtain a wide knowledge of the context of the period under study. The political, social and anthropological history of the island during this time was delved into deeply as training for undertaking the present study in accordance with Munslow's recommendations.¹⁴ Deeper study of historical events occurring in Malta during the period under study (1964-1996); many of which are in living memory, indicated that there are multiple realities resulting from interactions between nursing's internal, external and global environments. The construction model was therefore deemed to be constraining as it seeks to explain historical events within a predetermined framework. It is believed that the narrative emanating from this study needs to be free from such a framework and allowed to determine its own direction, especially since it is the first attempt at collating information regarding nursing in modern Malta.

Being the first of its nature in nursing, this study may lead to a way of interpreting the past of nursing in Malta. The author could not ignore the fact that in the attempt to recover the past that happens to be in her own memory, she could be imposing a narrative coloured by her own experience. Munslow maintained that: 'the positioning or organising of the evidence in relation to other examplesis where the historian's own views and cultural situation usually emerge'.¹⁵ In acknowledging this as part of the study, it is hoped that interpretation is based on openly acknowledged perspectives as well as raw evidence to produce what Munslow called 'a plausible narrative'.¹⁶

Moreover, personal experiences and ideologies certainly affect the resultant historical narrative that has not yet been produced. In interpreting themes emerging from data there may be a relativism of meaning resulting from personal experience, ideas and ideologies. According to Jordanova ideologies resulting from the author's assumption may lead to

¹⁴ Alan Munslow, *Deconstructing History*. 2nd edition (London: Routledge; 2006), 46.

¹⁵ Munslow, *Deconstructing History*, 8.

¹⁶ Munslow, *Deconstructing History*, 13.

evidence being distorted or ignored.¹⁷ Deconstruction acknowledges this stating that through interpretation of the different facets of the sources; the historian imposes an order of events.¹⁸ Sources were therefore looked at closely in order to delineate areas of agreement as well as opposing views regarding events, causality and effects. Jenkins and Munslow highlighted the fact that sources are really interpretations themselves and therefore history is based on multiple interpretations.¹⁹ In attempting to uncover relative meanings to texts according to their origin, the author sought to bring the past and the written history of nursing in post colonial Malta, as close to each other as possible.

Issues of cause and effect suggested by Munslow²⁰ along with drivers of historical change such as gender, class, culture, coincidence and politics were sought in this venture. Munslow contended that verifying the past by evidence is impossible due to the nature of the evidence; a narrative as perceived by the different authors. Of particular interest to this study is Munslow's reference to historians' access to the evidence including 'absence, silences and gaps, contrived nature of the archive, signifier-referent collapse, historian's bias and the structure of the historian's imposed and contrived narrative argument.'²¹

Since the remaining sources are oral interviews with nurses and the elite, the process of interpretation was actually heavily influenced by the interviewee as well as the interviewer and occasionally by more than one interviewee for the same event or aspect. Such an interpretation influences the final product and probably any work that follows. Alessandro Portelli contended that oral history has an inherently partial aspect as the account is personal and therefore recounts an individual's perspective.²²

¹⁷ Ludmilla Jordanova, *History in Practice* (London: Arnold; 2000), 112.

¹⁸ Keith Jenkins & Alan Munslow, (eds.) *The Nature of History Reader* (London: Routledge; 2004), 21.

¹⁹ Jenkins & Munslow, *The Nature of History Reader*, 3.

²⁰ Munslow, *Deconstructing History*, 12.

²¹ Munslow, *Deconstructing History*, 73.

²² Alessandro Portelli, The Peculiarities of Oral History *History Workshop Journal* 1981 (12) 98.

Jeff Mitscherling asserted that the art of hermeneutics is a necessity when producing works of historical nature.²³ Situations in which meanings need interpretation are suitable for the application of hermeneutics.²⁴ If ‘Historians bring their ideas and ideologies to bear upon the process of writing and researching history’;²⁵ they surely affect interpretation by their own presuppositions and/or prejudices. A hermeneutic approach was applied in the attempt to understand the meanings of the evidence gathered from all sources mentioned in accordance with Paul Thompson’s advice on the need for cross checking all sources.²⁶ Since most of the interviewees chose to speak in Maltese rather than English, idiomatic and symbolic language was interpreted in Maltese. This resulted in an additional challenge in reporting analysis, interpretation and eventual evaluation of evidence and will be discussed later on in this chapter. Ruth Tappen contended that historical research can actually resemble detective work as it involves searching archives, ‘unearthing forgotten documents, interviewing people who were on the scene of an important event or browsing the Internet for clues to the history of nursing and the nursing profession.’²⁷

2.6 Archival Sources and Documents

Published literature regarding the history of nursing in Malta since Independence is scarce. Polit and Beck asserted that: ‘Many historical materials may be difficult to obtain and, in many cases have been discarded’²⁸ while Susan McGann, an archivist stated that in the case of nursing there is a probability that documents have not been preserved.²⁹ However, Lesley

²³ Jeff Mitscherling, Truth and Method: Hermeneutics or History? *Journal of Philosophy* 2009 (11) 1.

²⁴ Hans-Georg Gadamer, The Universality of the Hermeneutical Problem. In: David E. Linge, (tr. & ed.), *Philosophical Hermeneutics* (Berkeley: University of California Press; 1976), 4.

²⁵ Rafferty, Writing, Researching and Reflexivity in Nursing History, 7.

²⁶ Paul Thompson, *The Voice of the Past: Oral History* (Oxford: Oxford University Press; 1984), 213.

²⁷ Ruth M. Tappen, *Advanced Nursing Research: From Theory to Practice* (United Kingdom: Jones & Bartlett; 2011), 255.

²⁸ Denise F. Polit & Cheryl Tatano Beck, *Nursing Research: Principles and Methods*. 7th edition (Philadelphia: Lippincott, Williams & Wilkins; 2004), 257.

²⁹ Susan McGann, Archival Sources for Research into History of Nursing; *Nurse Researcher* 1997 (5) 2:19.

Hall suggested that there are ‘oblique and unexpected sources for nurses and nursing.’³⁰ In this study documents other than those strictly pertaining to nursing were sought in order to find useful sources of information. Eleanor Krohn Herrmann’s list of possible sources to be explored was used as a guide for this search.³¹ According to McGann, since nursing exists as an integral part of society, nursing records or records associated with nursing may be in a variety of places.³² In Malta, the spread is smaller since nurse education and nursing activities in the island’s small number of hospitals and institutions were centralised and all were under central government control; yet access was still problematic.

Since this is the first work of its kind it was difficult to identify the right sources for the documents sought especially because the actual developments of the nursing profession were largely unknown. The absence of a nursing journal specifically for Malta during the period of study made such research even more difficult. The assistance from archivists and librarians was invaluable in tracing some documents. A systematic search procedure was carried out following the advice in Krohn Herrmann’s contribution about conducting research in developing countries,³³ along with Christine Hallett’s description about how to approach archives such as official and unofficial archives and libraries.³⁴ Brigid Lusk’s³⁵ suggestions were also considered although they referred mainly to research carried out in America where the history of nursing has been a subject of study for a relatively long time. Since this study was about the 1964-1996 period, there was an added difficulty to accessing documents that had been issued less than 30 years before due to political sensitivity and data protection

³⁰ Lesley A. Hall, Nurses in the Archives: Archival Sources for Nursing History. In: Ann Marie Rafferty, Jane Robinson and Ruth Elkan (eds.) *Nursing History and the Politics of Welfare* (London: Routledge; 1997), 267.

³¹ Eleanor Krohn Herrmann, Historical Research in Developing Countries. In: Lewenson & Krohn Herrmann (eds.) *Capturing Nursing History* 126.

³² McGann, Archival Sources for Research into History of Nursing, 21.

³³ Krohn Herrmann, Historical Research in Developing Countries, 126.

³⁴ Christine E. Hallett, “The Truth About the Past?” The Art of Working With Archival Materials, In Lewenson, & Krohn Herrmann, (eds.) *Capturing Nursing History*, 149.

³⁵ Brigid Lusk, Historical Methodology for Nursing Research, *Journal of Nursing Scholarship* 1997 (29) 4:356.

issues. Munslow asserted that the search for evidence is very important if historical study is not to be fictional.³⁶

Most of the documents pertaining to the age of the British Rule in Malta are gathered at the National Archives of Malta (NAM), at Rabat where they are kept at the site of the oldest recorded hospital building in Malta. Documents issued from the Medical and Health Department after 1921 are not housed in these archives but there are documents from the Ministry of Social Policy that include materials relating to health and the elderly between 1987 and 1992. A search in the data base of these archives using the keywords ‘nurs...’, ‘medic...’, ‘hospital/s’ yielded round 100 documents. The description of each entry was assessed for relevance and nine were found to be irrelevant. Closer study of the rest resulted in very little direct information on nursing. During the course of the study, the Archives received more documents regarding health care that were treated and evaluated by the archivists and added to this study’s data base. Eight documents were accessed in this way. At the National Archives documents are kept in boxes that are given codes according to their provenance such as GMR and ME.

The 1957 Report on the Medical Services of Malta by J. Cronin was found in the National Archives and had been previously cited by Maltese medical historians. According to Lino German, a long serving member of the Medical Officers’ Union (MOU), the Times (of London) had announced that Cronin had been invited by the then Prime Minister Dom Mintoff to advise the Maltese Government on the reorganisation of the medical services in Malta.³⁷ However, a report in the British Medical Journal said that the Maltese Government had also sought Cronin’s advice on the eventual introduction of a national health service.³⁸

Cronin, a British orthopaedic surgeon and Labour MP was also close to the Communist

³⁶ Alan Munslow, *The Routledge Companion to Historical Studies* (London: Routledge; 2000), 94.

³⁷ Lino J. German, *Landmarks in Medical Unionism in Malta 1937-1987* (Malta: Media Centre Publications; 1991), 33.

³⁸ National Archives of Malta (NAM)/GMR/1953/1957 John Cronin, *Report on the Medical Services of Health*. (Malta: Department of Information, 1957).

Russian Parliamentary Group.³⁹ Reasons for Mintoff's requests to Cronin are not clear but German interpreted this action as a sign of disappointment in the nominees for a specially nominated commission.⁴⁰

Cronin's Report is twenty one pages long and describes the medical and health services of the time. It was compiled during the author's purposely scheduled one week's visit to Malta during which he conducted visits to all the health institutions in Malta personally inspecting all the wards therein, interviewed 53 doctors, many patients, Sisters of Charity, nurses, the General Workers' Union representatives and many representatives of government authorities. Only one page is dedicated to nursing.⁴¹ The variety of sources consulted makes it a comprehensive report that can be a reliable source of information on the health scenario in Malta in October of 1957 - before independence. Although as a commissioned report it may be expected to laud the achievement of the Maltese authorities, Cronin's comments and recommendations criticise many aspects of the medical and health situation.⁴² These included quite heavy criticism of the medical profession which may be in partial appeasement of Mintoff who had commissioned the report just after a bitterly fought industrial strike ordered by the MOU.⁴³

At the NAM there is another document attributed to Cronin that is actually made up of the one already described together with two other documents, namely: a Report on a Hospital Building Programme for Malta signed by J.O.F. Davies and a Report of the Medical Services

³⁹ DE 6338 'Political Papers of John Cronin (1916-1986) M.P. for Loughborough (1956-2002). Available at: <http://discovery.nationalarchives.gov.uk/browse/r/cf07da1c-4194-48ee-853e-6f0a16369575> [Accessed: 25 March 2016].

⁴⁰ German, *Landmarks in Medical Unionism in Malta*, 30.

⁴¹ NAM/ GMR/ 1953/1957 Cronin; *Report on the Medical Services of Health*, 5.

⁴² Cronin heavily criticised the practices allegedly happening at the time that included fee-splitting; deliberately misleading certification and immoral relations with patients. He also commented on the ease of access to the Minister of Health to employees and recommended that representations should be made from senior officers.

⁴³ German, *Landmarks in Medical Unionism in Malta 1937-1987*, 30.

Commission signed by Leslie Farrer-Brown, Harold Boldero and J.B. Oldham.⁴⁴ Davies' report deals mainly with hospital extensions while, the Medical Services Commission headed by Farrer-Brown had terms of reference that were almost identical to Cronin's. This is perhaps why all reports were published by the Office of Information in one booklet that seems to have been attributed to Cronin by other historians writing on health in Malta.⁴⁵ Names of signatories are at the very last page of the document possibly leading to their being overlooked.

Farrer-Brown was a lawyer, economist and charity administrator who was a Director of the Nuffield Foundation and contributed greatly to the recognition of Occupational Therapists as a profession.⁴⁶ He had been seconded to the Ministry of Health (UK) in the early 1940s and according to German was widely conversant with medical organisation and was considered 'anti-doctor'.⁴⁷ Harold Boldero was a physician who had participated in both World Wars and had given a lot of advice on the setting up of the National Health Service (NHS) in the UK.⁴⁸ The Royal College of Surgeons' Lives of the fellows described James Bagot Oldham as a Surgeon Commander during World War 2 who held various posts in surgery in the UK including that of President of Surgeons of Great Britain and Ireland who 'was a perfectionist

⁴⁴ NAM/ GMR/ 1999/1957 Report on the Medical Services of Health and a Hospital Building Programme for Malta. (Malta: Department of Information, 1957), 52:2. The last section of this document is headed Report of the Medical Services Commission. This Commission had been appointed with Mintoff's endorsement after much controversy, as part of an interim agreement with the Medical Officer's Union following a bitterly disputed industrial action by doctors against Prime Minister Mintoff's administration in 1956: German, *Landmarks in Medical Unionism in Malta*, 30.

⁴⁵ Alexander Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta* (Malta: PEG; 2002), Charles Savona Ventura, *Outlines of Maltese Medical History* (Malta: Mizzi Books; 1997) mention Cronin only while Paul Cassar *Medical History of Malta* (London and Beccles: William Clowes and Sons Ltd; 1965) does not mention any one of these signatories. Cassar's failure to include the reports in his book may be due to their being too close to the publishing date of the book and the controversy that surrounded the issue leading to the reports. Cassar was a medical doctor in government service appointment and may have felt that mentioning any of the reports could threaten his employment or position among peers.

⁴⁶ Anon, Obituary of Dr. Leslie Farrer Brown, *British Journal of Occupational Therapy*, 57 (7) 1994, 281.

⁴⁷ German, *Landmarks in Medical Unionism in Malta*, 31.

⁴⁸ Royal College of Physicians, Lives of the Fellows. Harold Esmond Arnison (Sir) Boldero. Vol 5 p. 43. Available at: <http://munksroll.rcplondon.ac.uk/Biography/Details/459> [Accessed: 27 June 2016].

who could be outspoken.’⁴⁹ The composition of the Commission indicates that its members had a vast experience of medical organisation and could adequately appraise the Maltese medical services. While Farrer-Brown was the Chairman, the Royal College of Physicians and the Royal College of Surgeons had each nominated a member and therefore the services and conditions of the medical profession were emphasised;⁵⁰ a fact that may have been expected since the commission had itself been appointed ‘to undertake a comprehensive review of the medical services and to submit recommendations for its future organisation and terms and conditions of employment.’⁵¹

The document they produced is 97 pages long and was compiled during a week’s visit within a month after Cronin’s. They gathered information from all those who were willing to meet them or write statements on the medical services including the Malta Memorial District Nursing Association (MMDNA).⁵² One of its eight chapters is dedicated to nursing and is ten pages long although it is not known how much of it was based on interviews with nurses. It includes an overview of nursing in 1956 describing nurse education as well as the organisation of nursing on the wards in the different institutions in Malta and Gozo. The report is an evaluation that is forthright and underlines the needs of the department. Cronin’s and Farrer-Brown and colleagues’ reports gave a good basis for this study as they depicted the Maltese Health System just before the period under study.

⁴⁹ Royal College of Surgeons, Plarr’s Lives of the Fellows. Oldham, James Bagot (1899 - 1977). Available at: <http://livesonline.rcseng.ac.uk/biogs/E006830b.htm> [Accessed: 27 June 2016].

⁵⁰ The Commission discussed the conditions of work of various members of the medical profession working in Malta but seemingly contradicted Cronin’s report on certain practices allegedly used by doctors. The Commission reported that it did not find ‘any foundation for the allegations.’ NAM/GMR/1999/1957 Leslie Farrer-Brown, Harold Boldero & James B. Oldham; *Report of the Medical Services Commission* (Malta: Department of Information; 1957), 27: 106-109.

⁵¹ Farrer-Brown, Boldero & Oldham; *Report on the Medical Services Commission*, 52:1.

⁵² Farrer-Brown, Boldero & Oldham; *Report on the Medical Services Commission*, Appendix.

Several annual reports issued after these reports, each entitled 'Report on Medical Conditions and Works of the Medical and Health Department' were also accessed.⁵³ Some of these are included as part of the Report on the Working of the Government Departments.⁵⁴ These reports were compiled annually by the Chief Government Medical Officer (CGMO) of the time and were intended for publication. The reports may therefore fail to mention problematic areas and possibly inflate successful projects since the authors may have perceived them as reflecting their own performance. Patricia Munhall contended that this kind of selective reporting may compromise accuracy.⁵⁵ Each report is around 150 pages long and they seem to allocate importance to particular aspects of health at given times but nursing is only mentioned around ten times in each report mainly with reference to how many calls for applications were issued and to the number of students qualifying to become nurses during the year under report. Individual reports emphasise one issue or another such as the shortage of nurses,⁵⁶ or the training school for nurses.⁵⁷

The Lists of Government Employees (Staff List) for the years 1956-1985 were also accessed in an exercise to determine the changing numbers of nurses over these years. These lists were not all available at the National Archives and some were not even available at the National Library and may therefore be assumed not to have been issued at all. Those that are extant appear to have been compiled meticulously as they were the basis upon which seniority was calculated for the purpose of promoting government employees. They are therefore probably a reliable source for statistical data regarding numbers, years of experience and ages. Many of the lists accessed were separated according to gender but some

⁵³ NAM/GMR: 1942/1956; 4000/1957; 2157/1958; 2193/1959; 2263/1960; 2385/1961; 2496/1962; 2546/1963; 2654/1964; 3782/1965, 1966, 1967; 3139/1968, 1969; 3241/1970; 3333/1971; *Reports on the Medical Conditions and Works of the Medical and Health Department*, for years 1958- 1978.

⁵⁴ NAM/GMR: 3469/1974; 3512/1975; 3541/1976; 3570/1977; 3598/1978; 3617/1980; 3636/1981; 3681/1982; 3726/1984; 3741/1985; 3758/1988; 3805/1990; 3806/1991; 3807/1992; 3808/1996.

⁵⁵ Patricia L. Munhall, *Nursing Research; A Qualitative Perspective*. 5th edition (London: Jones & Bartlett; 2012), 386.

⁵⁶ NAM/GMR/2157/1958, 17.

⁵⁷ NAM/GMR/21937/1959, 58, 61; NAM/GMR/2385/1961, 151.

had all nurses in a particular grade being included within one group. First names were then used to determine gender. After 1985 all government employees were listed according to their pay scale rather than grades so that individual nurses could no longer be identified. The study was, in some respects prosopographical as attempts were made to find out individuals' career progressions using dates of birth and dates of first appointment in government service. This was in an attempt to understand the procedure used to grant the grade of Enrolled Nurse. Work at the Archives was time consuming and laborious, as it involved going through files and documents page by page, often gleaning very little information. A particular challenge was presented by the large volumes of the Malta Government Gazette (MGG). The first edition of the MGG was published on 13th October, 1813.⁵⁸ At present it is published twice a week and includes all the notices of the various government ministries. The notices are published in Maltese and English running side by side. All editions for a year are hardbound and can have up to 5,000 pages besides two supplements for the Legislation Ordinances or Acts passed through parliament and Bills presented. Only three of the 36 editions searched were indexed, resulting in the need to go through each of the rest page by page; the books were as thick as fifteen centimetres. All notices including the term 'nurse' were read and analysed for relevance to the present study. In each year, there were around twenty five entries about nursing including Acts and Bills of law, legal notices; pensionable posts; tenders for uniform items; names of foreign individuals working in Malta as nurses; the number of unemployed nurses and calls for application for entrance examinations leading to nursing courses and calls for applications to fill vacancies in nursing. The latter two were particularly interesting as they gave details of entry requirements and allowances of student and pupil nurses. Changes could therefore be traced for the time period under study. Other notices that informed the present study were those regarding opportunities for post-secondary

⁵⁸ Anon, *A Classified Catalogue of the Malta Garrison Library* (Malta: Mission Press; 1840),168. Each MGG edition has a number and for referencing purposes, each reference refers to the edition number followed by the date of publication (Appendix I, Referencing Guidelines – Style Sheet).

studies for men and women. The Government Gazette is a reliable source of information as it is formal, impersonal and intended for publishing. It is therefore generally devoid of metaphors and figurative speech that could lead to ambiguity of meaning.⁵⁹

Documents coming from the Department of Education were also studied at the National Archives to find out about secondary and post secondary education in Malta during the period under study. A particular document of interest was that issued in 1965 on access of girls and women to higher education.⁶⁰ This was produced in response to a questionnaire issued by the Division of Women Rights and Education of International Understanding, United Nations Educational, Scientific and Cultural Organisation (UNESCO) in 1965. The document was signed by the Director of Education, and acknowledged that professional openings for girls were only available in teaching. Documentation was not attached to the supplement except for a copy of an article written by the Assistant Director of Education, Margaret Mortimer, in the Malta Year Book – 1965. The document seems to be factual but lacks any reference to sources of data. It also contains very little comment except for Mortimer's contribution that resembles prose rather than factual comment.

Parts of the National Archives were not accessible for study due to the 30 year bar on government information and data protection. However, the archivists suggested material that could be of interest to the study when this was deemed to be devoid of the need for protection. Such material included menu books for different hospitals in which daily records of food ordered by ward was documented that could indicate number of patients on wards per day and internal memos. Decontamination and vetting of documents prior to their release for access by readers is ongoing and there are still many documents pending treatment that may have been useful sources for the present study. Moreover, the journalist Saviour Aquilina quoted eminent Maltese historian Henry Frendo as saying in an interview that parts of the

⁵⁹ Munslow, *Deconstructing History*, 14.

⁶⁰ NAM/ME/251/1966, *Report on Access of Girls and Women to Higher Education*. (Malta: Department of Education; 1966).

archive with respect to documents produced within different Ministries during the 1970s and 1980s may be missing.⁶¹ Reasons for this have not been given. Although it may prove difficult, analysis of missing data may also inform the researcher on events shedding a light on the role of the gatekeepers of information whose actions may condemn facts from becoming history because the hard evidence cannot be found. Patricia Munhall recommended this analysis of missing data in search of their meaning that could contribute towards reaching conclusions.⁶² Oisín Tansey stated that while documents may be displaced or unintentionally discarded, those regarding political processes may be lost over time when archives are destroyed or to withhold them from analysis by the public.⁶³ This may be true in the case of some documents regarding the present study as for example the Report on the Working of the Government Department of 1978⁶⁴ does not mention the doctors' strike that had caused an upheaval in the entire National Health Service and Private Health services that was to continue for ten years. Reference to the extra efforts made to employ foreign doctors to substitute those who had been locked out would have been expected. This instance is an illustration of the fact that even the most 'official' of documents can be subject to distortion, whether by altering included data or by not including data at all.

The main part of the Medical and Health Archive is kept at Mount Carmel Hospital, Attard. This includes documents originating from the Medical and Health Department after 1921 and until around 30 years ago. It is not classified in any way and there is very little knowledge on the kind of documents that it may include besides the medical notes of patients who have passed away. However, it is not accessible at present due to the potentially dangerous

⁶¹ Saviour Aquilina, 'Remembrance of Things Past.' *The Sunday Circle Online Magazine*. 12.8.2011 Available at: www.sundaycircle.com/2011/08/remembrance-of-things-past-prof-henry-frendo [Accessed: 15 January 2014].

⁶² Munhall, *Nursing Research*, 385.

⁶³ Oisín Tansey, Process Tracing and Elite Interviewing: A Case for Non-probability Sampling. *PS: Political Science & Politics* 2007 40:8.

⁶⁴ NAM/GMR/3598/1978 *Report on the Working of the Government Departments of Malta 1.4.1978 - 13.4.1979*. (Malta: Department of Information).

conditions under which it is stored including damp, mould and the possible presence of vermin. Figures 2.1- 2.4 indicate the extent of this archive and the state it is in at present.



Figure 2.1 – Archives Health Department



Figure 2.2 – Archives Health Department



Figure 2.3 – Archives Health Department



Figure 2.4 – Archives Health Department

The rest of the Archive is the one being most frequently used at present that is kept at the Ministry of Health in Valletta. A large part of it is still under the 30-Year Bar that forbids the inspection of public records by the public before the expiration of thirty years from their creation.⁶⁵ Although permission had been granted for some files to be accessible, classification of this archive is by year only so it is very difficult to find specific records

⁶⁵ MGG Supplement B 7388 National Archives Act, Act V of 2005 as amended by Legal Notice 427 of 2007, Para 10.2, p. 6.

unless one already has a reference or a year when a particular document may have been produced. For this reason only three files were accessed from this archive.⁶⁶

Records from the School for Nurses had been accessed by the author during the course of a previous assignment in 1990 when the School was still in operation. They were originally compiled by the Principal Nurse Tutor who was also a nun. Most of them are personal files of student and pupil nurses since the school was opened in 1964 and are still under a 70-Year Bar that forbids access to personal files. These records are now kept at part of the premises of St. Luke's Hospital and they are also not classified and in an unknown condition. Records accessible to the author during 1990 consisted of factual data such as number of admissions and qualification per group of pupil or student nurses. These were used in an unpublished report of a study on international comparisons of staffing in nursing in Malta by Audrey Miller and Gill Tipping.⁶⁷ Since only part of the archive was available one cannot appraise it for bias in what was included and what was deemed important to retain in the archives as recommended by Sandra Lewenson and Annmarie McAllister.⁶⁸ Records quoted in this study are those compiled in 1990 and included in the original report.

It is assumed that official documents found are authentic. However, there may have been bias in the selection of facts that were to be included or omitted. Officially printed and published documents rarely include comment but the choice of areas that needed highlighting may indicate bias or increased concern. Seemingly neutral documents may have an agenda by the fact that they were produced at all. Eric Foner contended that even texts such as the Constitution of America may possess more than one objective meaning.⁶⁹ Their meaning needs to be examined in the light of how, when and why they were produced. Hallett stated

⁶⁶ Medical & Health Archive, File 2297/88 BSc Nursing Course at University of Malta.

⁶⁷ Audrey Miller & Gill Tipping, *International Comparisons of Nursing Manpower and Nursing Officers' Opinions of their Work in Malta* (Unpublished Report, Institute of Health Care, University of Malta: 1990).

⁶⁸ Sandra B. Lewenson & Annmarie McAllister, Learning the Historical Method: Step by Step. In: Mary De Chesney (ed), *Nursing Research Using Historical Methods* (New York: Springer; 2015), 11.

⁶⁹ Eric Foner, *Who Owns History? Rethinking the Past* (New York: Hill & Wang; 2002), x.

that historians need to know how to appraise texts by looking at how they were produced and considering the different ways they can be interpreted with an awareness of the difficulties that can be encountered when working with them.⁷⁰ According to Hallett, factors to be considered during appraisal include the background of the author and his/her intentions when writing, the publishers' economic and ideological intentions as well as the kind of readers they were intended for. Ian Lustick said that for every source one needs to check for authenticity, authority, bias/authority and intelligibility.⁷¹ Documents issued by the Government may be authentic and of authority but the degree of truth they depict may be questionable as they often describe the official version of events that may be different from what actually happened or led to a particular decision being made. The paucity of documents produced or preserved by employees for example may contribute to a lack of evidence; thus the official version is the one found printed so that it remains the main 'evidence' of an event. According to Munhall this leads to what Orwell referred to when writing that: 'History is written by the winners.'⁷²

Rafferty admitted that historiography is highly influenced by political interests.⁷³ In Malta political uncertainties during the 1980s have contributed to a relative vacuum during that period in terms of documentary evidence. Kenneth Zammit Tabona, an opinion writer in *The Times of Malta* wrote that the 1980s:

all but ruined my youth with its regime of intimidation and violence, times when one's words were weighed and masticated 100 times before being uttered let alone written, times when we did not dare to speak about politics openly or on the phone for fear of it being tapped, times when most of the articles I write today would not have been able to be published for fear of violent reprisal, times when our weekend outings consisted of one political rally after the other.⁷⁴

⁷⁰ Christine E. Hallett, Historical Texts: Factors Affecting their Interpretation. *Nurse Researcher* 1997 (5) 2:61.

⁷¹ Ian S. Lustick, History, Historiography and Political Science: Multiple Historical Records and the Problem of Selection bias. *American Political Science Review*. 1996 (90) 3:605.

⁷² Munhall, *Nursing Research*, 386.

⁷³ Rafferty, Writing, Researching and Reflexivity in Nursing History, 5-16.

⁷⁴ Kenneth Zammit Tabona, The Politics of Persuasion and other stories, *The Times of Malta (TOM)* 8.1.2008, 7.

That time period still seems to instil some fear in those who would otherwise be able to contribute their experiences. This compounds the problem of the scarcity of documents pertaining to the ordinary people with a resulting existence of the opinions and documents from people who were courageous enough to write or speak. In an interview given to Peter Fleri Soler in 2012, Peter Ellul, a film director said that people did not want to be recorded when they spoke critically of their experiences under former Prime Minister Dom Mintoff, ‘So it was a matter of finding people who were willing to stick their neck out.’⁷⁵ Frendo stated that he had received a death threat during the 1980s for attempting to produce work on certain subjects. Although he did not specify these subjects he suggested that this aura of fear may be a possible reason why this era has not been much explored yet.⁷⁶ He wrote that ‘future historians ...will have the temerity ... to tackle this very recent, vitally consequential period.’⁷⁷ In Aquilina’s interview, Frendo suggested that official documents pertaining to this period (1980s) and that should be released from the 30-Year Bar, may not be ‘intact’ and therefore important sources of information may be lost.⁷⁸ In this study this lacuna may also result from the fact that personal files are still not accessible for researchers due to data protection laws. The resulting evidence may therefore lead to a greater approximation of the past than that referred to by Foner who described historical truth as existing as a reasonable approximation rather than in the scientific sense.⁷⁹ It may be however, that in the conscious or unconscious decision to omit facts from documents or destroy documents altogether, authorities and other influencing figures in the past have actually produced some of the bias through a lack of available evidence so that an interpretation leading to plausible explanation in one direction may actually have revealed something very different if there had been more evidence available.

⁷⁵ Peter Fleri Soler, Talking About Extremes. *The Sunday Times* 18.3.2012, 33.

⁷⁶ Aquilina, Remembrance of Things Past.

⁷⁷ Henry Frendo, *Censu Tabone: The Man and His Century* (Malta: Maltese Studies; 2000), 196.

⁷⁸ Aquilina, Remembrance of Things Past.

⁷⁹ Foner, *Who Owns History?* xii.

Some documents that could partly furnish an equivalent to the lack of documents about nursing education in Malta were obtained from private collections as original documents or photocopies of originals. These include documents from the private collection of the former Principal of the School for Nurses consisting mainly of commissioned reports by foreign visitors to Malta;⁸⁰ drafts of curricula for student and pupil nurses, communication with the UKCC regarding conversion courses for Enrolled Nurses, school regulations and laws upon which they were founded, work on a procedure book for nurses and correspondence regarding the modular system of delivery of nursing courses. The documents were all together in boxes that also contained articles on aspects of practical nursing and management and conference proceedings. The authentication of these documents is difficult and one must rely on information gathered from the donors. The choice of which documents to donate may also introduce bias.

Photographs and copies of documents were also obtained from a former nurse tutor who was also a nurse manager during the period under study. Other documents shedding light on nurse education during this time are notes and past papers distributed by nursing tutors and used by students during training. Copies of commissioned reports, speeches and presentations that shed a light on how tertiary education for nurses was initiated and some of the work done in the area of mental health care were obtained from a former Parliamentary Secretary for Health and Chancellor of the University of Malta, Prof. John Rizzo Naudi. Private collections may also have some bias through the fact that what may have motivated the owner to keep or discard a document may itself lead to a bias in favour or against an interpretation. Foner stated that: ‘The very selection and ordering of some “facts” while ignoring others is in itself an act of interpretation.’⁸¹

⁸⁰ Janice Crackett & Denise Donnelly, *Positional Report on Nursing Education and Nursing Management in Malta* (1988); Betty Kershaw, *Report of visit by Betty Kershaw 19.06.89-29.06.89*; Andrew Main, *Preparation of Nurse Teachers – Malta 24/6/89 – 29/6/89*.

⁸¹ Foner, *Who Owns History? Rethinking the Past*, x.

The archive of the Sisters of Charity in Malta may have been a good source of information regarding the contribution of the nuns to nursing in Malta during the period 1964-1996 and any contribution they may have made to the changes occurring at this time. These sources were mentioned by Bonnici in his book on the history of the Sisters of Charity in Malta.⁸² However, the ‘archives’ shown to the author of this work consisted of pictures, leaflets and information about the Sisters of Charity contained in a file.⁸³ Photographs found in this file and which were copied and donated to the author were useful in portraying the layout of wards at St. Luke’s Hospital and enable better understanding of the conditions of work of nurses at the time. The existence of the archive mentioned by Bonnici in his book,⁸⁴ was not pointed out in order to respect the nuns’ undeclared wishes and avoid potential problems for future researchers.

Research at the National Library involved a search through the newspapers that are on microfiche reels. These exist for six daily newspapers and two Sunday papers. A day by day search beginning in 1964 was initiated but the very small yield of data on nursing resulting from many hours of searching through the first year led to a change of strategy whereby particular dates would be sought in other journals if nursing was mentioned during that time in *The Times of Malta* or *The Sunday Times of Malta*.⁸⁵ These two papers are published by the Allied Newspapers Limited and have been issued for eighty years without interruption. They are not at present backed by a political party; however, the original publishers were the Stricklands; founders of the Constitutional Party; an overtly pro British party.⁸⁶ They were

⁸² Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 14

⁸³ Fr. Alexander Bonnici, a Church historian who was commissioned to write the story of these nuns in Malta, referred to: “a large quantity of inedited material” that was in possession of the Sisters of Charity: Alexander Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 14. The archive includes the “*Kronaka*” that is a daily record of occurrences within the congregation that a priest may be allowed to study but not a lay person.

⁸⁴ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 14

⁸⁵ The word Malta had to be removed from the titles of these newspapers in November 1978 as a law had been passed restricting its use to those who were granted official permission.

⁸⁶ Dennis Castillo, *The Maltese Cross: A Strategic History of Malta*, (London: Praeger; 2006), 143.

also the most widely read papers at least until 2007 according to available sources.⁸⁷ All issues have been placed in an online archive that can be accessed upon payment of a subscription. A search was conducted through this archive using the keyword ‘nurs*’ and choosing a time span between 1.1.1964 and 12.12.1996 that yielded 12,678 hits. These were presented according to relevance (as defined by the creator of the archive) and could be viewed up to five at a time for selection of item. Selection was based on relevance to the present study and items selected were then sorted according to year published. There were 956 such entries consisting mainly of letters to the Editor praising the medical and nursing staff of wards, parliamentary reports and reports of industrial actions by nurses. Newspapers can be considered as secondary sources since they report their perception of what happened.⁸⁸ They are often highly partial and politically biased. However, newspaper reports shed a light on what happened and can therefore contribute to the facts as they happened especially where there is a lack of alternative sources.

The Library at the University of Malta was consulted for dissertations or thesis that could enlighten the present study. The theses database yielded a thesis on the history of nurse regulation in Malta, one on the Central Hospital, Floriana that had already been closed in 1964, another about nursing education and two dissertations that were about young people’s inclinations when making career choices. Other dissertations consulted were those regarding specific nursing procedures aspects such as admission and pressure area care which were presented between 1992 and 1996.⁸⁹ There were only 67 as the number of students graduating between 1992 and 1996 was small. These archival sources yielded some information but oral history interviews complemented this information to form a stronger basis for interpretation of events.

⁸⁷ Media Warehouse Survey, 2007. Available at: www.informa.com.mt/Media_Warehouse.html [Accessed: 1 February 2016].

⁸⁸ Jordanova, *History in Practice*, 100.

⁸⁹ These specific studies could not be utilised for the study presented here as they were too specific.

2.7 Oral History

Oral history involves the collection and study of historical information through the use of often audio recorded interviews with people who have direct personal experience and knowledge of past events. It is therefore a historical methodology requiring an interaction between interviewer and interviewee that allows the latter and therefore the narrator, space and freedom to express ideas and put forward thoughts regarding their experience. Geertje Boschma, Margaret Scaia, Nerrisa Bonifacio and Erica Roberts asserted that oral history fills the gaps left in documentation and also provides an opportunity to create the history of ordinary people who lived alongside those in power who have been studied and commemorated so far.⁹⁰ This is in agreement with Portelli's suggestion that oral history provides information about 'people or social groups whose history is either absent or distorted in the written record.'⁹¹ In the relative absence of documentary evidence about the history of nursing in Malta after colonialism oral history interviews emerged as sources for studying this period if people would grant such interviews. According to Thompson oral history is useful in studying the social history of minority groups as it offers new dimensions.⁹² Moreover, Robert Perks and Alistair Thomson suggested that oral history can be used to 'pin down evidence where it is needed' so its use in the absence of documented evidence was deemed to be appropriate.⁹³

Boschma and colleagues asserted that: 'Oral history provides a means of understanding events as seen by those who experienced them' and 'is a crucial methodology in capturing nursing's past, because often nurses left behind little documentation of their work.'⁹⁴

According to Portelli oral history is very useful in revealing meaning and also often reveals

⁹⁰ Geertje Boschma, Margaret Scaia, Nerissa Bonifacio & Erica Roberts, Oral History Research In: Lewenson S.B. & Krohn Hermann (eds.) *Capturing Nursing History*, 81.

⁹¹ Portelli, *The Peculiarities of Oral History*, 97.

⁹² Thompson, *The Voice of the Past*, 88.

⁹³ Robert Perks & Alistair Thomson, *The Oral History Reader*. 2nd edition (London: Routledge; 2006), 26.

⁹⁴ Boschma, Scaia, Bonifacio & Roberts, Oral History Research. In: Lewenson & Krohn Hermann (eds.) *Capturing Nursing History*, 81.

information about events that were previously unknown.⁹⁵ This method was therefore considered appropriate for attempting to understand changes in the organisation and practice of nursing in Malta after independence. Anthony Seldon and Joanna Pappworth suggested that a lack of documented evidence gives rise to a paucity of information and that this gap can be filled by oral history interviews.⁹⁶

This study intended to portray how nurses carried out their work and how they acted and reacted when changes occurred in their profession. Information from interviews with persons from the government and nurse education was also gathered in order to bring evidence relating to those who had the power to instigate change and the process of professionalisation. Therefore this study fits into the category of “a history built around people” -the definition of oral history put forward by Thompson.⁹⁷ Thompson discussed interviewing techniques and the effect of the difference between interviewer and interviewee. If they are both ‘insiders’ to the situation under study as in this case, there can be an advantage in that data can be richer, deeper and more authentic. Meanings can be similar for the interviewer and interviewee. However, according to Thompson there is a danger of the interviewer being perceived as ‘higher’ than the interviewee that may influence interviewees into trying to sound more knowledgeable or offer expected answers. According to Sean Field the interviewee’s experience and knowledge makes him/her the expert in this relationship while the researcher can be said to be less knowledgeable.⁹⁸ This interaction results in the

⁹⁵ Portelli, *The Peculiarities of Oral History*, 97.

⁹⁶ Anthony Seldon & Joanna Pappworth. *By Word of Mouth: “Elite” Oral History* (New York: Methuen; 1983), 36.

⁹⁷ Thompson, *The Voice of the Past*, 18.

⁹⁸ Sean Field, *Oral History Methodology*. Centre for Popular Memory. Historical Studies Department, University of Cape Town; South Africa. (2007) Available at: http://iohanet.com/resources/documents/Sean_Field_sephisoralhistoryinstructionpaper.pdf p1. [Accessed: 2 April 2016].

compilation of historical evidence as interpreted by these contributors and in view of shared knowledge and experiences which Michael Frisch called ‘a shared authority.’⁹⁹

During oral history interviews there is the possibility that some interviewees steer away from mentioning events that are still sensitive. In the case of this study interviewees may have been involved in decisions to which they did not concur but had to accept either because of their position as members of committees or because they would otherwise have had to resign their post and risk losing employment. The turbulent times of the 1980s were only hinted at by interviewees in the knowledge that the interviewer would understand. For example interviewees who had been transferred from one place of work to another which they interpreted as a direct result of their political affiliation alluded to this but did not mention it explicitly.¹⁰⁰ Bearing in mind, James Fogerty’s counsel,¹⁰¹ the author took care not to introduce bias during the interview by asking questions that may have elicited one aspect more than the other even though this could not be totally excluded.

For interpretation, Thompson said that repeated listening to the original audio files and approaching interviews with a view to critical inquiry are important to identify the interviewees’ world view broadly and then to find out the experience as they view it. Oral history interviews and methods of interpretation suggested by Thompson were used as a guide when preparing for oral history interviewing, transcribing and interpreting.¹⁰² Portelli insisted that listening to the actual audio tape (file) is important as no amount of punctuation marks will depict changes in pitch of voice or in speed of speech that may have implications

⁹⁹ Michael Frisch, *A Shared Authority: Essays on the Craft and Meaning of Oral and Public History*, (New York: State University of New York Press; 1990), xxii.

¹⁰⁰ Quentin Borg, Konrad Cauchi, David Attard, Gerard Spiteri [names of the interviewees except for the elite interviewees are all pseudonyms (see Appendix II)] were all transferred from one hospital to another and under different governments. They all refer to it subtly and infer the meaning seemingly admitting that this is acceptable.

¹⁰¹ James E. Fogerty, Oral History & Archives: Documenting Context. In: Thomas L. Charlton, Lois E. Myers & Rebecca Sharpless (eds.) *History of Oral History: Foundations & Methodology* (Lanham: Rowman & Littlefield Publishing Group; 2007), 208.

¹⁰² Thompson, *The Voice of the Past*, 168.

on interpretation.¹⁰³ In this study there were also facial expressions that were used in a meaningful way for the interviewer to understand that which was being inferred.¹⁰⁴

Interviews were conducted at each participant's convenience either at their home or in another place of their choice that was considered to be suitable for this kind of recording. Participants were interviewed in their native language mostly Maltese according to their preference. Many interviews took one session but there were some that necessitated more than one appointment. Field notes were also taken during interviews to enhance the recorded data. Although care was taken to ensure that interruptions and environmental noises were kept to a minimum, this was not always possible. A 2GB Sony recorder with memory card slot was used for high quality audio recording to facilitate their archiving after the study is finished.¹⁰⁵ The recorder uses both battery and mains power as necessary but only batteries were used during data collection to avoid the necessity of requesting to use mains power at participants' homes. Spare batteries were carried by the researcher. Uploading was done regularly to ensure that recording space was available in the recorder. The recording equipment was tested each time before the interview began and frequent checks that it was still running were made during the interview so as to avoid losing data or needing repeated interviews. Data collected was uploaded onto a computer using Sound Organizer software that was purchased with the digital recorder and used to transcribe interviews verbatim.

2.8 Interviews with Nurses

Oral history methodology was used to gather data about nurses' experiences. Some of the respondents experienced management as well as grass root nursing and their insights may have affected their perceptions. Interviews sought to elicit information on practical as well as professional and leadership issues. A semi structured interview guide (Appendix III) was

¹⁰³ Portelli, *The Peculiarities of Oral History*, 97.

¹⁰⁴ These included winks and gestures to refer to reasons for transfer or persons in authority.

¹⁰⁵ Oral History British Library Sound Archive. Digital Equipment Guidelines. (2009).

used to ease the flow of the oral history interview and facilitate interaction between the researcher and interviewee; adhering to Kirby's advice of using interview time for eliciting and elaborating on events.¹⁰⁶ Narratives were allowed to go on in order to guide the study further.

2.9 Interviews with the 'Elite'

Tansey stated that in order 'to establish the decisions and actions that lay behind an event or a series of events' elite interviews are valuable.¹⁰⁷ In research the 'elite' are persons whose social position puts them in a position of power to decide or otherwise affect decisions.¹⁰⁸ For this study these included influential people who contributed to the development of nursing between 1964 and 1996. Conducting this kind of interview was new to the author and necessitated thorough preparation including thorough reading on the subject to optimise the opportunity to interview these persons. Mental preparedness for these interviews was also necessary in order to overcome a sense of awe since many of the elite interviewees had been in positions of authority when the researcher was a student nurse or just after qualification. Oral history methodology requires 'a dialogical, relational approach, a nonhierarchical relationship between researcher and participant.'¹⁰⁹

Validity and reliability of these interviews as sources depend on many factors. Jeffrey Berry advised on issues of truthfulness, passion, exaggerated roles and the delicate act of probing in an adequate manner; offering hints on how to best approach these issues. Other important means of securing rigour included adequate preparation with background reading, open ended questions, possible probes and ways of referring back to areas where answers may not have

¹⁰⁶ Stephanie Kirby, The Resurgence of Oral History and the New Issues It Raises. *Nurse Researcher* 1997 (5) 2:50.

¹⁰⁷ Tansey, Process Tracing and Elite Interviewing: A Case for Non-Probability Sampling, 4.

¹⁰⁸ Glenn Beamer, Elite Interviews and State Politics Research. *State Political Policy Quarterly*. 2002 (2) 1:89.

¹⁰⁹ Adeline R. Falk Rafael, Advocacy Oral History: A Research Methodology for Social Activism in Nursing. *Advances in Nursing Science*, 1997 (20) 2:36.

been those desired.¹¹⁰ Kenneth Goldstein confirmed this adding that access is important to ensure that an event or topic is covered from many angles.¹¹¹ Joanne McEvoy's article on elite interviewing in a divided society is particularly relevant to the situation in Malta where there is political division in a small country. McEvoy cautioned that politicians in this situation are often reluctant to move away from their party line. Responses may also be tailored according to what respondents believe may be those expected by the researcher given the latter's political opinion. McEvoy also hinted at how the interviewer may introduce bias by the kind of questions asked, time allowed for discussion, the decision to probe or not and how to do so without seeming to be challenging.¹¹² Cohen and colleagues asserted that powerful people: 'may be overly assertive' adding that, at times the researcher may feel obliged to pretend to be less knowledgeable than s/he actually is.¹¹³ In this study there were instances when the researcher chose to accept the version given by the interviewee rather than challenge to avoid antagonism towards any further research that might be conducted in future by the researcher or others. This was also in accordance with Esther Priyadharshini's recommendation that a more inquisitorial process is preferable than an adversarial one.¹¹⁴ Restraint was particularly needed when interviewing individuals who had made decisions affecting the researcher personally. A sense of anger was also felt when respondents seemingly feigned ignorance when asked particular questions rather than taking sides in a politically charged issue. Not voicing one's opinion felt to the researcher as a betrayal of belief or a compromise of principles but voicing disagreement may have had an element of

¹¹⁰ Jeffrey M. Berry, Validity and Reliability Issues in Elite Interviewing. *PS: Political Science and Politics*, 2002 (35) 4:678.

¹¹¹ Kenneth Goldstein, Getting in the Door: Sampling & Completing Elite Interviews. *PS: Political Science and Politics*. 2002 (35) 4:671.

¹¹² Joanne Mc Evoy, Elite Interviewing in a Divided Society: Lessons from Northern Ireland. *Politics* 2006 (26) 5:189.

¹¹³ Cohen, Manion & Morrison, *Research Methods in Education*, 51.

¹¹⁴ Esther Priyadharshini, Coming Unstuck: Thinking Otherwise about Studying Up. *Anthropology and Education Quarterly* 2003 (34) 4:420.

what Rosalind Edwards and Janet Holland called negative transference.¹¹⁵ They also noted that emotions may be conscious and unconscious and that the researcher/ interviewer needs to be aware of his/her own ideological views and the emotion dynamics at work during interviews. However, Walford also cautioned that those in power are: ‘well able to deal with interviews; to answer and avoid particular questions to suit their own ends and to present their own role in events in a favourable light.’¹¹⁶

2.10 Data analysis

A reflective approach was adopted in the analysis of data gathered from literary sources and government reports in order to analyse, compare and contrast content to elicit the best chronological sequence and changes in nursing at the time and therefore attempt to interpret them as advised by Hallett.¹¹⁷ Munslow advocated that the form, use of metaphor and style are also important in analysis and interpretation and this eventual interpretation as written history during one period of time is an interpretation based on the writer’s experience and knowledge on the event up till that time.¹¹⁸ This was felt to be relevant to this study since it is a first in the field. Knowledge of particular events and consequences may have been limited affecting interpretation.

Interviews with Maltese respondents were conducted in Maltese. This was important as this was the interviewee’s preferred language so interviewees could really use the terms they wanted to use. Many of the respondents used English phrases and idiomatic expressions interspersed within their answers; an indication that their expression was the fruit of the Maltese meaning of the concepts expressed and based on Maltese culture as well as a contribution of British culture. Maltese respondents had been brought up reading and writing in English through all their life within an education system based on the British one and using

¹¹⁵ Rosalind Edwards & Janet Holland, *What is Qualitative Interviewing?* (London: Bloomsberry; 2013), 65.

¹¹⁶ Geoffrey Walford, Reflections on Researching the Powerful. In: Geoffrey Walford (ed.) *Researching the Powerful in Education* (London: Routledge; 2011), 225.

¹¹⁷ Hallett, *Historical Texts*, 63.

¹¹⁸ Munslow, *Deconstructing History*, 34.

British textbooks and literature.¹¹⁹ This may be a unique situation in the world where respondents and researcher do not only speak the same native language but are also both conversant with the other language as well as having a good grounding in both cultures.¹²⁰

Verbatim transcription was carried out by the researcher within a few days of being held. The purpose of the time lapse being short was so that the attitude during interview would not be forgotten. Translation into English was also carried out by the researcher. Avoiding the contribution of a translator was deemed important in order to ensure confidentiality and also because translators may bring in yet a different interpretation of language than those of the respondent and the researcher since neutrality is difficult to achieve when constructing meaning.¹²¹ Particular attention was exercised during translation to ensure that meaning was not much altered bearing in mind Portelli's caution that translation can never be wholly literal and the implication that there will always be some changes however subtle.¹²² In this study, translation was necessary for academic purposes only but meanings may differ slightly when reporting speech in a different language from the original.

The effect of language use on perspective of nurses may have been diminished by the fact that the researcher's first language was Maltese. According to Bogusia Temple and Alys Young: 'concepts and words differ in meaning across languages'¹²³ which difference may affect the value demonstrated within the same text in different languages.

Thematic analysis was carried out on the transcriptions after reading through them repeatedly to elicit themes in view also of the data collected from documents. Relevant notes were taken

¹¹⁹ Leona M. English & Peter Mayo, *Learning with Adults: A Critical Pedagogical Introduction* (Rotterdam: Sense Publishers; 2012), 70.

¹²⁰ Maltese people have adopted an Anglicised way of living in Malta mixing their culture with that of the British not only because Malta was a colony for over 150 years but also because throughout those years much of the teaching of history, geography and general knowledge was based on Britain's. Traditions from Britain are more closely adhered to than those of geographically closer countries like Sicily, Italy or Tunisia. Books used in schools are mostly in English and produced for use in English schools so the basis of education is English and since the island is a very small one education can be said to be quite homogenous for a cohort.

¹²¹ Bogusia Temple and Alys Young, *Qualitative Research and Translation Dilemmas*, *Qualitative Research* 2004 4:164.

¹²² Portelli, *The Peculiarities of Oral History*, 97.

¹²³ Temple & Young, *Qualitative Research and Translation Dilemmas*, 163.

from printed sources as well as manuscripts methodologically as advised by Lusk.¹²⁴ This was to complement the data collected from oral history and offer explanations for some narrated facts. Content analysis of all the resultant data was carried out and used concurrently in an attempt to contextualise the changes in nursing in Malta and factors affecting them.¹²⁵ These factors included political, socioeconomic, modernisation of medicine and education conditions at the time. Consideration was also given to external and internal criticism as described by Lusk,¹²⁶ when describing authenticity of documents and manuscripts, and reliability of information therein. Available guidelines were used to assist in criticism and validation as well attempting to find meaning and interpreting data.¹²⁷

Lynn Abrams commented on the historical authenticity of life story research saying that these are based on keeping to the meaning rather than to strict accuracy.¹²⁸ This is in agreement with Portelli who explained the difference between credibility of oral sources and credibility of other sources because the former are influenced by narrators' imagination, symbolism and desire.¹²⁹ This implies that these sources can be subjective. Thompson acknowledged that their value lies in the insights they offer into people's interpretations of events and their implications rather than in offering proof or truth.¹³⁰

The process of analysing data from more than one source contributed towards corroborating data from records and compiling historical testimony.¹³¹ Discussing challenges of interpretation of historical texts, John B. Thompson mentioned four issues, namely, a potential change in meaning between the time of the text being written and the time of its

¹²⁴ Lusk, *Historical Methodology for Nursing Research*, 357.

¹²⁵ Kirby, *The Resurgence of Oral History and the New Issues it Raises*, 55.

¹²⁶ Lusk, *Historical Methodology for Nursing Research*, 357.

¹²⁷ Kathleen S. Hanson & M. Patricia Donahue, *The Diary as Historical Evidence: The Case of Sarah Gregg*. *Nursing History Review* 1996 4:176. Jennifer Platt, *Evidence and Proof in Documentary Research*. *Sociological Review* 1981 (29) 1:35. Barbara W. Tuchman, *Practising History* (New York: Knopf; 1981), 82.

¹²⁸ Lynn Abrams, *Oral History Theory*. (London and New York: Routledge; 2010), 46.

¹²⁹ Portelli, *The Peculiarities of Oral History*, 107.

¹³⁰ Thompson, *The Voice of the Past*, 165-226.

¹³¹ Boschma, Scaia, Bonifacio & Roberts, *Oral History Research in Lewenson & Krohn Hermann (eds.) Capturing Nursing History*, 85.

interpretation; the difference between what the writer intended to say and that which s/he actually wrote; the decontextualisation of the text from its original circumstances and finally the experience and background of the historian.¹³² In this aspect, the author acknowledges that her experience of life in Malta between 1964 and 1996 and of actually nursing in Malta during the period 1983-1996, will emerge overtly or covertly. Hence, a section relating to self-reflection is included later in this chapter.

2.11 Rigour

All efforts were made to produce work that is trustworthy and of good historical quality. Reading of historiography texts was used to inform the search and selection of data from documents, analysis and interpretation of all data collected and writing the final research report and to ensure that perceptions were not mistaken for truth and to provide sound arguments to enhance credibility while accepting that accuracy cannot be ascertained. According to Munslow: 'The past as it actually was and the individual historical statements composing its narrative can never coincide precisely.'¹³³ Rigour in searching documents included a broad search for sources and thorough investigation within sources after appraising the source as advised by Glenn Bowen.¹³⁴

Issues of reflexivity were kept in mind during the whole process. A continuous process of verification was adopted through triangulation of data from documents, oral history and elite interviews. A detailed description of the setting has been provided together with a critique of the archival sources, for readers to have enough information to enable them to judge the findings.

¹³² John B. Thompson, *Paul Ricoeur: Hermeneutics and the Human Science*. (Cambridge: Cambridge University Press; 1981), 13.

¹³³ Munslow, *Deconstructing History*, 73.

¹³⁴ Glen Bowen, Document Analysis as a Qualitative Research Method, *Qualitative Research Journal*, 2009 (9) 2:29.

2.12 Reflections on the author as a historian

Karen Henwood and Nick Pidgeon name reflexivity as one of the attributes that characterise good qualitative research.¹³⁵ In this work, the potential for introducing bias all through the research due to experience and resultant perceptions is acknowledged. The period under study (1964-1996) begins at the researcher's year of birth and therefore most of it is within memory and experience. While contributing to credibility by affording prolonged engagement with the themes, this proximity with the work could have further influenced my perceptions. The following is a brief description of the most salient personal life - events facts that may affected my interpretation of study findings.

Growing up in a family that depended on the British Services due to the breadwinner's employment, I was negatively affected by the government's decisions affecting this employment. Changes in curricula and entry requirements for University were also to affect my future career. Political strife and acts of violence against pro democracy protesters also contributed to a view of the then Labour government as being against freedom of expression. In the 1981 elections the Labour Party gained a majority of seats without having a majority of votes and continued to govern for another term against the wishes of the public resulting in continuing tension and increasing violence until 1987.¹³⁶ Changes in nurse education were also implemented that also affected the author as a student nurse not only because they increased the physical hardship of the work experience but also through the lack of opportunity to further one's studies. The loss of mutual recognition of the nursing registration between Malta and the UK as a result of the 'lock out' of striking doctors was of

¹³⁵ Karen L. Henwood & Nick F. Pidgeon, Qualitative Research and Psychology Theorising. *British Journal of Psychology* 1992 (83) 1:110.

¹³⁶ Edgar Mizzi, *Malta in the Making 1962-1987: An Eyewitness Account*. (Malta: Mizzi; 1995), 429-455. Mizzi was the Attorney General (1971-1981) and Chairman of the law revision commission (1981-1983) as well as special legal advisor to Prime Minister Mintoff (1981-1987) at the time (Michael Schiavone, *Dictionary of Maltese Biographies* Vol II, Malta: PIN; 1192). Mizzi refers to the 1981 election as having brought a political crisis through 'the inequity of the result : a majority of votes were cast in favour of the Nationalist Party and, at the same time, a majority of Labour candidates elected' in a representative electoral system (429).

particular significance since it effectively barred nurses from taking courses in the UK which had a practical component.

The introduction of education to tertiary level was to my benefit, since I was one of the students accepted into the first degree course in nursing offered by the University of Malta. However, this meant that I had to resign my full time post as staff nurse in order to avoid entering into a hypotech with the Government who was offering the sponsorship. Through this hypotech the Government had a right as a scholarship provider to take the scholarship holder's property if the obligation (4 years' service to Government or part thereof) was not satisfied, but in the meantime, the property stayed in the holder's possession. I could not accept these conditions at the time.

2.13 Ethical issues

Ethical approval to carry out this study was granted by the University of Manchester Research Ethics Committee and the researcher adhered to all recommendations of this committee. Special concerns treated prior to granting approval included personal safety of the researcher when conducting interviews at residencies and the researcher's social position as a nurse who was closely involved in the nursing profession in Malta, at many levels. This was to protect nurse participants who might have still been in employment. Conservation of privacy and integrity of individuals mentioned in unpublished documents and during interviews was a main ethical concern when using archival sources for data collection.¹³⁷ The existence of a single nursing school and few health institutions in Malta makes workers, especially key ones such as matrons, superintendents, chief government medical officers, professors, chaplains in these areas more easily identifiable especially by people who worked at a particular institution for a long time.

¹³⁷ Hallett, "The Truth About the Past?" 61-71.

Permission was sought from the Research Ethics Committee of the University of Manchester as well as the Research Ethics Committee of the Department of Health, Malta (Appendix IV) to conduct this research. Applications for approval included proposed actions to abide by Ethical and legal frameworks. These included specific regulations regarding accessing and perusing data of potential research participants in order to safeguard individual rights to refrain from or accept to participate in research in Malta. This is even more important in a small country as many potential participants would be acquaintances or relatives of researchers in the same field. Permission was also sought from The Sisters of Charity of St. Jeanne Antide, for data collection in the archives available (Appendix V). An appointment was given for a visit to the Provincial House of the Sisters of Charity where the nun in charge of the archives provided some documents as already explained. The researcher's social position as a nurse in Malta posed a further challenge in ensuring that interviewees accepted to be interviewed voluntarily. A call for nurses to volunteer their participation was made in the MUMN quarterly journal *'Il-Musbieh'* (Appendix IX). Persons for elite interviews were asked for an interview by means of a letter (Appendix VI) to which was attached an information sheet regarding the study. Elite interviewees were given a 'cooling off' period of at least forty eight hours after they had expressed an interest in being interviewed, before a further letter was sent.

An explanatory letter regarding the study was also sent to nurses who answered the advert (Appendix IX) and other participants (Appendix VI). All participants were given a formal consent form (Appendix VII). Information regarding participants' right to withdraw from the study at any time or to stop the interview at any time was also included. Participants were also asked to sign a deposit agreement (Appendix VIII) for their audio recorded voices during the interview being donated to the National Archives. Interviews were carried out with respect and courtesy at a place preferred by the participant. During the interview special

attention was paid to exclude the names of living or non-living persons in order to protect individuals and preserve confidentiality. Although oral history is intrinsically used to record named people's narratives as it 'rescues the individual from the crowd',¹³⁸ participants in this study were still given the option of remaining anonymous or of allowing limited access to their interview. None of them chose any of these options but nevertheless nurse –participants and nursing lecturers have been given pseudonyms to protect their identities. Kader Parahoo emphasised the need to respect the principle of non-maleficence including psychological harm to participants.¹³⁹ In this study, participants may have felt threatened by the fact that they were recounting incidents or events that were politically charged and for which being named may have exposed them and/or their relatives to overt or covert repercussions.

Data collected were kept in a locked cabinet while the study was ongoing. This was for safe keeping as well as maintenance of confidentiality. Donation to the National Archives of Malta will be made of oral history interviews after the project is finished. Parts of the transcripts that are quoted in this work and which may be politically sensitive were sent to the respective interviewees to ensure that the latter were cognisant that they were going to be included in this thesis. Written consent was obtained before including sensitive quotations, particularly from the named, elite interviewees.

2.14 Limitations of the Study

The study has some limitations that result from methodological shortcomings and circumstances surrounding the study. The length of time taken for ethical approval to be granted by the University of Manchester Research Ethics Committee was one such circumstance that delayed the collection of data. Planning of interviews was also problematic since it depended on availability of both researcher and interviewee. The researcher's work as a nurse on night shift brought with it specific challenges in this aspect.

¹³⁸ Thompson, *The Voice of the Past*, 7.

¹³⁹ Kader Parahoo, *Nursing Research: Principles, Process and Issues*. 3rd edition (London: Palgrave Macmillan; 2014), 67.

Needing interviews from foreign participants entailed travelling to the UK. Time schedules could therefore not be well planned and data collection went on for quite a long time.

The snowball sampling method used to recruit respondents for the oral history data may have resulted in themes not being uncovered. In requesting interviews with foreign nurse tutors an attempt was made to capture the nature of nurse education at tertiary level. Data collected through oral history informed the rest of the study. Interviews were carried out in English and Maltese according to the interviewees' preferences. Since many of the respondents were Maltese, the quotations from interviews utilised for this study are a translation and may therefore be inaccurate in meaning and resulting portrayal of changes in nursing in Malta.

Another limitation of the study resulted from limited access to the archives at the Department of Health and Mount Carmel Hospital. The Archive at the Ministry of Health is not systematically organised for files that are considered to be 'old' while the storage of files at Mount Carmel Hospital is haphazard and in an environment where access may be hazardous. Some information of relevance to this study may therefore have been untapped. Although Bonnici referred to an extensive archive belonging to the Sisters of Charity,¹⁴⁰ this was not available to the author and may have been a useful source of information on the contribution of the nuns. Other sources such as private archives that may also be existent but unknown to the author may also have more information.

This study on the history of nursing in Malta during the immediate post Independence period is an in depth one. The resultant narrative is outlined with some detail even if simplistic by the fact that several factors acting together may have been inadequately described so that the complexity of the situation may not be explicit.

¹⁴⁰ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 14.

2.15 Conclusion

The study of professionalisation of nursing in Malta (1964-1996) is reported through the analysis and interpretation of data from archival sources and oral history interviews with nurses and elite persons. This presented particular challenges in the paucity of documents directly dealing with the subject due to data protection issues and because informants, were recalling events from several decades ago the causes and effects of some of which are still being debated today. The political influences pervading Maltese society may have influenced the availability of documents and the quality of the interviews.

This study was, perhaps, unusual, in that it afforded equal value to documentary and oral history sources. Many oral histories in the field of History of Nursing prioritise oral history data, using documentary sources to support and contextualize findings. This study offers what is hoped is a particularly balanced empirical base.

Chapter 3

THE SHIFTING NATURE OF THE NURSING WORKFORCE

3.0 Introduction

This chapter considers the shifts within the grades of the nursing workforce during the period 1964 to 1996 and how the manner of those shifts impacted on professionalisation. The hierarchical structure of the nursing profession is described including the different grades making up the profession and their roles. Changes in grades and how they may have affected the process of professionalisation in Maltese nurses are also discussed together with gender issues and issues regarding the effect of education on recruitment and nursing practice. Figures drawn from archival sources and oral history interviews with nurses and influential persons are presented and discussed in the light of available literature in order to highlight the changes occurring within the organisation of nursing. In keeping with the hermeneutic approach, some of the discussion draws on the background chapter as a means of suggesting possible support for the discussion through the interpretation of meaning which participants may have been reluctant to make.

3.1 The Organisational Structure of Nursing in Malta 1964-1996

Leslie Farrer-Brown, Harold Boldero and James Oldham described the organisation of nursing staff in Malta in 1957 as consisting of nuns (members of the Sisters of Charity), Ward Masters, State Registered Nurses (SRN) and Hospital Attendants (HA).¹ These are shown in Figures 3.1. and 3.2 and indicate that below the authority of the Medical Superintendent there were two different lines of accountability based on gender; the Mother Superior being in

¹ NAM/GMR/1999/1957 Leslie Farrer-Brown, Harold Boldero & James B. Oldham, *Report of the Medical Services Commission*, 52:187. Although this report was compiled in 1957, there is no evidence to show that changes had been affected by 1964; the beginning of the period under study for this thesis.

charge of female personnel while the Ward master and Chief Male Nurse was in charge of male personnel. The nuns could influence the Ward Master and the Chief Male Nurse regarding deployment of male personnel as attested by an interviewee for this study.² There were also an undetermined number of substitute HAs that were casually employed according to daily needs.³ The number of student nurses per year was variable due to the varying number of entrants and attrition rates (Table 3.1 & Figure 3.3). During the 1960s there was also a British Matron,⁴ and a Maltese assistant matron who was also a nun was appointed in 1967.⁵

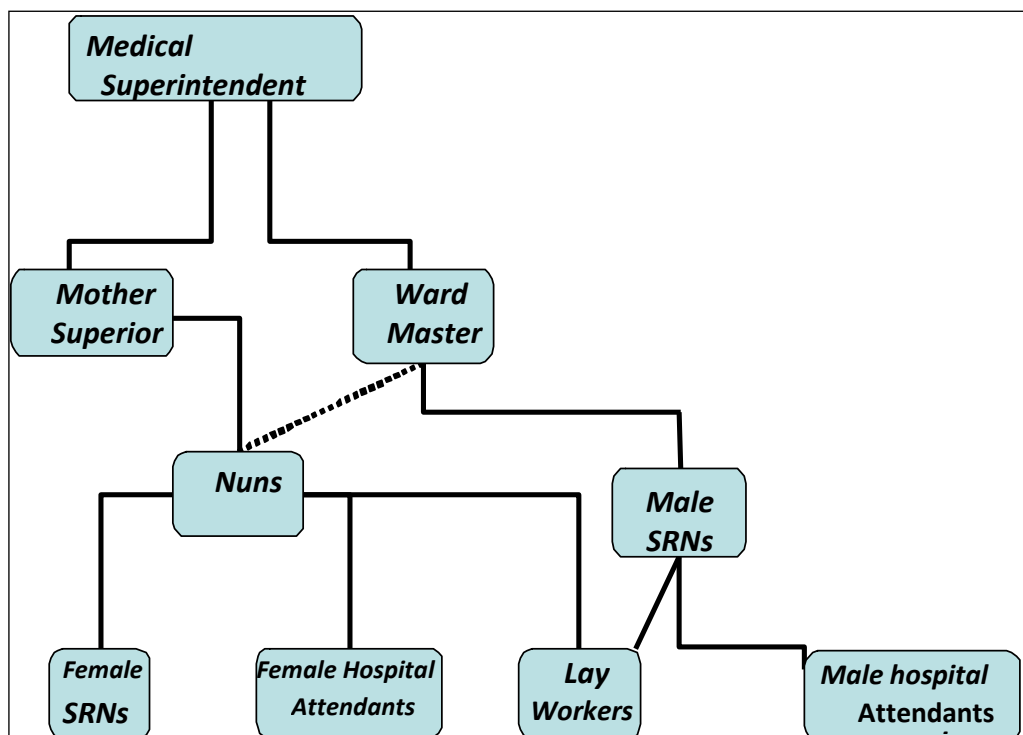


Figure 3.1 - Organisation of Staff at St. Luke's Hospital (1957)

² Interview with David Attard.

³ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 55: 196, iv.

⁴ Interview with Olivia Gatt.

⁵ NAM/GMR/3099/1969 Staff List, 121.

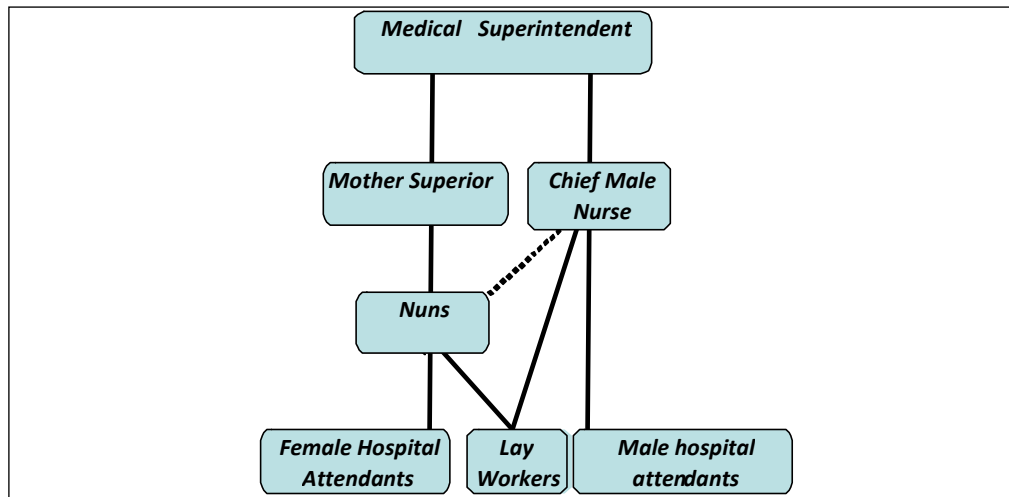


Figure 3.2 – Organisation of Staff at other Hospitals

The latter became matron in 1970 designated as Principal Nursing Officer (PNO)⁶ when there was also the introduction of the grades of Nursing Officer (NO)⁷ and Senior Nursing Officer (SNO).⁸ The organisation of the lower grades presumably remained the same until 1969 when there was the introduction of the State Enrolled Nurse (SEN).⁹ The government commissioned Report on the Medical Services of Health by Cronin¹⁰ and the Report of the Medical Services Commission by Farrer-Brown and colleagues,¹¹ both compiled in 1957, noted that the number of registered nurses was very small compared with a much larger number of HAs although they did not agree in the actual numbers given. The reports considered the resultant skill mix to be hindering a raise in standards of nursing¹² although details were not given to demonstrate this. Sources of information and ways of compilation of numbers were not mentioned so one cannot ascertain whether statistics included any

⁶ NAM/GMR/3460/1973 Staff List, 157.

⁷ Malta National Library, Staff List 1972, 158.

⁸ Malta National Library, Staff List 1977, 133.

⁹ MGG Supplement A, ACT No XXII of 1968. Medical and Kindred Professions Ordinance (Chapter 51) Substitution of Section 66 of principal law, 235.

¹⁰ NAM/GMR/1953/1957 John Cronin, *Report on the Medical Services of Health*. (Malta: Department of Information; 1957)

¹¹ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*.

¹² Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:187; John Cronin, *Report on the Medical Services of Health*. (Malta: Department of Information; 1957), 5:29-30.

STATE REGISTERED NURSES (SRNs)						
Year	No of entrants to the SRN course			No of qualified SRNs		
	Male	Female	Total	Male	Female	Total
1965	4	37	41	-	-	-
1966	0	36	36	-	-	-
1967	4	31	35	-	-	-
1968	5	37	42	3	21	24
1969	6	34	40	0	14	14
1970	13	52	65	2	18	20
1971	0	73	73	5	26	31
1972	0	51	51	4	27	31
1973	0	58	58	13	37	50
1974	0	46	46	0	47	47
1975	5	37	42	0	40	40
1976	9	79	88	0	46	46
1977	47	113	160	0	35	35
1978	25	49	74	4	28	32
1979	0	106	106	9	64	73
1980	40	71	111	40	86	126
1981	28	43	71	23	28	51
1982	50	47	97	0	71	71
1983	26	32	58	32	55	87
1984	31	57	88	16	31	47
1985	33	59	92	40	40	77
1986	38	47	85	17	15	32
1987	0	28	28	25	45	70
1988	0	46	46	23	43	66
1989	18	35	53	0	15	15
1990	10	15	25	-	-	-

Table 3.1 – Number of SRN Students and SRNs who qualified (1965-1990). Source: Miller & Tipping, *International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta* (1990).¹³

¹³ Audrey Miller & Gill Tipping, *International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta* (Unpublished Report, Institute of Health Care, University of Malta: 1990), 26. (Author's collection)

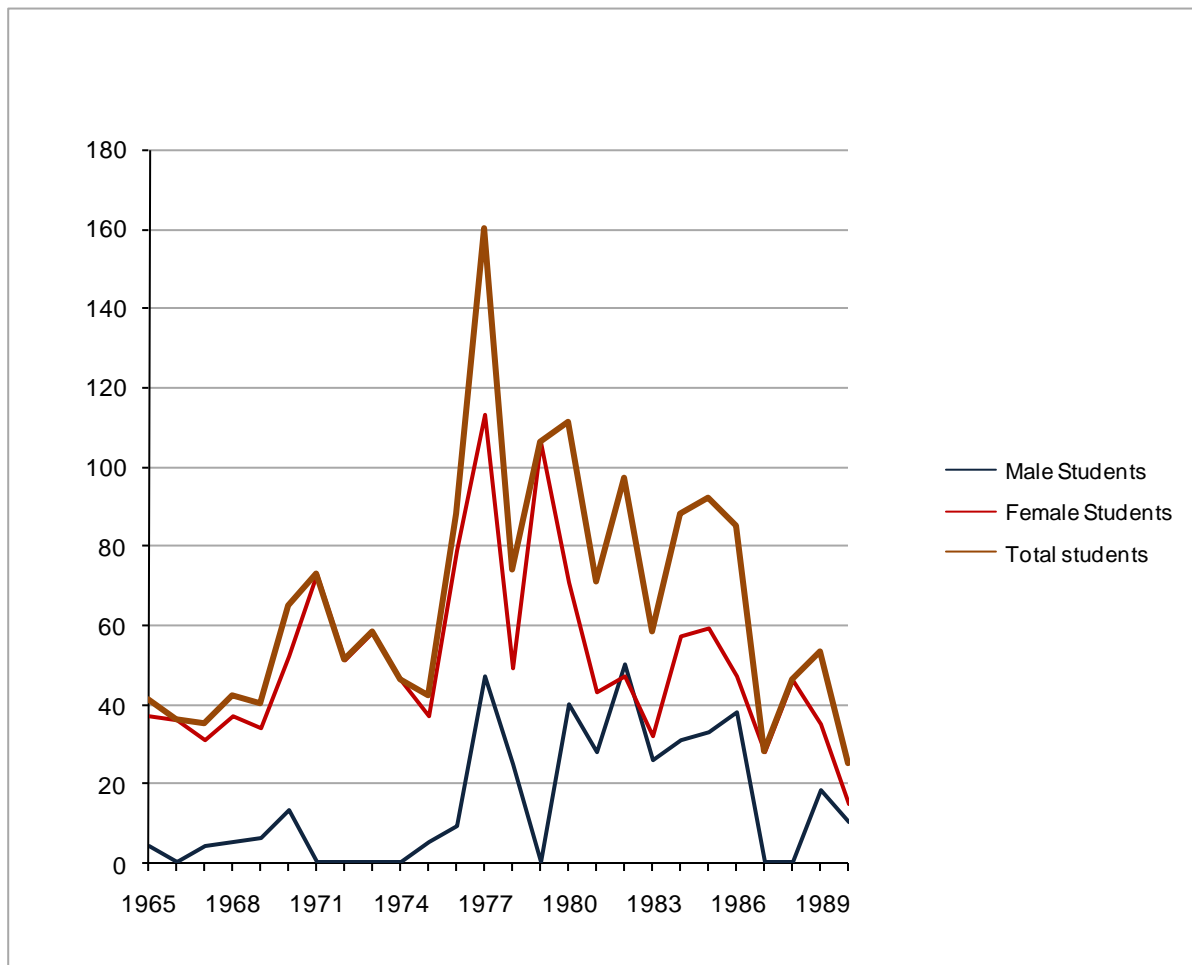


Figure 3.3 – Number of students who entered the SRN course per year. Source: Miller & Tipping, *International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta* (1990).¹⁴

‘casual’ employees or the number of nuns. The 1957 Staff List mentioned an even smaller number of SRNs (14) but included the grade of Chief Male Nurse.¹⁵

Organisational distinction existed between SRNs and HAs and between HAs and student nurses who had passed their preliminary exam (called ‘Blue belts’ for the light blue belts they wore instead of white ones reserved for new entrants). However, this distinction was not very obvious as all the work that needed to be done was carried out by all grades. SRNs assisted in

¹⁴ Miller & Tipping, *International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta*, 26, 28.

¹⁵ NAM/GMR/2062/1957 Staff List, 89.

cleaning and tidying equipment, folding sheets and cleaning window sills.¹⁶ This lack of distinction between the work of trained and untrained personnel was also present, to a lesser extent, in the UK after World War II when less qualified or even untrained volunteers worked alongside trained nurses.¹⁷ No evidence has been found of any efforts made by the Maltese authorities to maintain nursing standards and this role seems to have been left to the nuns and later to the lay registered nurses who replaced them as NOs. Each individual nun or NO kept his/her own standards in the ward but documents have not been found regarding how these were ensured especially when considering the great discrepancies in numbers between trained staff and HAs who later became known as SENs (Fig 3.4).

3.2 Changes in the lowest grades in nursing – hospital attendants and student nurses

During the 1960s the nursing personnel in Malta consisted mainly of HAs (Fig 3.4). In 1957, Farrer-Brown and colleagues reported that there were 646 HAs in Malta and Gozo compared to 87 fully trained nurses 42 of whom worked in hospitals.¹⁸ This situation was similar to that in 1960s and 1970s UK where the number of registered nurses remained small while that of nurses in the lower grades grew.¹⁹ The latter had minimal training²⁰ in similar circumstances to those cited by Farrer-Brown and colleagues who stated that in Malta there were only 50 out of 646 HAs who had attended a year long course of training and held the certificate of HA.²¹ The 1972 Report of the Committee on Nursing in UK (under the Chairmanship of Professor Asa Briggs) found that 50% of the 1,600 nursing auxiliaries included in their inquiry had no induction or later training, 25% had induction training only while 25% had later training only which ranged from ten hours to over forty hours. In Malta there may have been some later

¹⁶ Interviews with Denise Galea, Kevin Abela, Olivia Gatt and Edward Urpani.

¹⁷ Hannah Cooke & Christine Hallett. *Historical Investigations into the Professional Self Regulation of Nursing and Midwifery 1860-1998 Volume 1 Nursing*. Nursing and Midwifery Council (2011). eScholarID:156064,121. Available at the Nursing and Midwifery Council Archives, London, UK.

¹⁸ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:188.

¹⁹ Ian Kessler, Paul Heron & Sue Dopson, *The Modernisation of the Nursing Workforce: Valuing the Health Care Assistant*. (United Kingdom: Oxford University Press; 2012), 22.

²⁰ Asa Briggs. *Report of the Committee on Nursing* (London: HMSO; 1972), 199.

²¹ Farrer-Brown, Boldero & Oldham; *Report of the Medical Services Commission*, 52:188.

training as indicated by one interviewee for this study who said that he had entered nursing as a HA and then proceeded to train for registration in the next call for applicants for the SRN course.²² During the time when he worked as an ‘extra’ HA he was given training which was delivered in a purposely designated hall in sessions lasting one or two hours.²³ According to a call for application, the minimum age for entry to the HAs’ course in Malta was 17 years,²⁴ as it was in Australia but lower than the age of 18 mandated in UK, Peru and New Zealand.²⁵ Entry requirements also included a Standard V of Primary School education (equivalent to seven years of education) and passing an entrance exam in English and Arithmetic. Successful candidates had to attend an interview for assessment of appearance, personality, alertness, aptitude and other qualities which were not specified. Global marks were very important as they were the basis of a ranking system for applicants to be called for duty as Substitute Hospital Attendants according to necessity while attending the course.²⁶ This may explain the fact that while Farrer-Brown and colleagues reported the number of HAs in hospitals as 646,²⁷ the Staff List for 1957 included the names of 209 HAs only.²⁸ The HA: SRN ratio may in fact have been greater than that shown in Figure 3.4 indicating that those delivering care were not very highly trained. The utilisation of substitutes may have been a cost effective option that allowed the authorities to lay off workers easily if the workload decreased.

Exact figures of the gender distribution of HAs are not available since the Staff Lists included only those officially appointed. Figure 3.4 indicates that there were more females than males after 1965. According to Emma Vere Jones, in the UK, the need for more females for

²² Interview with David Attard.

²³ Interview with David Attard.

²⁴ MGG No 11,862 15.2.1966, 472.

²⁵ Red Cross International, *The Auxiliary Nurse: International Review of the Red Cross*. 1966 (6) 65:444.

²⁶ MGG No 11,862 15.2.1966, 472.

²⁷ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:188.

²⁸ NAM/GMR/2062/1957. List of Government Employees for 1957 (Staff List) Malta: Department of Information, 89.

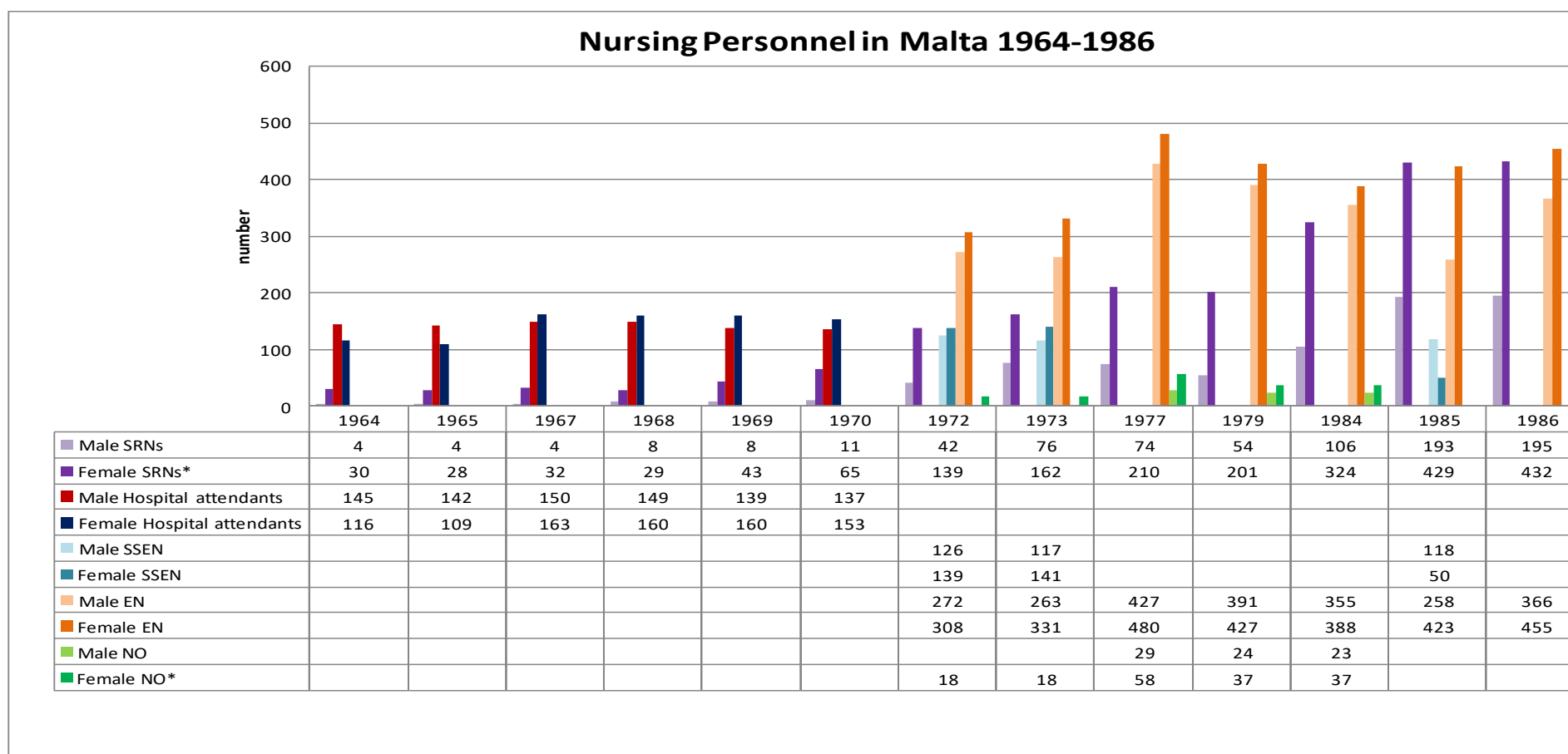


Figure 3.4 – Gender and Number of Nurses and Hospital Attendants (Source: Staff Lists 1964-1986).²⁹ *Excluding nuns

²⁹ NAM/GMR/2675/1964 Staff List, 153; NAM/GMR/2720/1965 Staff List, 164; NAM/GMR/2916/1967 Staff List, 119; NAM/GMR/3050/1968 Staff List, 121; NAM/GMR/3099/1969 Staff List, 121; NAM/GMR/3239/1970 Staff List, 126; NAM/GMR/3460/1973 Staff List, 157; Malta National Library Staff List 1977, 133; Malta National Library Staff List 1979, 137 NAM/GMR/3730/1984 Staff List, 190; NAM/GMR/3750/1985 Staff List, 181; Malta National Library Staff List 1986.

obstetric care and the trend for nursing personnel to be more female dominated contributed to this.³⁰ A similar situation occurred in Malta and was perhaps even more accentuated as wards were segregated according to gender. The Davies Report issued in 1957 stated that there were 192 beds reserved for women out of a total of 382 beds at St. Luke's Hospital.³¹ Demographic changes resulting from the post-war emigration of men brought about a disproportionate number of women in Malta.³² Emigration had reached a peak during the 1960s³³ because of high unemployment and the decline in expenditure of the Services in the rundown produced by the transition from colony to independent state.³⁴ The increasing urbanisation in Malta³⁵ led to women seeking employment outside of the home, a situation that had been rare prior to the war and not yet fully accepted by Maltese society.³⁶ This reluctance to accept women's full participation in life outside the household had also been experienced in 1950s' elsewhere in Europe.³⁷ However, it had been generally accepted in the UK that women could nurse and this may have facilitated their being accepted to work outside of the home from years earlier.³⁸ In Malta, this shift towards an acceptance of women working out of the home had

³⁰ Emma Vere Jones, Why are There so Few Men in Nursing? *Nursing Times* 2008 (104) 9:18.

³¹ NAM/GMR1953/1957 J.O.F Davies, *Report on a Hospital Building Programme for Malta* (Part II of document) (Malta: Department of Information; 1957), 2.

³² Bernardette Vella, *Maltese Settlement in the United States, 1945-1964* (Unpublished M.A. Dissertation, University of Malta, 2013), 112.

³³ Lawrence E. Attard, *L-Emigrazzjoni Maltija: Is-Seklu Dsatax u Ghoxrin.*, (Malta: *Publikazzjoni Indipendenza* PIN; 1999), 180. While the population of Malta was around 300,000; between 1957 and 1967 there were about 3000 people who emigrated every year with a peak of 8000 being reached in 1964 and 1965. Most of them were unemployed young people mostly men who had writing skills and could speak English.

³⁴ Simon C. Smith, (ed) *British Documents on the End of Empire: Malta* Series B No 11, (London: TSO; 2006), 211.

³⁵ Salvino Busuttil, *Agriculture in Malta: A Historical Note.* (2010) Available at: resources.cihaem.org/om/pdf/b07/934/00006.pdf [Accessed 20 January 2016].

³⁶ Mary Darmanin. The Labour Market of Schooling: Maltese Girls in Education and Economic Planning, *Gender and Education*, 1992 (4) 1:113.

³⁷ Jennifer Redmond & Judith Harford, "One man one job": The Marriage Ban and the Employment of Women Teachers in Irish Primary Schools. *PaedagogHist* 2010 (46) 5:642.

³⁸ Kara Dixon Vuic, *War-time Nursing and Power.* In: Patricia D'Antonio, Julie A. Fairman & Jean C. Whelan, *Routledge Handbook on the Global History of Nursing.* (Oxford: Routledge; 2013), 23.

gradually increased since World War II when women contributed greatly to Malta's efforts.³⁹

Employment of nursing personnel favoured women.

Calls for application to follow a HAs' course advertised 20 vacancies for men and 60 for women. The 1966 call for application for HAs' course stipulated that allowance during the course would be according to age and females were paid 75% of the amount received by males as can be seen in Table 3.2. The remuneration for work as Substitute Hospital Attendants is not available but Farrer-Brown and colleagues stated that without having any training HAs received £20 per month as well as free meals and extra pay for extra hours.⁴⁰ A large number of individuals delivering care at the bedside were therefore not qualified in nursing with little motivation to gain knowledge.

The report by Farrer-Brown and colleagues described a strategy to raise the standards of HAs through which preference for employment as HAs was given to women who had a secondary level of education.⁴¹ These were immediately placed at the top of the long waiting list. Although it may have raised the standard of entry into the HAs' grade it may also have encouraged those who were more educated to seek employment as Substitute Hospital Attendants rather than follow a course of education and training. HA courses were few and far between and admitted only up to 80 candidates per course.⁴² Moreover, the prospect of immediate employment may have attracted the more qualified women towards the HA grade rather than the student nurse status especially since student nurses received less than a student hospital attendant (Table 3.2).

Table 3.2 also includes statistics of allowances for following other post elementary courses where students were not expected to work as part of the workforce like student nurses. The

³⁹ Simon Cusens, *The Role of Women in World War II: The Case of Malta*, (Unpublished M.A. Dissertation University of Malta; 2014), 90.

⁴⁰ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 55:196 (iii).

⁴¹ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 55:196 (iv).

⁴² Between 1964 and 1966 there were only two courses for Hospital Attendants of 80 vacancies each: MGG: No 11,707 10.11.1964, 3032; No 11,862 15.2.1966, 472. Courses for Hospital Attendants were stopped after 1966.

Student Hospital Attendant (1966) *			Student Nurse (1966) #		Hospital Attendant (1967)~		SRN (1967) **		Housecraft School (1964) ##		Handyman Skills (1964) ##	
Age	Allowance (male)	Allowance (female)	Year of study	Allowance (m & f)	Salary (male)	Salary (female)	Salary (male)	Salary (female)	Age	Allowance	Age	Allowance
< 18	£188 18s	£139 8s 6d	1 st	£117	£320	£256	£360	£288	16+	£39	19	£78
<19	£220 7s	£166 5s 2 ½ d	2 nd	£123	increased by £10 p.a. to £410	increased by £8 p.a. to £328	increased by £15 p.a. to £540	increased by £12p.a. to £432.	17+	£52	20	£91
>19	£334 15s	£251 1s 2 ½ d	3 rd	£202					18+	£65	21+	£104 £169 if married
<p>*Based on a 312-day year. <i>Source - MGG 11,862 15.2.1966, 472</i> # <i>Source – MGG 11,918, 15.7.1966, 2109</i> ~ <i>Source – NAM, GMR 2916, Staff list 1967, 120, 122.</i> ** <i>Source – NAM, GMR 2916, Staff list 1967, 119.</i> ## <i>Source – MGG 11,662, 14.7.1964, 1945.</i></p>												

Table 3.2 – Comparison of salaries and allowances (1964-1967)

remuneration given to student nurses and the kind of work they did resulted in nursing not being very attractive and this may be one reason why the number of registered nurses remained so small compared to that of HAs (Figure 3.3.). A correspondent to the Times of Malta reported that male student teachers were asking for an increase in their allowances stating that these were £18 per year. According to the report male student nurses' allowance was £125 per annum while that of a Marsa Industrial trainee's was £2 per week (£104 per year) and that of a Hamrun Technical student £1.10s per week (£78 per year). All student teachers had free lodging while male student nurses lived at home.⁴³

At a time when many patients were on 'strict bed rest' the hospital attendants' work consisted mainly of attending to the patients' basic hygiene and toilet needs and delivering fundamental, then considered basic, nursing care. The nurses' image was one of workers who constantly did all kinds of menial tasks and rarely made any decisions since they had to be supervised at all times and needed to be disciplined by the nuns. This image may have reinforced popular perception thus further harming the professionalisation of nursing. Farrer-Brown and colleagues reported that: 'Most of the nursing of patients is done by hospital attendants'.⁴⁴ Delivery of care seems to have been carried out by those in the lower grades in many parts of the world. According to Karen Flynn, after the Second World War in Canada health care aides and nursing assistants 'constituted the hands that performed routine work that were directed by others'.⁴⁵ Farrer-Brown and colleagues reported that the Maltese HAs had to 'learn on the job, working in many cases under the direction of seniors who themselves are untrained. The general educational standard of most hospital attendants is lower than that required of student nurses'.⁴⁶ Student nurses worked alongside the HAs.

⁴³ TOM 18.5.1964 Maturity Course Students at St. Michael's College, 11.

⁴⁴ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:188.

⁴⁵ Karen Flynn, Experience Identity: Black Immigrant Nurses in Canada 1950-1980. In: Franca Iacovetta, Francis Sawyer & Marlene Epp (eds.), *Sisters or Strangers: Immigrant Ethnic and Racialised Women in Canadian History*, (London: University of Toronto Press Incorporated; 2004), 387.

⁴⁶ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:188.

Until 1990 student nurses and pupil nurses followed courses in nursing in an apprenticeship style; being allocated to wards on a rotation basis so that all students experienced working in all the different areas of nursing. The increasing mandatory age for mandatory education and changes in nurse education brought about changes in the quantity, quality and characteristics of students and pupil nurses that will be discussed separately in this study. The shift towards a more knowledgeable learner and the greater contact these had with patients may have contributed towards nurses becoming more articulate and willing to voice concerns regarding their working conditions. This was true both for students and for qualified nurses after the 1960s.⁴⁷ Students worked morning, evening and night shifts forming part of the staff complement of wards, operating theatres and specialised units. Interviewees for this study mentioned the arduous work they used to do as students mostly dealing with cleaning of equipment, running errands and assisting in fundamental nursing care.⁴⁸

One interviewee who qualified in 1967 said that as a student he would be allocated to work with the most senior HA on duty unless there was a SRN, a relatively rare occurrence since there were few registered nurses at the time.⁴⁹ Students and HAs would do all that was needed for the patient under the constant supervision of the nun. Therefore these were the people who were the ‘front liners’ in nursing and represented nursing to Maltese society also providing the image of nursing as one of a ‘servant.’ This title was used when referring to a hospital carer⁵⁰ probably coming from the time of the Knights of St. John who used to call them ‘*servitici*’.⁵¹ The ‘servant’ included all those attending on patients whether these were mental health patients needing the services of a guardian, elderly people at the residence for the elderly or acutely ill patients at the general hospital.

⁴⁷ These will be discussed as part of the endeavour to reach higher esteem as a profession.

⁴⁸ Interview with Iris Naudi, Ingrid Tanti and Denise Galea.

⁴⁹ Staff Lists 1964, 1965 and 1966.

⁵⁰ Interviews with Louis Galea, Quentin Borg.

⁵¹ Cassar, *Medical History of Malta*, 395.

3.3 The Middle Grade - The State Enrolled Nurses

The grade of State Enrolled Nurse was established by a law of 1968 that stated that applicants could be admitted into the roll if:

‘...on the first day of March, 1968 was enrolled as a Hospital Attendant and was performing duties of a hospital attendant.’⁵²

This followed the change of law in UK where the law establishing the Roll of Nurses was enacted in 1943 allowing those who had been practicing as nurse assistants for two years to apply for enrolment.⁵³ HAs began to be called State Enrolled Nurses (SEN). The list of SENs in the Staff List of 1970 includes the names of all those who had been in the HAs’ list of 1969.⁵⁴ Most of these names then appear in the Staff List of 1972 as Senior State Enrolled Nurses (SSEN) while the rest remained in the SEN List together with around 500 new names that did not feature in any previous Staff List. No evidence has been found regarding these ‘new’ entrants in the Staff List and it is hoped that when the archives of the Medical and Health Department are catalogued, more files will become accessible where information can be found. More research needs to be done to establish how these people qualified especially considering that their documented dates of first appointment ranged from 1936 to 1969 with around 300 being first appointed during the 1960s. An interviewee whose father had been a HA at the Mental Hospital during this time recalled that they had been given a course to become ENs.⁵⁵ No evidence has been found to show whether this took place for all ENs and what this course entailed. Delivering courses to over 500 individuals in a short time must have been a daunting task that needed time to finish especially since they had to be organised in a way that would cause minimal disturbance to the organisation of ongoing service

⁵² MGG Supplement A 1968, ACT No XXII of 1968, 235.

⁵³ Hallett & Cooke. *Historical Investigations into the Professional Self Regulation of Nursing and Midwifery 1860-1998 Volume 1*, 108.

⁵⁴ Staff List 1969, 123-126, Staff List 1970, 128-131

⁵⁵ Interview with Kevin Abela.

provision. At the Mental Hospital there was a programme for specialised courses to be delivered by a World Health Organisation (WHO) Mental Health and Psychiatric Nursing Advisor brought to Malta purposely by the Department of Health.⁵⁶ However, it is not known whether these courses had any connection with the granting of EN status.

Criteria used to grant the grade of SSEN are not known but some HAs did not reach it in spite of having been at the top of the list of HAs thus having long experience. Reasons for this are not known and may include a reluctance to be considered for the grade if it meant having to attend lectures and pass examinations especially if HAs were approaching retirement and/or were already receiving salaries that were equal to those received by qualified nurses at the time.⁵⁷ If Farrer-Brown and colleagues were right when they asserted that only 50 of the HAs had followed the course by 1957⁵⁸ and if all 160 applicants for the next two courses⁵⁹ had qualified, there would still be a discrepancy between the number of HAs officially certified and the 265 names found in the grade of SSEN in the Staff List of 1972.

Thus there was a sudden surge in the number of ENs (Fig 3.4) even if many lacked adequate formal training. The nursing body thus became largely one with minimal theoretical knowledge that could have led to a disempowerment on the part of the nurses and an added need for guidance leading to a further disposition to accept dependence on the nun who was deemed more knowledgeable. The nurses' lack of knowledge and the assigned authority to the nun led to a situation of blind faith in the nun and her complete control. One interviewee depicted the situation thus:

You could read the reports but they were mostly read by whoever was in charge, mostly the nun used to read them. The sister used to read them mostly. They started immediately and then she would perhaps tell him: "You have that one for theatre," if

⁵⁶ Charles Savona Ventura, *Mental Disease in Malta*, Association for the study of Maltese History (2004) Available at: staff.um.edu.mt/csav1/books/psychiatry.pdf [Accessed: 20 January 2016].

⁵⁷ Staff List 1969, 122 indicates that around 30 Enrolled nurses earned a salary on a personal basis that was equal to that of a midwife. Many of them were still in the EN list in 1972.

⁵⁸ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:188.

⁵⁹ MGG: No 11,707 10.11.1964, 3032; 11,862 15.2.1966, 472

they are in surgery, “the other is fasting.” She tells them and they do not have to go and read the report.⁶⁰

The public does not seem to have given this change much attention at the time as there is no reference to it in the newspapers of the time. This indicates that it may have been a way of legitimising a situation that had been in situ for a long time or that nursing was not given much importance by the rest of society and it was allowed to go on without much comment. One reason may be that the Maltese had low expectations of nursing that led them to accept any care. It may also indicate the tendency to accept what the authorities offered either through a sense of helplessness that change cannot be brought about from beneath or as a result of centuries of being governed by ‘others.’ Another explanation may be Friggieri’s claim that governments treat the Maltese as children and that the relationship between the citizen and the politicians resembles the feudal lord and his servant.⁶¹

A letter to the Editor appearing in *The Times of Malta* in 1964 and signed by a reputable Maltese surgeon claimed that:

It might surprise the public to know that over 85 percent of nurses and sisters who tend the sick in the wards and help doctors in their clinics and in the operating Theatres do not hold the SRN or comparable education...Not uncommonly such nurses have never had a day’s organised training in their lives.⁶²

This indicates that the public was not aware of the situation in 1964 and there is no evidence to show that the situation had changed much by 1969. Therefore while the HA grade was abolished on paper, in reality there was still no apparent distinction between the trained and untrained staff even though the title ‘senior’ indicated a hierarchy. Although this may have been an attempt to emulate what had happened in the UK, the results were different. In the UK, the Nurses’ Act (1943) had installed the grade of Enrolled Assistant Nurse for those who had been practicing as nurses but were untrained without changing the proportion of these

⁶⁰ Interview with Quentin Borg.

⁶¹ Oliver Friggieri, *Fil-Għira Taparsi Jikbru l-Fjuri*, (Malta: Grima Printing & Publishing Industries; 1991), xiv.

⁶² Joseph Muscat, The Nursing Profession, Letters to the Editor, *TOM* 4.9.1964, 8.

nurses that was still small when compared with the number of Registered Nurses.⁶³ The distinction between trained and untrained nurses had been made.⁶⁴ The Council of the College of Nursing had favoured the grade of ‘assistant nurse’ to be responsible for the care of the sick in a chronic setting. In Malta, HAs were designated ENs and their number was so much larger than that of SRNs that the nursing workforce was heavily dependent on them (Fig. 3.4). ENs made up the entire nursing workforce in the care of the chronically ill such as at the Mental Hospital and St. Vincent de Paul Hospital for the elderly.⁶⁵

Other reasons for implementing the change in law may have included a necessity for nursing to be made attractive to potential recruits, international comparisons of number of personnel per population, or number of qualified staff as a measure of countries’ development as well as political exigencies of a government that was approaching an election.⁶⁶ Documented reasons for this reform have not yet been found, nor have any calls for its necessity been detected in the newspapers from any individual, institution or board. A newspaper report said that Minister of Health had explained that:

the CGMO has carried out a reorganisation of the nursing staff in government hospitals. The aim was to change the service in hospitals to modern lines and to create as many promotions’ openings for nurses as possible.⁶⁷

An agreement between the government and the General Workers’ Union (GWU) in Malta was reached in 1970 whereby there were promotions of Ward Masters (who were not trained nurses) to SNOs, promotions of SRNs to Staff Nurses and openings for ENs to become

⁶³ Monica E. Baly, *Nursing and Social Change* 2nd edition (London: Heinemann; 1985), 235.

⁶⁴ Hallett & Cooke, *Historical Investigations into the Professional Self Regulation of Nursing and Midwifery 1860-1998* Volume 1, 122.

⁶⁵ In 1967 there was only one SRN at the Mental Hospital: Interviews with Quentin Borg and Konrad Cauchi. SRNs were only deployed to St. Vincent de Paul in 1969: Interview with Olivia Gatt.

⁶⁶ According to Godfrey Pirotta, Isabelle Calleja & Cesar Colino, ‘the standard practice for appointments and promotions is essentially a recommendation from party headquarters’ and merit has for long not been the established criteria for government recruitment and promotion: *Sustainable Governance Indicators: 2014 Malta Report*. Bertelsmann-Stiftung (eds.), 5. Available at:

[www.sgi-network.org/docs/2014/country/SGI2014 Malta.pdf](http://www.sgi-network.org/docs/2014/country/SGI2014%20Malta.pdf) [Accessed: 21 December 2015].

⁶⁷ Anon, *TOM* 26.1.1971, 13

SSEns.⁶⁸ All promotions carried an increase in salary that was also the effect of a similar exercise happening in the UK, in 1943.⁶⁹ This arrangement could also have had a counterproductive effect on the image of nursing in Malta and eventual professionalisation. Minimally trained personnel being at the helm of the profession could have contributed to its maintaining low expectations and therefore not working to reach higher degrees of professionalisation. A lack of knowledge could have caused these 'leaders' to fail to notice the necessity for actions leading to professionalisation such as autonomous decisions based on knowledge and research. Nor did they seek to have self regulation within the profession. According to Michael Bowman if nurses do not address their own inadequacies, they compromise the integrity of the profession and the delivery of quality care.⁷⁰

The Nursing and Midwifery Board had not yet been constituted and it would not be established until 1973.⁷¹ The authorities may thus have had a free rein to implement such changes that appear to have been met with little resistance even from the medical profession. Reasons for this may have been political in that the number of HAs who were to benefit was relatively large and could potentially influence many votes so that both political sides could suffer by showing disapproval. The SRNs were so few that they could hardly expect to be given much attention had they the courage to voice their concerns. This act would have entailed speaking out against a move that was to their work colleagues' great benefit. Given the latter's economic interest and Boissevain's observation of the Maltese as having 'amoral familism',⁷² there may have been serious consequences for those speaking out. The absence of a professional association contributed further to making them voiceless.

⁶⁸ Anon, Mediation efforts continue *TOM* 24.4.1970, 2. The Union may have been motivated to encourage membership.

⁶⁹ Baly, *Nursing and Social Change*, 183.

⁷⁰ Michael Bowman, *The Professional Nurse: Coping with Change, Now and the Future*. (London: Chapman & Hall; 1995), 10.

⁷¹ Lawrence Bonavia, *A Historical Survey of the Legislation that Regulates Nurse Registration in Malta*. (Unpublished Masters dissertation, University of Malta, 2007), 62.

⁷² Kurt Sansone, All in the Name of the Family; *Malta Today* 8.4.2001, 7. Interview with Jeremy Boissevain.

The nuns also refrained from any documented comment. Reasons for this may have been a necessity to maintain good working relationships with all personnel, discourage dissent and not appearing to take sides in any way even though, the responsibility for standards of care actually fell on them since they supervised nursing at all times. Lay nurses could not be seen as being much more than servants even though their pay conditions may have been improved.⁷³ From the viewpoint of the nuns nothing had changed except the name of the grade. The change had contributed very little if anything to the professionalisation of nursing in Malta. Indeed it may have been detrimental over the passage of time as nurses could virtually be perceived by the administration and the general population as being passive and accepting all conditions without much resistance. Such compliance may have actually encouraged other health professionals to make demands on nurses they would not have otherwise made.⁷⁴

The Advisory and Executive Board was the entity that administered the Register and the Roll and it included a nurse in its Administrative Council.⁷⁵ However, there is no recorded comment from it either in favour or against the change introducing the EN grade. Public service administrators seem to have been very powerful, backed by politicians. Referring to the transfer of power in the civil service before 1964, Edward Warrington remarked that ‘professional matters were inadequately safeguarded from improper administrative or political interference.’⁷⁶ There seems to have been a system whereby changes could be implemented

⁷³ Staff List 1969, Staff List 1970, show different pay scales for the different grades that were also higher than the previous pay scales

⁷⁴ These included filling of forms, taking consent for procedures from patients, sending requests and chasing movement of patients notes as attested by interviewees for this study: Interviews with Olivia Gatt, Quentin Borg and David Attard.

⁷⁵ The admission of a nurse on the Administration Council of the Advisory and Executive Board came in 1968 through an amendment to the law in 1968: ACT XXIII (1968) The Medical and Health Department Constitution Ordinance Cap 148. The nurse had to be elected by Registered Nurses.

⁷⁶ Edward Warrington, *The Fall from Grace of an Administrative Elite - The Administrative Class of the Malta Civil Service and the Transfer of Power- April 1958 to September 1964*, *Journal of Maltese History*, 2008 (1), ⁵⁴. This article refers to pre independence time but changes took a long time to be affected possibly because there was a lot of political contention during those years including a referendum: Joseph M. Pirotta *Fortress Colony: The Final Act 1945-1964. Vol. 1* (Malta: Studia Editions; 1987), 89.

without much discussion. This is similar to what Stevens remarked regarding the Health Department in the UK during the 1950s and early 1960s where changes in the specialisation of medical doctors that were regarded as not being controversial were decided upon within the Ministry without appointing special professional bodies or consulting existing ones.⁷⁷ In Malta, there may have been a similar situation and the introduction of the EN may have been one such case where controversy was not expected and does indeed seem to have been absent. The change may have been so subtle that it did not cause a large stir. The actual actors were the same and the practices on the ward could not have been much different. Over time, a need for change had come about through the introduction of medical technology and the increased knowledge that had occurred after 1945.⁷⁸

During this time technological advances were being made and more knowledge was becoming necessary to interpret data resulting from such technology and making accurate decisions on care according to recordings. Nurse education was becoming even more important in maintaining high standards of care. These may have been stymied as the number of nurses who were knowledgeable enough during the 1960s was too small for them to adequately disseminate knowledge even if they had the will and time to do it. The daily routines and tasks remained unchanged for a long time as attested by the interviewees for this study who although having studied at different times mentioned the same tasks and routines even up to the early 1980s (Table 3.4). Through their move to introduce the EN grade, the authorities had not heeded Farrer-Brown and colleagues who had commented on this saying:

modern medical procedures demand as the doctor's closest partners nurses who combine with a love of humanity, knowledge and technical skills of a higher order such

⁷⁷ Rosemary Stevens, *Medical Practice in Modern England: The Impact of Specialisation and State Medicine*. (London: Transaction Publishers; 2003), 264.

⁷⁸ Chris N. Trueman, 'Medical Changes from 1945. The History Learning Site (March 2016)'. Available at: <http://www.historylearningsite.co.uk/a-history-of-medicine/medical-changes-from-1945/> [Accessed: 16 March 2016].

as few can acquire without several years of theoretical and practical training based upon a good standard of general education.⁷⁹

There was a need for qualified personnel rather than merely numbers. Research carried out in 1953 in the UK indicated that in the prevailing system, acute hospitals did not need ENs very much and the student nurses' contribution to direct patient care represented around 74% of the overall time taken.⁸⁰ Although exact figures per hospital have not been found, statistics indicate that the acute hospital in Malta was still largely staffed by ENs until the 1980s (Figure 3.3). Teams of nurses on the wards consisted of groups of three, one SRN and two SENs, a combination that was changed after 1980 to teams consisting of one SRN and one SEN.⁸¹

After 1969, SENs were admitted into the Roll upon successfully completing a purposely designated course lasting two years and consisting of theoretical and practical elements. Minimum entry requirements for this course included a Form III secondary school leaving certificate equivalent to nine years of education. The shorter course may have made it more attractive for women approaching marriage bar than that for registration while it also contributed to a larger number of nurses qualifying within the same time span. This had its repercussions even when the marriage bar was lifted as those returning to nursing were mostly SENs and it was therefore difficult for the standard of academic achievement of the nursing force to rise.

The lack of highly educated nurses persisted while other professions such as Physiotherapy, Occupational Therapy and Social Work had come into being and gradually established themselves as being of a higher standard of education than nursing as had happened

⁷⁹ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 53: 192.

⁸⁰ Henry Alexander Goddard, *The Work of Nurses in Hospital Wards: Report of a Job Analysis*. (Oxford: Nuffield Provincial Hospital Trust; 1953), 120.

⁸¹ Interview with David Attard.

elsewhere. In the UK the resultant competition had been noted by Wood⁸² in 1947 and Platt⁸³ in 1961 in their respective reports on nursing recruitment in the UK. Courses leading to these 'new' professions led to Diploma level while many nurses were seen as being of the lower grade equivalent to Certificate level. This may have contributed to these professions gradually being perceived as higher and more prestigious leading to a competition in attracting academically prepared recruits to become SRNs; fully trained nurses.

3.4 The Supervisory Grade - The State Registered Nurses (SRNs)

Farrer-Brown and colleagues reported that in 1957 there were a total of 87 fully trained nurses for the whole of Malta and Gozo of whom 45 were in government employment.⁸⁴ Sources for these figures were not given but the Report states that there were 57 qualified registered nurses through the School of Nurses after 1948. However, the Staff List of 1957 lists only 14 registered nurses⁸⁵ and the difference may be explained by the number of nuns who were also SRNs but were not listed in that Staff List. The number of lay SRNs increased gradually and the staff list of 1964 includes the names of 34 SRNs of whom four were men.⁸⁶ Table 3.3 shows the number of nurses qualified as reported by Audrey Miller and Gill Tipping from the School for Nurses,⁸⁷ and the net change shown in the staff lists for the grades of Male Registered Nurse and Female Registered Nurse.⁸⁸

The numbers of male and female SRNs increased steadily except for exceptional instances 1977 and 1979. After 1970, the increase in number of SRNs on the Staff List is higher than the number of nurses qualifying. Names in the staff list are Maltese so the chances of having

⁸² Robert Wood, *Report of the Working Party on the Recruitment and Training of Nurses* (London: HMSO; 1947), 189.

⁸³ Robert Platt, *Report of the Joint Working Party on the Medical Staffing Structure in the Hospital Service*. (London: HMSO; 1961), 101.

⁸⁴ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:188.

⁸⁵ NAM/GMR 2062 Staff List 1957, 91.

⁸⁶ NAM/GMR 2675 Staff List 1964, 153.

⁸⁷ Miller & Tipping, *International Comparisons of Nursing Management and Nursing Officers' Opinion of their work in Malta* 26.

⁸⁸ Staff Lists available at NAM and National Library.

qualified nurses coming from abroad are small. Returning migrants could also remotely account for the added numbers as only a few Maltese emigrants had done so in those years.⁸⁹

	Number of Newly Qualified Nurses				Change in Number of Nurses in Staff List			
Year	Male SRN	Female SRN	Male SEN	Female SEN	Male SRN	Female SRN	Male SEN	Female SEN
1968	3	21			4	-3		
1969	0	14	53	72	0	14		
1970	2	18	9	72	3	22		
1971	5	26	10	68	n/a	n/a		
1972	4	27	0	40	31	74	398	447
1973	13	37	0	5	34	23	-11	25
1974	0	47	0	44	n/a			
1975	0	40	0	14	n/a			
1976	0	46	0	20	n/a			
1977	0	35	13	34	-2	48	29	108
1978	4	28	0	33	n/a			
1979	9	64	5	35	-20	-9	-36	53
1980	40	86	12	70	n/a			
1981	23	28	0	19	n/a			
1982	0	71	14	43	n/a			
1983	32	55	12	29	n/a			
1984	16	31	30	8	52	123	-64	-97
1985	40	40	40	43	87	105	21	85
1986	17	15	16	17	2	3	-10	32

Table 3.3 - Qualified nurses and respective changes in numbers for each grade and gender (Sources: Audrey Miller, Audrey & Gill Tipping. *International Comparisons of Nursing Manpower and Nursing Officer's Opinions of their work in Malta*. (Malta: Institute of Health Care, University of Malta; 1990). Staff Lists available at NAM and National Library – refer to Bibliography section 1.3.4 *List of Government Employees (Staff lists)*)

A more plausible explanation may be what one interviewee referred to as: ‘of the Kindred Professions’, a kind of ‘grandfather’ clause through which individuals could first become SENs and then go on to be registered.⁹⁰ ACT No. XXVI of 1969 stated that a person could apply for registration if he/she:

⁸⁹ Between 1969 and 1974 there were around 1500 returned migrants but documents do not show their profession: Attard, *L-Emigrazzjoni Maltija*, 180.

⁹⁰ Interview with Kevin Abela.

has for three years immediately preceding the first day of April 1948, been *bona fide* engaged in practice as a nurse in attendance on the sick, under conditions which appear to the Advisory and Executive Board to be satisfactory and was on the first day of January 1949 in possession of a certificate, to the satisfaction of the Chief Government Medical Officer testifying that he/she had passed a nursing examination held under the auspices of the Medical and Health Department or if not in possession of such certificate, has for ten years immediately preceding the first of April, 1948, been *bona fide* engaged in practice as a nurse in attendance on the sick, under conditions which appear to the Advisory and Executive Board to be satisfactory, and passes an oral and practical nursing exam to the satisfaction of the Chief Government Medical Officer.⁹¹

A detailed study of the names of registered nurses listed in the Government Staff Lists for the years; 1969, 1970, 1972 and 1973 shows that in 1973 there were 39 registered nurses (29 men and 10 women) whose details were identical to those in each of the 1969 Hospital Attendants' list, the 1970 State Enrolled Nurses' List and the 1972 Senior State Enrolled Nurses' List.⁹² This indicates that they were registered in 1972, possibly by virtue of the grandfather clause as some (n=16) were first appointed in government service before 1938 while the rest (n=13) had been so appointed prior to 1945. In the case of male SRNs the number of untrained SRNs (n=29) made up nearly 40% of the whole workforce (n=76) so those who were next in line in management had a high probability of being untrained. At least one of these can be found in the Nursing Officers' List of 1980.

The purpose of a grandfather clause is to allow practitioners to maintain their post after new qualifications have been enacted into the law.⁹³ However, in this case the grade of SRN had been in effect since 1936⁹⁴ so the purpose of the grandfather clause as quoted above was not a valid reason for admitting these individuals into the register. The age range of these 'new' staff nurses was between 47 and 60 years so this could have been a way of acknowledging

⁹¹ MGG Supplement 1969 B ACT No. XXVI of 1969, 298

⁹² Staff Lists - NAM/GMR 3099/1969 List of Government Employees (Malta) (Staff List) 1969, p.121 NAM/GMR 3239/1970 List of Government Employees (Malta) (Staff List) 1970, 126 National Library (Malta) List of Government Employees (Malta) (Staff List) 1972, p.163 NAM/GMR 3460/1973 List of Government Employees (Malta) (Staff List) 1973, 157

⁹³ Janice Rider Ellis & Celia Love Hartley, *Nursing in Today's World: Trends, Issues and Management* (8th ed) (London: Lippincott & Wilkins; 2008), 220.

⁹⁴ MGG, Supplement B Medical and Kindred Professions Ordinance No VIII of 1936, 145.

their long years of service that ranged between 28 and 41 years. It may have served the aim of a grandfather clause that is described by Ellis and Hartley as to protect the right to practice,⁹⁵ but in so doing individuals who were HAs in 1969 had been appointed independent practitioners by 1973 solely by virtue of their having been first appointed as HA as early as 1936. The lack of formal education, may have left these nurses ill prepared for the advances that were happening in the medical field and their numbers impinged on the image of the nurse since the nurse was more commonly middle aged (at least on the male side) as well as lacking training. Moreover, their having been in a subordinate position for a long time, coupled with the mindset of a colonised population, made the transition to a supervisory role very difficult to achieve. Referring to the nuns who were still at the helm, one interviewee said that in the 1970s although they were fully qualified SRNs: ‘That is what they used to do aye?SRNs would still be told: “Go and wash the sinks.”’⁹⁶

The resultant image may have then been that the SRNs were not knowledgeable, could hardly take on a supervisory role and they would be amenable to other professions and the Hospital Authorities. On the female side there were only 10 out of 162 SRNs who had been HAs and this aspect may have been less prominent but in this category, the average number of years of experience was very low (4.8 years excluding the 9 SRNs with over 20 years experience). The lack of experience may have still impinged on the nurses’ image since while being knowledgeable, they lacked the expertise and therefore still had to rely on those who were their elders including the nuns and SSENs. Their young age, lack of experience and gender may have further contributed to their being perceived as needing supervision and accommodating to other professions and the Hospital Authorities. Until the late 1970s manywards were still under the nun’s supervision day and night⁹⁷ so the SRNs could not

⁹⁵ Rider Ellis & Love Hartley, *Nursing in Today’s World*, 220.

⁹⁶ Interview with Kevin Abela.

⁹⁷ Interview with David Attard.

List of Duties	Nursing Grades			
	HA	EN	SRN	Student
Day Duty (7.00 am – 8.00 am)				
Bed Baths – Big Ward	√	√	√	√
Bed Making	√	√	√	√
Bedpan round				√
Breakfast	√	√		
Cleaning of bed lockers and bed tables				√
Cleaning of sluice room equipment	√			√
Laundry – counting of	√	√		
Dressings (surgical ward)	√	√	√	
Bedpan round/emptying of urine bags				√
Administration of medicines	√	√	√	
Writing of reports			√	
Giving out meals			√	
Drying of dishes	√	√		√
Counting of cutlery				√
Ask and record menu choices for next day.				√
Bedpan Round/emptying urinary catheter bags				√
Tea Round		√		
Temperature, pulse, respiration recording for all patients				√
Bed Making	√	√	√	√
Laundry counting	√	√		
Giving out of meals			√	
Administration of Medicines			√	
Intake/Output Checks			√	
Drying of dishes	√	√		√
Counting cutlery	√	√		√
Handover			√	
Night Duty (8.00 pm – 7.00 am)				
Tea Round	√	√		
Administration of medicines			√	
Bedpan round	√	√		√
Preparation of Sandwiches for Breakfast				√
Special procedures: Insertion of suppositories, enemata, preop urinary catheterization, preop Shaving	√	√	√	
Bed Making – settling patients to sleep	√	√	√	√
Preparing dressing packs & swabs	√	√	√	√
Filling ‘drums’	√	√	√	√
Writing Reports			√	
Early morning tea	√	√		
Bed bath (side wards)				
Administration of Medicines			√	
Parameter checking				√
Bedpan round	√	√		√
Emptying of urinary bags, nasogastric tube drainage bags				√
Balance intake and output charts			√	
Preparation for Breakfast – boiling eggs, preparing kettles and trolley for tea	√	√		
Handover			√	
Students also ran errands to and from laboratories, blood bank, X-Ray department, pharmacy, operating theatre, central sterile supplies department, stationery, outpatient department and medical records. Staff nurses also accompanied Ward rounds in the absence of the nun/nursing officer; filled in ordering forms for pharmacy medicinal items and ordinary items, and food such as eggs, sugar and tea; filled in lab request forms and prepared patients’ notes for ward rounds.				

Table 3.4 - List of tasks on daily routine (1960-1980)(Source: Interviews with nurses)⁹⁸

⁹⁸ Interviews with Nathalie Caruana, Quentin Borg, Iris Naudi, Kevin Abela, David Attard, Ingrid Tanti and Noella Delia.

exercise their supervisory role. After 1980, a team complement consisted of an SRN and two SENs and two or more students while the number of patients in a ward could exceed 60.⁹⁹ A SSEN could replace a SRN so there would be nights when only SENs (probably all former HA) were on duty. During the day there would be two teams working together since a shift for a team consisted of two or more days in succession.¹⁰⁰ One team would therefore be working the first day of the roster while the other would be on the second or third day. During the 1960s nurses worked consecutive night shifts for a whole week. This shift was changed and all nurses in the different hospitals in Malta worked on a ten day shift of days and nights.¹⁰¹ No evidence has been found on how vacancies were filled and it is not known whether skill mix was considered. Interviewees for this study mentioned that the nun in charge of the ward would recruit from among newly qualified SRNs¹⁰² and one interviewee said that the nun could influence decisions on who was to be retained as a student and as a HA.¹⁰³ With regards to skill mix, one interviewee mentioned that in the 1960s when he was working at the operating theatre he had learnt a lot from an orderly and upon being sent to work in a medical ward in the 1970s he sought and received a lot of advice from the SSEN regarding the management of patients who were newly admitted to the ward during the night and about certain tasks such as urine testing.¹⁰⁴ Although the SSEN's experience may have mitigated the lack of experience of the SRN, the lack of formal training of SSENs at the time may have led to erroneous decisions which the SRN was unwittingly responsible for. The dependency of SRNs on SSENs may have contributed to a lack of delineation between their work, further obfuscating the image of the nurse as a decision maker and an autonomous,

⁹⁹ Interview with Kevin Abela.

¹⁰⁰ All the nurses working in hospitals followed the same roster that repeated itself around the year and was on an ABO ABOO NNO basis (an A duty was from 6.30 am to 8.00 pm; B duty started at 7.00 am and ended at 6.00pm while a night duty (N) was between 7.00pm and 7.00am.) Nurses who had a 46 hour week worked an extra half day between 7.00 am and 1.00 pm on the first of the off days preceding the Night duty. Interview with David Attard.

¹⁰¹ Interview with Kevin Abela.

¹⁰² Interview with Olivia Gatt, Iris Naudi.

¹⁰³ Interview with Quentin Borg.

¹⁰⁴ Interview with David Attard.

knowledgeable practitioner. The high turnover of women in nursing persisted until the marriage bar was lifted in 1981,¹⁰⁵ by which time the nuns had become too few in number to affect supervision. The relatively small number of SRNs who were supposed to have a supervisory role may have been ineffective so that the standard of care may have been ‘unpolished’ if not actually poor.

On day duty the role of the SRN was to carry out the more technical work and assist the nun (and later the NO) in ward administration. According to one interviewee, as a student he would be assigned to the SRN on duty (if there were any since their number was so small) and work with him learning by experience.¹⁰⁶ They would also supervise the administration of medicine if this was being done by a student.¹⁰⁷ Two interviewees said that they even did much of the work when a patient was admitted as an emergency, including airway support,¹⁰⁸ and setting up of intravenous infusions using equipment that had to be assembled.¹⁰⁹ The preparation for ward rounds was also part of the role of the SRN and it included ensuring that all results were in the ward and stuck with glue in patients’ notes, drawing blood and saving urine samples.¹¹⁰

One interviewee described a typical day as a Staff Nurse in 1970 saying that it began with the handover that was written on a ledger consisting of foolscaps bound by the nurses themselves.¹¹¹ Then all the patients were washed and those who could were mobilised. This had to be finished by 9.00 am as the ward round used to come at that time. The SRN used to accompany the ward round and she would note the changes in treatment. Nurses could not write in any part of the patients’ notes except for the charts. Treatment charts consisted of

¹⁰⁵ Irene Sciriha, Faculty of Science University of Malta for Helsinki Group on Women and Science. Available at: https://cordis.europa.eu/pub/improving/docs/women_national_report_malta.pdf (2001) [Accessed: 29 November 2015].

¹⁰⁶ Interview with Quentin Borg.

¹⁰⁷ Interview with Iris Naudi.

¹⁰⁸ Interview with David Attard.

¹⁰⁹ Interview with Kevin Abela.

¹¹⁰ Blood samples were taken for Erythrocyte Sedimentation Rate (ESR) and urine samples were saved for Specific Gravity. These tests were performed on the wards using simple equipment.

¹¹¹ Interview with Nathalie Caruana.

pieces of cardboard holding foolscaps that were changed every Sunday by the nurses. Treatment on these foolscaps was written in pencil so changes could easily be made. Then it was time for the administration of medicines and injections and time for testing urines and bloods. Setting up of drips included bringing a cannula in an iron box sealed with tape from a central area, then setting up a trolley with this cannula and other equipment for infusion that had to be washed and sent for autoclaving at the end of the infusion. Bottles of infusion fluids were made of glass and were reused. Splints were used to keep arms in position made up of wood covered with cotton wool and bandages, all made by the staff. The infusion set consisted of: a needle to be inserted in the bottle's rubber bung; transparent tubing that used to have a regulator and a site for attachment of the needle at its end. Every week they had to write down a list of medicines needed for the ward while dressings and gauze swabs had to be cut out of large rolls and packed into large round stainless steel 'drums' to be sent for autoclave daily. SRNs also had to write the day and night report and assist in all other activities according to need irrespective of whether these were of a technical nature or not. This shows that much of the work done did not involve much decision making and involved clerical work, procurement and improvisation of equipment. The role of the SRN was constantly shifting from the technical work to the fundamental care and to some aspects of administration. During the night, the SRN was supposed to be in charge of the ward, but the nuns had to be consulted for decisions such as calling the doctor.¹¹²

There is no evidence to show that there was any tension between the nuns and the SRNs who seem to have accepted the situation without much protest. This may have been because of their small number and also because they had entered into nursing when the organisation was already functioning in this way. There may have been a lack of ambition or reluctance to instigate change at the peril of being seen as disobedient or even disrespectful towards the

¹¹² Interview with Quentin Borg

nuns. Such a reputation could have meant being given a hard time when asking for vacation leave or for a change of ward. Maltese nurses would always have to appeal to the same authorities so it was in their interest to be compliant and in the favour of the authorities. Moreover, if many of the SRNs were young women lacking experience they may have also lacked a vision that things can be organised in another way especially if their only experience had been within a single organisation. The lack of a professional association that could voice a collective opinion contributed to this silence and possibly delayed professionalisation.

There seems to have been a move to instigate change by the unions who remarked that some nuns were not fully qualified to nurse.¹¹³ This may have been a factor that led to the government's 1970 decision not to allow nuns to continue working after retirement as had been the norm.¹¹⁴ However, the nuns' excellent reputation with the doctors and the people in general may have mitigated the lack of qualification and the government attempted to solve this by deploying newly qualified SRNs in all wards as much as possible. This may have been why one interviewee said:

at the time they had a problem in the other hospitals....because... the nuns who used to be in charge of the wards were not even qualified as enrolled nurses and so they had a problem with the General Workers' Union which at the time was also representing the nurses because the General Workers' Union was telling them: 'They do not have qualified nurses running, running the wards.' So she told us: 'They want to put you in charge of the wards.' You know in brackets we were in charge because the nuns were still in charge... so that the authorities would be happy that on paper there was a State Registered Nurse.

In this way the nuns kept their authority while the Health Department could truly say that there were SRNs on the wards. Since the nuns were officially not on establishment posts, their names do not appear anywhere on the Staff Lists until 1972. In this year they appear as Nursing Officers, SRNs or SENs who may have benefitted from the grandfather clause when

¹¹³ Interview with Olivia Gatt.

¹¹⁴ Alexander Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*. (Malta: Sisters of Charity; 2002), 343.

there was the change from Health Assistant to Enrolled Nurse. The GWU may have been the only body to speak out on this situation at the time. The motive of the government does not seem to have been the acknowledgement of training and qualification rather than the pay that promotions carried with them as it is the salaries that were given most importance when the Minister spoke in Parliament about the agreement endorsing these changes.¹¹⁵ The government agreed to these claims by the GWU upon condition that the latter would not take any industrial action on issues regarding the organisation of the nursing service. Reasons for this may have been the approaching general elections in 1971 but there may also have been an awareness that since there were many SRNs who had benefitted from the grandfather clause, there was not much point in changing untrained nuns for untrained nurses at the helm of wards, when the untrained nuns had the moral authority and the experience. This may have been a reason for the lack of comment arising from the physicians and surgeons. Ultimately, the nuns who remained in place were still at the helm while the SRNs carried out technical work that may have been more demanding of academic qualities.

At St Vincent de Paul's Hospital (SVPH) when SRNs first arrived in 1968 they carried out much of the technical work like:

dressings. At the time we used to do a non touch sterile technique even for the most fungating wound and we used to wear the masks so you can see me, white apron I used to have, mask always washed everyday and clean in our pockets eee ... I would start the dressings and go on till about one 'o' clock doing them, then I would go for lunch in the afternoon emm in the.. before I left I would give the treatment again the BDs or TDS at at lunch time we give them again and in the afternoons I would do the dressings again because the routine was when I went that they used to do the dressing for all these fungating breasts once a day and the gangrenes and you know these poor women there lying in bed no air conditioning, the summer heat in bed, you know the smell until the morning was horrible.¹¹⁶

¹¹⁵ *TOM* 19.12.1970 Nursing Services Reorganisation: Agreement being Implemented, 32. Nursing Reorganisation Agreement MH 692/1967; MH1198/1972; MH1113/1970(ii),1.

¹¹⁶ Interview with Olivia Gatt.

In 1967, there was only one SRN at Mount Carmel Hospital (MCH) who was then joined by another three SRNs. One of these said:

There were no nurses. They used to be called emm Attendants, Hospital Attendants. And that was the beginning we were posted to a ward. I remember choosing the geriatric ward, psycho geriatric because I thought it would be similar to a medical ward... I liked Medicine very much.... so I said: "I am going to Mount Carmel... There was a relative of mine, my brother in-law and he told me: "Here it is like being in a medical ward just the same. So although they have mental disorders the conditions are those of the elderly and so on. You sort of have not changed much from working at St. Luke's medical ward to psycho geriatric ward". There wasn't much difference; I didn't feel it much.... You couldn't go and give out the pills according to how someone said the green one or the blue in that way. You had to read the treatment ...then we began to make some inspections in the ward..... Supervision rather, not inspection. Ward supervision and we used to teach them. Besides the theoretical lectures we used to do ward supervision to assess what was happening and offer assistance.¹¹⁷

The small number of qualified SRNs and the way they worked must have made some impression on the authorities probably backed by the fact that they were qualified from the School for Nurses and had recognition by the General Nursing Council (GNC). One nurse interviewee working at St. Vincent de Paul's described it as:

And when they (the Attendants) saw me using the mask to do the dressings they used to think I was you know cuckoo, but they never dared tell me anything...you could see they (the nuns) were proud of your work if not of you and you know the way you look and how smart you were.....nurses had status nurses were really treated well at the time and respected because we respected our profession so we earned others' respect.... we had our own quarters there the SRNs. It wasn't with the other nurses there.... in the large dining room; we had our quarters next to the doctors' quarters and they cooked especially for us like they cooked for the doctors...¹¹⁸

A SRN working at the Mental Hospital (Mount Carmel Hospital as it became known later) also explained:

...we were held in high esteem because we were SRNs and the authorities were very happy with us. We were trying to make a break through to be able to.... change the situation of there not being any male nurses. As I have said there was only one trained nurse. Otherwise there were those who were in charge of the ward who were called charge nurses but they did not have SRN training or so.. we were held in high esteem in that we were perceived Even the doctors then... I remember when I went, there was Dr Pullicino, who was the Superintendent and everyone used to say they were afraid of

¹¹⁷ Interview with Konrad Cauchi.

¹¹⁸ Interview with Olivia Gatt.

him.... And they used to say that he was strict and so on but we used to work well with him because he understood us and we obviously understood him.¹¹⁹

Although SRNs were somewhat privileged within the organisation their rarity contributed to making them largely irrelevant in that the impact of their knowledgeable practice could not be appreciated by more than the few patients they came in contact with. The respect towards the SRN may have been augmented by the camaraderie existing between nurses working on the same shift. The perceived privileges could also have brought some grudges from SENs although evidence of this has not been found.

Celia Davies asserted that anger and bitterness can easily result when there is a system of formal regulation, labelling with titles and dress that emphasise the position of ENs as subordinate to SRNs but puts them on a *quasi* equal par with them on days when nursing work requires them to be so only to use them as an auxiliary on the next.¹²⁰ The small number of SRNs that continued to be a reality until the 1980s (Figure 3.1) did not allow much segregation except for that mandated by the system such as the use of separate dining halls. There was a move towards bringing all grades of nursing together by removing the separation in dining halls and locker rooms. The change may have been due to the growing numbers of Enrolled Nurses but could also have been based on the socialist ideal of equality between workers since it was brought in after the 1971 change in government from Nationalist to Labour.

One interviewee explained that later on upon considering why segregation was necessary, he realised that the familiarity between those supervising and their subordinates may have caused a loss of esteem and authority:

Then, you know, you start questioning: A soldier in the army goes to war. In the army there is the SMO or whatever he is called... the lieutenant; then there are the sergeants, there are the officers and everyone has their own Mess and I used to say: "Why?" So

¹¹⁹ Interview with Konrad Cauchi.

¹²⁰ Celia Davies, *Gender and the Professional Predicament of Nursing*, (Buckingham: Open University Press; 1995), 6.

that there wouldn't be familiarity between.... during duties and so on, that is why... I used to say: What has happened? The more there is of this, the more mixing like this the more there will be...¹²¹

Being in such small numbers SRNs were compelled to mix with their less qualified colleagues while on the ward or risk being isolated. Friendships developed through which the lay nurses felt they had to stick together and help each other during work until there were virtually no boundaries between what was considered to be the SRN's work and the SEN's duties. Lines of authority were very blurred resulting in a lack of distinction of rank and roles. Patients could only distinguish between the nurse and the nun who was later to be replaced by the NO wearing blue uniforms. All other lay female nurses wore white dresses while all male hospital personnel wore white overcoats. Amongst the female nursing staff, the only distinguishing factor was the colour of belts; blue for student nurses and registered nurses and green for pupil nurses and enrolled nurses. Registered nurses and enrolled nurses wore buckles on their belts that were also different. Male registered nurses were supposed to wear epaulettes but these were not commonly used. Patients and visitors could hardly distinguish between one kind of nurse and another and the use of aprons covering the waist made this even harder undermining the ability to perceive nurses as knowledgeable and able to make decisions on care. There was a resultant general perception that decisions were only for the consultant and the nun.

Nurses interviewed for this study seem to have accepted this even though they were SRNs. None of them mentioned that they ever argued that they should be able to make their own decisions, seemingly accepting the authority of the nun as shall be discussed in the next chapter. This may have been another instance of the Maltese culture of apparent submission where the authorities are not openly challenged unless absolutely necessary. However, it was not long before nurses began to adopt a more obviously assertive stance as they then decided

¹²¹ Interview with David Attard.

to set up their own union, Malta Union of Nurses in 1976.¹²² A founder member of this union said that nurses had felt too inferior to have their own union and needed a lot of encouragement to take this decision and actualise it. Among the first grievances to be addressed were the non-nursing tasks and administrative tasks nurses had to do and industrial actions were undertaken.¹²³ There may have been individuals who showed their disagreement. A male SRN working in the 1970s stated that he refused to obey the nun's order to clean the ward's windowsills, while another female SRN (qualified in 1968) claimed that she insisted on working according to what she had learnt even though the practice of the ward where she had been deployed had been different.¹²⁴ Both situations did not seem to bring much reaction from the respective nuns indicating perhaps that the latter knew they did not have much power when confronted by knowledgeable nurses. It may have been the earliest realisation that the nun's habit would soon not be enough to commend authority.

3.5 Conclusion

Changes in the organisational structure of nursing in Malta occurring between 1964 and 1996 involved all the grades existing at the time. The abolition of the Hospital Attendant grade to be replaced by the Enrolled Nurse grade did not bring with it much real change as the actual delivery of care remained in the hands of the same individuals for quite some time afterwards. The emergence of trained enrolled nurses and the increase in registered nurses brought with it changes that were small but led to a more knowledgeable practitioner who could be more prepared for the increasing medical technology. Changes were not only happening in the lower grades of nursing but also in what can be considered to have been the nursing elite. Modernisation of technology, a move towards better education in post Independent Malta and the prospect of promotion brought about changes affecting all grades of nursing, from the lowest to the elite.

¹²² Interview with Edward Urpani.

¹²³ Interview with Edward Urpani. *TOM* 10.7.1977, 1, 32.

¹²⁴ Interview with K. Abela and N. Caruana

Chapter 4

THE TRANSFORMATION OF THE NURSING ELITE

4.0 Introduction

The higher grades of nursing in Malta; the nuns and the hospital nursing management, were also affected by changes occurring during the period 1964-1996. Nursing in Malta gradually moved from being managed by the nuns and the medical professions who were apart from it, towards a greater autonomy and self management. The transformation may have resulted from changes within nursing as a professional body such as level of education coupled with extraneous factors such as demographic changes in religious vocations, political expediency and industrial militancy. This chapter will describe the grades of the elite of nursing and explore the factors that brought about a transformation. Discussion draws from the background chapter to offer support through a hermeneutic approach that may enhance interpretation.

4.1 Nursing Management Structures

In 1957 the Medical Services Commission headed by Farrer-Brown reported that while Mother Superiors managed all the hospitals, none of them acted as a matron in the same way as understood in the UK.¹ Such an absence had resulted in a coexistence of different management systems (Figures 3.1. and 3.2) under the control of the Medical Superintendents. Duties seem to have been undefined as the Ward masters at the hospitals for the chronically

¹ NAM/GMR/1999/1957 Leslie Farrer-Brown, Harold Boldero & James B. Oldham, *Report of the Medical Services Commission*, (Malta: Department of Information; 1957), 53:190.

ill who were not registered nurses,² had duties that were incorporated within the role of the Mother Superior at the acute hospitals.³ According to one interviewee for this study, in 1958, the Ward master at St. Luke's Hospital was responsible for the deployment of Hospital Attendants:

The staff, if she [the nun] saw that one of them was lazy, not good for her ward and he doesn't want to listen, she would go to the Ward Master and tell him: "If possible do not send me this one any more."⁴

The Mother Superior at St. Luke's Hospital may have therefore been in a position where her authority was impinged upon by the Medical Superintendent, the lay Administrator (Hospital Secretary) and the Ward master even though she may have been the only one of them to be qualified in nursing.⁵

Farrer-Brown and colleagues contended that the dissimilarity in administration of nurses was not satisfactory and appeared to their Commission: 'to aggravate rather than relieve the difficulties necessarily produced by an inadequately trained nursing staff.'⁶ Such an aggravation may have resulted from the different management styles adopted by the male and female administrators; the difference in social backgrounds from which nuns and Ward masters or chief male nurses came and the differences in preparation for the job, both academically and otherwise. There may also have been a different philosophy underlying the vision of different individuals in that nuns may have been motivated by their vocation to be of service to the sick while their male counterparts in management were employed to earn a living.

Ward masters and charge nurses were not trained in nursing. One interviewee for this study who had worked alongside a charge nurse at the Hospital for Mental Diseases said that:

² These hospitals included the Hospital for Mental Diseases, Chambrai Hospital Gozo also for mentally ill patients and St. Vincent De Paul Hospital for the elderly.

³ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 52:189.

⁴ Interview with David Attard.

⁵ There is no evidence that Mother Superiors were nurses but some of them may have had nursing experience in Malta or Italy due to the charisma of the Order of St Jean Antide that includes the care of the sick.

⁶ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 58: 207.

Charge Nurses as they were called, who did not know much. They didn't.. was in charge but did not know much; he knew administration, administration not management, administration that is different. [He was] in administration who, who then began to need my assistance, then he saw that I was genuine and that I had no intention of taking his place. ... he then started to seek my assistance himself. He used to tell me: "Listen ... a doctor has come or a psychiatrist, can you go with him?" and so on.⁷

Another interviewee who was also working at the Hospital for Mental Diseases during the same time said:

He was in charge of the ward.... They placed us under their authority. They had done the course of Hospital Auxiliaries, had been promoted over time by virtue of their seniority, we were... Suffice to say that I once went into the ward and I was giving insulin. They used to give Insulin. The Hospital Auxiliary told me: "I am going to give.. I will take care of the insulin". I told him: "Alright" and I saw him putting the syringe and the needles in the kidney dish, he put them on the burner, left them to boil and then went on to cool them off by putting them under running tap water.... I mean... These people were at that stage. They weren't.... the pills were not generally.. they used to recognise them by their colours; knowing that Stelazine was blue and the Tryptizol was reddish or something like that and many of them were generally like that.⁸

The small number of registered nurses and lack of knowledge may have prompted Farrer-Brown and colleagues to note and express their disagreement with Cronin's previous suggestion for Malta to appoint a Superintendent of Nurses at the Medical and Health Office to supervise and improve the standards of nursing.⁹ Farrer-Brown and colleagues declared that they did not agree stating that appointment of Matrons was more essential and sufficient.¹⁰ They may have lacked confidence in the ability of Maltese nurses to fill such a place.¹¹ Cronin had recommended a Superintendent of Nurses to be at par with the Medical Superintendent, a step that may have been too ambitious at the time since suitable candidates may have been scarce. Appointing an individual who was not adequately prepared would not have been effective and there may also have been a situation where the only Maltese individual who was adequately prepared for the position was a nun who could not be

⁷ Interview with Kevin Cauchi

⁸ Interview with Quentin Borg

⁹ NAM/ GMR/ 1953/1957 John Cronin, *Report on the Medical Services of Health*. (Malta: Department of Information; 1957), 6:32.

¹⁰ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 60:215.

¹¹ Evidence has not been found that any official or non official body commented on the suggestion of appointing a Superintendent of Nurses.

permitted to be away from the convent.¹² Appointing a nun may have been an obvious choice since according to the Commission:

...the Sisters of Charity form the largest body of state registered nurses in the islands' and 'the Mother Provincial of the Order realises the need for more fully trained religious Sisters and intends to send an increasing number of sisters to the United Kingdom not only to obtain state registration but for post-graduate courses – for sister tutors and administrators.¹³

Such an arrangement saved the government the expenses involved in training while avoiding the problem of choosing the individual to be sent abroad at risk of being perceived as being partial to one individual. A nun would also have an increased chance of providing continuity since her chances of leaving the services were more remote than those of lay female nurses who would have to resign upon marriage while there were only three male SRNs at the time. Moreover, the nuns who were already managing wards had the experience which lay nurses did not. The future of nursing seems to have been dependent on the nuns.

A first step towards including nursing at the highest echelon of management may have been the admission of a nurse elected by registered nurses into the Medical and Health Department Advisory and Executive Board in 1959¹⁴. However, autonomy was still hardly possible as Farrer-Brown and colleagues indicated that in 1957 decisions on nursing may have been influenced not only by the Medical Superintendent but also by the Hospital Secretary who also gave the Mother Superior directions 'concerning matters entrusted to her.'¹⁵ Farrer-

¹² Activities of religious congregations were much more regulated and restrictive before Vatican Council II. They are still very much associated with the needs of the congregation to lead a community life to the extent that individuals whose talents could possibly isolate him/her from the community cannot be accepted into that congregation: Magisterium on Religious Life; par22 available at: http://www.vatican.va/roman_curia/congregations/ccsclife/documents/rc_con_ccsclife_doc_31051983_magisterium-on-religious-life_en.html [Accessed: 10 December 2016].

¹³ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 58:205. (The Mother Provincial is the nun responsible for the congregation within a diocese.)

¹⁴ MGG Supplement A 1959 Emergency Ordinance No 1 of 1959, 1. The Advisory and Executive Board was to advise the Governor on the terms and conditions of health workers including nurses, their deployment and promotion. The admission of a nurse into the Administration Council of this Board came in 1968 through an amendment to the law: The Medical and Health Department Constitution Ordinance ACT XXIII (1968) Cap 148.

¹⁵ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 59:209.

Brown's Commission stressed the need for matrons to be 'a state registered nurse with suitable administrative experience' who would also be above the Ward masters 'in so far as their work in nursing administrative duties [were] are concerned.' Emphasis was placed on the autonomy of the Matron and equal partnership between her and the Medical Superintendent. No evidence has been found regarding how these recommendations were implemented but interviewees for this study mentioned that in 1964 and afterwards there was a British matron at St. Luke's Hospital, Miss Griffin.¹⁶ Very little information has been found regarding Miss Griffin.¹⁷ Her name cannot be found in any of the staff lists or Government Gazette editions studied;¹⁸ possibly indicating that she was not a government employee and may have been on some other type of contract. One possible explanation may be that the British matron was brought to Malta as part of the British Government's policy of recruiting British nurses and sending them to every dominion allowing mobility across colonies and creating conditions for international reciprocity in nurse education and training.¹⁹ In this case, once more Maltese nursing was being led by an 'imported' person. The colonialist perception may have been still prevailing but it may also have been a lack of adequately prepared Maltese nurses to fill this post.

Farrer-Brown and colleagues had also recommended that a Sister of Charity should be appointed assistant matron; under the matron's authority: 'to look after the welfare of the staff and the patients.'²⁰ Compliance with this recommendation may have been Sr. Bernardette Fava's appointment of assistant to the matron of St. Luke's Hospital in 1967.²¹ She had successfully completed training in hospital administration in the UK as this was not

¹⁶ Interview with Denise Galea.

¹⁷ Only one reference was found to Miss Griffin in *The Times of Malta (TOM)* where she appeared in a photo alongside other nurses who attended a meeting of the Malta Professional Nurses Association: *TOM* 3.9.1965, 6.

¹⁸ The Government Gazette used to announce the names of foreign individuals working in Malta and their respective occupation.

¹⁹ Anne Marie Rafferty & Diana Solano, The Rise and Demise of the Colonial Nursing Service British Nurses in Colonies, 1896-1966, *Nursing History Review*, 2007 (15) 26.

²⁰ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 53.

²¹ NAM/ GMR 2050/1968 Staff List 1968, 121.

available in Malta at the time. No evidence has been found on the role of the Matron in 1964 and afterwards but she was not on the Hospital Management Committee of St. Luke's Hospital.²² Such an arrangement may be evidence of Malta's authorities following those in the 1940s in the UK where matrons did not have access to hospitals' governing bodies.²³

The British matron, Miss Griffin may have been sent to Malta as a means of improving the hospital.²⁴ The situation in Malta may have been atypical due to the established system that was altered to include her rather than overhauled to allow her autonomy and authority. Her insertion into the service may have been another minor change to follow the recommendations of the Commission as well as complying with the expectations of the authorities in the UK. This change however, does not seem to have had much impact on nursing in Malta; possibly another instance of the Maltese *modus operandi* of accepting imposed changes as long as they did not affect financial gain and carrying on in the old way as much as possible.

No evidence has yet been found on how the Matron operated in Malta but it may have included some contribution in nurse training. This contribution supports Rafferty's assertion that British nurses sent to the colonies held superior positions as sisters and matrons being also responsible for training the local student nurses.²⁵ Although the head of the school for nurses was a nun, two interviewees for this study who had started training in 1965 mentioned

²² MGG Supplement A 1959 Emergency Ordinance No 1 of 1959, 6. The Committee was 'to be responsible ... for the proper performance of their respective duties by all members of the staff of the Hospital ... to consider any complaints regarding the work within the Hospital of any member of the staff.

²³ Monica E. Baly, *Nursing and Social Change*. 3rd edition (London: Routledge; 1995), 198.

²⁴ Debbie Mc Collin, World War II to Independence. In: Juanita De Barros, Steven Palmer and David Wright (eds) *Health and Medicine in the Circum-Caribbean 1800-1968*, (New York: Routledge; 2009), 239 gave this reason for British nurses being sent to the colonies. Ann Marie Rafferty, claimed that they were viewed as 'being crucial to the success of government hospitals throughout the Empire.': Ann Marie Rafferty, Nurses. In: Cooter, & Pickstone, *Companion to Medicine in the Twentieth Century*, 521. Alexander Bonnici stated that there were two other British nurses working in the paediatric wards in Malta until 1962 who were then replaced by nuns who had paediatric training: Alexander Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, (Malta: Sisters of Charity; 2002), 343.

²⁵ Rafferty, Nurses, 521.

the matron as being in control of the student nurses.²⁶ They recounted how Miss Griffin had expected them to inform her personally when they had planned to go out of the school beyond usual curfew times. One interviewee mentioned her once more as the person deciding when students passing the Preliminary Exam could put on their blue belt on duty.²⁷ In Malta the Matron's role was perhaps to be in a superior position but to collaborate with those who had been superiors for quite some time before her – the nuns.

4.2 The Superior Grade – The Nuns

In 1964, the Sisters of Charity were responsible for nursing at hospital level in many of the hospitals on the island.²⁸ Their supervision included that of the nursing staff in the wards and the servants who performed cleaning duties not connected to patients. The Sisters of Charity first came to nurse in Malta from Italy in 1871.²⁹ Before their arrival, nurses in Malta seem to have been more notorious for being the 'most troublesome class of public servants',³⁰ than for their delivery of care. According to Cassar the quality of nursing was poor because nurses had poor social standards and lacked good manners. Theft was so rife as to warrant all articles to be branded.³¹ The belief that nurses' lacked moral values seems to have been common elsewhere in the world in the early nineteenth century.³² Rafferty asserted this in her writing on nineteenth century nurses in the UK,³³ while Fealy wrote about similar occurrences at around the same time in Ireland.³⁴ Lewenson stated that during this time nurses in America: 'were stereotyped as slovenly, unkempt, and immoral; many were drunkards, prisoners or

²⁶ Interviews with Diane Galea, Olivia Gatt.

²⁷ Interview with Olivia Gatt.

²⁸ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 328.

²⁹ Paul Cassar, *Medical History of Malta*, (London: Wellcome Historical Medical Library; 1965), 407.

³⁰ Cassar, *Medical History of Malta*, 399 quoting a letter from the Comptroller of Charitable Institutions.

³¹ Cassar, *Medical History of Malta*, 397.

³² This notion of pre-reform nurses being so troublesome may have been emphasised to reinforce the perceived need for reformation.

³³ Anne Marie Rafferty, *The Politics of Nursing Knowledge*. (London: Routledge; 1996), 1.

³⁴ Gerard M. Fealy, *A History of Apprenticeship Nurse Training in Ireland*. (London: Routledge; 2006), 18.

patients themselves.³⁵ The early nineteenth century social standards of living were also blamed by Dingwall, Rafferty and Webster for the resultant ‘mixture of kindness, squalor, superstition, corruption and abuse’ that made up nursing at the time.³⁶ Although Cassar stated that problems of alcoholism were not common in Malta, the nurses’ unsavoury behaviour caused the Comptroller of Charitable Institutions Sir Ferdinando Vincenzo Inglott much anxiety and the difficulty in finding suitable individuals for nursing even led him to contemplate offering his resignation.³⁷ Instead, he cooperated with the Medical Superintendent of the Lunatic Asylum Dr George Xuereb and the Governor Sir Patrick Grant to appeal to the Sisters of Charity in Italy to fill those situations that fell vacant in all Charitable Institutions in Malta.³⁸ The decision may have been influenced by others taken abroad. In London in 1857, hospital Boards had discussed whether to employ ladies as superintendents or head nurses,³⁹ while the Board of Guardians of the Limerick Workhouse Infirmary in Ireland had appointed three Sisters of Mercy to act as nurses there in 1861 in an effort to establish some central control.⁴⁰ According to Sue Hawkins one attractive aspect of such employment would have been the hope that the ladies would instil discipline among nurses and this may well have been one of the reasons the Maltese Authorities had for introducing nuns in hospitals. Another reason may have been the lack of workers available to work in hospitals in a society that was still based on farming.⁴¹ In Canada this was the main

³⁵ Sandra Beth Lewenson, *Taking Charge: Nursing, Suffrage, and Feminism in America 1873-1920* (New York: Routledge; 2013), 3.

³⁶ Robert Dingwall, Anne Marie Rafferty & Charles Webster, *An Introduction to the Social History of Nursing* (London: Routledge; 1988), 32.

³⁷ Cassar, *Medical History of Malta*, 399.

³⁸ Cassar, *Medical History of Malta*, 407.

³⁹ Sue Hawkins, *Nursing and Women’s Labour in the Nineteenth Century: The quest for Independence*. (London: Routledge; 2010), 37.

⁴⁰ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 13.

⁴¹ Salvino Busuttil, ‘Agriculture in Malta: A Historical Note.’ (2010) Available at: resources.cihaem.org/om/pdf/b07/934/00006.pdf [Accessed: 20 January 2016].

reason why the Grey Nuns had been requested to go to Alberta to offer health services, education and shelter to those in need.⁴²

Upon their arrival in Malta the nuns were placed in a position of control over lay nurses entering a situation that was in a way opposite to that of other nuns abroad who had been placed as subordinates to lay nurses. In Europe lay nurses in management had replaced nuns as a result of the Protestant Reformation and the Revolution in France.⁴³ This event may have been a coincidence but it is somewhat ironic that while there was widespread secularisation elsewhere,⁴⁴ a Government professing Anglicanism had actually ‘handed over’ state owned health Charitable Institutions including hospitals to a religious congregation of Catholic denomination. The Catholic Church in Malta had never been directly responsible for these entities.⁴⁵ The nuns in Malta did not build or own any hospital as their counterparts did in America⁴⁶ and Australia where nuns owned many hospitals and had full authority of the nursing care within them.⁴⁷ Malta seems to have followed the model that was also present

⁴² Janet C. Ross-Kerr; *Prepared to Care: Nurses and Nursing in Alberta (1859-1996)*. (Alberta, Canada: University of Alberta Press; 1998), 3.

⁴³ Patricia Wittberg, *From Piety to Professionalism... and Back? Transformations of Organised Religious Virtuosity*, (Oxford: Lexington Books; 2006), 5, 20.

⁴⁴ In other countries such as the UK, Germany, France and Italy, religious orders organised care for the sick for a long time: Vern L. Bullough & Bonnie Bullough, *Medieval Nursing*, *Nursing History Review*, 1993, (1) 100.

⁴⁵ In Malta, the government had maintained the responsibility of providing care for the sick in hospitals since the latter’s earliest existence and therefore those who took care of the sick were secular workers. The concept of being called to care for the sick as a vocation for life was therefore virtually non-existent in Malta. Fiorini described the way in which the Church in Malta and the state ran Santo Spirito in the late Middle Ages as being ‘hand-in-glove’ since it involved the administration by lay people of an entity that was under the jurisdiction of the Church: Stanley Fiorini, *Santo Spirito Hospital at Rabat, Malta: The Early Years to 1575*, (Malta: Department of Information; 1989), 8. During the rule of the Knights of the Order of St. John of Jerusalem (1530-1798) the *Sacra Infermeria* was financed by the Order but care of the sick was delivered by lay people. The Order was a religious one and the knights were called Hospitallers: Cassar, *Medical History of Malta*, 37. This arrangement seems to have been similar to that of nineteenth century Ireland where women’s religious congregations provided nursing in partnership with the Government: Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 10. In America religious congregations either owned and ran charity institutions or managed them only: Barbra Mann Wall, “‘We Might As Well Burn It’ Catholic Sister Nurses and Hospital Control, *U.S. Catholic Historian*. 20 (1) 24.

⁴⁶ According to Mann Wall, pontifically approved congregations operated sixty hospitals in the West and Midwest between 1865 and 1920: *We Might As Well Burn It’: Catholic Sister-Nurses and Hospital Control 1865-1930*, 23. Mann Wall stated that most of the Catholic Hospitals in America were built, financed and administered by nuns: *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace 1865-1925*, Ohio State University Press; 2005, 4.

⁴⁷ Wittberg, *From Piety to Professionalism...* 90.

during the late 19th century and the early 20th century in France at the time, which consisted of the nuns occupying supervisory roles but not owning the hospital.⁴⁸

Nuns in Malta occupied supervisory posts in nursing, portering, catering and laundry⁴⁹ effectively managing most of the service. Their constant presence may have contributed further to the nuns establishing their authority in all hospitals in Malta seemingly without much interference from the higher authorities and an equal acquiescence from the nurses.⁵⁰ This was similar to the situation in some American Catholic Hospitals in the early 20th century where the Mother Superior reigned supreme without much opposition; nuns were in charge of all floors and departments while the training school was also under the supervision of a nun.⁵¹

Upon their arrival in Malta the nuns had a lack of familiarity with the people and with the authorities giving them a similar ‘outsider status’ to those described by Mann Wall when nuns arrived in America in the early 20th century.⁵² There may have been communication problems as the nuns spoke Italian,⁵³ the higher authorities could only communicate in English, while the Maltese nurses spoke Maltese only. This ‘outsider status’ may have been

⁴⁸ Katrin Schultheiss, *Bodies and Souls: Politics and Professionalisation of Nursing in France 1880-1922*. (London: Harvard University Press; 2001), 4.

⁴⁹ Cassar, *Medical History of Malta*, 399.

⁵⁰ This may be a clear indication of the uniqueness of Malta as a colony and more so of the Maltese as a ‘colonialised’ people. The Maltese were ready to ask for protection from the British under the belief that this protection would respect their sovereignty: Henry Frendo, *The Origins of Maltese Statehood*, (Malta: PEG; 1999), 23. They accepted their eventual destiny as a colony asserting their right to an elected Congress, and lived generally tranquilly in a cold war with the government: Geoffrey Hull, *The Maltese Language Question: A Study in Cultural Imperialism*, (Malta: Said International Ltd, 1993), 5. Meanwhile they went on with their own lives in spite of the government. In a similar way, the nurses accepted their ‘new’ managers but seemingly got on with their lives nevertheless as discussed later.

⁵¹ Barbra Mann Wall, *Definite Lines of Influence: Catholic Sisters and Nurse Training Schools 1890-1920*. *Nursing Research* 50:5 (2002), 315. Available at: <http://www.nursingcenter.com> [Accessed: 19 October 2015].

⁵² Mann Wall, *Definite Lines of Influence*, 315.

⁵³ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 55. Italian had been the official language used in court and in official documents since the time of the Knights: Hull, *The Malta Language Question*, 7. It had ‘become the dominant language “of convenience”...slowly infiltrating many areas of public life’: Carmel Cassar, *Malta: Language, Literacy and Identity in a Mediterranean Island Society*, *National Identities*, 3:3, 267.

another unusual occurrence in Malta since the small size of the island and its high population density encourage networking, inter professional and intra professional relationships. Very often, incidental acquaintances also had familial ties. Since the Italian nuns did not have any such family ties, acquaintances or friendships on the island, there was a resultant gap and perhaps a change in the *modus operandi* of hospitals when the individuals in management i.e. the nuns, were no longer of the inside circle. As a result they were more at liberty to take decisions without fear of affecting inner circle individuals negatively. They could not easily enter into alliances within the organisation (with superiors, peers and subordinates) which Kanter lists as being a condition for empowerment.⁵⁴ Social connections, and the development of communication and informal channels with sponsors, peers, supervisors, subordinates, and cross-functional groups yields informal power that enhances access to empowerment structures for employees.⁵⁵ However, this is assuming that all participants in the organisation are professional and no favouritisms are allowed to occur within the organisation.

At a time when extended families were common,⁵⁶ the lack of family ties also meant that the nun could focus on her vocation and work without much distraction and to the benefit of the health authorities. In early 20th century France, doctors had favoured the service of nuns claiming that the devotion necessary for caring of the sick could only be given by ‘unsexed’ religious sisters who had chosen to replace service to the family with service to God.⁵⁷ In

⁵⁴ Rosabeth Moss Kanter, *Men and Women of the Corporation* 2nd edition (New York: Basic Books; 1993), 190.

⁵⁵ Alejandro Orgambidez-Ramos, Yolanda Borrego-Alés, ‘Empowering employees: Structural empowerment as antecedent of job satisfaction in university settings.’ *Psychological Thought* 7:1 (2014), pp. 28-36. Available at: psyc.psychopen.eu/article/view/88/html#d2e987 [Accessed: 30 March 2016].

⁵⁶ Charlie Azzopardi, *Expectations of Marriage Before and After Marriage Among Maltese Catholic Couples*. Unpublished Doctoral Thesis. University of East London (2007), 32.

⁵⁷ Schultheiss, *Bodies and Souls*, 7.

Malta, the nuns requested to be allowed to work within the demands of their religious life saying that this meant they had to be autonomous in how they were organised.⁵⁸

Maltese nurses in general seem to have traditionally been disinclined to react to changes as no evidence has been found to show that these nineteenth century Maltese nurses protested or commented in any way about the presumably 'new' style of management of the hospital. Expected reactions (or lack thereof) from nurses in the 1960s discussed in the previous chapter would have been in relation to peers and fellow Maltese individuals; in the case of the arrival of the nuns a reaction would have been in relation to foreign individuals. A possible reason for this may have been the mental conditioning of a people that had been colonised for a long time by different colonisers. For Maltese nurses (and the people) this may have been another of the imported traditions they had come accept as necessary for their survival. Frendo refers to a 'cultural nationalism' rather than an economic one since economical dependency was an indisputable fact.⁵⁹

Such sentiments and the sociological aspect of colonisation can perhaps be used to attempt to explain the Maltese nurses' reaction. According to Said, in colonisation the majority is somehow expected to allow the minority to absorb it.⁶⁰ Maltese nurses may therefore have preferred to allow the minority of nuns to rule them as long as their livelihood had not been touched.⁶¹ Although there were few nuns in Malta, within the hospital walls the nun to lay

⁵⁸ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 326.

⁵⁹ Henry Frendo, *Europe and Empire: Culture, Politics and Identity in Malta and the Mediterranean* (Malta: Midsea Books; 2012), 331

⁶⁰ In the case of the nuns who were brought to Malta this minority was really minor and actually different from the colonising minority as the nuns were Italian and Catholic whereas the authorities were British and Anglicans. This may indicate a complete trust in the nuns or a desperate need for assistance in the management of nursing in hospitals that necessitated such drastic measures as the 'importation' of nuns not only at an extra expense but also in forfeiture of the British authorities' power on the actual management of the hospital. It also indicates that nurses may have not been in a position to appreciate their power and act upon it, probably due to their poor social backgrounds and lack of ambition.

⁶¹ Nurses' protests could only be found in reports in the *TOM* from 1970 onwards and these were about conditions of pay and equality in this with other sectors of the Civil Service: *TOM* 24.1.1970, 2; 26.1.1970. 16). In 1977 there were industrial actions on the performance of non-nursing tasks.

nurse ratio may have been relatively high even if the nuns were still a minority.⁶² The backing of the authorities may have compensated for their minority status resulting in dominance by the nuns and a feeling of lack of power in nurses that was to last until the nuns ceased to operate within the health system in Malta. It may also have been that Maltese nurses of the time were not very knowledgeable as attested by the Comptroller of Charities of the time who said that the nurses were ‘generally illiterate’⁶³ and that they came from ‘the illiterate and uneducated classes.’⁶⁴ An awareness of their lack of knowledge may have caused the nurses to refrain further from making any reaction to the changes in the hospital management.

Although the nuns had the full support of the government in implementing changes at the Central Hospital as they deemed fit,⁶⁵ nurses may have found out a way of carrying on in their way in spite of the nuns’ authority. The authorities seem to have been greatly appreciative of the nuns’ work of introducing order and discipline into the Government Institutions.⁶⁶ The nuns’ experience in running hospitals in Rome may have made up for their lack of specialisation, while their religious way of life implied a dedication towards the sick. This was perhaps enough at the time of the nuns’ arrival in Malta when medical technology was rudimentary and antiseptic practices had not been discovered since hospitals could only offer

⁶² Statistics on their actual numbers have not been found but may have been available at the archives of the Sisters of Charity.

⁶³ Cassar, *Medical History of Malta*, 402. Quotation from letters of Ferdinand Inglott at the old Archives of the Medical and Health Department.

⁶⁴ Cassar, *Medical History of Malta*, 399.

⁶⁵ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 56.

⁶⁶ There is no evidence to show that the authorities ever showed any displeasure or dissatisfaction with the nuns. On the contrary they expressed satisfaction and declared they had never had cause to complain. Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 56; Cassar, 407; Debates of the Council of Government of Malta, 15.3.1882, 470; 27.11.1895, 397.

fundamental care.⁶⁷ There may have been some nursing training in their convents as happened in American Convents at the time.⁶⁸

The situation does not seem to have changed much with time although the knowledge of nurses was gradually increasing. By the 1960s individuals wishing to enter nursing had to have a minimum number of years of schooling and be literate.⁶⁹ Interviewees for this study commented on the nuns behaviour saying that they were generally aloof from their subordinates in that they only used titles and surnames to address their colleagues and subordinates. They were strict with everyone they met and would reprimand them if anything went wrong.⁷⁰ According to one interviewee, one did not dare ask to leave the ward for any personal reason not even for sickness.⁷¹ The nuns did not allow anyone to interfere in their decisions.⁷² They would not admit to being wrong and never complimented their subordinates even if they were pleased with the work carried out.⁷³ This may have been one way of avoiding becoming partial towards those they came into contact with in order to follow their call of being wholly dedicated to God.⁷⁴

However, partiality and acquaintances were inevitable, more so when the nuns eventually became all Maltese as the congregation grew. Several interviewees for this study mentioned being in the nun's favour or disfavour. Being in the nun's favour could result in being more trusted than all the other nurses in the ward on a particular shift, even as a student. One

⁶⁷ Wittberg, *From Piety to Professionalism...* ? 32.

⁶⁸ Mann Wall, 'Definite Lines of Influence': Catholic Sisters and Nurse Training Schools 1890-1920. *Nursing Research* 50:5 (2002), 315-6. Available at: <http://www.nursingcenter.com> [Accessed: 19 October 2015].

⁶⁹ Interview with David Attard. Call for applications for Hospital Attendants Course: MGG 11,707 10.11.1964, 3032.

⁷⁰ Interview with Iris Naudi.

⁷¹ Interview with Olivia Gatt.

⁷² Interview with David Attard.

⁷³ Interview with Olivia Gatt.

⁷⁴ The motto of St. Jean Antide, the founder of the Sisters of Charity is 'God Alone' signifying a whole dedication to God and detachment from worldly things: Luigi Mezzadri, 'Jean Antide Thouret: Her Spiritual Profile', 1. Available at: http://www.suoredellacarita.org/index.php?option=com_content&view=article&id=103&Itemid=140&lang=en [Accessed: 12 March 2016].

interviewee said that when he was a student on a particular ward, the nun used to trust him with the bottle of whisky that was to be administered to patients as part of treatment for various complaints:

The bottle was hidden in a special place and locked but she used to trust me. She used to tell me: "I'm leaving this in your hands. Don't you dare leave it lying around." And I was a student then.⁷⁵

As a student during the 1960s, another interviewee found herself not being in one nun's favour initially but managing to change her opinion after some time. As proof of such negative treatment this nurse mentioned being sent to assist in the shrouding of four dead patients on her very first day on the ward as well as being sent to the mortuary to do the same, when it was not the practice for students to be sent there. The nurse expressed this treatment as being exceptional stating:

this was only one nun in the whole hospital but then she began to like me, so much that when we reached our final she wanted me to go.... I told Sr. Aldegonda,...: "I'm not going." And she told me: "She has asked for you." I told her: "No, crying time is over thank you. I'm not going to that ward" and I didn't go....but then all the nuns who used to be in charge of the hospital.....all of them loved me until their dying day.⁷⁶

The effect of such treatment as a student may have been shorter lasting than when a qualified nurse had to work in a ward and be aware that s/he was not in the nun's favour. A nurse interviewee who claimed not to have been in the nun's favour said that this lack of favour was even extended to his then girlfriend upon the nun having been informed that they were courting. He said: 'I was so much not in the nun's favour that when came to the ward as a student she didn't even sign her practice document upon learning that she was going out with me.'⁷⁷ Asked whether being in the nun's favour made a difference one interviewee said: 'Of course it did!... Ee even if only to be granted a day's leave.'⁷⁸ This indicates that there were favouritisms even when granting vacation leave or time off and it paid to be in the nun's

⁷⁵ Interview with Quentin Borg.

⁷⁶ Interview with Olivia Gatt.

⁷⁷ Interview with Kevin Abela.

⁷⁸ Interview with Kevin Abela.

good books. It also indicates that there was an infantilising way of treating nurses and student nurses and exacting respect by exerting total discretion on issuing rightful allowances as privileges. This may have led to abuses and to one nurse attempting to appease the nun more than others in order to encourage favouritism towards him/her. According to one interviewee there was a competition for the nun's favour.⁷⁹ Ways of achieving this were not related during interviews but they may have had to do with increased servility and submissiveness rather than worldly possessions.

The nuns' vow of poverty did not allow them to accept 'gifts' which could be used to make them decide favourably towards the donor, nor did it allow them to have personal belongings that could be damaged in vengeance. One interviewee explained that this added to their liberty to correct nurses saying:

I mean, they, they did not find it difficult to correct you because they had nothing to lose. However, for example it is not the first time I have heard utterance such as: 'As if I am going to speak to that one. If I did I would only go out and find that my car has been scratched' for example. The nuns did not care about any of this.⁸⁰

These factors allowed the nuns in Malta to operate in an autonomous way and implement the changes they had been brought over to affect. The nuns' autonomy may have been extended to the way they eventually ran hospitals and practically the nursing service since they sanctioned student nurses, hospital attendants and qualified nurses as well as running their wards where: 'Nobody interfered... No one... Nobody.'⁸¹ This is similar to the Irish scenario where by the turn of the 20th century the nuns controlled nursing services in workhouse infirmaries.⁸² At around the same time in America, the nuns owned hospitals and ruled over them.⁸³

⁷⁹ Interview with Kevin Abela.

⁸⁰ Interview with Eliza Camilleri.

⁸¹ Interview with David Attard.

⁸² Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 15.

⁸³ Mann Wall, *Definite Lines of Influence: Catholic Sisters and Nurse Training Schools 1890-1920*. *Nursing Research* 2003 (50) 5:315-6. Available at: <http://www.nursingcenter.com> [Accessed 19 October 2015].

Being foreigners the nuns in Malta were also above any political involvement so their actions or failure to act could hardly be interpreted as being politically motivated. This became more difficult as time went by when Maltese nuns began to work in the wards and when the politico-religious conflict of the 1960s caused a further drift between the Labour leaning nurses and the nuns who represented the Church. It was also difficult for lay nurses who substituted nuns as ward managers during the late 1970s since the political patronage system that had infiltrated through Maltese society⁸⁴ did not allow managers the freedom to act especially when sanctioning bad behaviour. When lay nurses took over the nursing management in Maltese hospitals in the late 1970s, Maltese society had become so characterised by patronage that being close to the party in power was tantamount to being able to obtain favours rather than what was rightfully due.⁸⁵

It is not known whether the few positions held by nuns during this time were also affected by the ubiquity of politics but according to Bonnici the congregation was going through a time of tension one reason being the government's constant demands for changes in how the nuns' service was to be delivered.⁸⁶ This may have had cascading effects on the service although there is no evidence that the nuns commented on this. A desire to continue their pastoral work may have led to the apparent non reaction of the nuns to the restrictions being imposed on them but there may also have been financial reasons for this since the 36 nuns in Government employment had each by now been receiving a salary.

The Colonial authorities may have accepted the employment of the nuns upon reaching a favourable agreement with them whereby the Government of Malta would issue fewer salaries to the congregation than there were nuns in service thus procuring a perceived better

⁸⁴ James A. Craig, Malta: Mintoff's Election Victory. *West European Politics* 2007 (5) 3:320; Jeremy Boissevain, *Saints and Fireworks: Religion and Politics in Rural Malta*. (Malta: Progress Press; 1993),70.

⁸⁵ Craig, Malta: Mintoff's Election Victory, 320.

⁸⁶ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 345.

quality of service at a lower financial price.⁸⁷ The perception that nuns provided better quality was also mentioned by Wittberg who asserted that in 19th century America, Church leaders and the laity often believed that teaching or nursing by a sister or deaconess was superior in quality to the same activity performed by a hired lay staff member.⁸⁸ Reasons for this include their constant presence in the wards leading to their being seen as ‘not failing’ the patients like the lay nurses who had to go home to their family when duty time ended.

According to one interviewee the nuns were on the ward:

Every day. Both of them. Every day, Saturday and Sunday. They weren't both there only if one of them was on a retreat. Then they used to go to lunch together and come back and then prepare to leave for the convent at around half past five.⁸⁹

The night duty nuns would then take over dividing the responsibilities according to area.

The Sisters of Charity were fully responsible for the deployment of nuns so wards were never understaffed and the authorities were satisfied. This was particularly convenient in times of the nurses' strike in 1970.⁹⁰ The nuns went on working and the service suffered less through the dedication of the nuns but perhaps to the detriment of the nurses' intended impact on society. One interviewee for this study described the nun's role in the 1960s and early 1970s as being:

the factotum... No, the sister who was going round the hospital... During the night there used to be five sisters in charge. There used to be one for Medicine, one for Maternity, another one for Surgery and there was the other one for Children's.... And this one of the Theatre, they used to phone her to come. She would be asleep and then she would come... I mean you can imagine, so to speak, that certain level of seriousness and discipline... She used to come round during the night and all... And everyone used to pay a lot of attention during the night. Because the Sister used to do... do the supervision over what was being done... She would come and look, checking. She would write down the requisitions for what she needed, if the families were coming then

⁸⁷ In 1944 there were 105 nuns working in hospitals with the government issuing only 63 salaries: Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 326.

⁸⁸ Wittberg, *From Piety to Professionalism... and Back?* 69.

⁸⁹ Interview with Nathalie Caruana.

⁹⁰ *TOM* 14.5.1970, 12. In a letter to the editor 'Eyewitness' upheld the Sisters of Charity who had continued with all the hospital work needed for it to go on operating as normally as possible. To quote 'Eyewitness' they '...accomplished all the multiple duties and chores – treatment of patients, personal cleanliness of the sick, laundering, ironing and cooking... maintaining discipline.'

she... you know she did not only do the supervision. Being in-charge consisted of everything... The allocation... when you have your own ward it is like having an orchestra with the maestro conducting. Besides conducting he has to know how that one is playing. For example, she would know that when she allocated Mr. A and B together to wash the patients, by ten the patients had to be ready so she would start to check. She would say: "I will not put these two together any more, I will put somebody else who will finish them at half past nine, before the ward round." There used to be much of that... And she would see that other things came, the ration. She had to give out the food... She would change allocations [of nurses] to wards who would stay there and see whether anyone wanted some coffee or they would squeeze oranges for the patients.... What she says goes... She was responsible, she was the be all and end all... at times I used to doze off for five seconds while sitting on the chair without realising it... It is not the first time I woke up to find the nun in front of me.⁹¹

Another interviewee said:

The sister used to gather the nurses to tell them...eee she mostly used to assign the ee for example she would tell him; "Go to the big ward, side, side A" and she would tell the other to go to the big ward Side B.... You would be washing the sick or giving.. or ee making beds and she would be at the door of the big ward and walking up and down the corridor and saying the rosary.... when she came into the Big ward she used to go in and go straight into the big ward and stay behind the screen, she would open the screen to see what you were doing.... I mean she used to exert total surveillance, eh I mean the nun.⁹²

This portrays the virtual ubiquity of the nuns and their constant supervision may have augmented their power due to the knowledge they had of all that was going on.⁹³ One interviewee said that the nun was to be contacted even before the decision to call a doctor was made.⁹⁴ The nun was therefore almost the only medium through which the doctor communicated with the nurses and HAs. One interviewee said that during ward rounds the nun was almost always present and the consultant would only communicate with her even if he needed some information about a patient from another nurse. He explained:

He [the consultant] did not look at you, he asked the nun... He would for example say: "Sister ...how is he [the patient] doing on these antibiotics?" And you would be present

⁹¹ Interview with David Attard.

⁹² Interview with Quentin Borg.

⁹³ In her Theory of Organisational Behaviour, Rosabeth Moss Kanter posits that access to information about all the facets of the organisation is key contributor to empowerment: *The Change Masters: Corporate Entrepreneurs at Work* (London: International Thomson Business Press; 1997), 219.

⁹⁴ Interview with Quentin Borg.

there.. He would not look at you he would look at the nun so that the nun would ask you. Then you would tell the nun and the nun would tell the consultant.'⁹⁵

This access to the 'higher authority' in the ward increased the power of the nun. Access to the consultant further augmented this power and rendered the nuns as being superior even to the qualified SRNs. A consultant who worked at St. Luke's Hospital in the 1960s said that the nun would assist him when he performed lumbar punctures.⁹⁶ The nun held a lot of information and was a major medium for information flow to nurses. According to Kanter access to information is a structural condition contributing to empowerment.⁹⁷ Nurses were therefore further disempowered by their lack of access to information or their lack of seeking information. Although nuns may not have had any power on who was first engaged to nurse as a student or as a HA 'Extra',⁹⁸ they certainly had power to influence decisions on who would continue to nurse as one interviewee testified: '.... if the sister comes and sees you fainting [upon witnessing a ghastly scene such as gangrene]she may say that you are not good for nursing...'⁹⁹ Another one said that the nun could request the Ward Master not to send her a HA who she perceived as being lazy and disobedient.¹⁰⁰

The night and day vigilance may have kept nurses more attentive towards their work so as not to cause the nun any displeasure since this may have had grave consequence. This constituted the discipline which seems to have become their hallmark and apparently gained them most respect from the authorities. Two of the 'elite' interviewees who were involved in hospital work commented that:

They were very good for discipline.... In the ward, everyone how do you say it... Everyone in his place... At the time you entered a ward... patients all in a good place, cleanliness, ward rounds with a certain order¹⁰¹

⁹⁵ Interview with Keith Holmes.

⁹⁶ Interview with John Rizzo Naudi.

⁹⁷ Kanter, *Men and Women of the Corporation* 2nd edition, 272.

⁹⁸ Cronin, *Report on the Medical Services of Malta*, 53:190.

⁹⁹ Interview with Quentin Borg.

¹⁰⁰ Interview with David Attard.

¹⁰¹ Interview with Rizzo Naudi.

and

There was a dedication and discipline in the wards... They had a certain eh, although you could perhaps also call it fear, but they had respect for the... I believe there was more respect at that time.... possibly coming from fear! (Laughter) Because of the discipline, they had a lot of discipline.¹⁰²

A former nurse described this discipline as:

Discipline in everything, that there was no... that everyone does their own work aye? Everyone does their own work, aye their own work... She used to take great pains in her work, more than I.. and she used to want everything according to the book... Everyone was afraid of her and I felt so good I clicked so much because I sort of said... apart from her discipline that I had always liked I sort of said: “She is going to deal with me according to my character sort of.”¹⁰³

Another interviewee said:

When she [Sr. Aldegonda] asked [where I wanted to work] I told her WMB (Women’s Medical Ward B) which was the ward nobody wanted to work in with Sr ‘Cos Sr ... was really hard and disciplined, very strict but you know I got on well with her. I was disciplined myself..... All the time picking on you like... For everything, how you spoke, how you walked, how you put the sheet... In detail. She was never like this with me because I always tried to do everything perfectly. And I started challenging myself to notice as a student I was, I couldn’t speak, to notice what she would notice which wasn’t right...the beds had to be straight, the counterpanes the way you put them they had all to be the same; one foot below the level of the bed everything ship shape.... if the glass is on the locker, the saucer is there and we had doilies even to cover the glass, the tumblers. No they had to be all in the same position on the lockers....¹⁰⁴

Referring to another nun this interviewee said: ‘...she was a strict nun, nobody wanted to work with her.... She used to go around, observing, making us work, upset everyone’¹⁰⁵ Evidence of how upsetting this authoritarian attitude was, is not available in the documents but discipline and the nuns’ constant presence in all parts of the hospitals may have facilitated changes the nuns were to affect in that they secured obedience and lack of protest.

The nurses’ dependency on the nuns’ decision at ward level and at hospital level perpetuated their subordination. It was through the nun that they had access to knowledge; both formal

¹⁰² Interview with Benjamin Walters.

¹⁰³ Interview with Denise Galea.

¹⁰⁴ Interview with Olivia Gatt.

¹⁰⁵ Interview with Olivia Gatt.

and informal, support and supplies up to the smallest item for making tea¹⁰⁶ so one could not afford to be in the nun's disfavour. Another one said: 'Before it was a kind of policy of phoning her before phoning for the doctor, she was the first resort.'¹⁰⁷ At hospital level, the matron who was also a nun, controlled deployment and dealt with disciplinary actions that could affect wages. It may also have been a contributory factor in instilling a sense of awe of nuns so that no one dared question them.¹⁰⁸ This sense of awe may have led the Maltese to hold them in great respect.¹⁰⁹ The attitude of respect towards those caring for the sick may have resulted from the patients' perception of order and cleanliness. However, there may have been aspects in the nuns' way of management that were less than ideal. One elite interviewee referred to the nuns as having 'many defects,'¹¹⁰ while a former nurse said that 'they were cruel' even if she was quick to add that not all of them were like that.¹¹¹ A former lay NO said that he might also have been perceived as being 'cruel' when he was supervising.¹¹² The picture that emerges from these testimonies is one of fear in the nurses and domination by the nuns presumably aimed at keeping order and discipline in the ward for all the work to be done effectively and efficiently. There may have been some confusion in perception between being strict and cruelty as there may have been instances where the boundaries between strictness and harshness verging on cruelty were crossed.

Although anecdotes have been told that indicate that there were favouritisms and individual nuns failing to take action when they knew of cases of negligence, this has not yet been recorded. The fact that all the nuns lived together in the same convent on the hospital premises¹¹³ made it even more difficult for nurses to speak or pass comment since there was

¹⁰⁶ Interview with David Attard.

¹⁰⁷ Interview with David Attard.

¹⁰⁸ Interviews with Keith Holmes, Olivia Gatt and Kevin Abela.

¹⁰⁹ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 344.

¹¹⁰ Interview with Benjamin Walters.

¹¹¹ Interview with Iris Naudi.

¹¹² Interview with David Attard.

¹¹³ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 326.

the possibility that an incident may be recounted within the convent walls and all the nuns would be aware of it potentially resulting in ostracisation or loss of favour. One interviewee said:

I told her: “Am I going to be here?” She told me: “Yes, Matron told me.” I told her: “What am I going to do?” She told me: “Get a basin and start washing the windowsills” I told her: “What did you say?” I told her: “I am going away.” She wanted me to wash the windowsills. The cleaner was chatting and laughing away and so on and then anyway she did take a sort of dislike towards me.¹¹⁴

Fear of losing favour and a dependency upon the nun’s perceived greater knowledge and power could also have hindered nurses from voicing any concern and they may have felt intimidated by the large number of nuns. This position did not change much over time in spite of Maltese nurses receiving training and as already explained, the nuns continued to run all the hospitals even though they themselves were not all academically prepared for nursing. According to Bonnici during the 1940s, 1950s and 1960s the nuns sought specialisation in nursing and had even acquired a home in the UK for nuns to stay at while studying nursing and taking up specialised courses there. Among these Bonnici mentions a Maltese nun who trained to become a Nurse Tutor and two who trained to become Matrons.¹¹⁵

The deployment of nuns was at the full discretion of the Mother Superior¹¹⁶ but she had to notify the Chief Government Medical Officer (CGMO) who in turn had to ensure that such deployment was carried out at a time and in a way as to cause the least disruption to the

¹¹⁴ Interview with Kevin Abela.

¹¹⁵ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 324.

¹¹⁶ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 62. The Mother Superior had full autonomy over the nuns’ deployment. However, the nun may have been selected for this post by the congregation before it became available: Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 324. The call for application for assistant matron for St. Luke’s Hospital (SLH) found in the Government Gazette listed a Certificate of Nursing Administration (Hospital) of the RCN and the National Council of Nurses of the UK as a requisite. It did not mention the marriage bar, indicating that this post was intended for a nun: MGG 11,976 13.1.1967, 106. A similar call for applications for Nursing Sisters mentioned the resignation upon marriage: 11,979 24.1.67, 185. Nuns were not at the time employed on a personal level and only three nuns appeared by name as government employees until 1972, namely the Principal and Assistant Principal Nurse Tutors and the Assistant Matron: Staff Lists 1967, 1968, 1970.

service.¹¹⁷ In 1957, Farrer-Brown and colleagues stated that the nuns: ‘provide the backbone of the existing nursing service’ since they made up most of the ward sisters while the Mother Superior was responsible for the supervision of female nursing and lay staff in all hospitals. The nuns acting as ward sisters at St. Luke’s Hospital were mostly SRNs but few of those in the other hospitals were so qualified.¹¹⁸ The exact number of nuns in government service before 1970 cannot be ascertained but Bonnici claimed that there were more than 60 nuns at St. Luke’s Hospital.¹¹⁹ These may have included nuns who had kept on working beyond retirement age who were withdrawn by the government that same year.¹²⁰ The official number of nuns in Government employment was 44.¹²¹ However, there may still have been more nuns on the wards carrying out pastoral work.

Pastoral work by nuns in Maltese hospitals was not very evident probably because they were not the ones to introduce charitable acts and Christian images in Maltese hospitals.¹²² Each ward at St. Luke’s Hospital had a small table in the entrance hall upon which there were holy images. The presence of chapels in hospitals indicates that the spiritual needs of the patients were catered for by chaplains who were purposely deployed to serve there.¹²³ However, one interviewee said that nuns regularly organised religious activities such as the Sunday Mass

¹¹⁷ TOM 29.6.1966, 12. Question time in Parliament. The Minister stated that: ‘No transfer of nuns had been of harm to the patients.’

¹¹⁸ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 58:204.

¹¹⁹ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 343.

¹²⁰ Anon. *Sorijiet Xjuh imneħħija mill-Isptarijiet, Il-Hajja*, 7.4.70, 7.

¹²¹ NAM/GMR/4004 Report on the Health Conditions of the Maltese Islands and on the Work of the Medical and Health Department for the Year 1971, 12.

¹²² Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*, 18. Reports describe the transfer of a large Crucifix that hung in the large ward of the *Sacra Infermeria* to the Central Hospital and then to St. Luke’s Hospital from where it was taken to *Mater Dei* Hospital where it hangs in the chapel: Anon, Tradition Renewed as 400 Year Old Crucifix is taken to Mater Dei Hospital, *The Malta Independent* (TMI) 30.10.2007, 5.

¹²³ Alexander Bonnici, *L-Istituti ta’ Hajja Kkonsagrata f’Malta* (Malta: PIN; 2000), 66. A chaplain was present at the Central Hospital, Floriana in 1900: Josette Calleja, *The Central Hospital at Floriana: History of a Civil Hospital*. Unpublished Dissertation for BA (Hons) History; University of Malta, 2004, 126.

and gave importance to sacramentals such as the daily Holy Communion distribution and prayers at different times of the day.¹²⁴

In 1970, a series of industrial actions and lobbying tactics executed by the General Workers Union representing nurses at the time were successful in providing openings for career progression for lay registered nurses to high administration posts and higher salaries as Principal Nursing Officers, Senior Nursing Officers and Nursing Officers.¹²⁵ Industrial actions included a strike showing that nurses were trying to improve their working conditions even if these were mostly related to pay and promotion opportunities. In 1972 the nomenclature of Nursing Sister and Male Registered Nurses was substituted by that of Staff Nurse.¹²⁶ Reasons for calling this reclassification a promotion are not known but it may have been connected to the pay scale nurses would be placed at. There could also have been an effort to establish a ranking system that would mark a hierarchical system of authority and this may have been another instance of Malta following the British system that had endeavoured to grant civil registered nurses the equivalent status of officer in the military.¹²⁷ According to Penny Starns there was an effort to elevate status and 'confirm the elite standing of registered nurses and endorse their legitimate authority.'¹²⁸ Adopting a military nomenclature in the 1970s may have served to perpetuate the idea that nurses were to be obedient and serve all exigencies of the service as they would if they were at war. The newly introduced nomenclature included terms such as Nursing Officer, Senior Nursing Officer and

¹²⁴ Interview with Konrad Cauchi.

¹²⁵ TOM 24.4.1970 Mediation Efforts Continue: Government and GWU exchange Counter-proposals, 2.

¹²⁶ TOM 26.1.1971 Prizes and certificates for nurses, 13.

¹²⁷ Penny Starns; *Fighting Militarism? British Nursing During the Second World War*. In: Roger Cooter, Mark Harrison and Steve Sturdy (eds.); *War, Medicine and Modernity*, (Gloucestershire: Sutton Publishing Ltd;1998), 198.

¹²⁸ Starns, *Fighting Militarism?* In: Cooter, Harrison and Sturdy (eds.), *War, Medicine and Modernity*, 194.

Principal Nursing Officer which terms had to be adopted for lay nurses and for nuns who had appeared as officially employed in the 1972 Staff List.¹²⁹

According to this list 18 nuns had been designated Nursing Officers and the Matron who was also a nun, had become known as Principal Nursing Officer. The remaining 27 nuns were employed as State Enrolled Nurses (SEN). The number of nuns in the Nursing Officer's grade increased to a total of 31 by 1977.¹³⁰ A new agreement had been reached through which the government engaged nuns individually granting them a salary and a pension.¹³¹ This may have been the first in a series of steps taken towards secularisation of the nursing administration that included: reducing the number of nuns working beyond retirement to be replaced by lay registered nurses;¹³² the introduction of the grade of Senior Nursing Officer (SNO) whereby ward masters who were not registered nurses were given this grade,¹³³ while granting the grade to only two nuns and 15 lay registered nurses.¹³⁴ No evidence has been found of comment about the apparent injustice being made regarding the nuns who may have benefitted from being promoted to SNO on the same basis as the ward masters. The nuns seem to have been repeatedly kept out of the promotion system in spite of their vast experience as this apparent exclusion happened again when the grade of Principal Nursing Officer was extended to include 11 nurses in 1980.¹³⁵ Only one nun, the Principal Nurse Tutor was so appointed since the matron who was a nun had been Principal Nursing Officer since 1970.¹³⁶

These actions may have been the result of nurses voicing their concerns regarding pay scales and career progression. There was a major change within a relatively short time since many

¹²⁹ Malta National Library, Staff List 1972, 163, 169, 170.

¹³⁰ Malta National Library, Staff List 1977, 133.

¹³¹ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 349.

¹³² Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 344.

¹³³ TOM 24.4.1970 Mediation Efforts Continue: Government and GWU exchange Counter-proposals, 2.

¹³⁴ Malta National Library, Staff List 1977, 133

¹³⁵ NAM/GMR/3730/1984 Staff List 1984, 190.

¹³⁶ NAM/GMR/3460/1973 Staff List 1973, 157.

of the nuns were of retiring age. Whether these actions were timely enough and/or of much benefit is questionable since the nuns had much experience and the discipline they commanded could mitigate the lack of knowledge of the nursing personnel that was still largely made up of Hospital Attendants (Fig. 3.4). Had these actions not been taken, the decreasing number of religious vocations would still have led to a natural extinction of the nuns from Maltese hospitals. The last one to retire did so in 2000.¹³⁷ The vacant Nursing Officer posts left by the retiring nuns were taken up by Staff Nurses.

4.3 The second Superior Grade - The lay Nursing Officers

The grade of Nursing Officer (NO) was first introduced in 1970 and it was then given to 18 nuns only.¹³⁸ By 1977 the number of NOs had increased to 77 while there were another 17 Senior Nursing Officers (SNO) bringing the nursing management staff to 94.¹³⁹ Four individuals appearing on the list had no nursing qualification (including two whose name does not feature earlier in any staff list analysed for this study) but had been in government employment for a long time. These may be the Ward masters or Chief Nurses that the 1970 agreement had envisaged would be given this grade due to their long years of service. Whether they were in any position of supervising or managing nurses is not known but two interviewees for this study mentioned that the Chief Nurses at the Hospital for Mental Diseases allowed them to manage the ward without much interference.¹⁴⁰ Staff Lists of previous years mention few Chief Male Nurses, Assistant Chief Male Nurses and Ward Masters¹⁴¹ indicating that these grades may have existed only at the Mental Hospitals.

With regards to the grade of Nursing Officer (NO) the 1977 Staff List includes the names, date of birth and date of appointment of seven individuals who could not be found in previous years' Staff Lists under any nursing grade and could therefore have been employees

¹³⁷ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 349.

¹³⁸ National Library, Staff List 1972, 163.

¹³⁹ National Library, Staff List 1977, 133.

¹⁴⁰ Interview with Quentin Borg, Interview with Konrad Cauchi.

¹⁴¹ NAM/GMR/2916/1967, Staff Lists, 1967, 119; NAM/GMR/3050/1968, Staff List 1968, 121.

who were not in nursing *per se*. An explanation for this is hard to find and they may have been given the grade for promotion's sake without actually working in nursing. This may have been a similar situation to that reported in 1972 where there were 30 men and seven women being paid as staff nurses on a personal basis who were not registered as SRNs.¹⁴² The GWU seems to have been quite satisfied with the arrangement as no evidence was found of its actions or comments. Nurses who were qualified but not promoted may have felt aggrieved and some may have been union members. This exercise may have meant a long wait for their turn since those promoted were men aged between 52 and 59 in 1977.¹⁴³ Moreover, not having reached the grade in 1977 may have caused them to be ineligible for the next set of promotions that were granted in 1980.¹⁴⁴ Requirements for eligibility change with calls for applications.

However, those who were seemingly unfairly treated did not make any representations that could be found in the newspapers or through the interviews even though this arrangement was costing them money in lost wages, the retirement grant and possibly the pension scale. It is less surprising that the other nurses seem not to have commented either since this was not affecting their wages even though it may have affected their profession. Any feelings of frustration and failure at not being given the opportunity to advance in their careers remained undeclared.¹⁴⁵ Maltese Staff Nurses may have seen their prospect of promotion diminish as they were not given higher administration grades even when the number of nuns had decreased. If the 'unqualified' NOs were in charge of wards then their limited knowledge may have affected the quality of nursing, the nursing image and the organisational behaviour. Since knowledge is so related to power structure, a lack of it implies loss of power due to a

¹⁴² TOM 4.2.1972, Questions in Parliament, 6.

¹⁴³ Malta National Library, Staff List 1977, 134.

¹⁴⁴ Staff Lists of 1977 and 1979 indicate that some of the 'unqualified' SNOs had probably retired by 1979. Staff Lists between 1980 and 1984 could not be found and may have not been published so there may have been lack of information for nurses to act upon.

¹⁴⁵ These feelings can result in employees exhibiting limited work aspirations, limited commitment to the organisation and caution of and resistance to change: Kanter, *Men and Women of the Corporation*, 161.

lack of ability to perform high profile activities.¹⁴⁶ Therefore nursing expertise was not in those holding the official posts but may have been more evident in their subordinates as happened in the case of Mount Carmel Hospital mentioned above.

The resulting image within the organisation may have been that of an inadequacy to maintain standards while outsiders may have raised the question that if the leaders did not know much technical knowledge then the standard of care might be jeopardised. Such a perception may have been accentuated since the Maltese appreciated the nuns' presence in hospitals which according to Bonnici led the Government to request that they maintain such a presence as much as possible even after 1988 when their numbers had already dwindled.¹⁴⁷ This is an apparent change in policy probably rising from a change in government in 1987. Mann Wall explained that the added respect and status attributed to nuns came from the religious order that gave them a sacramental power exercised through their mediation in sickness and in death.¹⁴⁸ According to Mann Wall, in 19th century American hospitals, lay people could not compete with the nuns' status which was achieved from their being the 'brides' of Christ.¹⁴⁹ Maria Luddy stated that in 1907, there was a call for all Irish workhouse infirmaries to be handed over to the nuns on the presupposition that lay nurses could never exhibit the same qualities that came with being a nun.¹⁵⁰

In a Catholic country such as Malta, this *quasi* reverence to consecrated individuals may have been more predominant presenting lay NOs with an extra hurdle to overcome when establishing their authority in wards upon replacing the nuns. Being SRNs may have mitigated this challenge since some nuns had not been so qualified (even if this was hardly

¹⁴⁶ Kanter, *Men and Women of the Corporation*. 2nd edition, 272. The author calls this Formal Power.

¹⁴⁷ Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f'Malta*, 348.

¹⁴⁸ Mann Wall *Unlikely Entrepreneurs*, 8.

¹⁴⁹ Mann Wall *Unlikely Entrepreneurs*, 151.

¹⁵⁰ Maria Luddy, *Angels of Mercy: Nuns as Workhouse Nurses 1861-1898*. In: Elizabeth Malcolm & Greta Jones (eds.), *Disease and the State in Ireland, 1650-1940*, (Ireland: Cork University Press; 1999), 115.

public knowledge).¹⁵¹ Moreover, the added knowledge of lay NOs could have been more modern since many of them were relatively young in 1977.¹⁵² Great advances in pharmaceuticals and medical technology had been achieved by then.¹⁵³ The knowledge should have made them even more powerful, as, on being promoted, they inherited the power from the nun becoming the ones to be knowledgeable about many if not all facets of the ward. Their attempt to emulate the nuns may have been manifested in their endeavour to keep ward routines that had been established by the nuns and also to maintain the same stance of discipline. The scenario in the average hospital ward had changed greatly. The NO was no longer the only academically qualified nurse on the ward as happened when the nuns were at the helm. Indeed by time the newly qualified SRNs working on the wards may have been more prepared. The lay NO thus lacked the awe inspiring quality of the consecrated nun but had not gained more skills and academic knowledge to increase his/her knowledge power. The ubiquity of the head of the ward that existed when the nuns were in charge also changed due to the working hours of the lay Nursing Officers. Consequently, they did not attend the ward every day as they worked a 40 or 46.66 hour week including a spell of night duties according to a predetermined roster.¹⁵⁴ As a result there were days when one of the nurses who may have been the least experienced had to take the role of charge nurse. A lack of continuation may have ensued contributing to an image of lack of standards. The lack of preparation for this responsibility may have compromised the service as decisions had to be taken on an *ad hoc* basis. It could also have produced an added stress on the individual nurse and his/her colleagues possibly affecting the delivery of care. The availability of more

¹⁵¹ Joseph Muscat, The Nursing Profession, Letters to the Editor *TOM* 4.9.1964, 8.

¹⁵² Many of the lay NOs were in their 30s and early 40s: Staff List 1977.

¹⁵³ Michael A. DeMiranda, Mark Doggett & Jane T. Evans, 'Medical Technology: Contexts and Content in Science and Technology' (2005) Available at: [Http://People.Wku.Edu/Mark.Doggett/Medtechprimer6.0.Pdf](http://People.Wku.Edu/Mark.Doggett/Medtechprimer6.0.Pdf) [Accessed: 19 June 2016].

¹⁵⁴ According to Edward Urpani, a founder member of the Malta Union of Nurses interviewed for this study; in 1956, the government had granted workers whose work was considered to be essential a vested right to work for an extra 1/6th of their working week regularly.

medical investigations including medical imaging techniques; blood investigations and operative technology brought about an added burden of organisation for patients to be escorted to and from other sections of the hospital, samples sent to the laboratory and results gathered. The minimal changes in ward staff numbers that occurred over a long period of time were probably not enough to cope with this added load of work. The care needed before and after procedures such as endoscopy and complicated surgery gradually added to the workload and conditions of work became less favourable for nurses.

By the 1970s the nurses had become more vociferous in their requests for improved conditions of work as they moved away from the concept of being ‘of charity’ as the nuns had been called. The unions had also become very strong so that nurses could now ‘dare to speak’.¹⁵⁵ Another factor that affected the ward environment and perhaps the health system in its entirety was political partisanship and the interference of politicians. The single transferable vote system for elections in Malta fosters clientelism¹⁵⁶ that was increasingly manifested when there are many contenders for the same post such as the prospect of a particular promotion. A recommendation from a Government Minister provided a greater chance of being promoted.¹⁵⁷ Applicants who were close to the Minister were therefore at an advantage especially if they hailed from the electoral district contested by the Minister. There was an understanding that these favouritisms garnered votes from the whole family since many families remained within the same district even after marriage. This had been the case for a long time but it had hardly had any effect in the nursing field prior to the advent of the possibility of promotions.

¹⁵⁵ One interviewee (Kevin Abela) said that the nurse did not dare speak out for fear of being dismissed from work while another (Quentin Borg) one said that the nun could influence decisions for student nurses to be kept on training or not.

¹⁵⁶ John P. Mitchell, Looking Forward to the Past: National Identity and History in Malta. *Identities: Global Studies in Culture*, 2003 (10) 3:386.

¹⁵⁷ Godfrey Pirotta, Isabelle Calleja, & Cesar Colino, *Sustainable Governance Indicators: 2014 Malta Report*. Bertelsmann-Stiftung (ed.) (2015). Available at: www.sgi-network.org/docs/2014/country/SGI2014_Malta.pdf [Accessed:12 February 2016].

Being close to the Minister may therefore have put one in a position of undermining colleagues' chances of promotion or even the authority of supervisors. This is because situations may have arisen where the Minister would be given personal information that would change his/her opinion of a particular contender for a particular post. In other circumstances the Minister may have felt obliged to overrule a supervisor's decision to sanction his/her constituent for fear of losing votes. One interviewee for this study hinted at how this worked by saying:

When I used to see certain things, I could not act as I wished as they would go to someone or other and so on..... Eh, he would come and tell you that he has sorted everything out and so on. And so we began, we began to have a lot of supremacy from certain political acts; the Nursing Officer was there without any strength.¹⁵⁸

The team dynamics were therefore changed even if this was not desirable for the NOs who had been trained (or literally 'brought up') to obey without question to all the nuns ordered presumably for the benefit of the patient. The NOs' behaviour as attested by interviewees for this study verged on bullying tactics such as regularly assigning much of the work to student nurses without offering any support, humiliating students and showing favouritism towards particular students.¹⁵⁹ These tactics seem to have been more apparent in female wards. One interviewee for this study who worked with lay NOs during the 1980s asserted that in her opinion the students 'were sort of abused.'¹⁶⁰ She recounted:

I answered a call from Xrays and they told me to take this patient for Xray. I said: "All right" and I replaced the telephone and went to find the NO to tell her.. "What do you mean?" And I remember there was the SRN but also the doctor. "What do you mean? I am here, the NO, the SRN is here, the doctor is here and you are just a mere (*biċċa*)¹⁶¹ student and you decide whether the patient goes for Xray! I said: "Have pity (*jaħasra*)¹⁶² I didn't decide myself Miss" I told her: "It's just that he told me and I am relaying the message!" " You should have spoken to me before you hung up. Now

¹⁵⁸ Interview with David Attard. The interviewee refers to the individual's close proximity to certain politicians who could then sort any difficulty with higher authorities overriding the NO's decisions as necessary.

¹⁵⁹ Interview with Noella Delia, Ingrid Tanti.

¹⁶⁰ Interview with Ingrid Tanti.

¹⁶¹ Literal translation of '*biċċa*' is 'a piece' emphasising the irrelevance of the student in the eyes of the NO.

¹⁶² This indicates how the student was at the mercy of the NO.

I don't have a wheelchair. Go and find a (*iddobba*)¹⁶³ wheelchair." And I had to go round the hospital I remember. I don't know what had happened on that day and how there was a shortage of wheelchairs and I found one from Casualty and went up. "And if necessary you stay without a break because now you have to take the patient down with the wheelchair." And I went down and I still remember choosing the wrong side to go down on purpose so that I would have to go through the whole length of the corridor in the basement and have some time to be able to cry without anyone seeing me. This was abuse. I felt I was broken.¹⁶⁴

Another interviewee could not find any words to excuse the behaviour of another NO at around the same time. According to the interviewee:

If she wanted she could tell you: "Go and clean the pantry and the cupboards from inside alright. All that was left for cleaning would be the window panes and the floor. We used to clean there but then...emm: "Go and start doing the dressings I mean, from all that scum. I mean we weren't studying to become cleaners with all due respect to the cleaners...emm "Go and start doing the dressings, go and boil the syringes" and she may well ask you to do the treatment round too. I remember how we were abused... I remember we were in our final month or so and I was working at M3, Miss... I remember asking her to allow me to go with the ward round because they never told us to go and follow the ward round. It was always work, work, work for us. I told her I was nearing my final exam. She didn't say anything. There was a student who had just begun his training, and when it was time for the ward round she called him to go with the ward round with her. And she told me: "And you go and clean the pantry." I was very near to the final exam. This was how we were treated. There was no hiding or making excuses for their behaviour.¹⁶⁵

This behaviour may have resulted from a lack of social competencies such as lack of emotional control. Dieter Zapf and Stale Einarsen asserted that such a lack of control may be manifested in regular shouting at subordinates.¹⁶⁶ The same authors posited that bullying tactics may be a result of lack of self reflection and considering perspectives indicating that the managers might not be aware of how they affect their subordinates. However, they also concluded that for these tactics to be ongoing, the organisation needs to be at least tolerant if not rewarding of this behaviour. According to Janice Langan-Fox and Michael Sankey

¹⁶³ This meant going round the wards asking to be allowed to use the needed equipment; a very time consuming, humiliating and unpleasant situation as staff on the wards did not allow this easily. The NO of the ward was responsible for all equipment and had to account for any loss of damage often making written statements and even police reports of stolen items.

¹⁶⁴ Interview with Ingrid Tanti.

¹⁶⁵ Interview with Noella Delia.

¹⁶⁶ Dieter Zapf & Stale Einarsen, Individual Antecedents of Bullying: Victims & Perpetrators. In: Stale Einarsen, Helge Hoel, Dieter Zapf & Cary L. Cooper (eds), *Bullying and Harassment in the Workplace: Developments in Theory, Research and Practice 2nd edition* (London: Taylor & Francis Group; 2011), 185.

superiors being brought up within an organisation where bullying tactics are common continue to adopt the same tactics so that bullying behaviour becomes institutionalised and not acknowledged as being bullying.¹⁶⁷ In fact none of the interviewees mentioned the term although many recounted that they feared the nun's authority or that of the NOs that could humiliate them.¹⁶⁸ Langan-Fox and Sankey suggested that a certain passivity to bullying behaviour results through the processes of learning and socialisation in the microcosm of the workplace and the macrocosm of life in general.¹⁶⁹

Moreover, Morten Birkeland Nielsen and colleagues stated that victims of bullying tactics need to feel victimised meaning that if the individual does not consider the perpetrator's behaviour as bullying then s/he will not become a victim.¹⁷⁰ Student nurses at the time may not have realised then that they were being bullied accepting instead that this was the norm. Students may have felt victimised since they lacked the resources to retaliate against the system.¹⁷¹ Klaus Niedl found that becoming a victim also results if individuals 'are unable to escape the situation as a result of any dependency on their part.'¹⁷² In the case of student nurses this inability resulted from being allocated to a ward for a period of time and depending on the Nursing Officer's favourable reports as evidence of their suitability to continue their studies. There was also the fear of gaining a reputation amongst NOs that would then have consequences on their future even upon qualifying.

¹⁶⁷ Janice Langan-Fox & Michael Sankey, *Tyrants and Workplace Bullying* in Janice Langan-Fox, Cary L. Cooper & Richard J. Klimoski (eds.) ; *Research Companion to the Dysfunctional Workplace: Management Challenges and Symptoms* (Cheltenham, UK: Edward Elgar; 2007), 65.

¹⁶⁸ Two interviewees who worked only with lay NOs mentioned abuse (Noella Delia and Ingrid Tanti) while another two (Iris Naudi and David Attard) mentioned the nuns as instilling fear.

¹⁶⁹ Langan-Fox & Sankey, *Tyrants and Workplace Bullying*. In: Langan-Fox, Cooper & Klimoski (eds.) ; *Research Companion to the Dysfunctional Workplace*, 65.

¹⁷⁰ Marten Birkeland Nielsen, Guy Notelaers & Stale Einerssen, *Measuring Exposure to Workplace Bullying*. In: Einerssen, Hoel, Zapf & Cooper (eds.), *Bullying and Harassment in the Workplace: Developments in Theory, Research and Practice*. 2nd edition, 167.

¹⁷¹ Birkeland Nielsen, Notelaers & Einerssen, *Measuring Exposure to Workplace Bullying*. In: Einerssen, Hoel, Zapf & Cooper (eds.), *Bullying and Harassment in the Workplace*, 167.

¹⁷² Klaus Niedl, *Mobbing Wellbeing: Economic and Personal Development Implications*, *European Journal of Work and Organisational Psychology* 1996 (5) 2:242.

The NOs' power could possibly compromise the chances of a newly qualified nurse being deployed to a place of work s/he favoured both upon qualification and later on upon request for transfer to another section or ward. This insecurity may have been one reason why little evidence has been found regarding retaliation of any form to unfair and aggressive treatment.¹⁷³ On a daily basis the NO's discretion to approve requests for leave for subordinates was also used to exercise power sometimes indiscriminately. This may have affected subordinate nurses' future for example when granting leave for them to be able to follow a sponsored course in the technical work of the ward as attested by a male interviewee who worked with a male NO.¹⁷⁴ In this case there may have been a feeling of being threatened by the added knowledge of the subordinate upon his return which may have compromised the NO's prospects of promotion. The prospects of promotion may have been of greater importance amongst male employees since the marriage bar would not affect their futures as in the case of females. In a system where the prospects of promotion were few; the competition, whether overt or otherwise, was quite harsh. This was especially so considering that selection boards for such promotions had to be composed at least partly from members of the same profession who could potentially be acquainted with or have knowledge about applicants.

Promotion prospects changed in 1993 when the posts of Deputy Nursing Officers (DNO) were first introduced in Malta.¹⁷⁵ Eligibility requirements for this promotion included only being a SRN and therefore the number of possible candidates was quite large. A new section of nursing elite was emerging that would give the opportunity for promotion to all SRNs irrespective of their knowledge. Proof of their competence for the grade was to be ascertained during an interview by a Board of Selection made up of nurses who themselves

¹⁷³ Staale Einarsen, Stig Berge Matthiesen & Lars Johan Hauge, *Bullying and Harassment at Work*. In: Susan Cartwright, Cary L. Cooper (eds.), *The Oxford Handbook of Personnel Psychology*, (Oxford: Oxford University Press; 2008), 484.

¹⁷⁴ Interview with Keith Holmes.

¹⁷⁵ DH 1208/2006 Nursing and Paramedical Class: Nursing Service Grades Sectoral Agreement 5 May 1993.

could not have been very much academically prepared since the first graduates in nursing had only just qualified in 1992. The effect of a lack of a knowledge base was to continue to affect nursing and possibly hinder the professionalisation of nursing as will be discussed in the following chapters.

4.4 Conclusion

Changes within the elite of nursing in Malta during the period from 1964 to 1996 may not have been foreseen as the decline in religious vocations contributed greatly to the transition from having nuns at the helm of nursing to having lay nurses. Newly appointed Nursing Officers were not very well prepared for the role their only source of preparation coming from their experience as subordinates to the nuns. The changing work load and the increasingly demanding subordinates brought about changes in the organisation of work necessitating alterations in management operations. Nursing officers may have struggled to master medical technology due to the shallowness of their knowledge base. They had little opportunity to acquire the knowledge needed. Professionalisation of nursing in Malta during the period 1964 and 1996 may have therefore been hindered.

Chapter 5

BARRIERS TO PROFESSIONALISATION

5.0 Introduction

This chapter explores the barriers impeding the movement of nursing in Malta as a profession during the period 1964-1996. Margaret Moloney's stages in professionalisation are used.¹ Changes occurring in nursing in Malta during this period are also discussed with respect to the factors delineating the professionalism of nurses as described by Fataneh Ghadirian, Mahvash Salasali and Mohammed Ali Cheraghi in their evolutionary concept analysis of professionalism.² Reference is made to demographic factors; gender, age, experience in nursing, educational factors and confusion in borders between lower grades and higher grades. Environmental factors affecting nurses are discussed including their status as care givers, appearance in the workplace, and organisational culture. The role of the medical profession and politics will also be discussed regarding their influence on the nursing profession in Malta. Although Moloney and Ghadirian and colleagues described professionalisation in general their conclusions can also be applied for the process of professionalisation of nursing in Malta. The same factors contributed to Maltese nurses' image as perceived by society and their move towards professionalisation. In this work image refers to how the profession is viewed by Maltese society and how much it is perceived as a desirable profession. The historical and anthropological background to the study presented in Chapter 1 is used in an attempt to further interpret evidence in a hermeneutic approach, illustrated by the Maltese way of coping with situations.

¹ Margaret M. Moloney, *Professionalisation of Nursing: Current Issues and Trends*. 2nd edition (Philadelphia: J.B. Lippincott Company; 1992), 17.

² Fataneh Ghadirian, Mahvash Salsali, & Mohammed Ali Cheraghi, Nursing Professionalism: An Evolutionary Concept Analysis. *Iranian Journal of Nursing and Midwifery Research* 2014 (19) 1:1-10.

5.1 Professionalisation of Nursing in Malta

Moloney stated that professionalisation is a continuum and although there are distinct stages characterising it, it is the presence and level of certain identifiable attributes that locate an occupation on this continuum. The first stage in professionalisation is the creation of a full time occupation. In 1964, nursing in Malta had been practised in some way since a long time. Documents cited by Cassar mention the work of ‘*servitici*’ at the *Sacra Infermeria* during the time of the Knight Hospitallers and later on during the 19th century by lay nurses in all the hospitals in Malta.³ Reference is made to nurses’ expected behaviour both day and night so it may be assumed that nursing was a full time occupation. In 1964 nurses and hospital attendants in Malta worked on a 46.66 hour basis⁴ that was close to the 1966 nurses’ working week in the UK which lasted 44 hours.⁵ The second stage in the professionalisation of nursing is the formation of training schools. Training schools for nurses have existed in Malta at least since the early 20th century.⁶ Before 1964, efforts made to recruit educated personnel into nursing did not yield much response and the rate of attrition amongst those recruited was also high (Table 5.1).

Table 5.2 shows how the number of recruits increased after 1964. There is no evidence to show that the increase was associated with the new school for nurses that had been built by then. However, the new premises may be assumed to have made some contribution however small. The Sisters of Charity who were in charge of the school had followed specialised courses in nursing education in the UK.⁷ The system adopted by the school was very similar to that in the UK where student nurses were part of the workforce.

³ Paul Cassar, *The Holy Infirmary of the Knights of St. John*. 2nd edition (Malta: Mediterranean Conference Centre; 1994), 24.

⁴ Interview with David Attard.

⁵ Monica E. Baly, *Nursing and Social Change*. (London: Heinemann; 1979), 160.

⁶ Paul Cassar, *Medical History of Malta*, (London & Beccles: William Clowes & Sons Ltd; 1965), 404.

⁷ Alexander Bonnici, *Is-Sorijiet tal-Karità u l-Hidma Tagħhom f’Malta*. (Malta: PEG; 2002), 350.

Year	Number of Admissions	Number qualified
1948	24	
1949	26	
1950	16	
1951	10	10
1952	20	14
1953	13	8
1954	22	14
1955	16	7
1956	5	4
Sub Total	152	57

Table 5.1 - Qualification Rate of Registered Nurses 1948-1956 (Source: Farrer-Brown, Boldero & Oldham, 1957).⁸

The creation of a professional association is Moloney's third stage in professionalisation. A Professional Nurses' Association⁹ was set up but its membership was never satisfactory and its functions were limited.¹⁰ In its early existence membership may have been limited by the very small number of State Registered Nurses (SRN). Since it was named Professional Nurses Association it excluded other nurses by definition. There may have been an implication that this was classist in philosophy and its members may have been perceived as encouraging division amongst colleagues.

⁸ NAM/GMR/1999/1957 Leslie Farrer-Brown, Harold Boldero & James B. Oldham, Report of the Medical Services Commission, (Malta: Department of Information, 1957), 54: 195. Students who failed an exam could sit for it again with the next group, often in the following year.

⁹ Reference to its activities during the 1960s and 1970s is limited to one report of a visit by a representative of ICN: *The Times of Malta (TOM)* 28.4.1965, 2 and a letter from the Association's President in response to an editorial regarding doctors: *TOM* 24.9.1970, 12. During the 1980s it was represented in an international nursing conference in London where the members also met with the Minister of Health of the UK in 1987, *The Times* 1.9.1987, 20. The association also organised a Public Lecture on the Nursing Process in 1989; *The Times* 19.5.1989, 8. Members of its Committee attended the International Council of Nurses Congress in Seoul in 1989, *The Times* 30.5.1989, 17.

¹⁰ Interview with Edward Urpani.

Years	Entered			Resigned			Discharged			Transferred			Qualified			Qualified Rate/%
	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All	
1965-1969	19	175	194	5	61	66		8	8				14	106	120	61.80
1970-1974	13	280	293		69	69		6	6				13	205	218	76.45
1975-1979	86	384	470	10	106	116		1	1				76	277	353	75.10
1980-1984	175	250	425	43	57	100		6	6	2	4	6	130	183	313	74.00
1985-1987	71	134	205	27	42	69		2	2				44	90	134	65.36
Total Male	364			85						2			277			76.00
Total Female		1223			335			23			4			861		70.40
Grand Total			1587			420			23			6			1138	71.70

Table 5.2 - Qualification Rate of Registered Nurses from the School For Nurses 1965-1986

In the UK, nurse associations had been set up to represent fully trained nurses¹¹ in an effort to delineate borders according to training but this does not seem to have happened in Malta as the Association was already in existence when there was the sudden upgrade of Hospital Attendants (HA) to State Enrolled Nurses (SEN). The Professional Nurses' Association stopped functioning for 15 years and there was another attempt to reactivate it in 1985.¹² However, it does not seem to have been very active or published its activities too much.¹³ These activities seem to have consisted of meetings and lectures on nursing by invited guests. These meetings did not include discussion of working conditions so that many nurses may not have seen its worth. According to Thornley a similar situation had ensued in the UK during the 1920s and 1930s when some nurses refrained from becoming members of professional associations preferring instead to join a union that would militate for improved working conditions and assert professionalism in that way.¹⁴

Moloney asserted that some nurses: 'may simply be satisfied with remaining at a subprofession or occupation level.'¹⁵ Maltese nurses may have had these limited aspirations especially when their career prospects were bleak and their expected duration of service was short. Remaining at occupation level may have been attractive in that it divested nurses from the obligation to seek to upgrade knowledge, make autonomous decisions and be fully accountable for them and enter into controversy with peers and other members of the health care team, particularly doctors.

¹¹ Carole Thornley, Segmentation and Inequality in the Nursing Workforce in Rosemary Crompton, Duncan Gallie & Kate Purcell, (eds) *Changing Forms of Employment: Organisations, Skills and Gender*. (London: Routledge; 2002), 163.

¹² Anon, 'Nurses Association Reactivated.' *The Times*, 3.11.1986, 11.

¹³ In 1994, the Nurses Association is reported to have reacted to the news that nurses were to be given what was then considered to be an extended role in administering intravenous treatment. *The Times*, 13.1.1994, 20. A Letter to the Editor from the Secretary of the Nurses' Association appeared in 1995 regarding Nursing Issues. *The Times* 15.4.1995, 4. The Nurses' Association also commented on legal issues regarding intravenous treatment administered by nurses: *The Times*, 20.5.1995, 44.

¹⁴ Thornley, Segmentation and Inequality in the Nursing Workforce in Crompton, Gallie & Purcell, (eds) *Changing Forms of Employment*, 165.

¹⁵ Moloney, *Professionalisation of Nursing*, 139.

According to Moloney, the fourth stage in professionalisation is the enactment of state licence law. This was achieved in Malta in 1936 when the Government enacted the Medical and Kindred Professions Ordinance No VIII that led to setting up of the Register of Nurses.¹⁶ The last stage in professionalisation is the development and creation of a code of ethics. In Malta, this was achieved in 1996. Records of the launching of the code of ethics have not been found but an original copy in the author's possession is dated 1996. Prior to this date nurses had used the British Code of Ethics as a reference when necessary.

Demographic factors such as gender, age, nurses' length of experience describe the state of the profession and shed light on its potential to reach professionalisation while also eliciting aspects that advanced and hindered the process of professionalisation.

5.2 Gender Distribution

Nursing in Malta has traditionally been female dominated (Figure 3.4). This is similar to many countries across the world.¹⁷ Evidence has not been found to indicate that training schools for nurses in Malta ever barred men from training as was the case in early 20th century UK and USA.¹⁸ Chadd O'Lynn and Russell Tranbarger stated that this resulted in men having a low representation as registered nurses while UK and Canada discriminated against men being registered as nurses. In Malta, the register for nurses was set up for 'all persons who satisfy the conditions for registration as a general nurse.'¹⁹ This may have been because in 1936 there had already been a move towards having registered male nurses abroad.

¹⁶ Medical and Kindred Professions Ordinance, MGG Supplement B 1936, 145.

¹⁷ Michael J. Villeneuve, Recruiting and Retaining Men in Nursing: A Review of the Literature. *Journal of Professional Nursing*, 1994 (10) 4:219.

¹⁸ Chad E. O'Lynn & Russell E. Tranbarger, *Men in Nursing: History, Challenges & Opportunities*, (New York: Springer Publishing Company; 2007), 25.

¹⁹ MGG Supplement 1936 ACT VIII of 1936. Medical and Kindred Professions Ordinance, 2.

Statistics for Malta show that although still a minority, men had a greater representation in nursing than in other countries (Figure 5.1).²⁰ However, there was discrimination on recruitment as calls for entrance into the school of nursing between 1960 and 1980 were either exclusively

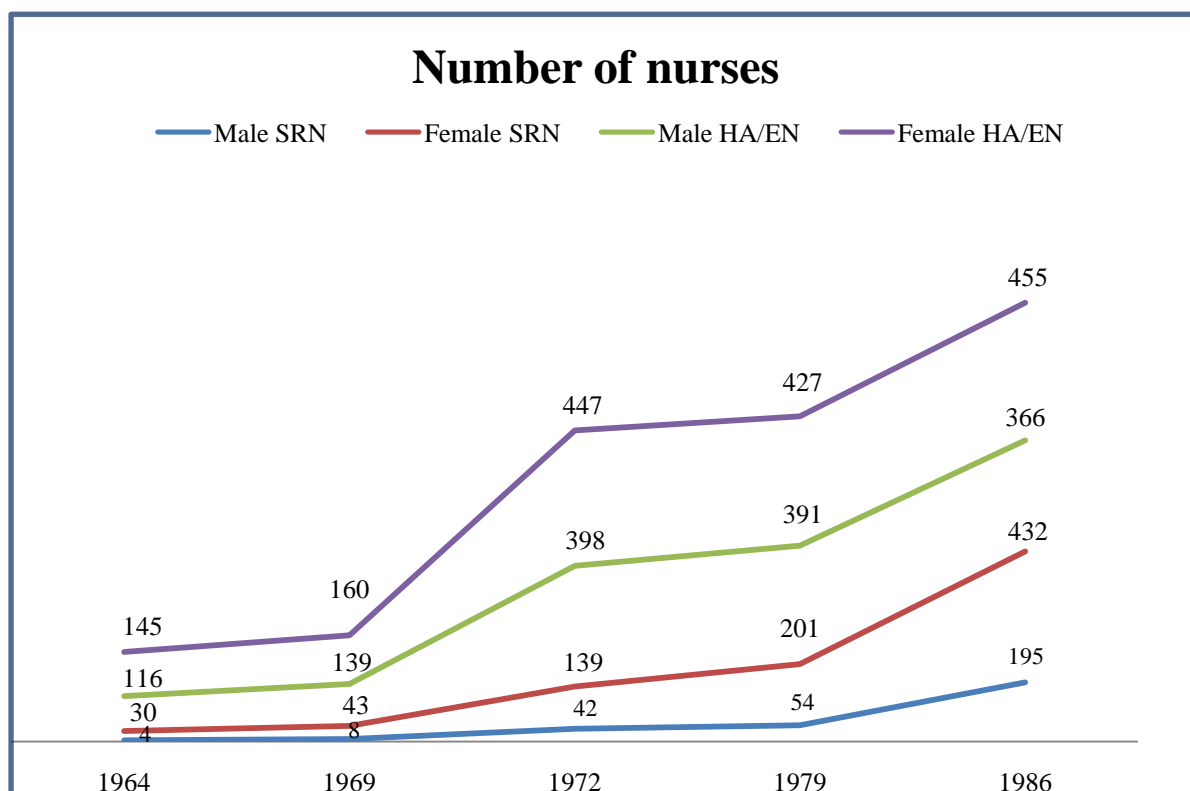


Figure 5.1 - The increase in numbers of nurses with time. (Source: Staff Lists 1964, 1969, 1972, 1979, 1986.²¹)

for women²² or were to include a small number (around 20%) of men.²³ The same calls for application for entrance into nursing had concurrent positive and negative discrimination

²⁰ Maria Fenech Adami, *An Exploratory Study of the Adequacy of the Nurse Education System in Malta*. (Unpublished doctoral thesis for University of Aberdeen, 2001), 11.

²¹ NAM/GMR/2675/1964, Staff List NAM/GMR/3099/1969; National Library; Staff List 1972, Staff List 1979, Malta National Library Staff List 1986

²² MGG: 11,606 31.1.64, 244; 11,918 15.7.1966, 2109; 12,200 6.12.68, 3390; 12,524 16.4.71, 1126; 12,698 27.6.1972, 1880; 12,906 15.1.1974, 159; 13,605 24.4.1979, 1225; 13,704 22.2.1980, 430.

²³ MGG: 11,649 29.5.64, 2049; 12,441 7.8.1970, 2154; 12,484 11.12.1970, 3370; 13,188 17.2.1976, 582.

towards recruiting women. While the number of vacancies available for women was larger in each call, women had to resign their post upon marriage²⁴ and were granted a lower allowance and eventual pay.²⁵ There is no indication that Maltese nurses ever commented against discrimination of any form. One reason for this may have been that the law actually stated that ‘The training school shall be open to female candidates’ and ‘The Chief Government Medical Officer may, occasionally admit male candidates to the training school.’²⁶ Although statistics have not yet been found regarding numbers of applicants by gender, applications from men were likely to be few²⁷ so the discrimination against their recruitment may not have been felt. Women may have accepted the mandatory marriage bar as a social requirement for fulfilling their traditional roles of family makers. The expected short length of time in nursing may have acted as a barrier to professionalisation of nursing since a lifetime commitment to a career is considered to be contributory to the process of professionalisation.²⁸ Although many more women qualified as SRNs, their resignation upon marriage allowed for a net increase in the number of male nurses.

The predominance of females in the profession may have meant that it was perceived as subordinate to male dominated professions such as those of physicians and administrators in the health department.²⁹ The nuns managing the wards and hospitals commanded power but were still subordinate to the consultants and would for example serve them tea after the ward round.³⁰ The strict segregation of male and female patients in different wards demanded that

²⁴ Until 1980 MGG editions in which calls for applications for training and calls for applications for the post of Nursing Sisters and Male SRNs included a clause stating that female applicants were to resign upon marriage.

²⁵ According to records, remuneration for women in employment during the 1960s was 25% less than those of men: MGG 11,969 20.12.1966, 11. It was gradually increased to reach the 100% of men’s wages on the 1st April 1971: MGG 12,489 29.12.70, 5. The same applied for students’ remuneration.

²⁶ MGG Supplement B 1971, Legal Notice 86 of 1971. Medical and Kindred Professions Ordinance (Cap 51) Training School for Registered (General) Nurses Regulations, 1971, 337

²⁷ Villeneuve, Recruiting and Retaining Men in Nursing, 217 stated that nursing continued to be given little consideration by men as a career choice even till 1994.

²⁸ Moloney, *Professionalisation of Nursing*, 26.

²⁹ O’Lynn & Tranbarger, *Men in Nursing*, 26.

³⁰ Interview with Keith Holmes.

all personnel in women's wards were women, while male patients were attended by men as much as possible. This was similar to the general perception in health care abroad.³¹ When the nuns stopped being ward managers, male Nursing Officers (NO) were deployed to men's wards and since there were few male SRNs their career progress was faster than that of females.³² However, on the men's side once a post had been filled there was little chance of its becoming vacant soon since men could only move out of the service upon retirement, resignation or death. The mechanism used for granting promotions is not known but years of experience may have been a contributing factor in determining who would be promoted, since there was hardly any opportunity for further education in nursing. Men who were promoted could go on to apply to become Senior Nursing Officers (SNO) or Principal Nursing Officer (PNO) equivalent to the post of matron.³³ The likelihood of promotion was further enhanced if the nurse had followed courses abroad that were offered from time to time to selected candidates. Only a few courses were on offer, usually on a scholarship basis abroad. The choice of nurses to follow such courses is unknown but many of them were males as attested by one interviewee who said that in 1966, he and another male nurse were sent to England on a management course and were joined by another male nurse who studied Theatre Nursing.³⁴ The Staff List of 1968 lists only 8 male SRNs so the three men could have made up at least 37%. Reasons for this are unknown but they may be related to the willingness of individuals to pursue knowledge, their ability and their social commitments in Malta. If the number of years of experience was a factor considered essential during the choice process then female applicants for these scholarships would once more have been at a disadvantage and future

³¹ Jane Greenlaw, *Delivery Rooms: For Women Only*. *Law, Medicine and Health Care*, 1982 (9) 6:28.

³² The Staff List of 1977 is the first to show men holding the position of SNO. Out of ten men in a list of seventeen, there were six who had been appointed as nurses during the 1960s while the women who were not nuns had been in service since the 1950s. There was a similar situation within the NO grade where men holding the post had around ten years of service less than women.

³³ National Library of Malta, Staff List 1977. The post of PNO at St. Luke's Hospital was kept by a nun until 1981 when it was taken by a female nurse. At Mount Carmel Hospital, it was given to two men who had previously been Chief Male Nurse Ward master and Assistant Chief Male Nurse even though they had not been trained as nurses.

³⁴ Interview with David Attard.

promotions would be more likely taken up by men. By 1984, four out of 11 nurses in the PNO grade and ten out of 17 in the SNO grade were men when the number of male SRNs was 106. This indicates that by 1984 male nurses were highly represented in the higher grades of nursing administration; in proportions that were not close to their respective numbers. There is little evidence to show that there was any discrimination in promotions but studies abroad indicate that men take much less time than women to reach nursing officer grade.³⁵ Explanations given include expectations of men in that they have a more positive sense of their ability to succeed as nurses when compared to women.³⁶ In 1995, Orla Muldoon and Jacqueline Reilly found that numbers of men holding leadership positions in nursing in the US represented a greater proportion than women, while in the UK men held 50% of leadership positions although they numbered 10% of the total population of nurses.

In 1967, a call for application for Assistant Matron was issued in the Malta Government Gazette that seems to have been purposely designed for a small group of nurses as applicants were to have a certificate in nursing administration of the RCN and National Council of Nurses of the UK.³⁷ The call did not specify that the successful applicant was to resign upon marriage indicating that the post was expected to be filled by a man or a nun. At a time when men were at the helm of all other secular institutions it might have been expected that men would also manage nursing except that in Malta there were nuns. In fact the post was given to Sr. Bernadette Fava who was later to become the first Maltese matron.³⁸

At Mount Carmel Hospital the Chief Male Nurse³⁹ and Assistant Chief Male Nurse⁴⁰ were appointed from among HAs who had been the only kind of workers attending to patients since

³⁵ Celia Davies & Jane Rosser, *Processes of Discrimination: A Report on a Study of Women Working in the NHS*. (London: DHSS; 1986), 78.

³⁶ Orla Muldoon & Jacqueline Reilly, *Career Choice in Nursing Students: Gendered Constructs as Psychological Barriers*, *Journal of Advanced Nursing* 2003 (43)1:95.

³⁷ MGG 11,976 3.10.67, 106.

³⁸ Staff List 1968, 121 indicates Sr Bernardette Fava as Assistant Matron without mentioning the post of matron, Staff List 1973, 157 shows Sr. Bernardette Fava as Principal Nursing Officer.

³⁹ MGG 11,603 21.1.64, 149.

⁴⁰ MGG 11,795 6.8.65, 2383.

there were no male SRNs until 1967. Therefore there could be little added knowledge introduced especially when considering that HAs for this hospital were mainly well built persons who were employed for their physical ability to control unruly behaviour and/or lift older people.⁴¹ This may have been in heeding Nightingale's reported opinion that men's only place in nursing was where there was the need for physical strength.⁴² The gradual increase in the number of male SRNs (Figure 3.4) resulted from accumulation over time, the granting of registration to nurses by a 'grandfather clause' in 1972 and the removal of discrimination at entrance into nursing courses.

According to Ghadirian and colleagues the nursing profession's predominance of women is actually a barrier to professionalisation mainly because women tend to take part time work and have a high work load.⁴³ According to Carole Thornley, part time work is associated with less opportunity for skills acquisition that would contribute to professionalism.⁴⁴ Part time work in nursing in Malta was only introduced in 1988 when nurses could be employed on a 'casual' basis.⁴⁵ Professionalisation was still hindered by the fact that many female nurses worked for a short period of time that may not have been enough for them to become experts⁴⁶ irrespective of their level of education. The small number of male SRNs led to the male wards being generally manned by the less qualified SENs and resulting in a divide in knowledge even if they were more experienced. Whether it is because of their small numbers or for other reasons there is little evidence to show that male SRNs sought professionalisation in as far as collective efforts are concerned such as in the setting up of a Nurses Association. The small numbers of qualified SRNs compared to the much larger numbers of SENs many of

⁴¹ Interview with Konrad Cauchi.

⁴² Philip A. Kalisch and Beatrice J. Kalisch, *American Nursing: A History*. 4th edition (Philadelphia: Lippincott, Williams & Wilkins; 2004), 166.

⁴³ Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 1.

⁴⁴ Thornley, *Segmentation and Inequality in the Nursing Workforce* in Crompton, Gallie & Purcell, (eds) *Changing Forms of Employment*, (London: Routledge; 2002), 161.

⁴⁵ MGG 15,045 1.11.1988, 4503.

⁴⁶ Patricia Benner, Christine Tanner & Catherine Chesla, *Expertise in Nursing Practice* (New York: Springer Publishing Company, 2009), 172.

whom had been Hospital Attendants (Figure 5.2) may have been one reason for incapacitating any efforts towards professionalisation. It may have been difficult for the few SRNs to lead and supervise the much greater number of SENs.

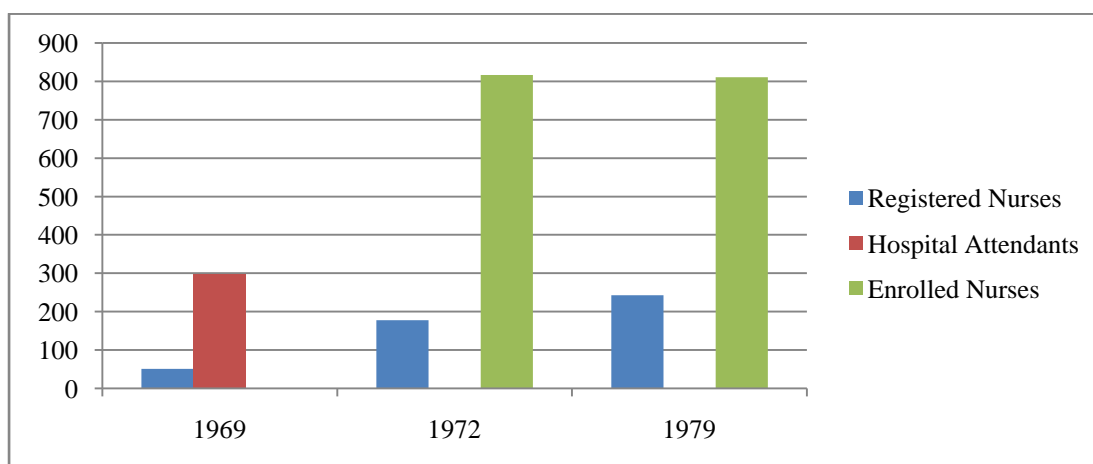


Figure 5.2 - Number of nurses in the different grades. (Source: Staff Lists 1969, 1972, 1979)⁴⁷

5.3 Age Distribution

The average age of nursing personnel in Malta according to gender has generally been higher for men than women in all grades as can be seen in Figure 5.3.

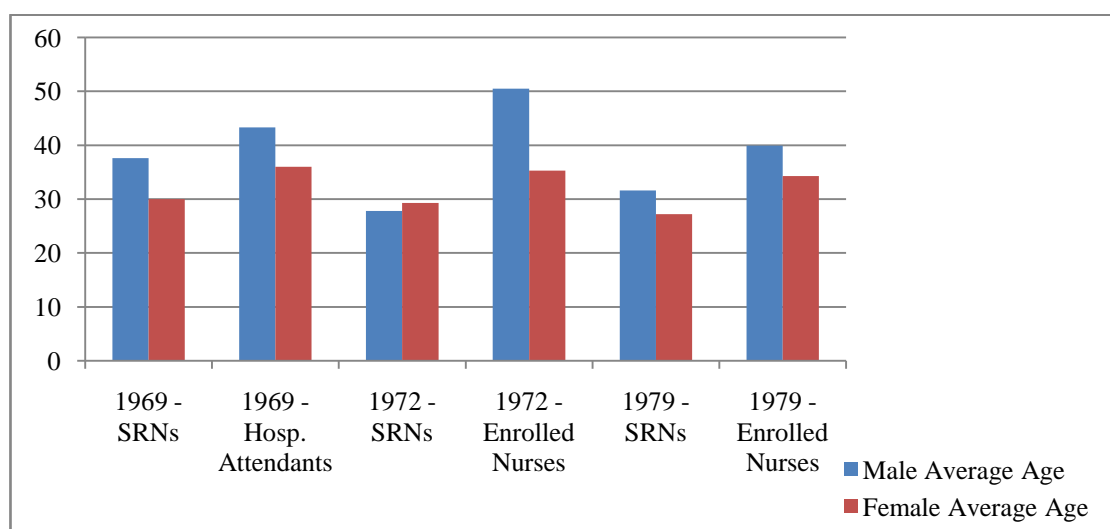


Figure 5.3 - Average age of nurses. (Source: Staff Lists 1969, 1972, 1979.)⁴⁸

⁴⁷ NAM/GMR/3099/1969; National Library; Staff List 1972, Staff List 1979.

However, a note must be made regarding average age. Since there were only eight male SRNs in 1969 and they were aged between 28 and 49, their calculated average age was 37.6 years.

By 1972 the number of male SRNs had reached 42 of whom 39 were in their twenties resulting in a lower average than that of females. In 1973 there was an influx of 30 male SRNs who had been registered by virtue of the grandfather clause in the law as previously explained and who were aged between 47 and 60 years thus raising the average age of male SRNs. There were only eleven female nurses benefitting from the same clause at this time who did not affect the average age for females very much since they had joined around 200 others whose average age was closer to the 20s. Michael Gilbraith stated that on average male nurses are older than female nurses as they enter nursing later often as a second career.⁴⁹ This may not have been true for the Maltese. In the Staff List for 1972, the dates of first appointment of many male SRNs indicate that they were in their early twenties and so had entered nursing at school leaving age.⁵⁰ The average age of male SENs was higher than that of SRNs throughout, reaching 50 in 1972 but remaining close to 40 throughout. Female SENs were also older than their SRN counterparts. There was a situation where the fewer younger qualified nurses were in a supervisory role above the more numerous older less qualified nurses and this could have had repercussions on the professionalisation of nursing as such supervision may have been difficult considering that the older nurses had more years of experience in hospitals even if not necessarily backed by much knowledge.

⁴⁸ NAM/GMR/3099/1969; National Library; Staff List 1972, Staff List 1979.

⁴⁹ Michael Gilbraith, Attracting Men to Nursing: What Will they Find Important in their Career? *Journal of Nursing Education*, 1991 (30) 4:184.

⁵⁰ Staff List 1971, 163.

5.4 Years of Experience

The average in years of experience is another factor to be considered in the analysis of the state of the profession of nursing in Malta between 1964 and 1996. It is often assumed that years of experience translate into expertise.⁵¹ However, the relationship between the two can be much more complicated than this. In the context under discussion, experience refers to number of years of service rather than the enriching circumstance resulting from reflection over encountered situations and refining decision making.⁵² Ghadirian's concept analysis refers to experience as 'being directly related to the nursing professionalisation and professional attitude'.⁵³ However, according to Moloney without a scientific knowledge base, professional responsibilities cannot be undertaken effectively and the heavy reliance on intuition hinders professionalisation and the acceptance of nursing as a profession by other professional groups.⁵⁴ Moloney contended that experience has been the source of nursing's knowledge base for a long time so it may be surmised that this fact may have contributed to the perception that nursing can be carried out by anyone. However, the need for knowledge as a basis for making decisions and professional accountability⁵⁵ arises in the quest for professionalisation rather than carrying out orders without questions. An interviewee for this study described this as happening in the 1960s in hospital wards in Malta where the nun would give orders for procedures to be done and then supervise that they were being done as ordered,⁵⁶ probably upon the instructions of the physician or surgeon.⁵⁷ This may have been

⁵¹ Benner, Tanner & Chesla, *Expertise in Nursing Practice*, 172. Although years of experience allow nurses to develop specialist skills, sufficient and special experiences together with expertise contribute greatly towards becoming a professional expert.

⁵² Barbara Simmons, Dorothy Lanuza, Marsha Fonteyn, Frank Hicks & Karyn Holm, Clinical Reasoning in Experienced Nurses. *Western Journal of Nursing Research* 2003 25: 703.

⁵³ Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 1.

⁵⁴ Moloney, *Professionalisation of Nursing*, 29.

⁵⁵ Angela Hall, Defining Nursing Knowledge. *Nursing Times*, 2004 (101) 48: 34-37

⁵⁶ Interview with Quentin Borg.

⁵⁷ Since many of the nuns were not yet qualified at the time, they may have had to rely on the physician to prescribe care.

common to other countries at the time, as acknowledged by Angela Hall.⁵⁸ The fact that much of the knowledge of nursing is ‘embedded’ in practice makes experience and skills gained through practice and repeated actions necessary to gain skills and move towards expertise.⁵⁹ The experienced nurse may be perceived as being more efficient and therefore ‘good’ even if close inspection of his/her work uncovers ‘mistakes’ that may be due to a lack of knowledge and potentially dangerous, such as not maintaining an aseptic technique during intravenous procedures. Competency levels and expertise levels do not necessarily coexist⁶⁰ and although competency may be gained through experience, expertise that may lead to being accepted as a professional may not be achieved even after long years of experience.

Figure 5.4 shows the average years of experience in the different categories with time. The discrepancies between the years of experience of SENs and those of SRNs are evident as well as the differences between the years of experience of men and women in all categories. The general picture of nursing as a body was therefore one where SENs, many of whom were not trained, had more experience than SRNs and the men had more experience than women (although they were fewer in number). However, in 1972 there was an influx of newly qualified male SRNs that skewed their average years of experience to below that of their female counterparts for that year. Male nurses stayed in service for longer than females since the marriage bar only affected the latter who being more numerous, lowered the average age by their entrance in greater numbers than exits. Calls for applications issued in 1980 and afterwards did not include the clause indicating the requisite of resignation upon marriage.⁶¹ Between 1982 and 1988 applicants for entrance into nursing were informed they had to enter

⁵⁸ Hall, *Defining Nursing Knowledge*, 3.

⁵⁹ Benner, Tanner & Chesla, *Expertise in Nursing Practice*, 150.

⁶⁰ Kathleen Bobay, Does Experience Really Matter? *Nursing Science Quarterly*, 2004 (20) 17: 314.

⁶¹ The last call for applications having this clause was that of the 28.10.1980: MGG 13,779, 2553.

into a hypothecation agreement to serve the government for three years upon completion of studies⁶² and this may have affected years of service of female nurses.

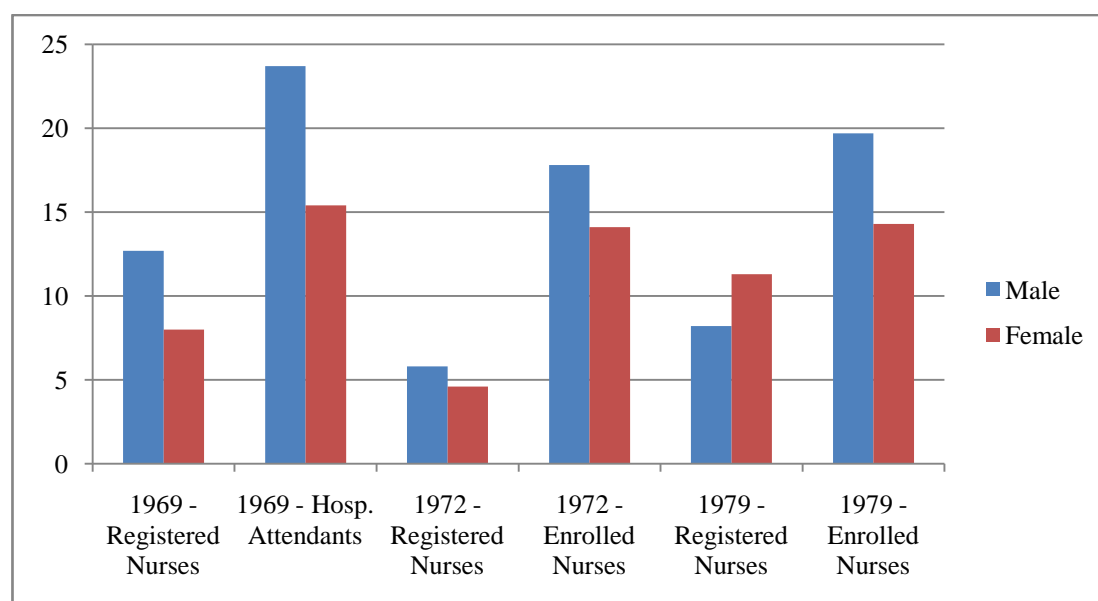


Figure 5.4 - Average number of years of experience according to grade. (Source: Staff Lists 1969, 1972, 1979.)⁶³

As already explained, years of experience may have been a criterion for career progression possibly resulting in nurse managers who were not all necessarily competent and qualified for their posts, not only in terms of scientific nursing knowledge but also in dealing and coping with conflicts, effective management styles and communication. In male wards, teams may have been more stable than in female wards where turnover of staff was greater due to the marriage bar. Many female SRNs could not further their studies as they were largely betrothed and expected to resign upon marriage. No evidence has been found to indicate that there was any opportunity for in-service post qualification courses of any kind during the period under study although a Minister of Health had announced plans for refresher courses in 1974.⁶⁴

⁶² The first call for applications to have such a clause was in the MGG 14,030 31.8.82, 2300.

⁶³ NAM/GMR/3099/1969; National Library; Staff List 1972, Staff List 1979.

⁶⁴ TOM 29.3.1974, 9.

The picture of nurses with long years of experience but little knowledge on which to base decisions may have hindered the attribution of autonomy and power to nurses by the authorities. The nuns continued to provide continuous supervision while the nurses accepted this supervision and were not evidently averse to being subordinate to the nuns and other professions while society did not offer much comment.⁶⁵ The nuns may not have been aware of their responsibility to encourage and foster leadership skills perhaps not realising that their successors were amongst their subordinates rather than in the members of the congregation as had previously happened. Subsequently they may have disabled the emergence of an opportunity structure for SRNs and may have even hindered leadership potential by inhibiting shared governance. Lee Galuska stated that shared governance promotes leadership development when nurses are engaged in it.⁶⁶ Moreover Galuska contended that the development of leadership skills may be significantly affected by key relationships in work lives. Carr and Clarke went as far as stating that the manager actually creates conditions for learning.⁶⁷ This implies that if the nuns did not achieve this then their successors could only learn what they had experienced including total control and supervision perpetuating this leadership style. Currie and colleagues referred to managers as being ‘gatekeepers’ who could seriously affect the success or otherwise of new practitioners in fulfilling leadership roles.⁶⁸ The resultant vacuum of leadership skills may have contributed to the late development of the profession of nursing in Malta alongside a lack of continuing education.

⁶⁵ Letters to the Editor in *The Times of Malta* between 1960 and 1996 included many compliments for the dedication of nurses at the various hospitals in Malta and some comments on uniforms and hours of work. The Editorial of 12.4.1975 regarded the community service. There was an absence of comment on nursing as a profession.

⁶⁶ Lee A. Galuska, Cultivating Nursing Leadership for our Envisioned Future. *Advances in Nursing Science*, (35) 44:338.

⁶⁷ Susan M. Carr & Charlotte L. Clarke, The Manager’s Role in Mobilising and Nurturing Development: Entrenched and Engaged Approaches to Nursing. *Journal of Nursing Management*, 2010 (18) 443.

⁶⁸ Kay Currie, Debbie Tolson & Jo Booth, Helping or Hindering the Role of Nurse Managers in the Transfer of Practice Development Learning, *Journal of Nursing Management*, 2007 (15) 6:587.

5.5 Educational factors

The long standing discrepancies between the number of SRNs and the number of SENs (Table 5.3) brought about a discrepancy in the standards of knowledge and practice. It also perpetuated the public's perception that nurses were not knowledgeable enough, and the lack of validation of this knowledge by other professional groups. According to Moloney such acknowledgements greatly influence the professionalisation process.⁶⁹

Year	Male SRNs	Female SRNs*	Male Hospital attendants	Female Hospital attendants	Male SSEN	Female SSEN	Male EN	Female EN	Male NO	Female NO*
1964	4	30	145	116						
1965	4	28	142	109						
1967	4	32	150	163						
1968	8	29	149	160						
1969	8	43	139	160						
1970	11	65	137	153						
1972	42	139			126	139	272	308		18
1973	76	162			117	141	263	331		18
1977	74	210					427	480	29	58
1979	54	201					391	427	24	37
1984	106	324					355	388	23	37
1985	193	429			118	50	258	423		
1986	195	432					366	455		

Table 5.3 - Number of nurses according to grade (Source: Staff Lists)⁷⁰

In 1964 the course leading to registration was presumably following the curriculum prescribed by the General Nursing Council for England and Wales and was satisfactory to the same council since recognition of registration that had been granted to Maltese nurses in 1951 remained mutual for both countries even after Malta gained Independence. The need for nurses to have a sound knowledge base seems to have been accepted and efforts to respond to this need and achieve such a knowledge base seem to have been sustained if not augmented

⁶⁹ Moloney, *Professionalisation of Nursing*, 24.

⁷⁰ NAM/GMR/3099/1969; National Library; Staff List 1972, Staff List 1979.

along the years. Courses were being organised erratically for trainee HAs who formed a large part of the nursing workforce.⁷¹ In 1969 a Training School for Enrolled Nurses was opened to offer courses leading to Enrolment.⁷²

According to Margaret Allen, Melody Allison and Sheryl Stevens the history of nurse education is closely associated with nursing's endeavour to reach professionalisation.⁷³ In its 1965 position paper the American Nurses Association stated that professional nursing could only be achieved through a baccalaureate degree.⁷⁴ In this international context professionalisation in Malta could not be achieved before the organisation of baccalaureate programs in 1988. The previous method of nurse education had consisted of an apprenticeship style education whereby student nurses learnt through the experience of long hours of practical nursing coupled with some instruction on the principles of nursing. This was very similar to the system adopted in the UK in the earlier part of the 20th century.⁷⁵

Advances in medical technology brought about an increased awareness of the need for nurses to be able to work in highly technical areas and in complex clinical situations. Maltese nurses had to learn new skills due to the gradual importation of technology in Malta.⁷⁶ Specialised certification and a degree programme were quoted by Ghadirian and colleagues as being factors affecting professionalisation. Interviewees for this study included the first nurse to train in renal nursing in the UK, a nurse who trained in endoscopy nursing, one who had been

⁷¹ Farrer-Brown, Boldero & Oldham, Report of the Medical Services Commission, 52:188.

⁷² MGG Supplement B Legal Notice 63 of 1969 Approved Training School for Enrolled Nurses Regulation, 298.

⁷³ Margaret Allen, Melody M. Allison & Sheryl Stevens, Mapping the Literature of Nursing Education, *Journal of the Medical Library Association* 2006 (94), 122.

⁷⁴ American Nurses Association, First Position on Education for Nurses. *American Journal of Nursing* 1965 (120) 107.

⁷⁵ Martha Scheckel, 'Nursing Education: Past, Present and Future.' In: Gayle M. Roux & Judith A. Halstead. (eds). *Issues and Trends in Nursing: Essential Knowledge for Today and Tomorrow* (Sudbury, MA: Jones and Bartlett Publishers, 2009), 33.

⁷⁶ The Annual Report on the Conditions and Works of the Medical and Health Department for the years 1971, 1972, 1974, 1976, 1978, 1981 and 1983 all include the opening of specialised units or modernisation thereof such as ITU, CCU, A&E Department, Radiography, Operating Theatres, Angiography, Cardiac surgery, Laser treatment in Ophthalmology, Burns Unit, and Renal Transplant.⁷⁶

sent on a scholarship regarding administration, a nurse who visited isolation hospitals and a nurse who had been sent to the UK to observe new approaches to geriatric nursing.⁷⁷ This is an indication of the kind of courses nurses followed.

Some SRNs benefitted from scholarships to attend courses in specialised areas such as critical care, coronary care, endoscopy and management. Having been the more senior and therefore eligible for promotion many of these SRNs were male. They were also the most experienced and therefore more easily chosen to travel to other countries for specialised instruction. Their home arrangements may have facilitated this since they did not have as many care commitments towards parents, siblings or children as these were left to the women. Female SRNs who were in service for long enough did eventually benefit from courses in various fields.⁷⁸ However, the new knowledge, nursing skills and management skills acquired by individual nurses could hardly have affected nursing as a body. There is little evidence that this acquired knowledge was officially communicated to the other staff and students working in the specialised units that were eventually opened. There was therefore a possibility that learned skills that had to be performed in order to utilise the imported technology were learnt vicariously and in an informal way leading to lack of standardisation and the associated risks such practices produce.

The aspiration of achieving excellence and professionalism may have driven some nurses to seek further education that they could then use in their clinical practice and instruction of colleagues and students.⁷⁹ One interviewee for this study described the situation in the 1980s saying:

Iwanted to keep on advancing....I'm not ambitious at all but clinically, ehe, I always wanted to know what I am doing, why I am doing it and if I could do it better. At that

⁷⁷ Interviews with Eliza Camilleri, Keith Holmes, David Attard, Olivia Gatt and Denise Galea.

⁷⁸ Interview with Nathalie Caruana, Eliza Camilleri, Olivia Gatt & Denise Galea.

⁷⁹ Education and educational readiness have a significant relationship with professionalisation: Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 4.

time, we were limited in Malta, I mean there was nothing as far as post grad training, post qualification training goes... You finished the course successfully, you were sent there, now if you were a passive person you just did your day, collected the wage at the end of the month and that was all. If you were a person who wanted to learn it was very tough because there was nothing, nothing, nothing. Not even a library....The problem was bigger because you couldn't say: "Alright let me go on the Internet or the library to get some material," as we do today. We didn't have access to a library, understand? So it was very hard in the beginning. Emm, we were given very little training.⁸⁰

This quote portrays the situation of the average nurse in a ward who could only rely on that which s/he was shown in the ward if s/he was to learn anything new after qualifying as an SRN or SEN. The fact that NOs were greatly promoted by virtue of years of experience led to a state of stagnation. None of the nursing personnel brought in new knowledge in any aspect of nursing within a particular ward, a fact that was perhaps even more accentuated in male wards where the staff turnover rate was lower than on the female wards. Evidence has not been found regarding any comment about this state of stagnation from any one. One interviewee stated that there was a medical consultant who had encouraged her and worked towards her being sent for training in the use of renal machines as these had been obtained before anyone could use them.⁸¹ A consultant had also written to the editor of a newspaper regarding the need for nurses to be trained overseas before the Renal Unit could be set up in Malta.⁸² The availability of scholarships in particular areas was probably the result of consultants asking for nurses to be adequately prepared to use the new imported technology.⁸³ Discussion in Parliament regarding expenses on equipment included the factor of needing specialised health professionals to operate such equipment.⁸⁴ In 1974, the Minister of Health had also announced that nurses would be sent abroad for courses in Intensive Care, Coronary

⁸⁰ Interview with Keith Holmes.

⁸¹ Interview with Eliza Camilleri.

⁸² *TOM* 19.12.1972, 12.

⁸³ There seems to be a tradition for nurses to be trained after medical consultants declare that there is such a need. The earliest nurse training courses in Malta apparently followed a letter to the Comptroller of Charitable Institutions complaining that nurses were not qualified enough to assist physicians adequately: Paul Cassar, *Medical History of Malta*, 402.

⁸⁴ *TOM* 1.6.1972, 20

Care and medico-social care.⁸⁵ By 1975 this had materialised when nurses were selected for training in Intensive Therapy at St. Mary's Hospital in London.⁸⁶ Evidence has not been found regarding how many nurses were sent for training abroad before the opening of the Intensive Therapy Unit (ITU) or what this training consisted of. According to Ghadirian and colleagues specialised certification, a degree in nursing and the length of the course all contribute to professionalisation.⁸⁷

There seemed to have been an *ad hoc* reaction to the needs of the service in response to the technology necessary to keep up with technological developments abroad. During 1978, an agreement was reached with the government of the Czech Republic that would offer specialisation for nurses in Malta.⁸⁸ When the service was in the midst of a strike by medical doctors that was to last for ten years, it was even reported that nurses were urged to continue studying to become doctors⁸⁹ but no other reference was found regarding this suggestion. An agreement with the Czech government had also been announced whereby a school for specialised courses for nurses would be set up in Malta⁹⁰ which never materialized. Records of post qualification courses have not been found but a 1989 report in the *Times of Malta* reported the opening of the seventh First Line Management course for nurses in management roles. The lack of organised continuous education for nurses may have been a strong element in the slow pace with which nursing in Malta moved towards professionalisation. This pace seems to have been accelerated by the introduction of the BSc in Nursing degree programme that was first mentioned by the Parliamentary Secretary for the Care of the Elderly in 1987.⁹¹ It was then launched in 1988⁹² and continued to be offered annually since then. A move to

⁸⁵ TOM 29.3.1974

⁸⁶ TOM 7.5.1975

⁸⁷ Ghadirian, Salsali & Cheraghi, Nursing Professionalism, 1.

⁸⁸ Anon, Czech-Maltese Health Care Agreements Signed, *The Times* 23.11.1978, 2.

⁸⁹ Anon. University Budget Carried *The Times* 20.11.1986, 24.

⁹⁰ TOM 23.11.1978, 2.

⁹¹ STOM 29.11.1987, 52.

⁹² TOM 25.2.1889, 11.

place all levels of nursing education at the University of Malta followed and the SRN course was replaced by a Diploma in Nursing while the SEN course was substituted by a Certificate in Nursing Practice and eventually terminated. These efforts were intended to raise the profile of nursing in Malta.

5.6 The image of Nursing

The Commission led by Farrer-Brown in 1957 noted that:

In the estimation of the general public, nursing does not rank high..... Parents whose daughters wish to go out to work are still averse to their taking up nursing... Women suitable for nursing are showing a preference for other occupations. Teaching and the civil service are said to be particularly popular – as being less arduous and better rewarded and generally more attractive.⁹³

This opinion of nursing does not seem to have changed much by 1992 when a study on school leavers showed that nursing was still not amongst Maltese young people's first career choices.⁹⁴ This was a common perception in many countries and Geeta Somjee attributed it to the association people make between nursing and assisting patients with their toilet needs.⁹⁵ Many factors may have contributed to such a perception that did not appear to have changed much over time even though nursing itself saw many changes as discussed in this work. The profile of nursing emerges from how the nurse is perceived in appearance at the work place, employment status, organisation and the position of the nurse as a practitioner. Expectations of standards of care and knowledge also affect nurses' profile.⁹⁶ The nurses' employment status as care workers may have further compromised their image as professionals since they were continuously viewed as being ancillary to medicine. The lack of knowledge base or lack

⁹³ NAM/GMR/1999/1957 Farrer-Brown, Boldero & Oldham; *Report of the Medical Services Commission*, 54:196.

⁹⁴ Alfred Briffa, School Leavers and Occupational Choice: Is Nursing an Appealing Career? (Unpublished Bachelor's dissertation, University of Malta, 1992), 87.

⁹⁵ According to Geeta Somjee: 'The term nurse evokes different reactions in different cultures, despite the fact that they all probably begin with the image of someone who handles socially less desirable things such as the bedpans': Geeta Somjee, *Social Change in the Nursing Profession in India* in Pat Holden & Jenny Littlewood (eds) *Anthropology and Nursing*, (New York: Routledge; 2016), 31.

⁹⁶ Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 1.

of reference to knowledge emphasises the view that nursing is not autonomous and relies on other professions to deliver care.⁹⁷ The use of uniforms provided a lack of distinction between nurses so that one individual represented all nurses irrespective of differences in personalities, knowledge and skills. Appearance has been linked to perceptions of professionalism and a study conducted in Canada regarding physiotherapists' attire showed that a lab coat was perceived as being the most professional by patients aged more than 36 years.⁹⁸ With regards to nurses, adults in 2008 ranked white uniforms as being more professional.⁹⁹ Studies on the necessity for nurses to be in uniform have not been found indicating nurses are expected to be in uniform. The uniforms of Maltese nurses between 1960 and 1990 have already been described as consisting of a white dress for women and white overcoat for men. Women used belts and buckles to distinguish between SENs who wore a green belt with a simple buckle and SRNs who had a navy blue belt and a silver buckle that was specific to the grade and had a Maltese Cross in its design (Figure 5.5)

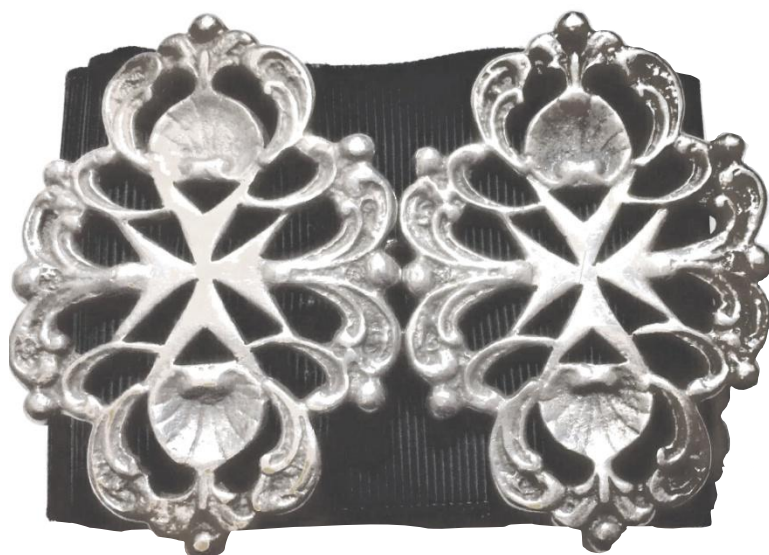


Figure 5.5 – Maltese S.R.N. buckle (Author's own collection.)

⁹⁷ Moloney, *Professionalisation of Nursing*, 24.

⁹⁸ Erin Mercer, Marilyn MacKay-Lyons, Nicki Conway, Jennifer Flynn, Chris Mercer, Perceptions of Outpatients Regarding the Attire of Physiotherapists. *Physiotherapy Canada*, 2008 (60) 4:351.

⁹⁹ Nancy M. Albert, Lucia Wocial, Kathryn H. Meyer, Jie Na & Kathleen Trochelman, Impact of Nurses' Uniform on Patient and Family Perceptions of Nurse Professionalism. *Applied Nursing Research*, 2008 (21) 4:187.

Female SRNs also had a navy blue cape for when they needed to go out of the wards. Men were supposed to use epaulettes to distinguish them from doctors and other categories of male hospital personnel but these were rarely used. The starched white cap on the female nurses' heads remained the same for a long time even after there was a change in women's attire around 1989 that involved a change in the colour of the dress to regent blue. Records have not been found regarding this fact but photographs of events happening in 1990 exist where SRNs are seen in a regent blue dress, navy blue belt and buckle while SENs wore ivy vine green attire. The same colours were used for tunics issued to men worn with grey trousers. NOs kept their attire throughout, the men wearing white overcoats and the women having a dark blue dress but keeping the starched cap and the SRN buckle. The issue of uniforms seems to have been taken for granted and there was little if any comment on these decisions.

The origins of the Maltese nurses' uniforms has not yet been investigated but it may have been introduced during the British Rule or by the nuns. In 1904, Joseph S. Galizia recommended the type of material a nurse should choose for his/her clothes, the length of women's skirts and the colour.¹⁰⁰ The same doctor recommended that women wear some form of a cap to cover their hair so that it would not become dirty as it was difficult to wash frequently.¹⁰¹ In this he suggested that they copied nurses from abroad. At a time when women were expected to cover their heads in public, nurses accepted the use of the cap and interviewees for this study described how they had to starch their caps regularly.¹⁰² The use of the cap was discontinued when trousers and tunics were introduced during the 1990s. These changes do not seem to have had a great impact on society as not a single comment has been

¹⁰⁰ Joseph S. Galizia, *Il-Ctieb Ta' L'Infermier: Lezionijet Mghotia lil Infermieri ta li Sptar*. (Malta, 1904), 23. Recommended material for nurses' clothes included cotton and linen that could be washed and boiled. A white colour was deemed to be ideal as it did not conceal dirt and could be washed accordingly. Sleeves were to be so designed as to allow for rolling upwards while the length of the female nurses' skirts was to be so that it would not touch the floor and unsettle the dust or gather it.

¹⁰¹ Galizia, *Il-Ctieb Ta' L'Infermier*, 20. There is no mention of adhering to the practices of women covering their heads when they went out as was normal at the time.

¹⁰² Interview with Iris Naudi, Olivia Gatt and Denise Galea.

found about them in the most widely read newspaper in Malta, the *Times of Malta*. This may be a sign of nurses not being perceived as deserving of much attention by Maltese society and therefore it is questionable how much the nurses' profile could have contributed to nursing being attributed any status much less that of professionalism.

One interviewee said that they were proud of their uniforms and described how they were eager to be allowed to use the blue belt having passed their preliminary exam.¹⁰³ This may have been because the blue belt marked the point where the student could be considered as being senior to the Hospital Attendant.¹⁰⁴ Brooks and Rafferty quote Reinkemeyer as stating that the differences in uniforms were there to define the nurse's boundaries in relationships with other hospital workers be they below her or above her.¹⁰⁵ In Malta the distinction in the colour of the belt may have been useful for identifying rank but no documents exist regarding whether any boundaries existed between hospital personnel. The only boundary referred to by interviewees was that between the nuns and consultants on one side and the rest of the nursing personnel on the other.¹⁰⁶ It may have been difficult to maintain boundaries when colleagues were also former school mates, members of lay societies or even blood relations. Moreover, nurses worked in small teams consisting of an SRN and two SENs that were later reduced to one SEN¹⁰⁷ for 40 to 46.66 hours per week on shifts that could last up to 13 hours and this could have distorted efforts to maintain boundaries.

¹⁰³ Interview with Olivia Gatt.

¹⁰⁴ Interview with Quentin Borg.

¹⁰⁵ Jane Brooks and Ann Marie Rafferty, Dress and Distinction in Nursing, 1860–1939: 'A Corporate (as well as Corporeal) Armour of Probity and Purity. *Women's History Review*, 2007 (16) 1:42.

¹⁰⁶ Interviewees Quentin Borg, David Attard and Keith Holmes all referred to the nun as being the one to communicate with the consultants exclusively.

¹⁰⁷ Interview with Kevin Abela.

5.7 Confusion in borders between lower grades and higher grades

The upgrade of HAs to SENs through ACT No XXII of 1968¹⁰⁸ resulted in a sudden increase in the number of nurses, possibly contributing to a general perception that SRNs could easily be substituted by ENs or even HAs. Indeed in practice this was happening often as, when SRNs were not on duty, students were assigned to work with HAs even if always under the supervision of the nun.¹⁰⁹ Maltese patients behave like those in many countries who were described by Anne Crowther and Susan McGann as tending to place all those who assist them under the name ‘nurse’ irrespective of education and training level.¹¹⁰ The multilevel of education has in turn been described as leading to insecure professions.¹¹¹

The availability of labour supply in nursing became increasingly restricted and this may have contributed to a blurred delineation of skills.¹¹² The definition of nursing duties and non nursing duties was not clear resulting in registered nurses performing non nursing duties while hospital attendants and student nurses carried out nursing duties as already discussed. A similar situation had happened in the UK in the early 1920s¹¹³ and during the war¹¹⁴ resulting in a grade dilution through the absorption and employment of less trained personnel who would presumably cost less. Moreover, according to Liz Hart, the fact that many nurses of all

¹⁰⁸ MGG Supplement A 1968, 235.

¹⁰⁹ Interview with Quentin Borg.

¹¹⁰ Anne Crowther & Susan McGann, Professionalism and Prestige, a British Perspective on International Nursing Organisation in the Twentieth Century, 3. available on line at : http://www.who.int/global_health_histories/seminars/presentation25.pdf [Accessed: 23 September 2016].

¹¹¹ Chris Nottingham, The Rise of the Insecure Professionals. *International Review of Social History*, 2007 (52) 2:456.

¹¹² Carole Thornley, Segmentation and Inequality in the Nursing Workforce: Re-evaluating the Evaluation of Skills. In: Crompton, Rosemary; Gallie, Duncam & Purcell Kate (eds). *Changing Forms of Employment: Organisations, Skills and Gender*. (London: Routledge; 2002), 181.

¹¹³ Thornley, Segmentation and Inequality in the Nursing Workforce. *Changing Forms of Employment*, 181.

¹¹⁴ Penny Starns, Fighting Militarism? British Nursing During the Second World War. In: Roger Cooter, Mark Harrison and Steve Sturdy (eds), *War, Medicine and Modernity* (Gloucestershire: Sutton Publishing Ltd; 1998), 192 refers to the Nurses Act of 1943 whereby assistant nurses were given official status.

grades and even domestics are women further contributes to the fluidity in boundaries due to the cleaning and caring roles that have traditionally been attributed to women in general.¹¹⁵

The changes in legislation occurring in both countries had accepted years of experience as a substitute for training. However, whereas in the UK it is recorded to have brought hostility between registered nurses and assistant nurses,¹¹⁶ in Malta there is no evidence that this was ever the case. Evidence has not been found of overt hostility between the different grades of nurses in Malta and this apparent unity should have contributed to professionalisation¹¹⁷ but it does not seem to have had much effect. Such a lack of reaction from nurses themselves probably undermined the process of professionalisation of nursing due to an act of omission that resulted in a lost opportunity to attract attention to nursing. Another possibility may have been the low expectations of the nurses themselves and a general resignation to 'soldier on' and get the work done. The absence of an association for nurses may have been one reason for this apparent silence coupled with a general lack of leaders from amongst them.

According to Moloney the scarcity of nursing scholars and the reluctance of those who may be more learned to assume leadership roles is also a barrier to professionalisation.¹¹⁸ In Malta, although potential leaders may not have had the opportunity to take leadership roles, there was a continuing lack of nursing scholars even from among the nuns.¹¹⁹ The move towards post registration education was slow in coming and not greatly encouraged by the authorities. There seems to have been a lack of appreciation of nursing as a knowledge-based profession when nursing was seen as a practice occupation. At the time the organisational culture in

¹¹⁵ Liz Hart, A Ward of My Own: Social Organisation and Identity Amongst Hospital Domestics in Holden & Littlewood (eds) *Anthropology and Nursing*, 87.

¹¹⁶ Starns, Fighting Militarism? in Cooter, Harrison and Sturdy (eds); *War, Medicine and Modernity*, 192.

¹¹⁷ Moloney, *Professionalisation of Nursing*. Moloney contended that disunity and divisiveness within nursing is a major barrier to professionalisation.

¹¹⁸ Moloney, *Professionalisation of Nursing*, 36.

¹¹⁹ Evidence has not been found to indicate that any Maltese nurse was taking an active part in scholarly meetings except for attendance in Conferences by members of the Professional Nurses Association: *The Times* 1.9.1987, 20; *The Times* 19.5.1989, 17.

health institutions was also not very conducive to fostering aspects of professionalisation such as autonomy and power.

5.8 Organisational culture

Benjamin Scheider and Karen Barbera defined organisational culture as: ‘The values and beliefs that characterise organisations as transmitted by the socialisation experiences newcomers have, the decisions made by management and the stories and myths people tell and retell about their organisation.’¹²⁰ Organisational culture in nursing has existed for a long time even though it first gained scholarly attention in the 1980s.¹²¹ The new entrant into nursing, experiences a time of ‘induction’ as s/he slowly finds out how to behave in a way that will be accepted by colleagues within the organisation and the authority. Although cultural values and norms may be slow in changing, external factors may act on them for the culture of a system to change more rapidly.

Nursing in Malta has traditionally been the main responsibility of the government and this may have generated a different culture from institutional nursing in the UK and other parts of Europe, which originated as charity work.¹²² Records in Malta show that those affecting fundamental care of the sick were employees who had not made any vows to join a religious order. In other countries nurses remained religious professionals until they moved from the religious to the secular.¹²³ Through this move male personnel began to supervise female nurses.¹²⁴ In Malta, the transition happened in the opposite direction when Church

¹²⁰ Benjamin Scheider & Karen M. Barbera, (eds) *The Oxford Handbook of Organisational Climate and Culture*, (Oxford: Oxford University Press; 2014), 10.

¹²¹ Dorothy J del Bueno & P.M. Vincent, Organisational Culture. How important is it? *Journal of Nursing Administration*, 1986 (16) 10:15.

¹²² Patricia Donahue, *Nursing: The Finest Art; An Illustrated History* (St. Louis: Mosby, 1985), 96.

¹²³ Ramon Camano-Puig, *Professionalisation of Nursing in England and Spain: A Comparative Study*, (Helsinki: Laurea Publications; 2005), 15.

¹²⁴ When lay hospitals were set up in England and France, the religious were substituted by lay male administrators as opposed to Spain where religious orders maintained their activity in nursing until the 1970s: Camano-Puig, *Professionalisation of Nursing in England and Spain*, 25. In Malta lay hospital administrators had managed hospitals for a long time until the nuns were given control of much of the hospital facilities which they maintained until the late 1970s when their numbers diminished and hospital administration was taken over by lay, often male, personnel.

representatives took over or were handed the management of hospitals.¹²⁵ Women essentially supervised nurses and effectively managed hospitals even if they had to contend with interference from lay administrators and superintendents.¹²⁶ Much of the work and the contact with the patient were made by lay people who did not have the benefit of being close to God as part of their image. However, the strong Catholicism of Malta that lasted well into the 20th century pervaded the culture of health institutions and nursing was perceived as being a ‘vocation’ implying a call from above and a sense of dedication.¹²⁷ This dedication was expected to translate itself into self sacrifice. Nurses were expected to do all that was necessary for the patient’s comfort and for tasks to be achieved within the expected time. This may have been why no evidence has been found to show that registered nurses commented over the lack of clear boundaries between their roles and those of their subordinates. One of the interviewees for this study, who was a SRN said:

The things we had to do. We had to wash the gloves, we had to wash the bandages (CS: And it was the nurses...) yes, yes, yes we had to wash even at St. Luke’s at the general hospital, in theatre we used to spend the whole afternoon washing gloves and bandages and we used as I told you with SVPR we had to cut up the dressings and swabs, so everyday, you had... if you had a minute’s peace like, you would do these things. There were other things like we didn’t have any top up system so we had to count the laun.. dirty laundry as I told you, but then the new, the fresh linen came, we had to count it again (CS: See how many you’ve been given) yes, yes of course and it didn’t come already (CS: In pack? Folded?) folded, no, no we had to..... Who was there? There was

¹²⁵ *Santo Spirito Hospital* (then known as San Francesco) was collated to the Franciscan Noccole’ Papalla in 1372. Lay workers are recorded to have worked there at the time. In 1433, bad administration led the king to transfer the hospital back to the governing body that worked very closely with the Church: Stanley Fiorini, *Santo Spirito Hospital at Rabat, Malta: The Early Years to 1575*, (Malta: Department of Information; 1989), 3. The Religious Order of the Knights of St. John established a hospital in 1530 that was administered by the Order while lay attendants were employed to assist physicians, surgeons and Knights in looking after patients: Cassar, *The Holy Infirmary of the Knights of St. John*, 407. During the British rule, the Comptroller of Charitable Institutions was responsible for hospitals and worked towards bringing the Sisters of Charity to Malta who would take the responsibility of nursing management in 1871: Cassar, *Medical History of Malta*, 407

¹²⁶ Farrer-Brown, Boldero & Oldham; Report of the Medical Services Commission, 54: 195.

¹²⁷ A 1966 editorial in the *Times of Malta (TOM)* stated that: ‘Nursing is more a vocation than a career’: *TOM* 19.10.1966, 8. A letter to the Editor read: ‘Above all things the nursing profession must be a *vocation* not just a means of employment... a nurse, a doctor and a priest of God are “created” and not “made”... to serve God through their selfless dedication to humanity.’: Joe Calleja, *TOM* 23.11.1966, 11. Another editorial in *The Times* stated that: ‘It is only a sense of vocation which keeps most of them going.’: *The Times*, 9.4.1985, 8. In 1989 the Archbishop of Malta was reported to have ‘expressed the wish that more young people chose nursing and carry it out more as a service to others rather than just to earn money’: *The Times* 4.3.1989, 15.

(*sic*) only the nurses and the cleaners. That's all (CS: You didn't call them servants, they were called cleaners) Maids, we used to call them maids. So it wasn't eem even at St. Luke's during night duty when it was a bit quiet we used to fold the sheets and towels and gowns and dressing gowns.... You had to do everything if you were an SRN at the time... it was expected ... you don't protest, if you're doing it for the patient and you don't protest. It was later when we started realising that you need more people, that there are skills, certain things which you don't need a nurses' skills to do... that came three decades after; decades after, not, not in the sixties. In the sixties we were really the angels. You're there and anything that has to be done for the benefit of the patient you do it. Like I wouldn't dream telling the superintendent I am not going to the disinfection station." When we had the foot and mouth disease, the farmers used to come with their pigs and things, I still had to go there to see that everything was done properly I, you know we never objected... you had to do it. I... most of my life I spent there 24/7. My life was always like that and at the Isolation for many years out of the ten years I was physically there for... Sometimes I used to go home, change and come back. That's why my boyfriend left me, for example.... And both of us ended up crying in the car but we left each other.¹²⁸

Such dedication may not have been expected but it was not discouraged and may have been one reason for the marriage bar. In Europe, as in most of the rest of the world, women's work may have been seen as a hindrance for working women to be fully dedicated to creating a family and accomplishing what was deemed to be their unique mission in society; to become spouses and mothers.¹²⁹ Expectation of dedication and self sacrifice as a sign of patient care may have led to a culture where 'failure' to be so dedicated implied a lack of commitment towards colleagues and staff. A similar situation was recorded in Britain in 1890 where endurance of hardship and discipline were viewed as signs of commitment.¹³⁰ Hospitals had an unwritten policy that would penalise those who did not 'live up to the ideal'; regarding nurses' sickness as character failure so that nurses at the London Hospital were 'too scared to report sick' even in 1932.¹³¹

No evidence has been found to show how the culture of dedication was manifested in male wards but interviewees for this study indicate that male nurses may have been less inclined to

¹²⁸ Interview with Olivia Gatt.

¹²⁹ Camano-Puig, *Professionalisation of Nursing in England and Spain*, 20.

¹³⁰ Debbie Palmer, *Who Cared for the Carers? A History of the Occupational Health of Nurses 1880-1948*, (Manchester: Manchester University Press; 2014), 37.

¹³¹ Palmer, *Who Cared for the Carers?* 162.

be so dedicated and may have found ways how to make their life easier. An interviewee for this study noted this saying:

The males I remember them, and you know they used to secure it [the needle] with the forceps and turn it well. He used to tell me: "I'd better touch it from down here because down here will not be going into the patient. So it will not get stuck, when I prick him it will take the wrong course" he used to say. I mean they had a rationale for it too. But emm aseptic technique alright, it was hard to use it.... we used to do our best.... I have always used it and I managed to use it such that it was a scandal for me not to use it... I think the men were less, less... There were men who were meticulous. There were men who were very meticulous. But if you were to see any carelessness you would see it from a man first.... For example emm dressings and so on. Now perhaps since I was still young I used to be impressed by their large hands handling the forceps, I used to think that perhaps they would contaminate....being clumsy... sometimes he used to tell me: "Now look at this; I am going to use a large piece of gauze and use my hands to clean thoroughly because like that I will clean more effectively than with the forceps. Because with the forceps I may scratch." He used to tell me: "Look, I do it better with my hands" He used to say: "Sort of I am not touching close to where the swab is touching the patient" Understand? He used to hold the swab with the forceps then hold it with his hand. He used to say: "Look, I can't reach this part with the forceps."¹³²

Another interviewee mentioned that on the male wards, during the 1960s nurses were not so much dedicated as motivated by the tips they used to get. He said:

Tips, and all kinds... oranges ...people used to bring oranges for example... if you were a patient everyone would bring you oranges. You used to see nurses going out with the bag of oranges and taking them home (Giggle).... It shouldn't be. I do not agree that it should be like that....Eeee it creates a preference and secondly if you came to work than you came to work. If anyone wanted to give you tips alright but you should not, then you do not sort of go round the patient too much. Or else you do not open his locker and say: "Goodness, how many oranges you have!" Understand?¹³³

This kind of behaviour infringed on hospital regulations and indicates that nurses were also disobedient. Nevertheless, obedience was deemed to be important, and this was probably based on the assumption that the administration consisted of virtuous men and women who knew what was best in a paternalistic way.¹³⁴ In terms of clinical practice, there was, a culture of non-questioning obedience by nurses; obedience to 'doctor's orders' and to the nun's

¹³² Interview with Nathalie Caruana.

¹³³ Interview with Quentin Borg.

¹³⁴ Camano-Puig, *Professionalisation of Nursing in England and Spain*, 18.

regulations. These orders and regulations resulted in a culture of discipline that did not encourage professionalisation in that orders given were not accompanied by a rationale, were often ritualistic rather than knowledge based or evidence based and did not take into account the uniqueness of the patient who may have had such needs as having a bed locker on the left due to a right hemiparesis. Changes such as moving lockers were not made irrespective of patients' comfort. One interviewee for this study mentioned how the ward was kept strictly clean and 'in order':

The lockers were always on the right so you would always see them uniformly distributed.... We were very organised. When you went into the ward, it was a pleasant sight... if there is going to be a ward round, at nine the consultant would come At nine, the door of the ward would be closed, those who were out remained out and those who were in stayed in..... There was a certain military discipline...¹³⁵

Nurses may have actually approved of this and graciously acquiesced. One interviewee mentioned how she had chosen to work in a ward where others did not want to go as the nun was very strict because both the nun and the new nurse were very particular on order. The same interviewee also mentioned how much she had appreciated the strictness of the staff at a Fever Unit in the UK.¹³⁶ Another interviewee also mentioned she had liked a particularly strict nun at St Vincent De Paul's and thought that they were like-minded.¹³⁷

The culture of dedication and obedience was perceived as being desirable by the nuns as well as the lay NOs. However, although it may have endeared the nurses to society it might have simultaneously compromised their image as professionals and thereby affected professionalisation. The nurses' accountability to the nuns and to the physicians brought about unquestioning obedience that may have partly resulted from an acknowledgement of the nurses' own lack of knowledge. Increased knowledge may have afforded them more autonomy. Instead, physicians' 'orders' were to be followed without comment on the premise

¹³⁵ Interview with Kevin Abela.

¹³⁶ Interview with Olivia Gatt.

¹³⁷ Interview with Denise Galea.

that they were more knowledgeable.¹³⁸ In his textbook for Maltese nurses Galizia entreated nurses to understand that they were not knowledgeable enough to interfere with treatment or comment publicly on it and to obey all that the doctor orders without changing anything.¹³⁹ The influence of British nursing on the Maltese may have reinforced such a perception. Maria Berghs, Bernadette Diercks de Casterle and Chris Gastmans stated that Nightingale who was probably also affected by the way society was organised at the time, had accepted that physicians were more knowledgeable regarding sanitation and its implementation and therefore urged nurses to obey.¹⁴⁰ An authoritarian model of health organisations evolved in which nurses became more submissive to those who claimed to be their superiors and passive enough as to carry out orders as a duty to affect care. Moreover, society also regarded the doctor's views as absolute and the medical profession as above all others, to be consulted upon all aspects of health.¹⁴¹ It was therefore difficult for nurses to describe and delineate their specific body of knowledge which contributes to professionalisation. The fact that medicine offered resistance to those who attempted to infiltrate its authority¹⁴² resulted in a barrier to professionalisation.

5.9 The Medical Profession

In Malta, the medical profession may have actually initiated the route to nurses' education that could have in turn brought about the initial move towards professionalisation. According to

¹³⁸ This notion had a long tradition. At *Santo Spirito* Hospital the physician was responsible for the treatment of patients and the one to give instructions. He even countersigned the surgeon's written instructions. 'Nurses' received instructions verbally indicating that they may have been illiterate: Cassar *Medical History of Malta*, 32. At the Holy Infirmary 'guardians' were forbidden from 'expressing opinions, sometimes with partiality, in favour of the sick' or interfering with the work of the physician or surgeon: Cassar, *Medical History of Malta*, 395.

¹³⁹ Galizia, *Il-Ctieb Ta' L'Infermier*, 21. This book was in use at least till 1938. A nurse's notebook from 1938 includes direct quotes from it including that referred to here.

¹⁴⁰ Maria Berghs, Bernadette Diercks de Casterle & Chris Gastmans. Nursing, Obedience and Complicity with Eugenics: A Contextual Interpretation of Nursing Morality at the Turn of the Twentieth Century. *Journal of Medical Ethics*, 2006 (32) 2:120.

¹⁴¹ Lynn Basford & Oliver Slavin, (eds) *Theory and Practice of Nursing: An Integrated Approach to Caring Practice* (2nd Ed), (United Kingdom: Nelson Thornes; 2003), 90.

¹⁴² Moloney, *Professionalisation of Nursing*, 24.

Cassar, in 1881 Professor Salvatore L. Pisani complained that the nurses in the Surgical Ward were generally not able to perform nursing tasks such as administration of medicines and taking temperatures.¹⁴³ He stated that there were: ‘none in fact who understands nursing. The consequence is a confusion in the nursing part of treatment.’ Cassar reported that Dr. T. Bonnici, the resident junior surgeon then proposed a scheme for nurse training that was accepted but was not very successful. Teaching of the attendants (who were called nurses) was then assigned to the Sisters of Charity since the attendants were still generally illiterate. The School for the Training of Nurses was then reorganised where doctors such as Dr. J. S. Galizia lectured while the Medical Superintendent of the Central Hospital was one of the examiners. The role of medical doctors in the teaching and examining of nurse trainees was to continue into the 20th century.¹⁴⁴ Many of the interviewees for this study mentioned how medical consultants and surgeons who were also lecturers at the University of Malta, had been their lecturers.

In this way doctors contributed to the initial steps of nursing towards professionalisation and may have been one contributing factor to the recognition of the Maltese registration by the General Nursing Council of England and Wales in 1952. Medical consultants and surgeons were also indirectly the cause for the withdrawal of this recognition in 1978 when their industrial action against the government led to their being locked out of the hospital. Since the consultants could not teach at the School for Nurses they could not guarantee the same standard of lectures.¹⁴⁵ Through their actions they may have contributed to an interruption in the nurses’ move towards professionalisation since a lack of recognition of registration rendered it very difficult to follow practice based courses in the UK.

¹⁴³ Cassar, *Medical History of Malta*, 397. Quoting from a letter to the Government. Pisani was a volunteer surgeon in Scutari during the Crimean War where he worked with Florence Nightingale: Michael J. Schiavone, *Dictionary of Maltese Biographies* Vol II, (Malta: PIN; 2009), 1295. Pisani may have followed her work in establishing a Nursing School afterwards.

¹⁴⁴ Cassar, *Medical History of Malta*, 404.

¹⁴⁵ Lino J. German, *Landmarks in Medical Unionism in Malta 1937-1987*. (Malta: Allied Publications; 2007), 112.

Interviewees for this study mentioned that consultants encouraged them to apply for scholarships or courses abroad, in areas where the doctor believed special education was needed such as in renal nursing¹⁴⁶ and infectious diseases.¹⁴⁷ This practice may have promoted individual nurses' professional practice while also introducing nurses to further education that is cited by Ghadirian and colleagues as a requisite of professionalism.¹⁴⁸

The situation on the wards was such that members of the medical profession kept their distance from nurses and hospital attendants. Interviewees for this study mentioned how the nun was the intermediary between the medical doctor and the nurses or others;

There was a system of three bulbs.... white... for the nun. Then the nun would get hold of the telephone and she would say: "What do you need?" And she would explain and tell her for example.... Before it was a kind of policy of phoning her before phoning for the doctor, she was the first resort.¹⁴⁹

Another interviewee mentioned that during ward rounds, the consultant would only speak to the nun. He said:

It was always the nun who went with the ward round.... As an EN you would hardly come close to the consultant... The consultant came in first followed by the senior assistant, then the junior doctors and then a herd of students. The door of the big ward was opened and the nun would welcome him.... as if only the nun took care of the patients, she gave the handover... even if you were present. We were never given much consideration because the consultant looked at the nun. He did not even look at you... as if you did not exist.¹⁵⁰

The lack of existence of nurses during ward rounds or special events occurring in the ward may have reinforced the perception that nurses were not very important. In an undated photograph¹⁵¹ of a typical Nightingale ward at St. Luke's Hospital (Figure 5.6), only one hospital attendant is seen and she is at the end of the ward and holding a tray full of crockery

¹⁴⁶ Interview with Eliza Camilleri.

¹⁴⁷ Interview with Olivia Gatt.

¹⁴⁸ Ghadirian, Salsali, & Cheraghi, *Nursing Professionalism*, 4.

¹⁴⁹ Interview with David Attard.

¹⁵⁰ Interview with Keith Holmes.

¹⁵¹ The nun's attire indicates that the photo was taken before 1965.

indicating that she was gathering cups.¹⁵² The doctor and nun are in the middle of the ward and they are performing a technical task (recording blood pressure) while a nun is carrying a tray of medicine containers. Another nun is assisting a patient to sit up in bed.

Once again this situation may have been copying what used to happen in England. According to Elsbeth Heaman, at St. Mary's in the 1930s, the entourage of medics and nurses also formed a procession headed by the consultant followed by the house physician and then the Sister where: 'The pomp and ritual of the ward round bolstered the mystique of medical authority.'¹⁵³ An interviewee for this study described the ward round in Malta as: 'almost like a Mass.'¹⁵⁴

In Malta, there was an added ritual during ward rounds that further indicates how the nurse was regarded as an inferior employee to doctors; a view that may have contributed to the poor image of nurses and nursing that was not conducive to attaining professionalisation. An interviewee for this study described this ritual thus:

The nurse would raise or even if I would be there, she would raise his vest like that and hold it there [making gestures to show how he kept the patient's clothing above the chest without taking them off]. You would turn his face way from the professor to..and you would cover his mouth so that the patient's breath would not reach the professor. And the professor would would listen (chuckle) with the stethoscope. I mean, imagine the patient is in this position [performing position] and there you are with your hand like that against his mouth so that the breath does not reach the professor (giggle)¹⁵⁵

¹⁵² The person does not have a nurse's cap.

¹⁵³ Elsbeth A. Heaman, *St. Mary's: The History of a London Teaching Hospital* (London: Liverpool University Press, 2003), 431.

¹⁵⁴ Interview with Kevin Abela. Refers to Catholic celebration

¹⁵⁵ Interview with Quentin Borg.



Figure 5.6 – An undated photograph of a typical Nightingale ward at St. Luke's Hospital. (Source: Sisters of Charity Archives).

The ward round may have been the ultimate show of doctors' power over nurses serving also to undermine aspirations to professionalisation. On a more senior level, doctors occupied positions of power in all policy making grades even in nurse education through their lecturing and examining roles. Doctors affected the work life and future of Maltese nurses and consequently emphasised the belief that doctors were the nurses' superiors. One interview for this study noted that:

At that time even the nurses' exams used to be done by the doctors... By the consultants. I think that says a lot..... he was your supervisor, the consultant... was examining you, you sort of remain a bit in awe of him.¹⁵⁶

Doctors could eventually reach higher levels of power even up to cabinet minister level. No evidence has been found to support the notion that ministers of health who were doctors were influenced by their profession when they treated with nurses and nursing. However, politicians certainly affected nursing in various ways.

5.10 Political Intervention

In Malta, the Government has always been the main if not the sole provider of the country's health service. Political commitment has had to be key to developments in health in order for nationwide policies to be implemented. When Malta became independent there was a transfer of power from the administrative elite to politicians; from a Council of Government including the administrative elites to a Cabinet of Ministers excluding them (1958-1964).¹⁵⁷ The direct intervention of the Minister or Parliamentary Secretary in policy making and actualisation, recruitment and everyday running of the service including nursing thus became common practice and it is difficult to separate the influence of the government from other factors. The absence of an outspoken profession that would strive for any change in any aspect of its

¹⁵⁶ Interview with Jesmond Tanti.

¹⁵⁷ Edward Warrington, The Fall from Grace of an Administrative Elite: The Administrative Class of the Malta Civil Service and the Transfer of Power – April 1958 to September 1964, *Journal of Maltese History* 2008 (1) 48.

activities left the government and the civil servants at the Medical and Health Department to their own devices in the pursuit of effective and efficient care; mainly by reacting to events as they happened or by following changes occurring in the medical field elsewhere. Politics may have been the single most determining factor in the ongoing process of professionalisation of nursing in Malta through policies and practices in recruitment, education and training and in practice.

According to Ghadirian and colleagues, barriers in the professionalisation of nursing include a lack of academic education at the entry level of nursing courses and a multilevel entry.¹⁵⁸ Both these barriers could be found in Maltese nursing around the time of Malta's independence in 1964 as will be discussed in the next chapter. In 1956 and later, entry into nursing could be through courses leading to registration or the certification of HA¹⁵⁹ or through the direct entry into practice as an 'extra' HA.¹⁶⁰ School education level beyond seven years of schooling was considered to be enough for entry into the lower grades.¹⁶¹ Entrance into registration courses required a secondary level of education and passes in 'O' levels or a pass in a specifically designed examination held for the purpose.¹⁶² Political intervention to encourage recruitment included frequent calls for application for both courses. In 1964 there was a call for applications for Hospital Attendants,¹⁶³ followed by a call for applications for the course leading to Certificate of Hospital Attendant in 1966.¹⁶⁴ Reasons for recruitment campaigns may have been an actual need for nurses or a need to satisfy a minimum standard in number of qualified nurses necessary for population international comparisons but evidence has not been found that much explanation was given regarding the need or importance of these changes that warranted legal notices. The Minister of Health, Dr

¹⁵⁸ Ghadirian, Mahvash & Cheraghi, *Nursing Professionalism*, 1.

¹⁵⁹ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 54:195.

¹⁶⁰ Staff Lists of 1956, 1957 do not include a grade of 'extra' or temporary Hospital Attendants.

¹⁶¹ Interview with David Attard.

¹⁶² Interviews with Konrad Cauchi, Quentin Borg and Denise Galea.

¹⁶³ MGG 11,707 10.11 1964, 3032

¹⁶⁴ MGG 11,862 15.2.1966, 472

Alexander Cachia Zammit who was a doctor may have been *au courant* with what was happening abroad, especially in the Commonwealth when he launched the Enrolment course in 1969.¹⁶⁵ As already discussed, this may have been another instance of the health authorities in Malta following the changes occurring in the UK.¹⁶⁶ However, its may also have been a move towards upgrading nursing standards in the best way available. If not enough SRNs could be obtained to enable the suppression of the Hospital Attendant grade, then a section of nurses that would be more educated than HAs would at least suffice. The less educated SENs thus formed a large proportion of nurses and may have hindered professionalisation irrespective of the existence of the SEN course since the newly qualified SENs were very few. Moreover, it would be the beginning of a two tier system of nursing education and practice certification that was to continue for a long time and may have negatively affected professionalisation. The definition of ‘nurse’ in Malta may have also become blurred due to the existence of two different levels that may also have affected the image of nursing.

The new course had lower entry requirements and was of shorter duration than that for registration¹⁶⁷ probably to attract those of lower education level and mitigate the shortage of recruits. In America offering a shorter course was seen as a means of producing more nurses to address the shortages and serve hospitals’ interests in the 1950s.¹⁶⁸ The nuns seem to have had some reservations about the Training School for Enrolled Nurses¹⁶⁹ and this may have been the reason why the Minister intervened in recruiting the nurse who would be entrusted

¹⁶⁵ MGG Supplement B 1969 Medical and Kindred Professions Ordinance (Cap51) Legal Notice 63 of 1969.

¹⁶⁶ Courses for Enrolled Nurses had been instated in UK in 1943: Linda Nazarko, *Careers and Jobs in Nursing*. (London: Kogan-Page Ltd; 2004), 48.

¹⁶⁷ MGG Supplement B 1971 Legal Notice 89 of 1971. Medical and Kindred Professions Ordinance (Cap 51) for Training School for Enrolled Nurses Regulations, 351-354 MGG Supplement 1980 B. Legal Notice 5 of 1980 Medical and Kindred Professions Ordinance (Cap 51) for Training School for Enrolled Nurses (Amendment) Regulations, 12

¹⁶⁸ Karen Anne Wolf, *The Slow March to Professional Practice* in Susan M. DeNisco & Anne M. Barker (eds) *Advanced Practice Nursing: Evolving Roles for the Transformation of the Profession*. 2nd edition (Burlington: Jones & Barner; 2013), 11.

¹⁶⁹ Documented evidence for this has not been found but the fact that they did not take responsibility for the Enrolment course suggests that they may have opposed it at least when it was launched.

with the task of initiating this training.¹⁷⁰ Implementation of policies seems to have depended much on the Minister's will. Discussing political intervention one interviewee for this study commented that: 'if there is a Minister with some initiative that he wants to implement, then alright.'¹⁷¹ No evidence has been found to indicate that there was any comment. There seems to have been a general agreement to allow legislation proposed by individual ministers to pass without much questioning. Whether this is an indication of faith in the politician's wisdom or whether nursing was not of much concern to the public in general, cannot be ascertained.

The minister may also have had an interest in providing employment opportunities to as many as possible within the Government service that was perceived as being desirable since it provided security of permanency in employment. It may lead to an erratic way of appointing employees with surges occurring just before Government elections to be neutralised by a slower rate of employment immediately afterwards. An interviewee for this study mentioned that during the 1980s the efforts to recruit individuals to follow nursing courses may have been detrimental to the profession itself since applicants may have applied to enter these courses as a means of entering the civil service at a time when the only way into the civil service was through entrance into health care professions.¹⁷² In spite of all efforts, the actual number of pupil nurses recruited during 1970 was 112 only (Table 5.5) indicating that there may have been a poor perception of nursing and that there may still have not been enough people who had the academic requirements for enrolment.

Government policies were addressed at recruiting from a young age and preventing attrition.¹⁷³ This prevention included mandatory entrance into a deed of hypothecation that may have acted as a deterrent against leaving nursing even upon the realisation that one did not have the aptitude for it. There may have been a resultant lack of motivation across all

¹⁷⁰ Oral History Interview with Bernard Dimech.

¹⁷¹ Oral History Interview with Benjamin Walters.

¹⁷² Oral History Interview with Benjamin Walters.

¹⁷³ This will be discussed further in the next chapter.

grades of nursing. According to Moloney, motivation is evidenced in commitment to the profession and contributes towards professionalisation.¹⁷⁴ Reversibly one can say that a lack of motivation hinders professionalisation and the poorly motivated people who entered nursing and then were allowed to stay and even progress in their career may have further contributed to lack of professionalisation through a lack of ability to inspire subordinates.

Documents on how promotions were given were not found but seniority was one factor that was considered. Some degree of political intervention may also have come into play as attested by Louis Galea, Minister for Social Policy (1987-1992) in an interview for this study:

political discretion was too much consistently used in an erroneous way such that people were given promotions, or were allocated places of work, and duties, not according to their competencies and the exigencies of the service but according to their political colour, according to their friendships, according to the nepotism and what they knew.¹⁷⁵

Political intervention at this level may even have amounted to interference. According to Jon P. Mitchell in 1994 Malta: ‘personal politics and the proximity of politicians to “the people” were a quintessential part of Maltese society and therefore ineradicable.’¹⁷⁶ As a result, the minister did not only know the final conclusions of discussions but was also privy to what was happening daily and indeed there were times when he would also intervene at a micro level that was also a national one. One such instance occurring in the 1970s involved the Minister assuring students that their final exam would be held within a given time after these students had walked out on strike on being told that their exam would be postponed to a later

¹⁷⁴ Moloney, *Professionalisation of Nursing*, 289

¹⁷⁵ Interview with Dr. Louis Galea.

¹⁷⁶ Jon P. Mitchell, *Ambivalent Europeans: Ritual, Memory and the Public Sphere in Malta*. (London: Routledge; 2002), 148.

Year	Entered			Resigned			Discharged or dismissed			Transfer to other			Number Qualified		
	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F
1965	41	4	37	17	1	16							24	3	21
1966	36		36	19		19	3		3				14		14
1967	35	4	31	12	2	10	3		3				20	2	18
1968	42	5	37	10		10	1		1				31	5	26
1969	40	6	34	8	2	6	1		1				31	4	27
1970	65	13	52	13		13	2		2				50	13	37
1971	73		73	23		23	3		3				47		47
1972	51		51	11		11							40		40
1973	58		58	11		11	1		1				46		46
1974	46		46	11		11							35		35
1975	42	5	37	10	1	9							32	4	28
1976	88	9	79	15		15							73	9	64
1977	160	47	113	34	7	27							126	40	86
1978	74	25	49	22	2	20	1		1				51	23	28
1979	106		106	35		35							71		71
1980	111	40	71	18	6	12	1		1	5	2	3	87	32	55
1981	71	28	43	22	12	10	2		2				47	16	31
1982	97	50	47	20	10	10							77	40	37
1983	58	26	32	23	9	14	2		2	1		1	32	17	15
1984	88	31	57	17	6	11	1		1				70	25	45
1985	92	33	59	26	10	16							66	23	43
1986	85	38	47	30	17	13	2		2				53	21	32
1987	28		28	13		13							15		15
1988	46		46	8		8									
1989	53	18	35	8	3	5									
1990	25	10	15												
Total	1711	392	1319	436	88	348	23		23	6	2	4	1138	277	861

Table 5.4 - Student nurse intake and output (1965-1990) (Source: Miller & Tipping International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta (1990) ¹⁷⁷

¹⁷⁷ Audrey Miller & Gill Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta (Unpublished Report, Institute of Health Care, University of Malta: 1990), 26.

Year	Entered			Resigned			Discharged /dismissed			Transfer to Student course			Number Qualified		
	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F
1969	154	67	87	20	9	11				9	5	4	125	53	72
1970	112	18	94	19	6	13	1		1	11	3	8	81	9	72
1971	122	10	112	21		21	11		11	12		12	78	10	68
1972	71		71	21		21	1		1	9		9	40		40
1973	17		17	4		4				8		8	5		5
1974	70	5	65	7	2	5				19	3	16	44		44
1975	31		31	7		7				10		10	14		14
1976	44		44	7		7				17		17	20		20
1977	110	47	63	13	5	8	1	1		49	28	21	47	13	34
1978	43		43	3		3				7		7	33		33
1979	64	11	53	6	4	2				18	2	16	40	5	35
1980	118	14	104	19	2	17	3		3	14		14	82	12	70
1981	39	5	34	2	1	1				18	5	13	19		19
1982	82	20	62	12	2	10	4	1	3	9	3	6	57	14	43
1983	84	36	48	9	5	4				34	19	15	41	12	29
1984	103	42	61	14	5	9				21	7	14	68	30	38
1985	131	58	73	22	6	16				26	12	14	83	40	43
1986	55	27	28	15	9	6				7	2	5	33	16	17
1987	74	40	34	19	11	8				13	8	5	42	21	21
1988	26		26	2		2				3		3			
1989	14	6	8	4	2	2	3		3	2	2				
1990	18	6	12	1		1				4	2	2			
Total	1582	412	1170	247	69	178	24	2	22	320	101	219	952	235	717

Table 5.5 - Pupil Nurse Intake and Output (1969-1990) Source: Miller &Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta (1990) 26

date.¹⁷⁸ In another instance students appealed to the minister for attention regarding the number of ‘off’ days they had as a result of working day and night shifts.¹⁷⁹ One interviewee for this study mentioned how she had personally visited the Minister to report a case of harassment and had been assured that he was going to take care of the situation.¹⁸⁰ Another interviewee mentioned how the Minister had told her he would be sending constituents to her office if they needed signatures on their repeat prescriptions.¹⁸¹ In a small island, politicians cannot afford to be perceived as being unaware of their constituents’ plights and aloof from the people as votes are important on a personal level and election into parliament can depend on a small number of votes.¹⁸² The Minister had to know the final conclusions of discussions as well as what was happening daily and indeed there were times when he would also intervene at a micro level that was also a National one. This is another situation that may be unique to Malta as existing literature from abroad does not include any mention of such a close proximity between politicians and particular schools of nursing.

This situation may have both hindered and facilitated professionalisation of nursing due to the support or lack thereof, Ministers gave to particular initiatives. Evidence of this is anecdotal probably due to what Mitchell refers to as a code of silence that is adopted by the Maltese and does not allow for proper investigation of reports. A former minister said:

There is no doubt that every public service is susceptible to, to a certain degree of discretion that ministers and politicians use and eee this discretion has sometimes been used erroneously through all times.... for example, in ’82 you had mass transfers

¹⁷⁸ Anon, ‘Minister’s Assurances to student nurses’, *TOM* 30.10.72, 2.

¹⁷⁹ Anon, Letters to the Editor from student *TOM* 8.10.75, 8.

¹⁸⁰ Interview with Noella Delia.

¹⁸¹ Interview with Olivia Gatt.

¹⁸² Baly (1962) concludes that the ‘Thirty Year War’ ending in having centralised registration was actually a Pyrrhic victory for nursing in that the profession had relinquished its control over standards of entry and basic requirements at the cost of a standard that may not have been as high as the profession desired since it was greatly established by those who had an interest in maintaining the lowest cost. The introduction of the Nurses’ Act by which Enrolment came into existence had also been the result of much discussion, reports and recommendations: Monica E. Baly *Nursing and Social Change*. 2nd edition (London: Heinemann Medical Books; 1980), 182.

of competent nurses fromspecialised wards to wards such as Mount Carmel, Has-Serh at that time, St. Vincent's.¹⁸³

Some interviewees for this study mentioned that they had been transferred from one hospital to another or from one ward to another without their request.¹⁸⁴ This indicates that nurses were excluded from decision making regarding their own future. They were also at risk of being deskilled upon being sent to work in different settings such as from mental health to acute surgical care so that they lost their expert power

The various factors affecting professionalisation of nursing in Malta included those that were described by Moloney and Ghadirian and colleagues such as entry requirements, age, gender and levels of nursing. However, particular events such as the granting of a nursing grade to hospital attendants and political contribution also influenced the process of professionalisation in a unique way. A particular example of this was the 1988 introduction of Nursing into the University of Malta that was also the result of much work carried out by the Parliamentary Secretary for the Elderly and will be described and discussed separately.

5.11 Conclusion

The process of professionalisation of nursing in Malta was affected by various factors acting as barriers to it. Being mostly women, Maltese nurses could not aspire to achieve professionalisation as they had to work for a short time due to the marriage bar. Few could make a lifelong commitment. Prolonged commitment to a profession contributes to professionalism and allows for attaining more skills. Age and years of experience also affect professionalisation in a similar way. Education of nurses may be the single factor that mostly

¹⁸³ Interview with Dr. Louis Galea.

¹⁸⁴ Konrad Cauchi said that he was transferred from Mount Carmel Hospital where he had worked for 13 years to work as a Nursing Officer at St. Luke's Hospital. David Attard stated that he had been sent to many hospitals including the one for lepers at Hal-Ferha Estate in Gharghur (which was opened in 1974): George G. Buttigieg, Charles Savona-Ventura, Kyril Micallef Stafrace, History of leprosy in Malta. *Malta Medical Journal*, (20) 4:37, Sir Paul Boffa Hospital, Floriana and Gozo General Hospital, while Kevin Abela stated he had worked at all hospitals except Mount Carmel Hospital due to several transfers. Keith Holmes was transferred from one medical ward to the next at St. Luke's Hospital.

affects professionalisation as the educated nurse can draw on his/her theoretic background and research during practice for the benefit of the patient. Nurses can then be viewed as knowledgeable practitioners that society can accept. A lack of theoretical background and research was therefore a barrier to professionalisation of nursing in Malta. Another barrier was the confusion in borders between lower and higher grades in nursing since prospects for career progression were few and there were too many of the lower grades of nursing. The organisational culture did not allow for much autonomy. Nursing was viewed as one that was subordinate to the nuns and the medical profession. Political intervention further compounded the challenge of Maltese nurses asserting their rightful position as professionals.

Chapter 6

THE RISE OF A KNOWLEDGE BASE

6.0 Introduction

This chapter describes changes in nursing education in Malta that happened between 1964 and 1987. The following chapter will discuss nurse education at tertiary level that began in 1988. This chapter explores the factors affecting nurse education during this time including general education in Malta, women's social role, nursing courses and entry requirements. Recruitment campaigns and modes of entry will also be described as well as how the theoretical and practical aspect of nurse education was organised. Factors relating to curriculum content and development will be highlighted. The changing examination system will also be described. In keeping with a hermenutic approach, there is also reference to the background provided earlier in this work that provides a holistic appreciation of the findings.

6.1 The need for more qualified nurses

The first attempts to organise training courses for nurses in 1882 were upon the initiative of the then Comptroller of Charitable Institutions, Ferdinand Inglott, a member of the higher civil service.¹ As already explained, the Chief Government Medical Officer (CGMO) at the time, Prof Salvatore Pisani had complained of the inadequacy of nurses resulting in a: 'confusion in the nursing part of treatment.'² Success was not forthcoming due to the poor literacy state of nurses at the time. Later, in 1938, Lord Bonham-Carter, the Governor of Malta mentioned 'our nursing problem' as a reason for visiting the General Nursing Council

¹ Paul Cassar, *Medical History of Malta* (London & Beccles: Wellcome Historical Medical Library, 1965), 402.

² Cassar, *Medical History of Malta*, 397.

in London.³ A law that introduced the register for nurses and standards for registration had been enacted in 1936.⁴ Twelve women were sent to England for training while an English-trained Sister Tutor Ms. M. L Doherty led the new St. Luke's School for Nurses that had been opened in 1938.⁵ The first six students of this school were all nuns.⁶ The problem of recruiting enough lay students to follow the three-year course for registration at the St. Luke's Training School for Nurses persisted and there were few State Registered General Nurses (SRNs) working in the wards. The Report on the Medical Conditions and Works of the Medical and Health Department for 1958 lamented the need for qualified nursing staff stating:

Our hospitals, like other hospitals abroad were handicapped by the shortage of fully qualified nursing staff. Unfortunately, this shortage was still acute during the year although we tried various means of attracting suitable young recruits. Many people, men and women applied for hospital employment but only as servants or Hospital Attendants, only few came forward to register for the full course of training in our school for nurses to become SRNs. It is this class of nurses that we require more than anything else because they set up a standard in our hospitals and because they constitute a stiffening element amongst the nursing staff.⁷

In the 1960s, the earliest part of the period under study, the nursing workforce consisted mainly of Hospital Attendants as has been described earlier.⁸ The Medical Services Commission (Farrer-Brown and colleagues) underlined the need to have:

a larger number of Student Nurses, available for duty in the wards, in lieu of unqualified Temporary Hospital Attendants that would enable an increased number of Registered Nurses, thus helping to raise the general nursing standard.⁹

Such a statement signifies that in 1957 the Government was aware that the general nursing standard was not as desired, that unqualified HAs did not contribute to a high standard of

³ John Manduca, *The Bonham-Carter Diaries (1936-1940)*, (Malta: Manduca; 2004), 220.

⁴ Malta Government Gazette (MGG), (1936) Supplement B, Medical and Kindred Professions Ordinance No VIII of 1936, 1.

⁵ Charles Savona Ventura, *Contemporary Medicine in Malta (1798-1979)*. (Malta: Publishers Enterprises Group (PEG); 2005), 331.

⁶ Cassar, *Medical History of Malta*, 404.

⁷ National Archives of Malta NAM/ GMR 4001/1958, GMR 2157/1958. Report on the Medical Conditions and Works of the Medical and Health Department. (Printed at the Department of Information and Tourist Services, 1959), 17.

⁸ NAM GMR/1999/1957 Leslie Farrer-Brown, Harold Boldero & James B. Oldham, Report of the Medical Services Commission, (Malta: Department of Information, 1957), 52:188.

⁹ Farrer-Brown, Boldero & Oldham, Report of the Medical Services Commission, 54:198.

nursing and that student nurses could be substitutes for them. Farrer-Brown and colleagues asserted that although the Government recognised the need for improvement, its determination and sense of urgency to affect changes were lacking.¹⁰ The problem of recruiting to these courses seems to have been accepted with complacency. The authorities may have been resigned in the belief that the status quo could not be changed much if applicants for entrance into nursing courses were not forthcoming.

Another problem that seemed to be acting against an eventual increase in the number nurses was that of attrition. The need for more qualified nurses could also not be satisfied easily, first because of the marriage bar imposed on women in civil service employment that remained in place till 1980, and, second because of the poor education in the Maltese population. In 1969 there was the opening of a Training School for Enrolled Nurses to offer courses leading to Enrolment.¹¹ This may have been a response to the need to offer courses that were academically lower than those leading to registration and accommodate those who would nurse but did not have the necessary entrance qualifications. The poor general education of the Maltese during the period under study had an effect on the number of potential candidates for nursing, their eventual admission into nursing, the standard achieved by students during the course, attrition and retention rates of students, the eventual standard of nursing of qualified nurses, and the development of the profession of nursing.

6.2 Education in Malta

Education in the general population may have contributed to the low number of applicants, the high attrition rate and the low number of nurses qualifying. In 1956, the Minister of Health declared that the Government was finding it difficult to recruit civil servants who were

¹⁰Farrer-Brown, Boldero. & Oldham, *Report of the Medical Services Commission*, 52:187.

¹¹ MGG Supplement B Legal Notice 63 of 1969, Approved Training School for Enrolled Nurses Regulation, 298.

educated enough to be efficient and adapted to the job.¹² Joseph Zammit Mangion mentioned that although progress in education had certainly been made before 1963, economic circumstances had kept it back when compared to Western European countries and America.¹³ The composition of the population from which potential recruits into nursing could be found may partly explain the persistently low recruitment rates until that time as well as the low rate of qualification. All children aged 6-14 years were mandated by law to follow primary schooling after which they could either go to secondary school or seek employment.¹⁴ The school leaving age was not raised to 16 years until the Education Act of 1974.¹⁵ This indicates a close following of educational developments in the UK where mandatory school attendance age had been raised to 16 years in 1972.¹⁶ Desmond Zammit Marmara, an educationalist, commented that in Malta during the 1960s a substantial part of the population had only a basic level of education while many people were completely illiterate.¹⁷

According to The National Statistics Office (NSO) the number of children enrolled in secondary schools in 1960 in all forms was 7,500 including 4,000 boys and 3,500 girls while the number of children aged between 12 and 16 years 1960 was around 42,000.¹⁸ This indicates that only around 18% of children eligible to attend secondary school did so. A 1965 Report on the Access of Girls and Women to Higher Education issued as part of a United Nations Educational Scientific and Cultural Organisation (UNESCO) questionnaire study, gave the numbers of boys and girls entering higher education institutions.¹⁹ Table 6.1 shows the low numbers of individuals completing secondary schooling, the low number of men

¹² NAM/GMR 2015/57 *Estimi tas-Saħħa* 1956-1957, 10.

¹³ Joseph Zammit Mangion, *L-Istorja ta' L-Edukazzjoni f'Malta*, (Malta: *Pubblikazzjoni Indipendenza* (PIN); 2000), 108.

¹⁴ Zammit Mangion, *L-Istorja ta' L-Edukazzjoni f'Malta*, 103.

¹⁵ MGG 12,993 23.8.1974 Act XXIX of 1974, 2608.

¹⁶ Paul Bolton, 'Education: Historical Statistics' (2012) Available at: www.parliament.uk/briefing-papers/SNO4252.pdf [Accessed: 12 February 2016].

¹⁷ Desmond Zammit Marmara, How Malta has Changed. *The Times* 8.9.2014, 5.

¹⁸ National Statistics Office (NSO); Children; (Malta: NSO, 2002), 26: 11-12.

¹⁹ NAM/ME/251/66 'Report on the Access of Girls and Women to Higher Education,' 2. The Report is a National one so it is assumed that these figures represent all those completing secondary school.

furthering their studies and the even lower number of women doing so. One exception is teaching, where these records show that year after year all vacancies were filled in each course. Another fact worth mentioning for the purpose of this study is the number of women enlisting for courses at the Malta College for Arts, Science and Technology (MCAST) who may have been potential nurse recruits. These courses were defined as being specially designed for women, awarded by higher education institutions that awarded degrees, diplomas and certificates.²⁰ The School for Nurses was not included probably because registration was not considered a higher certificate.

Entrants into the School for Nurses may not all have been through secondary school. During the inter-war period, nursing in Britain was attracting girls coming from depressed areas in Wales and Ireland who had not been through secondary school but could reach a higher social status by entering nursing.²¹

Year	Completing Secondary Education		Malta College of Arts, Science & Technology (MCAST)		Training Colleges		Royal University	
	Boys	Girls	Men	Women	Men	Women	Men	Women
1960	253	236	-	-	30	88	44	9
1961	226	198	125	-	60	121	45	4
1962	397	317	90	-	60	120	101	21
1963	331	306	202	-	66	125	95	37
1964	406	548	368	34	65	135	149	27

Table 6.1 – Admission into the first year of educational institution. Admission requirements are the same for men and women. Source: ‘Report on the Access of Girls and Women to Higher Education.’²²

²⁰ ‘Report on the Access of Girls and Women to Higher Education,’ 3. There were 16 entrants into the Secretarial course, 17 for Business Studies and 4 for Catering Management.

²¹ Jane Brooks, ‘Visiting Rights Only’: the Early Experience of Nurses in Higher Education, (Unpublished PhD thesis, The London School of Hygiene and Tropical Medicine, 2005), 300.

²² NAM/ME/251/66 ‘Report on the Access of Girls and Women to Higher Education.’

According to Fealy, in Ireland nursing was: ‘a vocational extension to secondary school’ and as such ‘resided outside the mainstream of higher educational provision’ indicating that this might have been a more widespread situation.²³ In 1999 Camilleri reported on a study conducted in Malta through face to face questionnaires amongst 800 (0.05% of females in the electoral register) randomly selected Maltese women from all the regions in Malta.²⁴ The response rate was 74% (n=592). Results provided included sample distribution in ten year age groups and according to highest level of schooling and highest educational qualifications achieved. Data extracted from the published results of this study indicate that a large percentage of those who could have entered nursing between 1964 and 1976 had only attended primary school or just completed secondary school (Table 6.2).

Highest level of education attended	Aged 15-24 years in 1964	%	Aged 15-24 years in 1974	%	Aged 15-24 years in 1984	%
No Schooling	3	2.0	2	1.2	0	0
Primary not completed	12	8.1	4	2.4	0	0
Primary completed	73	49.0	51	31.1	6	4.6
Secondary not completed (general)	16	10.7	27	16.5	14	10.8
Secondary completed (general)	28	18.8	65	39.6	76	58.5
Secondary not completed (vocational)	0	0	1	0.61	4	3.1
Secondary completed (vocational)	3	2.0	4	2.4	10	7.7
Tertiary not completed	2	1.3	3	1.8	8	6.2
Tertiary completed	10	6.7	4	2.4	6	4.6
Post graduate not completed	0	0	0	0	1	0.8
Post graduate completed	2	1.3	3	1.8	5	3.9
Total (N)	149	100	164	100	130	100

* Totals refer to number of respondents answering the question.

Table 6.2 - Highest level of education attended by women aged 15-24 in Malta (1964, 1974 & 1984). (Source: Camilleri, 2001, *A Day in Her Life*.)²⁵

²³ Gerard Fealy, *A History of Apprenticeship Nurse Training in Ireland*. (Oxford: Routledge, 2006), 1.

²⁴ Frances Camilleri, *A Day in Her Life*, (Malta: University of Malta, 2001), 32.

²⁵ Camilleri, *A Day in Her Life*, 33.

This indicates that even if they had wanted to enter nursing at registration level, many women did not have the necessary education level to successfully pass the entrance examination. The situation improved by 1984. However, the highest qualification obtained remained relatively low as in 1984 those without any qualifications were still 41.9% (Table 6.3). Women who could aspire to enter nursing were therefore very few. A similar situation seems to have occurred in 1950s youths in England and Wales as statistics show that only 10.7% of the relevant age group (male and female) passed five or more General Certificate of Education (GCE) O levels while 5.5% of the relevant age group passed one or more GCE A levels.²⁶

Highest educational qualifications	Aged 15-24 years in 1964	%	Aged 15-24 years in 1974	%	Aged 15-24 years in 1984	%
No qualifications	107	72.8	111	70.2	54	41.9
'O' level	21	14.3	26	16.5	33	25.6
'A' level	2	1.4	7	4.4	19	14.7
Trade certificate	4	2.7	3	1.9	8	6.2
Non-university certificate/diploma	4	2.7	5	3.2	3	2.3
University certificate/diploma below 1 st degree	2	1.4	2	1.3	5	3.9
University 1 st degree	5	3.4	3	1.9	3	2.3
University certificate/diploma above 1 st degree	1	0.7	0	0	3	2.3
Masters degree	1	0.7	1	0.6	1	0.8
Doctorate	0	0	0	0	0	0
Total (n)	147	100	158	100	129	100

Table 6.3 - Highest Educational qualifications attained by women in Malta according to age group (Data gathered in 1999). (Source: Camilleri, 2001 *A Day in Her Life*.)²⁷

Zammit Mangion commented that in Malta, during the 1960s, only a few hundred students chose secondary education even though schools had been set up to accommodate around

²⁶ Bolton, *Education: Historical Statistics*

²⁷ Camilleri, *A Day in Her Life*, 33.

6000.²⁸ However, entrance was restricted as, at the time, there was an examination for entry into secondary school.²⁹ This was another instance when Malta was following England and Wales where 11+ examinations had been introduced in 1944.³⁰ In 1964 there were upwards of 6,200 pupils who sat for the entrance examination in Malta of whom, only 30% were successful.³¹ The rest either left school altogether or stayed on at Primary school to continue their studies there and possibly sit for the examination in subsequent years. The high failure rate may have been a contributing factor to a general low uptake of secondary school by all children especially girls who were still perceived as future housewives.

These statistics underline the low level of education of workers in all sectors that may have had an effect on efficiency and productivity.³² By 1988, many members of the Maltese labour-force were only semi-literate.³³ Camilleri's study quoted above indicates that at least amongst young women, the level of education was not very high. As a result the number of potential recruits into nursing courses for registration (student nurses) as well as for enrolment (pupil nurses) would remain small (Table 6.4, Table 6.5). Very few would actually begin a nursing course and those qualifying would be even fewer (Table 6.4, Table 6.5). According to Camilleri's study, the level of highest education qualification achieved continued to improve after 1984 but this is not reflected in the number of entrants into nursing as the

²⁸ Zammit Mangion, *L-Istorja ta' L-Edukazzjoni f'Malta*, 101.

²⁹ NAM/GMR2656/63 'Educational Statistics 1963-64,' xvii.

³⁰ The National Archives (UK) Education Act 1944. Available at: <http://www.legislation.gov.uk/ukpga/Geo6/7-8/31/contents/enacted> [Accessed 12 February 2016].

³¹ 'Educational Statistics 1963-64,' xvii.

³² In 1966, the editorial of *The Times of Malta (TOM)* commented that the standard of Secondary School education at the time was not satisfactory and the civil service and industry were therefore recruiting employees, who would later on be in its leadership, whose education consisted of the bare essentials. It proposed that this was also a reason why the University of Malta was finding it difficult to find a sufficient number of entrants of high standards and had to do a lot of work that would have been unnecessary had students been of higher standard: Anon, Secondary Education (Editorial) *TOM*, 31.1.1966, 6. This assumes that leaders will rise through the ranks presumably by virtue of experience.

³³ Louis Galea, 'Malta's Changing Labour Market' in CIMIRA Conference Report, 1988 In: Ronald G.Sultana, Education and Social Transition: Vocationalism. Ideology and the Problem of Development *International Review of Education* 1995 (41) 3-4: 199-221. Available at: http://www.edu.mt/_data/assets/pdf_file/0004/39487/Vocationalism_Ideology_Development_IRE.pdf [Accessed: 20 December 2015].

Year	Entered			Resigned			Discharged or dismissed			Transfer to other courses			Number Qualified		
	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F
1965	41	4	37	17	1	16							24	3	21
1966	36		36	19		19	3		3				14		14
1967	35	4	31	12	2	10	3		3				20	2	18
1968	42	5	37	10		10	1		1				31	5	26
1969	40	6	34	8	2	6	1		1				31	4	27
1970	65	13	52	13		13	2		2				50	13	37
1971	73		73	23		23	3		3				47		47
1972	51		51	11		11							40		40
1973	58		58	11		11	1		1				46		46
1974	46		46	11		11							35		35
1975	42	5	37	10	1	9							32	4	28
1976	88	9	79	15		15							73	9	64
1977	160	47	113	34	7	27							126	40	86
1978	74	25	49	22	2	20	1		1				51	23	28
1979	106		106	35		35							71		71
1980	111	40	71	18	6	12	1		1	5	2	3	87	32	55
1981	71	28	43	22	12	10	2		2				47	16	31
1982	97	50	47	20	10	10							77	40	37
1983	58	26	32	23	9	14	2		2	1		1	32	17	15
1984	88	31	57	17	6	11	1		1				70	25	45
1985	92	33	59	26	10	16							66	23	43
1986	85	38	47	30	17	13	2		2				15		15
1987	28		28	13		13									
1988	46		46	8		8									
1989	53	18	35	8	3	5									
1990	25	10	15												
Total	1711	392	1319	436	88	348	23		23	6	2	4	1138	277	861

Table 6.4 - Student Nurse intake and output 1965-1990. Source: Miller & Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta, 26.³⁴

³⁴ Audrey Miller & Gill Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta (Unpublished Report, Institute of Health Care, University of Malta; 1990), 26.

Year	Entered			Resigned			Discharged or dismissed			Transfer to Student course			Number Qualified		
	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F
1969	154	67	87	20	9	11				9	5	4	125	53	72
1970	112	18	94	19	6	13	1		1	11	3	8	81	9	72
1971	122	10	112	21		21	11		11	12		12	78	10	68
1972	71		71	21		21	1		1	9		9	40		40
1973	17		17	4		4				8		8	5		5
1974	70	5	65	7	2	5				19	3	16	44		44
1975	31		31	7		7				10		10	14		14
1976	44		44	7		7				17		17	20		20
1977	110	47	63	13	5	8	1	1		49	28	21	47	13	34
1978	43		43	3		3				7		7	33		33
1979	64	11	53	6	4	2				18	2	16	40	5	35
1980	118	14	104	19	2	17	3		3	14		14	82	12	70
1981	39	5	34	2	1	1				18	5	13	19		19
1982	82	20	62	12	2	10	4	1	3	9	3	6	57	14	43
1983	84	36	48	9	5	4				34	19	15	41	12	29
1984	103	42	61	14	5	9				21	7	14	68	30	38
1985	131	58	73	22	6	16				26	12	14	83	40	43
1986	55	27	28	15	9	6				7	2	5	33	16	17
1987	74	40	34	19	11	8				13	8	5	42	21	21
1988	26		26	2		2				3		3			
1989	14	6	8	4	2	2	3		3	2	2				
1990	18	6	12	1		1				4	2	2			
Total	1582	412	1170	247	69	178	24	2	22	320	101	219	952	235	717

Table 6.5 - Pupil nurse Intake and Output 1969-1990. Source: Miller & Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta, 28.³⁵

³⁵ Miller & Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta, 28.

intakes in 1988, 1989 and 1990 were still low (Tables 6.4 and 6.5). This was irrespective of the change in the social notion of women's work out of the home that had become more acceptable.³⁶ There may have been a larger number of options available for work and for further study as well as demographic changes in cohorts since the birth rate had dropped progressively from 9,000 per year in 1961 to 5,000 in 1971.³⁷ The two factors were operating in tandem against recruitment in that the lower the population, the fewer candidates there would be for nursing courses, while having many individuals with few or no qualifications in a smaller population decreases the chances further that these individuals would enter nursing. Ghadirian and colleagues placed a lack of academic education at entry level of nursing courses as one of the barriers to professionalisation in nursing.³⁸

6.3 Course Entry Requirements

Failure to attract and retain sufficient numbers of recruits for training as SRNs, (Table 6.4) led the authorities to make calls for attracting individuals who would work by the bedside. In 1964 there was a call for applications to sit an examination session for eligibility to follow a course leading to the certificate of Hospital Attendant.³⁹ Applicants were to be at least 17 years of age, of good moral character and attended Primary School up to Class V that was equivalent to the first year of secondary school in modern times. They were to pass an examination in basic Arithmetic and English Language. A similar call for applications was announced in 1966.⁴⁰ Through this call successful applicants would be admitted according to the final mark and employed as Substitute Hospital Attendants while following the course. An interview was also to be held and marks allocated for appearance, personality, alertness,

³⁶ Camilleri, *A Day in Her Life*, 7.

³⁷ NSO, *Malta in Figures 2014*. (Malta: NSO, 2014), 7.

³⁸ Fataneh Ghadirian, Mahvash Salsali & Mohammed Ali Cheraghi, Nursing Professionalism: An Evolutionary Concept Analysis, *Iranian Journal of Nursing and Midwifery Research* 2014 (19) 1:3.

³⁹ MGG 11,707 10.11.1964, 3032.

⁴⁰ MGG 11,862, 15.2.1966, 472. The call includes a syllabus for the examinations that included testing skills in English Composition, letter writing and translation from Maltese as well as arithmetic skills such as money, time, capacity, area, fractions, simple interest, simple proportion, averages and percentages.

aptitude and other qualities. The ‘other qualities’ are not specified and this may have resulted in a lee way for the Board of Examiners to recruit people they would have previous acquaintance with or who had been recommended by influential individuals such as politicians.

During the 1960s the Government Gazette also issued calls for application for courses leading to SRN qualification which demanded a minimum number of ten students per course.⁴¹ Table 6.5 shows that recruitment remained generally low. In 1966, the minimum qualifications required for nursing included passes in ‘O’ Level English and Maths or a Form III level School leaving certificate and in the absence of these, a pass in a purposely designed entrance examination that was under the responsibility of the Department of Education.⁴² These minimum qualifications required for entry into nursing were very similar to those in the UK in 1962 which included two ‘O’ levels or a pass in an entrance examination.⁴³ The minimum requirements for entry into nursing in Malta were raised in 1967 to three ‘O’ Levels including English and Maths and a Form V level of education.⁴⁴ This level was the basis of an examination in Maths, English and General Knowledge for potential recruits who were not in possession of ‘O’ level certificates.⁴⁵ In the UK, prior to the implementation of Project 2000 in the 1990s, there was a similar condition where there was the possibility of entering nursing courses leading to RGN certificate through a General Nursing Council entry test.⁴⁶

⁴¹ MGG: 11,664 21.7.1964, 2049; 11,791 27.7.1965, 2289; 11,841 24.12.1965, 3713; 11,918 15.7.66, 2109; 11,969 21.12.1966, 3541.

⁴² MGG 11,918, 15.7.1966 2109.

⁴³ Andrew Hull & Andrea Jones, *Nursing, 1920-2000: The Dilemmas of Professionalisation* in Anne Borsay, & Billie Hunter (eds) *Nursing and Midwifery in Britain since 1700*. (Great Britain: Palgrave Macmillan, 2012), 8.

⁴⁴ In Malta, students attending Form III of secondary school are usually around 14 years old so they would have had around nine years of schooling. Form V is the final year at secondary school which students finish when they are 16 years or age.

⁴⁵ MGG 12,023 6.6.1967, 1374.

⁴⁶ Diane Carpenter, Alan Glasper, Rosalynd Jowett & Peter Nicholls, ‘Celebrating 30 years of Integrated undergraduate nursing at The University of Southampton, Working Papers in Health Science.’ (2012)

Available at:

[http://www.southampton.ac.uk/assets/centresresearch/documents/wphs/Celebrating%2030%20years%20of%](http://www.southampton.ac.uk/assets/centresresearch/documents/wphs/Celebrating%2030%20years%20of%20)

Entrance requirements for nursing courses seem to be low but they may have been quite common elsewhere in the world. For example in Turin, Italy in 1968 a Certificate of Education Standard V of Primary School was one requirement.⁴⁷ This can be seen in a sponsorship for a two year nursing course offered by the Sovereign Military Hospitalliers Order of Malta for training at '*La Scuola Convitto Internazionale per Infermieri Professionali*' in Turin. The notice advertising these scholarships does not specify which qualifications those chosen would achieve but in 1964 Malta, the same requirements were requested for application to sit for an examination to recruit students for a course leading to the Certificate of Hospital Attendant.⁴⁸ This indicates that the course in Turin may have been of a lower level than that for registration in Malta or that the qualification would be inferior.

When the new course leading to State Enrolment was launched in 1969, academic entry requirements included a Form III School Leaving Certificate and a pass in the entrance examination in English and Maths organised by the Education Department for the purpose.⁴⁹ Calls for application published in the Malta Government Gazette as late as 1988 had the same educational requirements for entry.⁵⁰ Table 6.3 shows that within twenty years the number of young women achieving 'O' and 'A' level standards had increased substantially.⁵¹ Students who were achieving two or three 'O' levels or a Pass in Form III level of education in 1988 were not at the upper end of achievement as had been the case during the 1960s and 1970s. The quality of entrants into Enrolment courses may have suffered since what was the lower academic requirement in 1968 was relatively much higher at a time when so few girls had

20integrated%20undergraduate%20nursing%20at%20The%20University%20of%20Southampton(1).pdf
[Accessed: 30 March 2016].

⁴⁷ MGG 12,203 8.10.1968, 2729.

⁴⁸ MGG 11,707 10.11.64, 3032.

⁴⁹ MGG 12,369 13.1.70, 85.

⁵⁰ MGG 15,000 19.7.1988, 2883; 15,007, 2.8.1988, 2886

⁵¹ Camilleri, *A Day in Her Life*, 32.

completed secondary school. Therefore, in the 1980s those who had not even achieved this but had to sit for the exam may have been even more academically challenged.

All entrance examinations for the SRN and the SEN courses were organised by the Education Department.⁵² There is little documented evidence on how examinations were set so the qualities sought in potential nurses are obscure. It may be presumed that the standards examined were at par with the minimum levels of education required for entry into the respective courses. However, the standards in successive sessions may have been different so that by coincidence there was a disagreement in entry requirements which could impinge on the level of students or pupils admitted through different examination sessions. There was a resultant lack of maintenance of relative standards so that a disagreement in entry requirements resulted along the years possibly contributing to a slow move towards professionalisation.⁵³ Admission was also dependent on passing an interview presumably to assess aptitude and suitability of candidates. Selection of entrants was mostly by merit but nepotism or political intervention for reasons already discussed, cannot be ruled out as being a decisive factor.

⁵² MGG: 11,862 15.2.1966, 472; 11,918 15.7.1966, 2109; 11,969 20.12.1966, 3541; 12,023 6.6.1967, 1374; 12,094 7.12.1967, 3131; 12,094 7.12.1967, 3125; 12,156 7.6.1968, 1535; 12,213 6.12.1968, 3390; 12,248, 8.7.1969, 2079; 12,270, 16.9.1969, 2872; 12,369, 13.1.1970, 85; 12,370 16.1.1970, 142; 12,411 12.5.1970, 1299; 12,435 17.7.1970, 1957; 12,441 7.8.1970, 2154; 12,455 22.9.1970, 2610; 12,484 11.12.1970, 3370; 12,489 29.12.1970, 3532; 12,500 5.2.1971, 352; 12,524 16.4.1971, 1126; 12,536 11.5.1971, 1388; 12,564 23.7.1971, 2204; 12,586 9.9.1971, 2831; 12,621 10.12.1971, 8784; 12,624 17.12.1971, 8822; 12,649 18.2.1972, 485; 12,698 27.6.1972, 1385; 12,759 1.12.1972, 33; 12,769 5.1.1973, 120; 12,794 10.3.1973, 754; 12,869 9.10.1973, 2981; 12,906 15.1.1974, 159; 12,938 18.3.1974, 1300; 12,985 26.7.1974, 2334; 13,022 19.11.1974, 3691; 13,082 11.4.1975, 1250; 13,089 29.4.1975, 1476; 13,130 5.9.1975, 2930; 13,134 16.9.1975, 3055; 13,167 9.12.1975, 3930; 13,188 20.1.1976, 582; 13,214 27.4.1976 1239; 25.5.1976 No 13,224, 1607; 13.8.1976 No 13,254, 2585; 22.11.1977 No 13,431, 3486; 25.11.1977 13,432, 3546; 13,470 10.3.1978, 669; 13,579 23.1.1979, 202; 13,605 24.4.1979, 3679; 13,637 27.7.1979, 2196; 13,678 30.11.1979, 85; 12,693 18.1.1980, 149; 13,704 22.2.1980, 430; 13,739 10.6.1980, 1346; 13,746 4.7.1980, 1519; 13,764 5.9.1980, 2131; 13,825 17.3.1981, 812; 13,842 18.5.1981, 1312; 13,849 26.5.1981, 1471; 13,856 16.6.1981, 1707; 13,866 21.7.1981, 2010; 13,876 21.8.1981, 2301; 13,884, 11.9.1981, 2535; 13,897 20.10.1981, 2910; 13,902 27.10.1981, 3002; 13,866 17.11.1981, 3391; 13,917 24.11.1981, 3438; 13,944 22.1.1982, 164; 13,963 5.3.1982, 573; 13,972 30.3.1982, 863; 13,988 7.5.1982 1200; 14,030 31.1.1982, 2300; 14,071 10.12.1982, 3254; 14,086 21.1.1983, 209; 14,171 19.8.1983, 2410; 14,246 28.2.1984, 697.

⁵³ Ghadirian, Mahvash & Cheraghi quote this as being a barrier to professionalism in nursing: *Nursing Professionalism*, 1.

Although a nurse tutor and a senior nurse were involved in the selection, Crackett and Donnelly commented in 1988, that the School for Nurses hardly had any control over the standard set for the entrance examination and little say in the selection of students.⁵⁴ This was in contrast to recruitment policies of British hospitals which had made recruitment campaigns amongst Maltese people during the 1960s where matrons or members of Health Boards had selected prospective students.⁵⁵ In Ireland, individual hospitals or health boards of schools for nurses were solely responsible for admitting new recruits.⁵⁶ In 1988 the teachers at the School for Nurses in Malta had expressed their concern regarding entrants they perceived as being ‘totally unsuitable and ill-equipped to meet the academic demands of the course.’⁵⁷ During the 1980s the system of recruitment following a call for applications was to issue the result according to order of merit of those passing through the selection process.⁵⁸ Those placing amongst the first 30 would be called for the first group and the next 30 for the second group beginning three months later and yet another 30 after another three months. Since all students in these groups had answered the same call, the last group may be assumed to have been the weakest so the different academic abilities could have resulted in difficulties in completing the course that was time constrained and succeeding to reach registration without repetition. Pupils who transferred to the registration course would gain marks in the interview and then precede others in merit who may have had better academic preparation for registration and were kept waiting for so long that they found alternative employment.⁵⁹ This

⁵⁴ Janice Crackett & Denise Donnelly, ‘*Positional Report on Nursing Education and Nursing Management in Malta*’ (1988), 3. (Author’s collection). This is a report on nursing education and nursing Management in Malta in 1988 commissioned by the Ministry for Social Policy. It was compiled after a five day programme of meetings with different categories of nurses and government officials involved in nursing at the time. The report also includes recommendations.

⁵⁵ *TOM*: 3.1. 1964, 11; 18.5.1964, 11 4.6.1964, 11; 29.9.1964, 7; 2.10.1964, 11; 13.11.1964, 11; 18.2.1965, 9; 23.3.1965, 7; 22.4.1966, 9. Reports and adverts of British hospitals recruiting from Malta.

⁵⁶ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 83.

⁵⁷ Crackett & Donnelly, *Positional Report on Nursing Education and Nursing Management in Malta*, 3.

⁵⁸ Interview with Nathalie Caruana.

⁵⁹ Waiting for another call could have meant financial hardship due to a prolonged time to start earning a full pay upon qualification. For women who had to resign upon marriage this meant a loss of opportunity to learn and earn money.

lack of consistency in student abilities was cause for concern to the Principal Nurse Tutor who in 1985, together with two other nurse tutors, wrote about it to the CGMO asking for a revision in recruitment.⁶⁰ They also expressed concern that some students had been admitted but the tutors feared they were not medically or psychologically fit to nurse. The last entrance examinations for courses leading to SRN and to SEN were held in 1990.⁶¹

There was a gradual if unconscious decline in the entry standards resulting from a failure to raise the entry requirements while other courses such as physiotherapy were being introduced with higher entry requirements. This may have contributed to the general standard of education among nurses becoming lower when compared to earlier times. Many respondents in this study entering nursing in the 1960s, mentioned that they had been eligible for entrance into teaching⁶² but having a Form III or Form V School leaving Certificate or even some 'O' levels would not have made a person eligible to teach in the 1980s. Teaching had therefore moved on while nursing remained at the same level. It may have also reinforced the perception that nursing was not a desirable career since it was not for highly educated school leavers. In the UK, the Royal College of Nurses (RCN) had fought hard to achieve minimum nurse entry requirements in 1964.⁶³ However, recommendations in the Brigg's Report of 1972 rendered it possible to have great flexibility in entrance requirements.⁶⁴

In 1980, admission requirements for the Doctor of Medicine Course at the University of Malta were 5 'O' Levels and 3 'A' levels in Science subjects at a minimum of two Grade C and one Grade D⁶⁵ while later on these grades became increasingly higher. Natasha Azzopardi Muscat, a University lecturer, and colleagues contended that having high academic admission

⁶⁰ Copy of letter sent to CGMO dated 7.2.1985 from Sr. Federica Galea. Author's collection.

⁶¹ MGG 15,248 16.3.90, 1138, MGG 15,309 24.7.90, 3313.

⁶² Interviews with Konrad Cauchi, Olivia Gatt and Eliza Camilleri

⁶³ Royal College of Nursing (RCN) *Platt Report, A Reform of Nursing Education. First Report of a Special Committee on Nurse Education* (London: RCN, 1964), 72.

⁶⁴ Abigail Beach & Celia Davies. *Interpreting Professional Self-Regulation: A History of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting*. (London: Routledge; 2000), 12.

⁶⁵ MGG 13,782, 4.11.1980, 2625.

requirements for the Doctor of Medicine course that had a *numerus clausus* rendered it to be a highly prestigious one.⁶⁶ Conversely, becoming increasingly less competitive, nursing may have lost prestige and unconsciously reinforced the idea amongst the public that there was little need for nurses to be skilful and academically well prepared. Devaluation of nursing may have been further escalated by the fact that there was a sudden increase in ‘nurses’ by the advent of the SEN grade in 1969 that was in fact the admission into the profession of the generally unqualified Hospital Attendants. Pierre Bourdieu mentioned that academic qualifications are devalued by the large number of people possessing them.⁶⁷ In this case the qualification was even more devalued by the people purporting to possess the grade and implying they had what in actual fact was not in existence. Ghadirian and colleagues contended that disagreement in educational requirements for entry into nursing is a barrier to professionalisation.⁶⁸

6.4 Courses in Nursing and Vacancies

The only available courses in nursing in Malta between 1948 and 1969 were a three year course at the School for Nurses to qualify as a State Registered Nurse (SRN) or a one year course leading to a Hospital Attendants Certificate. Courses for the latter were few and far between so applicants were put on a Temporary Hospital Attendants waiting list from which they could be asked to work random shifts until a permanent appointment as Hospital Attendant arose. During this time they might be required to attend lectures⁶⁹. A course leading to State Enrolment was introduced in 1969,⁷⁰ in a move that may have been another instance of the health authorities in Malta following actions taken in UK where these courses

⁶⁶ Natasha Azzopardi Muscat, Neville Calleja, Antoinette Calleja & Johnathan Cylus, *Health Care Systems in Transition - Malta European Observatory and Health Care Systems*. (Copenhagen: World Health Organization; 1999), 45.

⁶⁷ Pierre Bourdieu, *Sociology in Question*, (London: Sage Publications, 1993), 179.

⁶⁸ Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 7.

⁶⁹ Interview with David Attard.

⁷⁰ MGG Supplement B 1969 Medical and Kindred Professions Ordinance (Cap51) Legal Notice 63 of 1969, 240.

had been initiated in 1943.⁷¹ The course had been considered since 1959 when the Annual Report had mentioned:

A scheme for the training of assistant nurses.... replace the present nine months for the certificate of Assistant Nurse... and emphasis would be on the practical side of nursing.⁷²

Reasons for a prolonged actualisation of these plans have not been found. One reason may have been the political strife that Malta was going through in its decision on requesting independence.⁷³ Another reason could have been related to the different Ministers' will to affect change, which seems to have been a determining factor.

Courses leading to registration were delivered at a purposely built School for Nurses while those leading to enrolment were in separate premises but still within the precincts of St. Luke's Hospital. However, a report in the *Times of Malta* states that it was later amalgamated with the school for registered nurses in 1972.⁷⁴ Pupil nurses were taught by Registered Nurses,⁷⁵ but a list of lectures to be delivered by visiting staff suggested by the Principal Nurse Tutor in 1985 indicates that pupil nurses may also have had visiting staff teaching them at least after amalgamation.⁷⁶ Pupil nurses worked on the wards alongside the students but were also visited on the wards by their tutor where instruction in nursing practice was given.⁷⁷ This was in preparation for examinations.

Comparison of data of intakes of students and pupils (Table 6.4 & Table 6.5) indicates that in every year, intakes for students were generally much lower than those for pupils. Although

⁷¹ Linda Nazarko, *Careers and Jobs in Nursing* (London: Kogan-Page Ltd; 2004), 48.

⁷² NAM/GMR2193/1959 *Report on the Medical Conditions and Works of the Medical and Health Department*, 58.

⁷³ In 1958 there were anti-British riots and clashes and the suspension of responsible government. The politico-religious dispute followed and the island was in crisis for a long time: Herbert Ganado, *Rajt Malta Tinbidel* Vol IV (Malta: *Il-Hajja*; 1977) 72.

⁷⁴ Anon. Nurses' Prize Day. *TOM* 31.1.1972, 11.

⁷⁵ Interview with Bernard Dimech.

⁷⁶ Sr. Federica Galea, Suggested List of Lectures by Visiting Staff. Document dated 29.11.1985 (Author's collection).

⁷⁷ Interview with Bernard Dimech.

reasons for this apparent preference to admit pupil nurses rather than students has not been documented, possible reasons may have included the larger population of individuals who were less qualified and therefore eligible for the lower courses and its shorter duration of two years instead of the three for registration. The shorter duration could possibly lead to lower attrition rates and yield qualified enrolled nurses for earlier deployment. It may also have been more cost effective to admit pupil nurses instead of student nurses since the former were not resident and only entitled to free meals.⁷⁸

There were also repeated calls for application for pupil nurses with large numbers of vacancies including 270 in the first call in 1969 and another 200 in the second call for applications in that year.⁷⁹ Repeated calls for applications for such large numbers of pupils may have been issued since they were the first calls and could therefore allow for all applicants to be recruited. There are no statistics available on how many individuals applied, so the second call may have been for yet another large number of pupils to fill places that had not been taken up after the first call. Had all vacancies advertised been filled, there would have been 470 pupil nurses by the end of 1969 and another 310 by the end of 1970.⁸⁰ Recruiting large numbers may have been a move towards upgrading nursing standards in the best way available, meaning that if not enough SRNs could be obtained to enable the suppression of the Hospital Attendant grade, then a more qualified section of nurses would at least suffice. In spite of all efforts, the actual number of pupil nurses recruited during 1970 was 112 (Table 6.5) indicating that there may have been a poor perception of nursing and/or that there may still have not been enough people who had the academic requirements for enrolment.

⁷⁸ MGG 12,369 13.1.1970, 85.

⁷⁹ MGG 12,320 8.7.1969, 2079; 12,334 16.9.1969, 2872.

⁸⁰ MGG 12,369 13.1.1970, 85; 12,370 16.1.1970, 142; 12, 411 12.5.1970, 1299; 12,435 17.7.1970, 1957; 12,455 22.9.1970, 2612; 12,484 11.12.1970, 3370.

Another reason for the large number of vacancies for pupil nurses may have been the provision of employment opportunities to as many as possible within the Government service. Such an employment was perceived as being desirable since it provided security of employment. General elections were due in 1971 and this may have been a move towards attracting votes for the Nationalist Party then in Government and the Minister as an individual. The larger number of vacancies available in nursing and the lower academic qualifications required facilitated such an entry.

Repeated calls for entry may also have encouraged those who were qualified to seek entry into enrolment as a shorter way towards a stable salary than the registration course, especially considering that most of them would be women approaching marriage and therefore resignation. This was detrimental to the profession of nursing in that it continued to increase the number of lower educated nurses as compared to SRNs, most of whom had been through a three year course of study. In America, the American Nurses' Association had reacted to two year nursing courses leading to an Associate Degree by calling for the minimum qualification for nursing to be a baccalaureate in 1965 even though this did not materialise immediately.⁸¹ This was in view of the advancement of technology. In Malta, little was apparently done to raise the level of education of nurses in general even though developments such as opening specialised units had been achieved during the 1970s and 1980s.⁸² The need for nurses to take care of the elderly and the mentally ill may have been perceived to be more acute. These areas were considered to be needing less complex skills and could be greatly staffed by SENs. The Maltese Department of Health continued to recruit both kinds of nurses through various initiatives.

⁸¹ Karen J. Egenes, *History of Nursing*, 20. Available at: www.jblearning.com/samples/0763752258/52258_ch01_roux.pdf [Accessed:13 March 2016].

⁸² Individual nurses were sent to follow English National Board (ENB) courses in the UK or WHO sponsored courses in other countries as attested by interviewees for this study. (Interviews with Eliza Camilleri and Quentin Borg).

6.5 Strategies for Recruitment of Student and Pupil Nurses

Strategies for recruitment seem to have been targeted at recruiting girls as young as possible. Nurses were sent to government schools to talk to pupils to ‘encourage them to become nurses.’⁸³ In 1977, the Department of Education introduced nationwide examinations for entrance into Nursing Classes in the last two years of Secondary Schooling that would allow students automatic entry into training for Enrolment or Registration depending on their final achievement.⁸⁴ It may have been an attempt to emulate nursing cadet schemes existing in the UK during the 1950s, 60s and 70s.⁸⁵ Entrance at such a young age seems to have been common in nursing worldwide. Until 1941, in Canada there had also been such a low age of entrance⁸⁶ although in New Jersey (USA) the minimum age was already 18 years by 1939.⁸⁷ Such a low age limit may have been the case in earlier times in UK as McGrath reported that concessions were made to lower the age of entry during the late 19th and early 20th century.⁸⁸ In Fealy’s work on nursing schools in Ireland it is reported that in the 1950s student nurses were mostly young women coming from a secondary school system.⁸⁹ The Briggs’ Report recommended that the age of entry in the UK would be reduced to 17 years by the year 1975.⁹⁰ In Malta, the eventual calls for applications later in 1977, for pupil⁹¹ and student nurses,⁹² were for 16 to 30 year old females. It cannot be ascertained how long this scheme

⁸³ Interview with Bernard Dimech.

⁸⁴ Interviews with Noella Delia and Ingrid Tanti.

⁸⁵ Janet Draper, Debbie Halliday, Sandra Jowett, Ian Norman, Roger Watson, Jenifer Wilson-Bennett, Charles Normand & Kieran O’Brien, NHS Cadet Schemes: Student Experience, Commitment, Job Satisfaction and Job Stress. *Nurse Education Today*, 2004 (24) 3:223.

⁸⁶ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing 1900-1990* (Canada: University of Toronto; 2003), 117.

⁸⁷ Beth Houser & Kathy Player, *Pivotal Moments in Nursing Vol 1*. (Indianapolis: Sigma Theta Tau International; Jeff Burnham), 3.

⁸⁸ Alison Mc Grath, *Should I Stay or Should I Go? Towards an Understanding of Leaving Nursing*. Unpublished Doctoral Thesis. (Edinburgh: University of Edinburgh; 2006), 21.

⁸⁹ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 35

⁹⁰ Asa Briggs, Report of the Committee on Nursing (HMSO: 1972), 270.

⁹¹ MGG 13,431 22.11.77, 3486.

⁹² MGG 13,432 25.11.77, 3546.

lasted but the lower entrance age for nurse training applied till 1983,⁹³ when it was changed to 17 years and elongated to 35 years instead of 30 years.⁹⁴ The 16 to 35 years age limit reappeared in the 1990 call for applications for the courses leading to SRN⁹⁵ and to SEN.⁹⁶

No statistics have been found to determine how many girls opting to enter the nursing class when they were 14 years old eventually became student and pupil nurses or how many actually did become qualified nurses. This system applied only for girls in State Secondary and Trade Schools and there were two specialised centres on the island offering a class each year. The maximum number of girls going through this programme in one year was of around 60 but it is not known whether this had any effect on the relatively high entrances of students (Table 6.4) and pupils (Table 6.5) in 1979 and 1980. It is difficult to imagine how a 14 year old girl could make such a decision on a career which she may not have known much about. Two interviewees for this study had been through this programme and both stated that they had chosen it to remain with their school friends and eventually liked the course content.⁹⁷ The curriculum included First Aid, Basic Nursing and Nutrition⁹⁸.

No evidence has been found to justify the exclusion of boys from entering such classes but it is reasonable to believe that it was mainly due to a predicted lack of uptake into these classes by boys. The prevailing perception of nursing as being more suitable for women may have been strong at the time. Table 6.4 and Table 6.5 indicate that over a period of a year there would be many more female student and pupil nurses admitted than male. There may have been a lack of interest from men but calls for applications were repeatedly open for women

⁹³ MGG 14,171 19.8.83, 2410.

⁹⁴ MGG 14,297 26.6.84, 2021.

⁹⁵ MGG 15,248,16.3.90, 1138.

⁹⁶ MGG 15,309, 24.7.90, 3313.

⁹⁷ Interview with Noella Delia, Interview with Ingrid Tanti.

⁹⁸ Interview with Bernard Dimech.

only.⁹⁹ There were exceptions when the call would state that the CGMO could, in special circumstances, consider applications for men,¹⁰⁰ or where calls had a small proportion of vacancies for men.¹⁰¹ In the earlier years, (1964-1970) this small proportion would be as small as 5 out of 20¹⁰² or even 5 out of 70¹⁰³ and 5 out of 75 in the case of pupil nurse intakes.¹⁰⁴ There were instances where no mention of this was made such as in a 1975 call for pupil nurses,¹⁰⁵ and some calls after 1981 including calls for applications in 1988.¹⁰⁶ Reasons for this discrimination are not clear but may be related to women's options of employment being few due to how society worked at the time¹⁰⁷, the marriage bar imposed on women at the time¹⁰⁸ and an attempt to maintain equal numbers of men and women in nursing (Fig. 3.4). It is significant that the Maltese authorities chose to deliberately perpetuate the gender imbalance within nursing, and this is very likely to have related to the prevailing cultural expectation that women would be more suited to a nurturing role. This course of action indirectly affected the process of professionalisation, first because the nursing workforce continued to be mostly made up of women and second because it effectively prevented men who may have been more inclined to commit themselves to changes within nursing to improve their prospects for career advancement.

⁹⁹ MGG: 11,760 9.4.1965, 2289; 11,845 24.12.1965, 3713; 11,918 15.7.66, 2109; 11,969 20.12.1966, 3541; 12,094 7.12.1967, 3131; 12,123 6.12.1968, 3390, 12,369, 13.1.1970, 85; 12,435 17.7.1970, 1957; 12,489 29.12.1970, 3532; 12,455 22.9.1970, 2612; 12,524 16.4.1971, 1126; 12,500 5.2.1971, 352; 12,540 11.5.1971, 1388; 12,564 23.7.1971, 2204; 12,569 6.8.1971, 2438; 12,624, 8822; 12,649 18.2.1972, 340; 12,769 5.1.1973, 80; 12,79 410.3.1973, 754; 12,869 9.10.1973, 2981; 12,906 15.1.1974, 159; 12,985 26.7.1974, 2334; 13,082 11.4.1975, 1250; 13,089 29.4.1975, 1476; 13,134 16.9.1975, 3055; 13,214 27.4.1976, 1239; 13,224 25.5.1976, 1607; 13,252 13.8.1976, 2449; 13,277 28.9.1976, 3174, 13,297 12.11.76, 3701; 13,350 7.4.1977, 1070; 13,352, 15.4.1977, 116; 13,431 22.11.1976, 3486; 13,432, 25.11.1977, 3546; 13,470 10.3.1977, 669; 13,605 24.4.1979, 1225; 13,637 27.7.1979, 2196; 13,678 30.11.79, 3600; 13,704 22.2.1980, 430; 13,739 10.6.1980, 1346; 13,746, 4.7.1980, 1519; 13,764, 5.9.1980, 2131; 13,779 28.10.1980, 2553.

¹⁰⁰ MGG 12,156 7.6.1968, 1535

¹⁰¹ MGG: 12,270 16.9.1969, 2872; 12,938 18.3.1974, 1300; 13,022 19.11.1974, 3691; 13,299 19.11.1976, 3772; 13,315 4.1.1977, 9; 13,316 7.1.1977, 67; 13,376 28. 6.1977, 1968; 13,379 5.7.1977, 2079; 13,579, 23.1.1979, 202; 13,693, 18.1.1980, 149.

¹⁰² MGG: 11,664 21.7.1964, 2049; 12,023 6.6.1967, 1374; 12,441 7.8.1970, 2154.

¹⁰³ MGG 12,370 16.1.1970, 142.

¹⁰⁴ MGG 12,411 12.5.1970, 1299.

¹⁰⁵ MGG 13,167, 9.12.1975 3930.

¹⁰⁶ MGG: 14,931 29.1.1988, 363, 366; 15,000 19.7.1988, 2883, 2886; 15,007 2.8.1988, 3111.

¹⁰⁷ Marie Benoit, In Love with Life. *The Malta Independent on Sunday* 23.1.2011, 8.

¹⁰⁸ MGG 13,779, 28.10.1980, 2553.

Another attempt to attract recruits into nursing courses was an increase in the allowance of student and pupil nurses so that it reached the level of the minimum wage by 1988. This may also have had a counterproductive effect as it may have provided individuals who were not highly motivated with an added bonus for taking the opportunity of entering nursing. Their lack of motivation may have resulted in poor performance. These efforts may have affected recruitment but Table 6.6 show that attrition rates were high for both courses. Table 6.7 demonstrates that in the Enrolled Nurses course many pupil nurses (up to 20%) left their courses to become student nurses therefore taking up other potential students' places, contributing to a failure to fulfil predictions due to high attrition rates. After accounting for the transfer rates, attrition was still at around 20%; a problem that had also occurred in other countries such as the UK¹⁰⁹ and Canada.¹¹⁰

Reasons for this are unknown but may include the course work proving to be too difficult, or needing too much effort only to achieve a post in the lowest grade in nursing and then one with no opportunity for advancement. Attrition in student and pupil nurse groups may have also resulted from transfer to other employment or to other courses such as medicine. For example until 1978 courses leading to a doctorate of medicine; the only course offered in medicine, were only offered every alternate year. Students may have entered into nursing as a means of familiarising themselves with the environment while waiting for another course to become available. Sometimes this happened within a few weeks of the beginning of training.

In an apparent effort to prevent attrition, the Government issued a policy in 1982 through which prospective students (or their guardians if they were under 18 years of age) had to enter into a deed of hypothecation in favour of the Government binding themselves to serve

¹⁰⁹ Ann Marie Jinks, Kathleen Richardson, Colin Jones & Jennifer A. Kirton, Issues Concerning Recruitment, Retention and Attrition of Student Nurses in the 1950/60s: A Comparative Study. *Nurse Educ Pract*, 2014 (14) 6:643.

¹¹⁰ Janet C. Ross-Kerr; *Prepared to Care: Nurses and Nursing in Alberta (1859-1996)* (Alberta, Canada: The University of Alberta Press; 1998), 145.

the Government for two or three years after qualification depending on which course they followed.¹¹¹ A further attempt to impede attrition was made in 1984 through an amendment obliging students to reimburse the Government upon termination of their studies.¹¹² These policies may have been effective in controlling attrition rates as students could not leave easily upon finding alternative employment; simultaneously acting as barriers to entry by already hesitant potential recruits.

Years	% of SRN who qualified	Years	% of EN who qualified	% of EN transferred to RN
1965-1969	61.80	-	-	-
1970-1974	76.45	1969-1973	69.10	20.00
1975-1979	75.10	1974-1978	53.00	12.75
1980-1984	74.00	1979-1983	61.75	11.36
1985-1987	65.36	1984-1987	62.25	19.20

Table 6.6 - Percentage of students and pupil nurses qualifying from the School for Nurses. (Source: Adapted from Miller & Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta, 1990)

Another major change of policy to recruit new entrants into nursing took place with the change of government in 1987 when there was a strong commitment to putting nursing into tertiary level. This move towards Tertiary level is discussed in the next chapter. According to Professor Rizzo Naudi, former Parliamentary Secretary for the Elderly and Chancellor of the University of Malta, this change of policy was aimed at elevating the nurse professionally; the aim was to raise them through education.¹¹³

¹¹¹ MGG 14,030 31.8.82, 2300; MGG 14, 086 21.1.83, 209

¹¹² MGG 14,297 26.6.84, 2021; 14,422 3.5.1985, 1242; 14,438 11.6.1985, 1689; 14,564 4.4.1986, 1152; 14,598 17.6.1986, 1976; 14,838 11.8.1987, 3518, 3520.

¹¹³ Interview with John Rizzo Naudi.

Years	Entered			Resigned			Discharged			Transferred			Qualified			Qualified Rate/%	Transferred %
	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All		
1969-1973	95	381	476	15	70	85		13	13	8	41	49	72	257	329	69.10	20.00
1974-1978	52	246	298	7	30	37	1		1	31	71	102	13	145	158	53.00	12.75
1979-1983	86	301	387	14	34	48	1	6	7	29	64	93	43	196	239	61.75	11.36
1984-1987	167	196	363	31	39	70				29	38	67	107	119	226	62.25	19.20
Total Male	400			67			2			97			235			58.75	24.25
Total Female		1124			173			19			214			717		63.79	19.00
Grand Total			1524			240			21			311			952	62.46	20.40

Table 6.7 – Qualification Rate of Enrolled Nurses from the School for Nurses 1969-1987. (Source: Miller & Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta, 1990.)

The change was aimed at making nursing more attractive but the response was low. The number of applicants per year is not known and the rate of attrition cannot be calculated but the number of graduates per year remained small as will be discussed in the next chapter. Graduate nurses were destined to experience a long period during which they were outnumbered by the number of Enrolled Nurses and Registered Nurses who had not been through a University course. As a result the educational level of the nursing body would remain low in comparison with that of the other health care professionals such as Physiotherapy and Occupational Therapy.¹¹⁴

6.6 The Organisation of Nursing Courses

At St. Luke's School for Nurses student nurses followed courses leading to registration while pupil nurses attended courses leading to enrolment. Each group of new student/pupil nurses was given a number in succession and would be referred to by that number throughout the course. The number of students/pupil per group varied and attrition rates could severely reduce the initial number as can be seen in Table 6.4 and Table 6.5. Students in a group attended classes together during the initial phase that was called the 'Introductory Period' where they were given pre training lectures in Anatomy and Physiology, Health and Hygiene, First Aid and Nursing.¹¹⁵ One interviewee mentioned that before they learnt basic nursing they were taught about disinfectants, bandaging and bed making.¹¹⁶

During this time student nurses were initiated into nursing when they were allocated by the Principal Nurse Tutor to the wards for a few hours each morning or one day per week, working as part of the nursing staff. At the end of this period students sat for the Pre Training Session (PTS) examination. Calls for applications for entry into nursing in 1964

¹¹⁴ Courses in physiotherapy and occupational therapy had one level and were at a Diploma level before the setting up of the Institute of Health Care where they began to be offered on a degree basis only maintaining standards of entry as there were always many applicants.

¹¹⁵ Interview with Nathalie Caruana.

¹¹⁶ Interview with Iris Naudi.

and 1966 said that this period was to last for 12 weeks.¹¹⁷ However, by 1971 this period was defined by law as being eight weeks long.¹¹⁸ A 'Block' period of work on wards followed lasting for one year and leading to a month's full time study in preparation for the 'Preliminary' examination. The laws stipulated that the remaining two years leading to the Final examination were to be spent working on the wards and receiving instruction according to the relevant curriculum. The pupil nurse course leading to enrolment was organised similarly but the initial block preceding the PTS lasted four weeks while the working block between the PTS and Intermediate took nine months. There were 14 months preceding the Final Examination.¹¹⁹ The adoption of the Block system may have been imported from abroad by the nuns or on the advice of the General Nursing Council of the UK as according to Kerr it was a system that was commonly used abroad.¹²⁰ It had the advantage of ensuring the availability of students on the wards while allowing the time in the classroom for instruction. However, the ward exigencies often demanded that students who had very little preparation would be allocated to critical areas such as Coronary Care or Accident and Emergency where they may have benefitted minimally as they lacked the necessary competencies. One interviewee mentioned that as a pupil she would occasionally be sent with others to work for a night at another hospital if the need arose.¹²¹ Josephine Goldmark referred to a similar situation in 1920s America stating that the perception was that: 'the needs of the sick must predominate, the needs of education must yield.'¹²² In the mid twentieth century a perspective that had been associated with a nascent period for nursing education in America, still prevailed in Malta.

¹¹⁷ MGG: 11,664 21.7.1964, 2049; 11,918 15.7.1966, 2109.

¹¹⁸ MGG Supplement B Medical and Kindred Professions Ordinance (Cap 51) Training School for Registered (General) Nurses Regulations, 1971. L.N 86 of 1971, 336.

¹¹⁹ MGG Supplement B Medical and Kindred Professions Ordinance (Cap 51) Training School for Enrolled Nurses Regulations, 1971. L.N 89 of 1971, 351.

¹²⁰ Ross-Kerr, *Prepared to Care*, 146.

¹²¹ Interview with Noella Delia.

¹²² Josephine Goldmark, *Nursing and Nursing Education in the United States*, (New York: Macmillan; 1923), 193

Work assigned to students generally consisted of the fundamental work dealing with patients' needs in the physical activities of living as well as cleaning duties and running of errands. The latter held them out of the wards for long periods at a time. Class instruction was given after working hours and during one month 'Blocks' that were interspersed between working blocks. In this way, the student nurse was gradually inducted into the caring role of the nurse. According to Bradshaw: 'apprenticeship is intrinsic to the way of learning to be and become a nurse' and had traditionally been in nursing since the time of Nightingale's first training schools.¹²³

At the beginning of their studies, student and pupil nurses were issued with uniforms which had to be worn at all times during work and also for study days and study blocks.¹²⁴ Female students received white dresses with white fabric belts, white fabric caps, that had to be starched into shape, white socks and white shoes.¹²⁵ A navy blue cape was issued to female student nurses only. The blue colour indicates that it may have been an item to distinguish students from pupils; a distinction considered to be important in the running of hospitals and nursing schools.¹²⁶ The Maltese students' uniform also indicates that it may have been another 'imported' aspect since the cloak was also part of the nursing uniform abroad.¹²⁷ Male students received white overcoats, brown shoes and brown socks.¹²⁸ After passing the Preliminary exam, female student nurses wore a blue belt and were often called 'the blue belt' on the ward.¹²⁹ Their male counterparts received epaulettes.¹³⁰ Female pupil nurses

¹²³ Ann Bradshaw, *The Covenant of Care*; *Journal of Medical Ethics*, 1999 (25) 478.

¹²⁴ St. Luke's Training School for Nurses Regulations for Student Nurses. Donated copy in author's collection.

¹²⁵ Interview with Denise Galea.

¹²⁶ Jane Brooks & Anne Marie Rafferty, *Dress and Distinction in Nursing 1860-1939: A Corporate (as well as Corporeal) Armour of Probity and Purity*, *Women's History Review* 2007 (16) 1:42

¹²⁷ Anon, Heart Sisters. Available at: <https://myheartsisters.org/2013/05/07/a-nurses-life-in-1950/> [Accessed: 28 March 2016].

¹²⁸ Interview with Kevin Abela.

¹²⁹ Interviews with Olivia Gatt and Iris Naudi.

¹³⁰ Interviews with Bernard Dimech and Kevin Abela.

received a green belt on passing their Intermediate exam.¹³¹ The change of colour of belts signified that they could be entrusted with more responsibility on the wards. One interviewee stated that: ‘you became a blue belt and it was like you had already qualified... you could go to give out the medicines on your own, you could go to do the injections.’¹³² Ross-Kerr said that students in Alberta Canada had shown heroism when shouldering this responsibility.¹³³

Student and pupil nurses were often allocated to the same ward together. They were also assigned similar work unless the student was a ‘blue belt’. In this setting, they would have become dependent on each other to divide the load of tasks and assist each other in others. This interdependency may have influenced the eventual behaviour of registered and enrolled nurses who worked together in a similar way, dividing all the tasks to be done during a shift irrespective of the responsibility and the job description as discussed in Chapter 3. In this way there may have been a blurring of boundaries that resulted in the image of nursing remaining poor and inhibiting professionalisation as has already been discussed.

A group of students entering together would remain together for the duration of the course except for those who failed more than once in any exam and had to join the next group to repeat the exam. Describing a similar set up in Ireland in the 1960s and 1970s, Fealy commented that this group gave: ‘each student her identity within the organisation’ and also ‘conferred certain benefits including, companionship during training and lifelong friendships.’¹³⁴ During work blocks they were allocated to different wards and some were allocated to other hospitals, outpatients or the community service. Those who were on a shift basis had the same roster and this kept them in contact with each other. Ward

¹³¹ Interview with Ingrid Tanti.

¹³² Interview with Iris Naudi.

¹³³ Ross-Kerr; *Prepared to Care*, 153.

¹³⁴ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 8.

allocations were changed every 4 weeks and this constant change hindered students from feeling part of the ward team. At times when they were allocated to other hospitals or services, they could also feel lonely as the chances of meeting their peers became slimmer especially if they had different duty times. Simpson asserted this when commenting on how the group acted as a source of companionship and support when difficulties arose.¹³⁵

A similar situation seems to have occurred in Malta as many interviewees for this study mentioned that when they met with challenging situations on the wards they relied on their colleagues as a means of support.¹³⁶ During the time they were living in, female student nurses could discuss difficulties and situations as they arose, after duties in their rooms.¹³⁷ When asked about the support they had during their studies, they all agreed that this was minimal with regards to official support from qualified nurses, nuns or nurse tutors. There could also be an element of teasing within the group such as for example picking on one student as she was from Gozo¹³⁸ and on another who was quiet.¹³⁹

There was a Student Nurses' Association for some time and it was there to support students if they faced disciplinary action as well as represent students in meetings with the Health authorities including the Minister of Health and organise social events within the school.¹⁴⁰ Records of meetings and representations are scarce indicating that students did not have much support as they faced new challenges in their studies and in the kind of physically and emotionally demanding work that they were doing. It also indicates that there were few channels for addressing individual problems such as being bullied on the wards or otherwise treated unfairly. A former UK Royal College of Nursing (RCN) president was quoted as

¹³⁵ H. Marjorie Simpson, Satisfaction and Dissatisfaction of Student Life. *International Nursing Review* 1968 (15) 4:334.

¹³⁶ Interviews with Bernard Dimech, Iris Naudi, Keith Holmes, Eliza Camilleri and Quentin Borg.

¹³⁷ Interview with Iris Naudi.

¹³⁸ Interview with Iris Naudi.

¹³⁹ Interview with Olivia Gatt.

¹⁴⁰ Interviews with Keith Holmes, Noella Delia and Ingrid Tanti.

saying that when she was a student during the 1960s ‘the attitude was to do what you were told and not to ask questions.’¹⁴¹ In Malta this situation may have lasted longer as there does not seem to have been any way of questioning or challenging methods of treatment and conflicts between academic studies and practice on the wards, either on an individual level or as a group.

The resulting situation may have encouraged the emergence of a nursing profession that hardly questioned management decisions or political decisions even if these conflicted with current knowledge and practices, such as when extra beds were placed in between already existing ones on the wards¹⁴² that may have compromised infection control and safety regulations.¹⁴³ This lack of questioning and assertion may in turn have contributed a lack of achievement of professionalisation of nursing in Malta.

6.7 Nursing Course Content

The actual nursing content of courses delivered during the 1960s and 1970s is not found in the records but Cassar noted that the programme was raised to that in the UK.¹⁴⁴ This may have been one reason for the recognition granted to Maltese Nursing Registration by the General Nursing Council of England and Wales (GNC) UK in 1952.¹⁴⁵ Lectures were both theoretical and practical where practice instruction was given in a practical room at the

¹⁴¹ Adrian O’Dowd, ‘Nursing in the 70s: “You are here to do the work, so get on with it.”’ *Nursing Times* 3.3.2008 Available at: <http://www.nursingtimes.net/nursing-in-the-1970s-you-are-here-to-do-the-work-so-get-on-with-it/849257.fullarticle> [Accessed: 4 January 2016].

¹⁴² Interview with Nathalie Caruana.

¹⁴³ Since there is only one general hospital in Malta, there is an acute shortage of beds that becomes worse at certain times such as during winter when the incidence of chest infections rises. The practice of placing extra beds in between existing ones or in corridors was common at St. Luke’s Hospital. Interviewees for this study mentioned having extra beds called ‘*Korsija*’ from the Italian word *corsia* for passage as this was where beds were placed in between the others and very close to each other. There were problems of physical safety and infection control due to the close proximity of patients and the barriers to reach hand washing facilities. Other problems included patients’ dignity and privacy since only portable screens could be used around them during toileting and visits by health professionals. Evidence has not been found to show that nurses protested against these practices except to have more nurses who can care for the ‘extra’ patients.

¹⁴⁴ Cassar, *Medical History of Malta*, 404

¹⁴⁵ *TOM*, 21.2.1952, 8.

School for Nurses.¹⁴⁶ The GNC also allowed the use of its record of competencies in the School.¹⁴⁷

Many interviewees referred to the same kinds of things they learnt so the course content may have remained unchanged for a long time. As explained earlier, mutual recognition by the GNC remained effective until 1978 when it was revoked not because registration courses were found to be inadequate but because the medical doctors who were lecturing students could not continue to do so as they had been locked out of the hospital after participating in industrial action.¹⁴⁸ The EEC directives of 1977 set out a list of subjects to be included in nurse instruction but the extent to which this directive was adhered to or the action taken to do so is not known. The 1986 legislation to amend the regulations of the School for Nurses¹⁴⁹ states that: ‘When advising the said Minister on such changes the Nursing and Midwifery Board shall be guided by the relative rules of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting,’ indicating that Malta was generally following UK regulations. The initial course content used for training for enrolment is not known but learning objectives for 1985 indicate that they were more practical than theoretical.¹⁵⁰ During the 1970s and early 1980s documented changes in nurse education in Malta were mostly regarding hours of practice of students and how these were to be distributed to provide time for day and night duties as well as study.

A document dated 1985 with regards the training for enrolment lists the pupils’ objectives as:

¹⁴⁶ Interview with Eliza Camilleri.

¹⁴⁷ Copy of General Nursing Council student’s competency record in author’s archive.

¹⁴⁸ Charles Savona Ventura, *Contemporary Medicine in Malta (1798 – 1979)* (Malta: PEG; 2005), 334.

¹⁴⁹ Medical and Kindred Professions Ordinance (Chapter 51) L.N. 55 of 1986. Training School for Registered (General) Nurses Regulations, 1986 MGG 14,641 16.9.1986, 367.

¹⁵⁰ Anon (1985) Block Objectives – Pupil Nurses, Author’s own collection.

Identify the nursing needs and apply the nursing management of:-

- 1) Chronic Bronchites (sic)
- 2) Bronchial Asthma
- 3) Bronchictasis (sic)
- 4) Neoplasms of the lung
- 5) T.B. lungs
- 6) Pulmonary Oedema
- 7) Pulmonary Infarction
- 8) Emphysema
- 9) Pneumothorax
- 10) Occupational lung disease
- 11) Lung abscess
- 12) Lobar Pneumonia
- 13) Smoking and its complications¹⁵¹

This indicates that pupil nurses were taught that medical labels were of primary importance, and that they were expected to ‘manage’ nursing indicating that their role would be similar to that of registered nurses. There seems to have been a blurring of boundaries even at this level, a factor that may have contributed to confusion in boundaries when the trained enrolled nurses entered the clinical field.

Since 1964, the importance of technology has increased within the medical field and therefore affected nursing.¹⁵² Nursing education in Malta does not seem to have taken account of this immediately and few if any changes were made in course content and delivery. Interviewees for this study mentioned that they were learning things they would never get to use or even witness in the wards; such as a full list of equipment needed and the procedure for a blanket bath.¹⁵³ This was mentioned by nurses who had trained in the

¹⁵¹ Anon (1985) Block Objectives – Pupil Nurses Author’s own collection.

¹⁵² Carol Huston, ‘The impact of emerging technology on nursing care: Warp speed ahead.’ Online Journal of Issues in Nursing 18:2 (2013) Available at: nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No2-May-2013/Impact-of-Emerging-Technology.html [Accessed: 23 May 2016].

¹⁵³ Interviews with Iris Naudi, Nathalie Caruana, and Keith Holmes.

1960s¹⁵⁴ and 1970s¹⁵⁵ while documents show that these procedures were also being taught in the same fashion in 1985.¹⁵⁶

Text books used by student nurses, the lectures delivered by consultants and the continuance of the apprenticeship system indicate that there was little change in nurse education between 1965 and 1985.¹⁵⁷ The list of text books used for learning remained the same for a number of years the only changes being in the edition of the same text book. Books included a 1981 reprint of a 1970 edition¹⁵⁸ that was being used in 1983 and one that was the 1981 edition having been first printed in 1953.¹⁵⁹ These books included instruction on such old procedures as ironing patients' admission clothes with a hot iron to kill pediculi and their nits.¹⁶⁰ This indicates that the 'theory practice gap' during the 1980s was quite large and in reality it was in the reverse direction of what is usually the case. Rolfe defines the theory practice gap as one between what is learnt in theory and what works in a clinical setting.¹⁶¹ It follows therefore that theory should lead practice but what actually works should go back to inform theory. Rafferty, Alcock and Lathlean contended that the tension existing between theory and practice is necessary for change to be made in clinical practice.¹⁶² However, in Malta this tension seems to have happened in the opposite way as for example lectures on intravenous drug administration were being delivered long after nurses had begun to administer these treatments.

¹⁵⁴ Interviews with Iris Naudi, Konrad Cauchi and Denise Galea.

¹⁵⁵ Interviews with Noella Delia, Ingrid Tanti and Bernard Dimech.

¹⁵⁶ Printed handouts of trays and trolleys for procedures in author's collection.

¹⁵⁷ Interviewees for this study mentioned consultant surgeons, physicians and paediatricians when asked about who had given them lectures during their student days: Interviews with Nathalie Caruana, Iris Naudi, Denise Galea and Eliza Camilleri.

¹⁵⁸ Janet S. Ross & Kathleen J. W. Wilson, *Foundations of Nursing and First Aid*. 5th edition (Edinburgh: Churchill Livingstone; 1974) A handwritten date inside the book shows 1983.

¹⁵⁹ Arnold Bloom, *Toohey's Medicine for Nurses*. 13th edition (Edinburgh: Harcourt Brace/Churchill; Livingstone; 1981).

¹⁶⁰ Ross & Wilson, *Foundations of Nursing and First Aid*, 4.

¹⁶¹ Gary Rolfe, Closing the Theory-practice Gap: A Model of Nursing Praxis. *Journal of Clinical Nursing*, 1993 (2) 73.

¹⁶² Ann Marie Rafferty, Nick Allcock & Judith Lathlean, The Theory Practice 'Gap': Taking Issue with Issue. *Journal of Advanced Nursing*, 1996 (23) 4:687.

Reasons for a lack of change or discussion on new methods that were being discussed abroad have not yet been discovered but the fact that the school was run by the same individuals with lecturers remaining the same for years on end may have resulted in a run of the mill operation perpetuated in the run of the mill in the wards such that new ideas could not be introduced, piloted and eventually integrated into care. Reasons for employing two British nurse tutors during the early 1980s¹⁶³ are also not known but may have been related to a lack of adequately prepared Maltese nurses who could teach or a need for introducing modern trends in nursing. The school curriculum was still not much changed by 1989 when both had left. According to the School Regulations¹⁶⁴ the nursing school curriculum did not include nursing theory or theory based research till 1989 so that qualified nurses were hardly aware of the nursing concepts being discussed at the time. Ghadirian and colleagues found that a lack of theory and theory based research is one of the barriers to professionalisation in nursing.¹⁶⁵ According to Lambert and Glacken students claimed that the lack of theory base could lead to deprofessionalisation.¹⁶⁶ The image of the nurse who lacks updated knowledge also impinges on the professionalism viewed by other health care professionals and clients.¹⁶⁷

In Malta, changes in clinical technical practice due to technological advances were occurring and nurses on the wards performed skills that they had not been taught at the School. A ‘theory-practice gap’ had come into existence that may have been small during the 1960s due to knowledge in the School being up to date but gradually grew as changes in the curriculum and content of courses were minimal. Commenting on the 1986 system, one former nurse tutor said:

¹⁶³ Interview with Eliza Camilleri.

¹⁶⁴ St. Luke’s School for Nurses Regulations and Systems of Teaching. Author’s own collection.

¹⁶⁵ Ghadirian, Salsali & Cheraghi, Nursing Professionalism, 7.

¹⁶⁶ Veronica Lambert & Michele Glacken, Clinical Education Facilitators: A Literature Review. *Journal of Clinical Nursing*, 2005 (14) 6: 668.

¹⁶⁷ Khairulnissa Ajani & Salinia Moez, Gap between Knowledge and Practice in Nursing. *Procedia Social Behavioral Sciences*, 2011 (15) 3928.

what used to happen was that what we were practicing at the school was not being actually practiced in hospital; because they did not, because they did not allow us to do it... “Come on, come on because it is time.”¹⁶⁸

Very few fundamental changes were implemented for quite a long time, a phenomenon that was also evident in Ireland where nurse training did not change much for one hundred years.¹⁶⁹ This small change may have been one reason why Crackett and Donnelly commented that in 1988:

There is minimal understanding of the concept of curriculum development and design within the School for Nurses, and no involvement of the service staff in course planning.¹⁷⁰

More in depth study is needed to understand why this happened but a lack of experienced nurses on the ward, a lack of preparation of nurse tutors, lack of library sources, a lack of fora for discussion and isolation from professional bodies abroad may have contributed to a resultant lack of nursing knowledge. In a research study conducted in Australia on midwifery students, Wilson found that students attributed the theory practice gap to practice based on traditions, and that ways of coping with it included acceptance in the face of powerlessness.¹⁷¹ This may have been similar to the situation in Malta. Crackett and Donnelly reported that through discussion with Maltese nurses they had concluded that their Maltese professional colleagues were discouraged and felt helpless to make change.¹⁷² They expressed concern at the ‘lack of dialogue between the service and the education personnel’ and this may have been a main contributing factor to the metaphorical distance maintained between the School for Nurses and the clinical field.

¹⁶⁸ Interview with Bernard Dimech.

¹⁶⁹ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 1.

¹⁷⁰ Crackett & Donnelly, *Positional Report on Nursing Education and Nursing Management in Malta*, 6.

¹⁷¹ Judith Wilson, (2008) Bridging the Theory-practice Gap. University of Notre Dame, Australia

Research available at:

researchonline.nd.edu.au/cgi/viewcontent.cgi?article=1004&context=nursing_article [Accessed: 2 March 2016].

¹⁷² Crackett, & Donnelly, *Positional Report on Nursing Education and Nursing Management in Malta*. 4.

Outside forces that were also stakeholders in the quality of care and treatment did not seem to contribute much to change if indeed they perceived a need for it. For example there is no evidence to indicate that medical consultants exerted any pressure for the modernisation of nursing knowledge delivered in the general course even though they were lecturing at the School for Nurses and were members of the Nursing and Midwifery Board of Examiners. Moreover they seem to have supported the status quo, since students passed examinations. Doctors may not have given much importance to evidence based nursing care and corrected only those parts of answers which related to the nurses' ability to report signs and symptoms and deliver treatment. Their perception of nursing may also have been inaccurate and their regard for the role of the nurse may have been one of a low skilled occupation and therefore not needing much knowledge. If this was true then there is reason to question the standards used when correcting examination papers and during oral and practical examination sessions.

The other members of the Examination Board were also stakeholders in quality of care since they were Nursing Officers coming from the clinical field. Yet, they also seem to have accepted the *status quo* or even supported it when correcting examination papers and asking questions during oral and practical examinations. Copies of examination papers indicate that most of the written questions were of the recall type for which studying by heart would have ensured success. A situation therefore ensued where most student nurses were spending a lot of time learning procedures by heart which they then found were not being adhered to in practice, because it was practically impossible or because nurses had found other ways of doing them, possibly unwittingly making positive changes to practice or similarly unwittingly having detrimental effects on patient care. One interviewee commented for example that times for boiling equipment to be sterilised were shortened by some nurses.¹⁷³

¹⁷³Interview with Iris Naudi.

Another interviewee said that the same set of syringes had to be used over and over again to draw blood and administer injections so they were being boiled over and over again.¹⁷⁴ It is not known whether these times were scientifically based at all and how changes came about. They were not kept by a timer so erroneous short cuts could have been made. Changes in practice on the wards took a long time to be recognised by the school and this may have resulted from the lack of visits nurse tutors made to students on the wards who were generally being left to learn in a vicarious manner. This might have been sufficient when the technical care made up a small part of the nursing care given but it may have become increasingly wanting with the increased technology so that nurses could be viewed as not being well prepared.¹⁷⁵

Counting Dirty and clean Laundry
Cleaning of Lockers, Beds, Mattresses, Cots, Bedpans, Sluice toilets
Running errands to collect Xrays, Medical Records, items from stores.
Preparing and distributing breakfast and teas, squeezing oranges.
Washing and/or drying utensils
Preparation of baby feeds
Reception work
Counting/changing breakages
Moving Beds/Equipment

Table 6.8 - List of Non-Nursing Activities done by Nurses in 1990. Miller & Tipping, International Comparisons of Nursing Manpower and Nursing Officers' Opinion of their Work in Malta, 1990.

Carr contended that it is the nursing role that should define the curriculum.¹⁷⁶ According to Miller and Tipping nurses in Malta were performing cleaners' duties, clerical work, catering

¹⁷⁴ Interview with Nathalie Caruana.

¹⁷⁵ O'Dowd Nursing in the 70s: "You are here to do the work, so get on with it." Nursing Times 3.3.2008 Available at: <http://www.nursingtimes.net/nursing-in-the-1970s-you-are-here-to-do-the-work-so-get-on-with-it/849257.fullarticle> [Accessed: 4 January 2016].

¹⁷⁶ Graham Carr, Changes in Nurse Education: Delivering the Curriculum, *Nurse Education Today*. 2008 (28) 1:120. Carr conducted 37 in depth interviews with nurse teachers in London and came to these conclusions through analysis of these interviews

duties and washing or drying dishes and utensils at least until 1990.¹⁷⁷ (Table 6.8). This was not an accurate definition of the nursing role but one that may have tinged the perception of nursing and affected the process of professionalisation. This may be one reason why curricula had not changed significantly during the previous 20 years or so. However, changes in practice did occur even if they were not resulting from the theory learnt in class but from other, as yet unknown aspects. One cannot exclude the effect of an influx of knowledge accompanying the introduction of medical technology that necessitated ‘on the job’ learning and vicarious learning. The introduction of disposable equipment brought many changes. For example, while the procedure for administering an evacuant enema traditionally called for the use of a trolley with many items of equipment, the introduction of disposable ‘ready to use’ enema preparations did not necessitate so many items or the presence of two nurses during administration. Professional standards needed to be altered accordingly if the advancement of nursing practice was not to be hampered.¹⁷⁸ However, standards of clinical practice could not be established or assessed except perhaps from their perceived acceptability to doctors and nurses.

In the case of nursing in Malta advancement could have been impeded through a lack of theory based practice even though new methods were actually being introduced in the clinical areas. The situation in the 1980s consisted of nursing management personnel with long term experience in the clinical field who had learnt their theoretical base years before but who were using modern methods as dictated by the developing technology. Different wards and units seem to have been allocated different equipment so that some wards had less equipment than others. If equipment was causing nurses to change practice and increase

¹⁷⁷ Audrey Miller & Gill Tipping, ‘International Comparisons of Nursing Manpower and Nursing Officers’ Opinions of their work in Malta.’ Institute of Health Care, University of Malta, (1990), Unpublished report in author’s collection, 42.

¹⁷⁸ Pamela Baxter, The Care Model of Clinical Supervision: Bridging the Theory-practice Gap, *Nurse Education in Practice* 2007 (7) 2:105.

their knowledge, some may have had more opportunity to learn than others.¹⁷⁹ Nurses working in high technological areas such as ITU, Endoscopy and Renal Unit had to learn from their colleagues and superiors who had followed courses and gained experience abroad.¹⁸⁰ In a study of 85 (86%) Maltese Nursing Officers' perception of their work in 1990, many respondents mentioned a lack of basic equipment such as modern beds, drug trolleys, long lead buzzers and oxygen points.¹⁸¹ This indicates that there was a lack of homogeneity in the level of equipment. High technology was still not generally in the nurses' domain when compared to America where technology had been greatly expanded during the 1960s¹⁸² and was therefore in common usage by the 1980s. Courses at the School for Nurses catered for the preparation of general nurses who would then go to work in specialised wards and would therefore need to know about the technology they would be using. Provisions for this were unofficial as students were presumably expected to learn while on the wards and probably did so after qualifying when they had to learn in order to deliver the care as qualified staff. Standards could hardly be established or maintained in this way. Technology seems to have been gradually permeating through various areas in the clinical field and at different rates but the School for Nurses was not equipped to include it in its course delivery. One reason for this could be a lack of resources which in turn may have been a side effect of lack of commitment from higher authorities towards nursing or a lack of awareness that nurses needed to be so prepared.

There seems to have been an acceptance that student nurses were to be sent to work as needed as long as they could be recorded to have spent the necessary hours in a setting as

¹⁷⁹ Special units such as A&E, ITU and CCU may have had more equipment needing special training so nurses working in them may have had more opportunity to learn even if sessions were short and sporadic.

¹⁸⁰ Interview with Kevin Holmes.

¹⁸¹ Miller & Tipping, International Comparisons of Nursing Manpower and Nursing Officer's Opinions of their work in Malta, 50.

¹⁸² Rosemary Stevens, Health Care in the early 1960s. *Health Care Financing Review* 1996 (18) 2:13 Available at: www.ssa.gov/hstory/pdf/HealthCareEarly1960s.pdf [Accessed:12 February 2016].

laid down by the GNC or UKCC regulations for registration. The system was maintained even after mutual recognition had been lost presumably to facilitate registration in the UK and later to adhere with EEC regulations in view of an eventual admittance as a country. However, there were areas such as mental health and geriatric care where changes in mandatory practice were made along the years. Many interviewees for this study who studied nursing in the 1960s mentioned that they had not been sent to work as students in non acute settings such as the Mental Health hospital or geriatric institutions. This may have been due to the small number of student nurses at the time but it may also have been another instance where the Maltese system was following that in Britain. Brooks stated that at Tameside Hospital in Manchester, compulsory instruction in geriatric care was only included in the curriculum after the early 1980s.¹⁸³

The change towards tertiary education may be considered as a step towards modern and updated nurse education. It may also have been another instance where a change in nursing came from an outside force. The political determination was one such influence as will be shown in the next chapter. Another external influence was that of the British systems in course curricula and delivery systems.¹⁸⁴ The curricula for Diploma and BSc Nursing had to be approved by the Senate of the University of Malta, having been based on the current ones used and approved by the respective Universities in the UK. They also had to pass through the Nursing and Midwifery Board of Malta for approval before legislation¹⁸⁵ could be passed to recognise the course as that required for registration in Malta. The legislation of 1986 amending the Training School for Registered (General) Nurses Regulations included a

¹⁸³ Jane Brooks, A Poverty of Leadership in Gerard M. Fealy, Christine E. Hallett & Susanne Malchau Dietz (eds) *Histories of Nursing Practice*. (Manchester: Manchester University Press; 2015), 84.

¹⁸⁴ Interview with Nancy Harrison.

¹⁸⁵ MGG 1986 Supplement B Education Act, 1988 (ACT XXIV of 1988) The Course Leading to the Diploma in Nursing or Diploma in Midwifery Regulations 1992 L.N. 87/1992, 462.

detailed scheme of training comprising all the subjects to be taught during the course,¹⁸⁶ while that of 1992 regulating the course leading to the Diploma in Nursing or Diploma in Midwifery did not detail course contents choosing to put emphasis on the general components of the course.¹⁸⁷ The Nursing and Midwifery Board is not mentioned in this legislation.

According to Dame Elisabeth ‘Betty’ Kershaw, a British expert in nurse education and curriculum development in the UK, she had been sent to Malta in July 1988, to work with the School for Nurses in developing a Diploma Course similar to the Project 2000 course in the UK. Kershaw stated that a curriculum was developed that was used for a Diploma course in nursing starting in September 1988.¹⁸⁸ It is not known whether a Board of Studies responsible for the SRN/Diploma Course had been set up as advised by Kershaw in 1988.¹⁸⁹ This Diploma course was separate from that developed later under the auspices of the University of Malta¹⁹⁰ and with which it was eventually amalgamated.

Documents or records of whether there were changes in course content prior to this time and how they were planned and managed have not been found. In her interview Kershaw indicated that there were attempts to adopt curricula to the special circumstances of Malta after 1989.¹⁹¹ In her report on nurse education in Malta, Kershaw had identified: ‘A need to change the curriculum mode from a medical to a nursing approach, following the knowledge base developing through the undergraduate course.’ Since this was after the launching of the BSc Nursing course, it cannot be ascertained whether the need arose simply to have the same approach in both courses or from the fact that by then many nursing course curricula abroad

¹⁸⁶ MGG 1986 Supplement B Medical and Kindred Professions Ordinance (Chapter 51) LN 55/1986 372.

¹⁸⁷ MGG 15,654 18.9.1986, MGG 1986 Supplement B 462, Education Act, 1988 (ACT XXIV of 1988) L.N. 87/1992, The Course Leading to the Diploma in Nursing or Diploma in Midwifery Regulations 1992.

¹⁸⁸ Interview with Betty Kershaw

¹⁸⁹ Kershaw, *Report of visit by Betty Kershaw* 19.06.89-29.06.89, 5.

¹⁹⁰ Interview with Betty Kershaw.

¹⁹¹ Interview with Betty Kershaw.

had left the medical model and adopted a nursing approach. These changes may have also been influenced by the discussion happening in international fora as the WHO had called for nursing education curriculum to be changed in accordance with the vision of a community based service.¹⁹² The emphasis on wellness may have been contrasted with the previous concept of treatment in the medical model. American nurses were being instigated to change their paradigm of nurse education and indeed the approach from a medical diagnosis model to a community based, multidisciplinary patient care delivery systems.¹⁹³

6.8 The Learning Environment

The St. Luke's School of Nurses was officially opened on June 5th 1965.¹⁹⁴ New premises for the School of Nurses were built within St. Luke's Hospital to house more than a 100 residential student nurses.¹⁹⁵ The School was under the management of a fully qualified nurse tutor, Sr Aldegonda Farrugia, the Principal Nurse Tutor assisted by another qualified nurse tutor, the Assistant Sister Tutor Sr Federica Galea, who was also appointed in 1965.¹⁹⁶ Both were Sisters of Charity and were fully responsible for teaching of student nurses. Visiting lecturers, mostly consultant physicians and surgeons gave lectures too supplementing training in the wards. This was imitating to some degree the longstanding Nightingale method.¹⁹⁷ Upon its official opening in 1965, the School for Nurses was well equipped for its role at the time.¹⁹⁸ Resources included accommodation premises as well as classrooms, a library, a dining room and a recreational area for student nurses. A Principal Nurse Tutor was assisted by an Assistant Sister Tutor and a Home Sister in the management

¹⁹² World Health Organisation, *A Guide to Curriculum Review for Basic Nursing Education*. (Geneva: WHO; 1985), 5

¹⁹³ Laura A. Stokowski, Overhauling Nursing Education. Medscape Nurses (28 January 2011). Available at: <http://www.medscape.com/viewarticle/736236> [Accessed: 29 March 2016].

¹⁹⁴ Anon, Health Services *TOM* 7.6.1965, 6.

¹⁹⁵ Anon. New Nursing School and Home at St. Luke's Hospital *TOM* 29.7.1965, 9.

¹⁹⁶ *MGG* 11,796 19.5.1965, 2406.

¹⁹⁷ Lynn McDonald (ed), *Florence Nightingale: The Nightingale School; Vol 12 of The Collected Works of Florence Nightingale*. (Ontario, Canada: Wilfred Laurier University Press; 2009), 8.

¹⁹⁸ *TOM* 29.7.1965 New Nursing School and Home at St. Luke's Hospital, 9.

of the School.¹⁹⁹ Initially, teaching of students was carried out by three nuns and a group of visiting members from the medical profession. Personnel were also employed for the maintenance of cleanliness and preparation of meals.²⁰⁰ For student nurses, the learning environment also included the different wards to which they were allocated by the Principal Nurse Tutor to gain experience and training. Resources on the wards were therefore supportive of students' learning.

In 1957, the Medical Services Commission praised the decision to have a purposely built school for nurses within the premises of St. Luke's Hospital.²⁰¹ This may have been the change that was least challenging needing only financial commitment which was found through the Colonial Development and Welfare Funds. The new school was to replace the one used when the School for Nurses was reactivated after the War in 1948,²⁰² which consisted of two adapted houses that could host 40 female students living in while pursuing their training.²⁰³ According to the Medical Services Commission the old school also had a lecture room and a demonstration room which were inadequate, together with a kitchen, a dining room, a sitting room and a library. Female students were required to live there for three years where extra beds had to be set up in two-bedded rooms to accommodate some students. Nuns who were also student nurses²⁰⁴ were resident in their convent while male students travelled to and from the school daily.²⁰⁵

The official opening of the school heralded a new era for nurse education as it could house up to 120 students and provided modern equipment, a laboratory, a library and spacious

¹⁹⁹ Interviews with Nathalie Caruana, Olivia Gatt and Denise Galea.

²⁰⁰ Interview with Keith Holmes.

²⁰¹ Farrer-Brown, Boldero, & Oldham, Report of the Medical Services Commission, 52:194.

²⁰² Report on the Health Conditions of the Maltese Islands for the year 1948, 79.

²⁰³ Farrer-Brown, Boldero, & Oldham, Report of the Medical Services Commission, 52:194. Statistics of admission to the School show that there was initially an average of 15-20 admissions per year even though they did not all finish the course, so the number of students living together may have exceeded 40.

²⁰⁴ Bonnici, *Is-Sorjiet ta-Karità u l-Hidma Tagħhom f'Malta*, 335.

²⁰⁵ Interview with Konrad Cauchi.

classes.²⁰⁶ The Vice Chairman of the Hospital Management Committee of Public Health in Britain, Mr. G.D.Wallace, is reported to have said that the standard of accommodation for nurses at St. Luke's Hospital was indeed good.²⁰⁷ Nurses residing at this school mentioned that there was a common room and a sitting room where they could watch television.²⁰⁸ Although it is not known by which standards this was measured, all interviewees for this study who had been in residence there had favourable comments about the accommodation. Although male student nurses did not live in, one male nurse said that 'It was like a hotel.'²⁰⁹ Interviewees for this study all agreed that meals were abundant and very good including fried eggs, sausages, ham and cheese²¹⁰ or delicious bread with concentrated tomato sauce for morning break, custard or pies with custard fillings for tea break at around four and there were special arrangements for Christmas.²¹¹ There was also time for merriment and many interviewees mentioned how they would joke and laugh when they were in their bedrooms.²¹² Perceptions recounted by interviewees may have been biased and tinted by nostalgia. Interviewees may have been reluctant to criticise their former peers. There may also have been low expectations and low standards with which to compare considering that many students came from rural areas and large families. This environment, which seems to have caused positive nostalgia amongst nurses may have contributed to the student nurses' wellbeing and coping mechanisms which have been shown to enhance career prospects.²¹³

Farrer-Brown and colleagues had expressed concern that there had been plans to stop the school from being residential in order to save on capital expenditure, stating that a lack of

²⁰⁶ TOM 29.7.1965 New Nursing School and Home at St. Luke's Hospital, 9.

²⁰⁷ TOM 6.12.1965 British MP Stresses Malta's Need for more Light Industries, 3. There is no evidence indicating whether this was in comparison with other schools for nurses abroad.

²⁰⁸ Interview with Iris Naudi.

²⁰⁹ Interview with Bernard Dimech.

²¹⁰ Interview with Bernard Dimech.

²¹¹ Interview with Iris Naudi.

²¹² Interview with Iris Naudi.

²¹³ Beth Boynton, *Successful Nurse Communication: Safe Care, Healthy Workplaces & Rewarding Careers*. (Philadelphia: F.A. Davis Company; 2016), 102.

residential training would: 'jeopardise the quality of training' while questioning whether the General Nursing Council for England and Wales would continue to recognise non-residential training.²¹⁴ It is difficult to understand how quality of training could be affected by students being residential or not during training as the Commission based its assertion on experience. This may have stemmed from the general perception prevailing at the time, that 'Living-In' was a vital component of nurse training.²¹⁵ Commenting on this situation in Ireland, Fealy affirmed that the underlying rationale was to assist the student to make the transition from immaturity to the ability to accept responsibility for the sick.²¹⁶ In Alberta, Canada there was the same arrangements including curfews.²¹⁷

According to Baly the need for female students to live in while training was to provide training of character since much of the poor image of nursing during Nightingale's times was due to their inappropriate behaviour.²¹⁸ Fealy refers to this as 'having features of the finishing school for young ladies.'²¹⁹ Student nurses were expected to be residential for the first two years of their course in a similar situation to that described by Fealy for Ireland in the 1950-1980 period.²²⁰ In Malta, living in meant that students went home for the weekend if they were not working, to come back on Monday morning.²²¹ Before going home on Fridays during study blocks, they had to sit for a test regarding what they had learnt during that week's lectures.²²² At a time when means of transport were scarce, living in could also have avoided students needing to catch buses and walking before and after the hard work. However, it must be mentioned that at the time, student teachers both male and female were

²¹⁴ Farrer-Brown, Boldero & Oldham, *Report of the Medical Services Commission*, 56:200.

²¹⁵ Lynette Russell, *From Hospital to University –the transfer of nurse education*. (2005). Available at: <http://www.cdnm.edu.au/wp-content/uploads/2011/09/HistoryNursingEducation.pdf> [Accessed: 12 December 2015].

²¹⁶ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 30.

²¹⁷ Ross-Kerr, *Prepared to Care*, 151.

²¹⁸ Baly, *Nursing and Social Change*, 124.

²¹⁹ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 66.

²²⁰ Fealy, *A History of Apprenticeship Nurse Training in Ireland*, 113.

²²¹ Interview with Denise Galea & Nathalie Caruana.

²²² Interview with Nathalie Caruana.

living in throughout their two year course of training. Reasons for this and whether there is any association with improved performance upon qualification have not been found. One reason for attributing living in with better training may have been the regimentation of students who had to follow the School's Regulations that included being woken up by a bell at 6 o'clock in the morning and maintaining silence in the corridors during morning hours.²²³ Other rules included a strict timetable to be followed by students, a curfew for those going out as well as speaking in English when on the school premises. This regimentation may have been a way of habituating student nurses into following a routine in preparation for the strict routine and task allocation system they would need to adhere to on the wards.

Discipline was thus being fostered so that students would eventually learn obedience and self sacrifice in order for them to have the appropriate attitude on the wards when work practices bid obedience and hard work. Obedience to authority was emphasised and custodial control was exerted by the nun and Home Sister at the School for Nurses and the nuns on the wards. There was little room for decision making which Kanter referred to as being a key contributor to empowerment.²²⁴ The result was to be a nurse that would acquiesce to all that was asked of her and to depend on the nuns (and later the Nursing Officers) and medical consultants for all decisions regarding patient care. This may explain why qualified SRNs accepted such policies as informing the nun of an emergency situation so that she would call the doctor as necessary²²⁵ and following strict routines including tasks such as cleaning and folding sheets.²²⁶ This regimentation may have been detrimental to the process of professionalisation. Ghadirian found that autonomy and being trusted were motivational

²²³ Anon, St. Luke's Training School For Nurses Regulations for Student Nurses.

²²⁴ Rosabeth Moss Kanter; *Men and Women of the Corporation*. 2nd edition (New York: Basic Books; 1993), 175.

²²⁵ Interview with David Attard. In some sanatoria in UK, until 1952, the night sister was called in order for a doctor to be summoned: Martin McNamara and Gerard M. Fealy, In the Company of those Similarly Affected. In: Fealy, Hallett & Malchau Dietz (eds) *Histories of Nursing Practice*. 60.

²²⁶ Interviews with Olivia Gatt & Kevin Abela.

factors leading to professionalisation in nursing;²²⁷ but these appear to have been lacking in Malta in the 1960s and 1970s.

At the time there seems to have been a common belief that providing space and modern teaching facilities would positively affect recruitment. However, documents do not show that this was true in Malta. After the 1965 inauguration and until it stopped being residential in 1974,²²⁸ entrants varied between 40 and 60 per year some of whom were nuns and male students who were not residents.²²⁹ Table 5.1 and Table 5.2 show the figures for entrants of students into St. Luke's Training School for Nurses before the new premises were opened in 1965²³⁰ and afterwards.²³¹ Attrition rates were still quite high as students completing their studies numbered between 30 and 50 per year (Table 6.2). Other measures had to be found to increase recruitment and all budgetary measures, policies and practices had to be approved by the highest authority. Annual intakes of students at the time were around 20 per year while the number of students who completed their course was around 10 annually (Table 6.11).

The learning environment for clinical practice was somewhat different and although not homogenous the general picture depicted is one of students who were made to perform the most menial tasks.²³² They were also generally unsupported by qualified staff sometimes even when carrying out more responsible tasks such as administration of medicine.²³³ Bullying tactics by their superior whether these were nuns²³⁴ or lay nurses²³⁵ were also

²²⁷ Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 5

²²⁸ Interview with Kevin Abela.

²²⁹ Miller & Tipping, *International Comparisons of Nursing Manpower and Nursing Officers' Opinions of their Work in Malta*, 28.

²³⁰ *TOM* 7.6.1965 Anon, *Health Services*, 6.

²³¹ Miller & Tipping, *International Comparisons of Nursing Manpower and Nursing Officers' Opinions of their Work in Malta*, 28.

²³² Interview with Iris Naudi.

²³³ Interview with Noella Delia and Ingrid Tanti.

²³⁴ Interview with Iris Naudi.

²³⁵ Interview with Noella Delia and Ingrid Tanti.

mentioned as well as favouritism towards particular students²³⁶ and lack of sympathy towards others.²³⁷ None of the interviewees said that there was ever a time allocated for teaching on the wards and it does not seem to have been the practice that tutors visited students on the ward. The legislation on the provision and regulation of nursing training courses does not specify any need for clinical supervision during the stipulated hours of clinical practice mandated for registration or enrolment. None of the interviewees for this study mentioned being visited by nurse tutors while working as students on the wards although many of the relatively younger ones admitted, after being prompted, to having had a few visits.

One reason could be that nuns on the wards may have felt that their work would be scrutinised by the tutors who were nuns at the time. It could also be for lack of time but this can be viewed as a short coming as very good opportunities to teach and impart such useful things as communication skills must have been lost. The students would probably have liked it, not only because it would have provided time out from the skivvying they had to do, but also because it would have been an opportunity to learn. An interviewee who was the first tutor for pupil nurses mentioned this saying that student nurses actually requested that they would get the same visits made to the pupil nurses on the wards since he had introduced this as a regular system not only of controlling pupil nurses' attendance but also to teach in a hands on manner.²³⁸ Although he did not express this, it could have been a way of making up for a lack of space to hold practical sessions since the School for Enrolled Nurses was not in the School for General Registered Nurses at the time. Tutors began visiting both pupils and students occasionally when the schools were eventually amalgamated in 1974.²³⁹

²³⁶ Interview with Kevin Abela.

²³⁷ Interview with Olivia Gatt.

²³⁸ Interview with Bernard Dimech.

²³⁹ *TOM* 29.3.74, Plans for Community Nursing School, 9.

The main way of learning while on the wards was by doing and mostly by ‘being thrown in at the deep end.’²⁴⁰ Students narrated episodes of when they were on the wards describing how they were sent to perform tasks or procedures for which they were not prepared in any way nor supported by qualified staff. These episodes included undressing and soaking a gangrenous foot of a patient who had lost some toes²⁴¹; the shrouding of a patient on the first duty on the wards²⁴² and holding a lower limb that was being amputated.²⁴³ Regulation of clinical practice experience of students does not seem to have been very much in the nurse tutor’s responsibility. The general impression is that students were generally used as substitutes for all kinds of occupations as they did cleaning tasks, clerical work, basic nursing and technical nursing duties. Duties included washing all kinds of equipment from basins, bowls, kidney dishes, denture containers, sputum mugs, urine measuring jugs, enema containers, urinals bedpans to running all kinds of errands to procure X-Rays and their reports, test results, stationary, pharmacy items, sterile supplies, requests for consultation, laboratory investigation containers, and blood from the blood transfusion department.²⁴⁴

According to Crackett and Donnelly, in 1988 there was little guidance or organisation of learning and achievement of competencies and students were frequently reallocated between wards that were all deemed to be adequate in providing a suitable learning experience.²⁴⁵ The nursing personnel on the wards were mainly responsible for this and according to the same report they actually expressed concern when the modular training scheme was introduced in 1986 that resulted in reducing the number of students available for the wards. The nurse tutors seem to have felt helpless to intervene as attested by one interviewee for

²⁴⁰ Interviews with Ingrid Tanti and Olivia Gatt.

²⁴¹ Interview with Ingrid Tanti.

²⁴² Interview with Olivia Gatt.

²⁴³ Interview with Konrad Cauchi.

²⁴⁴ Interviews with Mariella Cassar, Helen Schembri and Denise Galea.

²⁴⁵ Crackett & Donnelly, *Positional Report on Nursing Education and Nursing Management in Malta*, 7.

this study²⁴⁶. Reasons for this are unknown but the virtual absence of tutors on the wards may have been one. This contrasted greatly with the system adopted for students following Diploma and Degree courses at the University of Malta since these students had, at the time, lecturers accompanying them for whole mornings on the wards.²⁴⁷ In this way they were guided as they learnt and practiced skills with the opportunity of discussing concepts as well as emotions arising during their experience. This support guided them to find ways of how to deal with situations as they arose as well as shielding them from the bullying tactics their predecessors had suffered from. The British tutors taught modern ways of nursing such as problem solving and evidence based wound care even though they had to work in ‘old’ organisation systems such as task allocation and strict ward routines.²⁴⁸ In this way, student nurses were learning to define their own role differently in what Burkey called ‘an evolution rather than a revolution.’²⁴⁹ Studies to quantify any differences in some way have not been carried out yet. Student nurses, pupil nurses and undergraduates spent their time on the wards in clinical practice during which they were supposed to prepare for their examinations and eventual practice as nurses.

6.9 Examinations

During the 1960s, the laws specified that examinations were to be conducted by a Board of Examiners that was to be appointed by and accountable to the Advisory and Executive Board.²⁵⁰ Boards of examinations differed in their makeup according to the level of examination but they always included two nurses and were chaired by a medical officer. This may have been another factor that inhibited autonomy in the nursing profession and could also have delayed professionalisation as it impeded professional identity; another

²⁴⁶ Interview with Nathalie Caruana.

²⁴⁷ Interviews with Nancy Harrison, Nicole Nelson and Tina Ingham.

²⁴⁸ Interview with Nancy Harrison.

²⁴⁹ Interview with Barbara Burkey.

²⁵⁰ Malta Government Gazette. Supplement 1959 A 16th January 1959. Emergency Ordinance No 1 of 1959 to amend the Medical and Health Department (Constitution) Ordinance Cap. 148.

motivational factor towards professionalisation.²⁵¹ One of the examiners in the Examination Boards for final examinations for students used to be a matron of a hospital that was not in the government service, namely the Army and Navy Hospitals and the Blue Sisters Hospital. All of them were British and this may have raised the expected standard of the nursing practice. It also placed extra burden on the students whose native language was Maltese even though they were fluent in English. Having to answer questions in a second language increases the possibility of committing mistakes due to the use of words that did not give the intended meaning.

After its foundation in 1973,²⁵² the Nursing and Midwifery Board became responsible for examinations that remained essentially the same. Many interviewees for this study mentioned the examinations as being frightening especially the oral test and the practical examination. PTS examinations included three sessions; written papers in Anatomy and Physiology and in Nursing and First Aid, and a Practical Examination where the student spent an equal amount of time being examined by each examiner in turn. The Preliminary and Final examinations were similarly constituted but the Final examination also had an oral examination in which the student had to answer questions that were made by the Board of examiners in an interview style. Questions in the written papers as well those asked during the practical and oral examinations were mainly of the recall kind and students had to study facts, management of care and pharmacological facts by heart.²⁵³ The practical examinations were held in the Practical Room at the School for Nurses and included the preparation of trays and trolleys, bed making, nursing procedures and First Aid.²⁵⁴ This part of the examination seems to have been most worrying for students and there were times

²⁵¹ Ghadirian, Salsali & Cheraghi, *Nursing Professionalism*, 7.

²⁵² Nursing and Midwifery Board Regulations 1973, MGG 12, 826 8 6.1973, 1605.

²⁵³ Interviews with Konrad Cauchi and Quentin Borg.

²⁵⁴ Interviews with Konrad Cauchi, Denise Galea and Olivia Gatt.

when the Principal Nurse tutor had to intervene when students were misunderstood.²⁵⁵ Pupil nurses' examinations were similarly constructed but of shorter duration.

Facing Examination Boards may have perpetuated the students' and pupils' awe of the doctors and nursing officers. The examination process may also have intensified the subservience that they had been trained to show during their student days. The skills examined during these examinations were mostly those of self confidence and communication of what had been learnt by heart. The small size of the service and the rotation system in the apprenticeship style training resulted in students being acquainted or familiar with many of the potential examiners; nursing officers and medical doctors. The students may therefore have been favourably or unfavourably marked according to previous incidents happening during allocation, family ties or social acquaintances. Pre conceived opinions may have resulted in negative or positive perceptions of individual student's skills and competence resulting in lack of equity.²⁵⁶ Passing the examination did not only lead to registration but also to a place on the Staff List allocating a more senior position according to the order of merit.²⁵⁷ This seniority would then be the basis for allowing the 'new' nurses to choose from among the vacancies available for work and for promotion to higher positions. In this way those who placed at the bottom of the list would always be left with the wards and hospitals that were not so popular with nurses including the mental health institution and the geriatric residence. Such a system was perpetuating if not creating what Brooks referred to as a 'Cinderella' service in psychiatry and geriatrics, a phenomenon that

²⁵⁵ Interview with Konrad Cauchi.

²⁵⁶ Research carried out abroad on oral examinations for medical student mention extra stress for students that results in low reliability, examiner bias due to ethnicity, age, gender, personality and manner with students: Margery Davis & Indika Karuanathilake, The Place of the Oral Examination in Today's Assessment System, *Medical Teacher* 2005 24 (4) 294; Dana J.H. Niehaus, E. Jordaan, L. Koen & S. Mall, Applicability and Fairness of the Oral Examination in Undergraduate Psychiatry Training in South Africa, *African Journal of Psychiatry* 2012 15:123.

²⁵⁷ Interview with Edward Urpani.

resulted in the UK through the lack of availability of recruits for these services that led hospitals to employ poorly qualified personnel.²⁵⁸

Undergraduates and Diploma students had examinations throughout their course as per the usual annual timetables at the end of each semester. Comprehensive examinations were not only of the recall type but included questions to show critical thinking, evidence based care and critical analysis. Final examinations were held at the end of the course and included a practical session where the student was assigned four preselected patients to take care of for a whole morning. The actual practice during this examination may also have put students under different levels of stress as real life situations cannot be fully controlled and therefore the examination could not be the same for all students. The examiners were nursing lecturers headed by purposely brought external examiners who were either British or American²⁵⁹ and therefore foreign to the system and culture in Malta if not also to each other's system and this could have further brought inequalities in marking.

6.10 Conclusion

Nurse education in Malta generally followed that in the UK until the 1970s when there seems to have been a time when the system remained static. Recruitment strategies and course entry requirements also followed those abroad but the general education in Malta at the time under study may have hindered recruitment of more academically prepared students and pupils. Learners went through similar ways of apprenticeship training that were also in common with other countries such as the UK, Ireland and Canada. The move towards tertiary level will be discussed in the next Chapter.

²⁵⁸ Jane Brooks, A Poverty of Leadership. In: Gerard M. Fealy, Christine E. Hallett & Susanne Melchau Dietz (eds). *Histories of Nursing Practice*. (Manchester: Manchester University Press; 2015), p. 90.

²⁵⁹ Examination Schedule for BSc Nursing Final Examination Session – 1992. Author's own collection.

Chapter 7

TERTIARY EDUCATION

7.0 Introduction

This chapter describes how the plan to introduce nursing education to tertiary level in Malta was set into motion soon after the change of Government of 1987. The actualisation of such a leap was fraught with challenges from many sides and needed great determination, lateral thinking and hard work. The government's support and some coincidences assisted the combined contribution of several individuals in bringing about a major change that may have given nursing in Malta a great push forwards along the continuum of professionalisation. The short time in which it was to be implemented brought with it added and unexpected obstacles that needed people who were adamant if they were to be overcome. The tortuous way followed in this quest may be a unique example of how close networks which are a feature of Maltese society may be used to achieve goals. It also suggests that the amount of support an initiative received from politicians determined its eventual success. The purchase of a BSc Nursing Course curriculum for undergraduate studies by the University of Malta from the University of Liverpool, hastened the introduction of tertiary level nurse education in Malta. A second programme, from the University of Manchester was purchased that was more suitable to be used for the first group of undergraduates who were all registered nurses except one. Such contingency actions characterized the implementation of a vision for nurse education that had been long in coming. Some of the discussion draws on the evidence presented in the background in keeping with a hermeneutic approach to suggest explanations of the findings.

7.1 The Planning Phase

In Malta, in the 1980s, the Minister set out the policy and was very much involved in decisions regarding its implementation including the choice of personnel, resources and public relations. Such deep involvement may be the result of politicians needing to be seen to be successful in fulfilling pre election promises in order to garner enough votes to be re-elected. The concept of having nurse education at tertiary level seems to have been embraced by the Nationalist Party well before it gained power. Documented evidence has not been found on the initial preparations but these seem to have been made earlier during the evolution of the electoral programme for the Nationalist Party. The Labour Party had been in government for 16 years and it had adopted a policy tending towards utilitarianism; reducing courses to those which would yield ‘workers’ where they were needed and effectively diminishing options of study so that by 1987 there were fewer than 1000 University students in total.¹ According to Zammit Mangion, the Nationalist Government revised the education law allowing more autonomy to the University of Malta so that new faculties could be opened and new courses offered.² Dr. Louis Galea who eventually became Minister for Social Policy and therefore responsible for nursing, explained that they had envisaged that these measures would impinge heavily on nursing recruitment, which the government needed to ensure in view of the plans for a new hospital and a health policy where there would be a greater focus on primary health care. There was therefore the necessity to attract new recruits to nursing.

According to Galea:

I was wholly involved in the planning of the policy the Party wanted to follow once it was in Government and I had the honour and the privilege to be within a small group of

¹ There was a closure of the Faculties for Arts and Science whereby courses leading to Bachelor of Arts or Bachelor of Science were stopped. The Research element of the University was also stopped so that it became a teaching university only. Joseph Zammit Mangion, *L-Istorja Ta' L-Edukazzjoni f'Malta*, (Malta: PIN; 2000), 133.

² Zammit Mangion, *L-Istorja Ta' L-Edukazzjoni f'Malta*, 140.

people who were devising the Electoral Programme ok? Eeee the '81 Electoral Programme but more so that of '87 was devised after a focused and in depth consultation on various areas and so....Health. So I had a lot of meetings with the doctors, a lot of meetings with nurses, with their Unions ok?...ee with the people in general... Don't forget that we were doing all this when there was a big crisis in the medical area of the hospital aye? The doctors had been locked out of the hospital,³ the private hospitals had been closed eee..... we used to request reports from people who were interested and experts in a field....And one that would reflect what those at the grass roots of society and its various levels were feeling.... the nurses used to feel.... lack of esteem...' ⁴

The new government was also aware of the poor perception of nursing in society that was one of the main reasons for a lack of recruitment of student nurses so it had to devise a policy that would be attractive and encourage students to enter nursing. Galea explained:

I mean the perception... there wasn't like when you think where would you tell your children to go to work? "Become a teacher, become a clerk." Ok?... And the University was opening many new courses so we said that as soon as this would happen, there were going to be fewer people entering nursing. And so we got the idea of having the Institute of Health Care at the University.We took the decision, we devised the policy that we were going to open, to set up the Institute of Health Care at that time ok?⁵

Parents were also the target of this policy as they influence their children's choices of careers.⁶ There seems to have been the belief that offering a university course in nursing would make nursing seem more prestigious and hence more desirable. The objective was mainly to enhance recruitment. However, there was another objective and that was to raise the profile of nursing as a profession. Prof. John Rizzo Naudi who eventually became Parliamentary Secretary responsible for the Elderly with a post secondary education incentives of all health personnel, said:

³ The doctors had been locked out after taking part in industrial actions and a mass exodus of consultants and doctors ensued, mostly replaced by doctors brought from eastern European block countries and newly qualified post graduate Maltese doctors who had been studying abroad. Nurses had the added burden of needing to translate for the foreign doctors who brought with them different practices and care pathways that may have been more modern or less modern than the ones used hitherto.

⁴ Interview with Louis Galea

⁵ Interview with Louis Galea

⁶ Bromley H. Kniveton, *The Influences and Motivations on Which Students Base their Choices of Career, Research Education* (Manchester: Manchester University Press; 2004) 72:55; George Bregman & Melanie Killen, Adolescents' and Young Adults' reasoning About Career Choice and the Role of Parental Influence, *Journal of Research on Adolescents* 1999 (9) 3:270.

We need to elevate them [nurses] professionally, raise them. The first thing that I did in '87 when I became parliamentary secretary... I had insisted with the Prime Minister.... they knew that I wanted to push things forward..... I wanted to go for Tertiary level from the beginning.... I knew where I was going.

Work seems to have been undertaken on two separate levels; one leading to tertiary level nurse education and the other leading to the transition. Galea seems to have favoured a transition from traditional courses leading to registration to a Diploma; as expressed below:

We took the decision, we devised the policy that we were going to open, to set up the Institute of Health Care. And to begin with the nurses, to convert the School of Nurses into this Institute that would begin to offer the Diploma, not the Nursing Certificate... at first we kept the Certificate ok, but the idea was that we would give a Diploma.⁷

Soon after the change in government, a delegation from the Ministry of Social Policy visited the UK and requested assistance with the developments planned within the health sector. Two nursing officers from the Department of Health and Social Security (DHSS), Janice Crackett and Denise Donnelly, were selected to compile a positional report on the nursing services in Malta including nursing education.⁸ They were also to make recommendations accordingly. The two authors of this report visited Malta and collected data between 11th and 15th April, 1988 through meetings and discussions with nurses as well as government officials and during visits to various clinical areas.⁹ Crackett and Donnelly suggested that there should first be a diploma in nursing programme which could eventually be developed in a full time degree course. This suggestion seems to have been accepted and acted upon immediately as Dame Betty Kershaw, an expert in curriculum development, recalls that in April 1988 she was asked by the Chief Nursing Officer, Anne Poole whether she:

would be interested in going to Malta to work with the School of Nursing in introducing the Diploma Programme similar to Project 2000... I ended up in July 1988 in Malta,

⁷ Interview with Louis Galea.

⁸ Janice Crackett & Denise Donnelly, Report on the Nursing Services, Nurse Education and Nursing Management in Malta, 1988, 1. Author's own collection.

⁹ Crackett & Donnelly, Report on the Nursing Services, Nurse Education and Nursing Management in Malta, 2.

emm working with the School of Nursing staff; [...] and the teachers in the School of Nursing to introduce a Diploma in Nursing.¹⁰

Kershaw stated that this work was being done alongside work on the degree programme emphasising that: 'This was completely isolated and separate from the degree programme.' Crackett and Donnelly dedicated half of their report to nursing education and included a section on a degree course which Rizzo Naudi had proposed would start in October 1988. The authors contended that this proposal was 'very ambitious' as new degree courses usually needed two years as 'lead-in' period, recording the problems they envisaged would be encountered should exigencies exist for its implementation. These problems included: 'the selection of students, the curriculum development, the provision of appropriately qualified teaching staff and the preparation of the learning environment.'¹¹

No evidence has been found of discussions or consultations having been carried out with any of the other stake holders. Nor has there been any evidence found regarding any kind of feedback from interested parties such as the School for Nurses, the Nursing and Midwifery Board or the Unions representing nurses at the time. Rizzo Naudi seems to have decided to go ahead with plans to introduce nursing at a degree level. It may have been another instance of following the UK but the time lapse between events happening in both countries had become much shorter as nursing in Malta was taken into tertiary level in 1988.¹² Remarking on the situation in UK Betty Kershaw said: 'The undergraduate degrees began to grow up in the late 1960s... but really didn't increase in number until the 1995, 1996.'¹³ Linda Shields and Roger Watson stated that nursing degree courses only came into mainstream education in

¹⁰ Interview with Betty Kershaw.

¹¹ Crackett & Donnelly, Report on the Nursing Services, Nurse Education and Nursing Management in Malta, 14.

¹² MGG Supplement B 1988 Education Act, 1988, 459; MGG Supplement 1992 L.N. 87 of 1992.

¹³ Interview with Betty Kershaw.

Australia in the 1990s¹⁴ so Malta was not very far off. Unusually Malta was slightly ahead of the game.

7.2 Head hunting and fact finding

Rizzo Naudi headed a delegation on a trip to the UK to find out more about these degrees visiting Edinburgh and Liverpool.¹⁵ The choice of universities was not wide as nursing degrees were only introduced in England in the 1970s.¹⁶ In this aspect Malta was unusually slightly ahead of many other health authorities and countries. Rizzo Naudi's past connections as a consultant physician stood him in good stead as he travelled seemingly informally with his 'delegation' driving around to search for assistance in this endeavour. He described this thus:

Tertiary level.... We began immediately. Don't forget eh Mater Dei¹⁷ was already here (gestures indicating mind). As soon as I was appointed for the Elderly, I first went abroad on my own. I went and spent fifteen days and then they scolded me. They told me: "How can you go abroad on your own Minister?" ... then we went to England. We went as a delegation.. I had....Fr Peter's brother... and.... He was marketing. They used to assist me. I had the secretary... Liverpool had, eh... Edinburgh... those two mostly [had a degree programme in nursing]. I had many acquaintances there [in Edinburgh]. They were my friends.¹⁸

Edinburgh had been the first to have a degree programme for nurses in the UK and Rizzo Naudi's delegation met with a nun who also claimed to be a professor and whose credentials were apparently quite impressive. However, Rizzo Naudi recounted that: 'There was something in her that did not convince me' so they decided to delay the decision to recruit her

¹⁴ Linda Shields & Roger Watson, The Demise of Nursing in the United Kingdom: A Warning to Medicine. *The Journal of the Royal Society of Medicine* 2007 (100) 2:70.

¹⁵ Interview with John Rizzo Naudi.

¹⁶ Diane Carpenter, Alan Glasper, Rosalyn Jowett & Peter Nicholls, Celebrating 30 years of Integrated undergraduate nursing at The University of Southampton, Working Papers in Health Science. (2012) Available at: [http://www.southampton.ac.uk/assets/centresresearch/documents/wphs/Celebrating%2030%20years%20of%20integrated%20undergraduate%20nursing%20at%20The%20University%20of%20Southampton\(1\).pdf](http://www.southampton.ac.uk/assets/centresresearch/documents/wphs/Celebrating%2030%20years%20of%20integrated%20undergraduate%20nursing%20at%20The%20University%20of%20Southampton(1).pdf) [Accessed 30 March 2016].

¹⁷ Mater Dei is the name of the new general hospital that was to be opened in 2007.

¹⁸ Interview with J. Rizzo Naudi. Professor Fr. Peter Seracino Inglott, was an advisor to Prime Minister Eddie Fenech Adami and an eminent philosopher who was well known in Europe for his views on social policy and Christian tradition. He became Rector of the University of Malta in 1987.

until they had seen the University of Liverpool programme. This university had been recommended as having a good degree in nursing programme by a friend of Rizzo Naudi, Professor Herbert Michael Gilles¹⁹ who was dean and director of tropical medicine. Discussions must have taken place then as Barbara Burkey who would later implement the degree course in Malta stated that in August her academic superior, Kate Morle had phoned her. Burkey recounted that:

She told me that they wanted somebody to work in Malta and how exciting it would be and she was... I mean it was obvious from her comments that she wanted me to take it up and I said: "No" at first. And, and I said: "I'm busy. I have to go on this conference.... "I'll speak to you when I get back."²⁰

According to Rizzo Naudi the decision regarding which programme to choose was postponed to when they had returned to Malta and become acquainted with the woman from the University of Edinburgh who was purposely invited to visit Malta. Rizzo Naudi said that:

She seemed a bit of a money seeker, understand? Now she was supposedly a nun. Are you noticing the supposedly? She was a proper nun, supposedly. And she came to Malta with lots of pomp and and after she had stayed for some time I told them: "I have decided. This one is no good. We will bring the one from Liverpool. We have more information and a good certification so to speak from there as we have a person, this Gillies who knows them well." Afterwards, about two months later it was revealed that she was a complete fraud.... She was neither a professor nor a nun.²¹

This indicates that the decision to adopt the University of Liverpool programme had practically been taken and Burkey's acceptance of the post was presumed to have been a fact.

According to Burkey:

So a week later she [Kate Morle] phoned me again and then she was telling me about how they were going to have this meeting in Liverpool University where I would, if I said yes, I would go and be interviewed, not interviewed, but looked at by all the people on the Board..... I thought it would be an experience and she said it was only for a year so I thought she knew what she was talking about. I went to this meeting I was sitting on a very long table with mostly men I think, I think it was 99 men ee per cent

¹⁹ Professor Gilles was of Maltese descent whose parents had emigrated to Egypt. He had graduated in Medicine from the University of Malta and had known Rizzo Naudi as they were both interested in tropical medicine. The delegation had worked with him on clinical pharmacy courses to be introduced in Malta.

²⁰ Interview with Barbara Burkey.

²¹ Interview with John Rizzo Naudi.

men. And they were talking about me as if I was not there. They were talking about the recruitee and where I was going and who would pay me and etcetera and at one point, when they were talking about me I sort of put my finger pointing at the top of my head (gesturing) saying: “This is me you’re talking about.” Otherwise I would have been ignored.’²²

In her interview Burkey did not mention much about this meeting except to say that she felt as if she was invisible and not being included in the decisions about herself. Reasons for her cooperation and eventual move to Malta might have included a need to cooperate with her superiors; a sense of adventure or a choice towards encouraging change and empowerment that Maltese nurses so obviously did not have at the time. She might also have hoped that she would not have to refuse since she requested a salary that was equivalent to the one she was earning in the UK that was higher than that proposed by the Maltese delegation. Burkey recounted this saying:

And at the end then I was told that, that I would get so much per month... and I said: “Well I can’t come then.” I said: “No way can I come with that salary.” And they said: “Well, that’s the salary and people are used to it in Malta.” I said: “I know, but I have just bought a new bungalow and it’s being done up and it’s taking an awful lot of work and I, I am removing myself from doing some physical work but I cannot remove my contribution to the expenses of getting it up.” I said: “No, I can’t go.” I, I didn’t think I was going to be coming but then I had a message to say that the Rector had agreed to the... to my demands... just to keep me.²³

This incident is an illustration of how Maltese nurses were not involved in any decision regarding their own future. Discussions might have taken place before the general elections but the actual implementation of the policies was left in the hands of others but not nurses. According to Burkey the delegation at the ‘interview’ consisted of the politician, his secretary; a political appointee, and a pharmacist. The absence of a nurses’ association or a nurses’ union may have facilitated this exclusion and it is difficult to understand why the head of the School for Nurses was not involved. Possible reasons may have included a hesitancy to cooperate in a programme of which nurse educators in

²² Interview with Barbara Burkey.

²³ Interview with Barbara Burkey.

Malta were also unsure and an acceptance that the degree programme possibly would be offered by the University of Malta with an adopted curriculum. Another possible reason might have been the preparations for introducing the Diploma Course in the following September.

7.3 The initial challenge of recruiting students for degree courses

The selection of students may not have been envisaged as a problem by the Maltese government as they believed that the measure of raising nursing education to tertiary level would encourage young people to enter into nursing. Applicants for the first BSc (Nursing Studies) course did not need to have any specific subject at A level. Applicants could come from any field of study provided they had obtained the minimum three A level subjects.²⁴ Only one student applied and the number of students in the following courses remained relatively low for some time.²⁵ Having one student might have been a setback for the authorities and a solution had to be found as the initiative had to be implemented once it had been announced even if only for the government to avoid the embarrassment of being perceived as having failed to succeed in their plans. Changes had to be made in order to go on with the initiative while registering support to innovations introduced by the new government. Decisions were taken at the highest political level²⁶ and the course was offered to already qualified nurses on a scholarship basis whereby ‘students’ would be paid their wages for 14 hours per week for four years and be expected to work in their previous nursing post for 26 hours weekly. In this way, credit was given for the years of experience of these students.

²⁴ MGG 15,071 31.8.88, 3489

²⁵ Medical and Health Archive (MDH) File Number 2297/88 BSc Nursing Course at University of Malta.

²⁶ Interview with John Rizzo Naudi.

No evidence has been uncovered on how this solution was found but Rizzo Naudi stated that they then decided to offer the course to:

persons in post.... the Nursing School... Some senior members... a certain age sort of and fortunately we did not leave anyone out. Because there were many who said: "Now I am not going to study." They did not apply... And we had applications from people who were of a certain.. in their 40s aye?"

Evidence has not been found on the way these vacancies were offered and there may have been a call for applications within the hospital since interviews were held at the University of Malta during the summer of 1988. A group of 26 employees were selected to be granted a scholarship to join the course including three nursing officers and nine nurse tutors who made up nearly all the nurse tutors working at the school for nurses at the time.²⁷ Burkey recalled interviewing all selected nurses again thus:

This was November. The courses at University all started in October so already we were a couple of months further down the line. Then I had to interview every member of that course to make sure they knew what they were coming in to and as a result a few dropped out... I interviewed everybody, wrote bits down about everybody whether they wanted to do it or not and I think they thought the course was, had been promised to them a lot easier than it was going to be...No I was making it far harder, they thought that it was going to be easier because of what they had been told. Now, I don't know exactly what they had been told but they certainly weren't expecting the course they got.... ehm and this was going to be a degree course. It wasn't meaning you'd get diploma standards. They were just... I felt they were trying to appease these group members who wanted to do this course and they thought would be put off by the academic standards that would then be required. But I did stick to what I wanted. The only thing I could not do any thing about was that they were still going to be working so they were going to be part time students but it was agreed. A few of the people who I had originally put the names down for it withdrew, and I don't know why.'²⁸

Burkey had therefore been presented with a group of students who had been selected already and in this way the tradition of nurse educators not being included in the selection had been maintained.²⁹ Burkey stated that she did not know enough of the system in Malta to be able to

²⁷ MDH/2297/88 BSc Nursing Course at University of Malta; No 28. The CGMO wrote to the Establishments Secretary giving him a list of 26 employees who would be joining the course and their grade.

²⁸ Interview with Barbara Burkey.

²⁹ Crackett & Donnelly, *Report on the Nursing Services, Nurse Education and Nursing Management in Malta*, 3.

give ideas or comment at the time so she accepted the situation not voicing her reservations. She may also have felt the urgency to embark on this new course. However, her direct communication with all prospective students may have made the latter realise that this course would not be suited for them.

7.4 The Curriculum – More challenges, more solutions

The course began in November 1988 but it was not to last long as it was stopped a few days later without any declared reason. There is a total silence on this episode as it is not mentioned in any document or interview except by Barbara Burkey who may have been instrumental in this suspension as she claimed that there may have been some conflict of ideas regarding the course content:

It was a new course they were starting and they had done some work into it and when I came and saw the work that they were going to put into it which I wasn't pleased with at all... too much focussed on medical technology.³⁰

The time taken for the Maltese delegation visiting the UK universities to purchase a curriculum may have compelled the organisers to produce a scheme of studies for the interim period. A 1988 document issued by the Institute of Health Care, University of Malta outlines the structure of the degree of BSc Nursing Studies.³¹ This seems to be part of a prospectus and includes subjects such as Clinical Physics and Mathematical Methods that are not found in the BSc Nursing Course transcript handed to students upon graduation.³² The document also includes a 'Position' with reasons for only presenting the syllabus for the first year. These included the need to hold consultations with experts in the field, an admission that if any consultations had been made these were still not enough. There was probably lack of time given that these experts had to be from overseas and there would be logistical problems involved which may have been envisaged by Crackett and Donnehey especially in view of the

³⁰ Interview with Barbara Burkey.

³¹ The University of Malta, (1988) The Institute of Health Care. Unsigned document in author's collection.

³² Author's own transcript of B.Sc (Nursing) Studies 1988-1992.

lack of communication facilities available at the time. If this document was presented as part of a prospectus, then the latest it could have been sent for publishing must have been around late August, and this was the time when Burkey said she was first offered the option of coming to Malta.³³ The document mentioned that the Board of the Institute of Health Care intended to appoint a non-Maltese co-ordinator and that the Government was still working ‘to secure specific support for the financing of the co-ordinator’ for this programme indicating that such a coordinator had not yet been found. Mention is also made that during the first year lecturing could be covered by existing staff of the University with ‘minor supplementation’ in the Nursing Programme on an *ad hoc* basis.³⁴

It is not known whether this document preceded the call for applications for prospective students and it is presumed to be so as it includes a prospectus. It may have therefore been drawn up before the agreement with the University of Liverpool had been finalised since the latter University is mentioned neither as the provider of the curriculum nor as the University endorsing the course. However, in interviews conducted for this study Rizzo Naudi,³⁵ Burkey³⁶ and Kershaw³⁷ agreed that there was an agreement through which the BSc Nursing Course curriculum for undergraduate studies was purchased by the University of Malta from the University of Liverpool and that Burkey was to be sent to Malta to run the first BSc Course.

Finances had been allocated for the purchase of the curriculum but this was only valid for the one student who was studying for registration. The poor response from undergraduates demanded changes to be made in the curriculum so as to adopt it for qualified nurses. Amendments had to be made to have a curriculum that would satisfy the needs of post-

³³ Interview with Barbara Burkey.

³⁴ The University of Malta, (1988) The Institute of Health Care. Unsigned document in author’s own collection, 23.

³⁵ Interview with John Rizzo Naudi.

³⁶ Interview with Barbara Burkey.

³⁷ Interview with Betty Kershaw.

registration students, which were very different from those of the unqualified students for whom the course was intended. Solutions for this problem may have seemed to be quite elusive but the will to push on with the course must have been great as a new curriculum was actually devised for the post registration group that the undergraduate could also benefit from. Credits included those in sociology, inequalities in health, health and wellness, nursing theory and advanced anatomy and physiology.³⁸ Burkey described this phase as:

I worked day and night to try to fathom out just the first year of the course. It was going to be around the course in Liverpool but not directly of the course in Liverpool because I got to know that people in Malta, they hadn't had the same University courses... You couldn't then mix things and I think I gave some lectures on nursing and it was quite disapproved of at the beginning because people said: "We are already nurses we do not need this" but I thought they did and their exam papers at the end proved it. So I, I did give them some nursing emm nursing lectures.³⁹

The time table allowing undergraduates to be away from the ward for 14 hours per week had been organised around the University time table so that BSc Nursing students could join others such as those of Social Policy for certain credits. A solution was found to satisfy the needs of the students but this was apparently in conflict with the University of Liverpool policies. Hence, the University of Manchester was approached to support the plan to provide a degree programme for already-registered nurses. However, the file entitled BSc Nursing Course at University of Malta available at the Medical and Health Department Archives does not include any document recording such a move. It is possible that there are other records of this move that were not available to this study. None of the official documents relating to the programme mention this, and none of the elite participants referred to it. Only Betty Kershaw mentions it in an interview:

The undergraduate BSc was purchased from Liverpool and there were some concerns that it was a Liverpool course being taught in Malta.. regarding the content.. Barbara Burkey spent much spent a considerable amount of time in the early nineties emm

³⁸ Although the nursing registration course included anatomy and physiology the level at which these had been delivered may have been below that necessary for undergraduate tertiary level studies.

³⁹ Interview with Barbara Burkey.

trying to persuade Liverpool to put more Malta.. more of Malta's needs into the curriculum but Professor Kate Morle who was the responsible for the Liverpool link and for whom.. to whom Barbara worked emm was emphatic that if it was Liverpool that was to award the degree it had to be the Liverpool curriculum.... We didn't have that problem with the BSc and I believe the BSc was validated at Manchester not at Liverpool and I think that was the reason... the post basic for post registered ones.⁴⁰

Kershaw was then involved in working with the University of Manchester towards validating the separate curriculum of studies for the post registration undergraduates. Her contribution may have resulted from the coincidence of Kershaw holding a post in a Manchester College of Nursing which had close links with the University of Manchester.⁴¹ However, it may also have been that the Maltese authorities were aware that the University of Manchester had been a pioneer in introducing nursing to University level as described by Hallett.⁴² However, at the end of the first academic year Rizzo Naudi was reported as saying that the first BSc course was based on the University of Liverpool nursing course.⁴³ Reasons for this are largely unknown but there may have been a decision not to show how problematic this change in nurse education was proving to be. The curriculum validated by the University of Manchester could only be pursued by the post-registration group. The one pre-registration student had been granted a scholarship by the government to follow the rest of his studies at Luther College (USA) on a scholarship.⁴⁴

The curriculum followed by the next courses should have been that purchased from Liverpool but there may have been some amendments. Burkey stated that she was persuaded to stay for more than the year she had come for and this may indicate that the terms of her contract were changed so she could stay under different conditions. By this time she had become a key

⁴⁰ Interview with Betty Kershaw.

⁴¹ Betty Kershaw was Director of Nursing Education Stockport Health Authority 1987, which school later amalgamated with Manchester University.

⁴² Christine Hallett, The 'Manchester Scheme': A study of the Diploma in Community Nursing, the first pre-registration nursing programme in a British University, *Nursing Enquiry* 2005 (12) 4:289.

⁴³ Anon, Nursing Course at University *The Times* 10.6.1989, 32

⁴⁴ Interview with Barbara Burkey. Professor Katherine Vigan visited Malta during 1989 and delivered lectures to the BSc students. She was instrumental in securing the scholarship for the sole undergraduate student who was not a registered nurse.

figure in all that was connected to nurse education in Malta. Under the new conditions there may have been a weakening of links with the University of Liverpool allowing changes to be made. Burkey's position may have been strengthened to give her the autonomy that was not intended originally. In her words:

Kate Morle, was going to be in charge of this course from Liverpool, was going to run this course. I don't know what I was going to do and emm she was going to get all the credit as far as I could see. And the gentleman from the University, I will always thank him because he said: "Who is going to be running this course and teaching it?" I said: "I am" so he said: "Well, I think you should be in charge of this then." And he pointed to the fact that there was an anomaly for me to go there and not be given the.. you know the sources to undertake the course... He very clearly said: "If you are running the course you are here running the course, you can't run it from Liverpool."⁴⁵

The changes in curriculum may have been made without informing the originator. They may have involved allocating more emphasis on certain aspects rather than on others. Burkey explained that the main problem was that the authorities in Malta wanted the course to lead to an honours degree probably to allow it more prestige, and that in Malta honours degrees were four year long courses. So:

I went back to Malta with mixed feelings because then I knew I had to get this course going for the four years and the fourth year of the Liverpool course was all to do with research, well that was impossible and there was a lot of stuff to get through but the rest of the University it had to be... they wanted to have it as a emm a special when you do an extra one

Although documentary evidence has not been found, two interviewees for this study who were British tutors mentioned that upon arriving in Malta in the early 1990s, they were involved in curriculum development.⁴⁶ Burkey may have believed that once she was responsible she needed to do all she could to deliver what she knew would be the best for Malta in the circumstances. By this time she may have realised that Malta needed unique solutions that sometimes involved unusual ways to overcome problems. She might have

⁴⁵ Interview with Barbara Burkey.

⁴⁶ Interviews with Nicole Nelson and Tina Ingham.

recognised problems in the way she herself had been recruited and how the first group of students had been chosen.

7.5 Implementing the change – The first steps

When Barbara Burkey was recruited a solution had been found for the Head of Nursing Studies at the Institute of Health Care who would be ready to work as a subordinate of the head of the Pharmacy Department at the University of Malta who was also Rizzo Naudi's collaborator. There may have been an added benefit in the coincidence that the head of the Pharmacy Department happened to be a brother of the rector, Fr. Peter Serracino Inglott. The rector was very supportive of the measure to initiate nursing courses at the University of Malta. His previous involvement in the drafting of the Nationalist Party's electoral programme and his role as a consultant to the prime minister of the time may have been fortuitous. The financial support was important but perhaps more important was the fact that the rector worked and lobbied for the bachelors degree programme to be accepted by the Senate of the University of Malta.

Rizzo Naudi stated that he was grateful for Fr Peter's contribution saying:

I always pray for him a lot. Because even to have it pass for us... through the Senate. In the Senate he let these wet blankets leave [CS: Wet blankets you are referring to those people who did not agree much with this idea] "A degree in nursing?" and ee "where are we heading?"... and at the end of the meeting...[pause] and then he facilitated its passing.... The BSc honours was the first to pass... For nurses.'⁴⁷

According to Galea:

Since there was Peter Seracino Inglott in charge we had full support there. There were a few... but, but as a rector and an influential person Peter Seracino Inglott ... First of all Peter was still at his best, he was still the truly most influential person at the University because he was even consultant to the Prime Minister, he was my consultant and therefore that of the government, ok?because Peter was with us when we modelled the electoral programme aye? So at the University as such, we did not have... if it had been in other times I think there would have been difficulties but in this case we didn't aye? I mean the statute had passed through the Council regularly, ok? The statutes

⁴⁷ Interview with John Rizzo Naudi.

were passed as necessary, the regulations etcetera, etcetera. Today it has become a Faculty like all the others. No problem.’⁴⁸

The problem emanating from the opposition against this move among members of the Senate was therefore overcome. Reasons for this opposition have not been given but they may have been associated with the perception of nursing as not being academic enough.⁴⁹ According to Hallett there had been a similar stance in universities in the UK when the first degree programmes had been introduced.⁵⁰ However, in contrast with the system in the UK, the reluctance to accept nursing at the University of Malta was overcome in a short time and this may have been the result of the way in which political influence and the close network of Maltese society works. The autonomy of the university is compromised by the fact that the Law stipulates that the university receives an annual budget voted by Parliament while the Chancellor is chosen by government in consultation with the opposition.⁵¹ Politicians are therefore very powerful and having friends and collaborators (if not family members) in the right positions facilitates the implementation of proposed measures.

Kershaw stated that the degree programme was bought from the University of Liverpool and it was to be implemented wholly without any modifications for Malta since it was to be validated by the University of Liverpool. In this way Crackett’s and Donnelly’s⁵² envisaged problem of curriculum development had been resolved. The Maltese delegation involved in its purchase may have presumed that the learning environment was already in place since nurse education had been in place for quite some time so it was not perceived as being problematic and the plan could go ahead. There may have been some discrepancies in the interpretation of what a learning environment for tertiary level education should be.

⁴⁸ Interview with Louis Galea.

⁴⁹ Interview with John Rizzo Naudi.

⁵⁰ Hallett, The ‘Manchester Scheme,’ 288.

⁵¹ Zammit Mangion, *L-Istorja Ta’ L-Edukazzjoni f’Malta*, 156.

⁵² Crackett & Donnelly, ‘Positional Report on Nursing Education and Nursing Management in Malta,’ 7.

Undergraduate students following diploma and degree courses would be supernumerary as opposed to the apprenticeship style organisation for traditional students.

In effect this measure brought about a disruption in the way the hospital had been organised for a long time. Mention has already been made of the way student nurses contributed greatly to the daily work undertaken on the wards and in outpatients. The brunt of the change in the student nurses' work scheme had to be borne by the nurses on the wards who found themselves without needed help, and the hospital management who had to suddenly find many more nurses if work was to continue as previously. Moreover, the undergraduate students following diploma and degree courses had to be supervised at all times and, initially, were observers only. The nurses were expecting them to contribute physically while the University needed to ensure patient safety by forbidding student nurses to do physical work unless they were fully supervised. This may have caused some jealousy and resentment from nurses against the students as the workload was also gradually increasing by the added technical work and the extended nurse's role that were encroaching upon the nurses' working system. These circumstances may have led to frustration at the inability to react.

Possible reasons for the lack of reaction or protest have already been given but it is pertinent to note that the resolute way with which the changes were introduced may have discouraged any attempt to raise a point regarding the situation. The determination to raise the level of nurses professionally may have actually brought about a compromise in standards that may have affected patient safety. In their reference to the learning environment, Crackett and Donnelly may have also implied these problems which were either mistakenly overlooked or dismissed in the determination to actualise the change in nurse education. In Rizzo Naudi's words: 'At that time, in '87 we had the green light go, go, go, go... for the next generation,

understand?'⁵³ There seems to have been a sense of urgency to begin this programme. The reason or reasons for this are not known but there may have been the necessity to start the courses in order to fulfil electoral promises or act without hesitancy to address the problem of shortage. One university lecturer said that the government was too politically committed to consider an alternative route.⁵⁴

7.6 Support for the Course – Resource Allocation

After 1989 the University of Malta offered courses in nursing for undergraduates who had no previous nurse training; following the University of Liverpool curriculum. Burkey had been the only nursing lecturer during the first year but more were needed for the next year especially because there would be a need for supervision of undergraduate students on the wards. According to Burkey:

I had to put an advert in to get some help and the beginning of the next year emm we went over to London with Prof Rizzo Naudi and Seracino Inglott and Josef came.... and we chose two people to come...[one] took over the research bit because she was a PhD.... [Another] took on the first year course I think.

One respondent [who is being referred to as Nancy Harrison] said that:

The advert.. was through the University of Liverpool and it was clear that you're being, that you're going to be working in Malta to set up a nursing degree.... And so I got called out for an interview; it was in London, I can't remember where and Kate Morle was definitely on the interview panel emmm and I'm not sure whether it was Prof Rizzo Naudi or not, I can't remember. There were three people. Emm, the interview went well emm and then I was offered the post.... I didn't finish my dissertation until the end of September so what transpired was... that I would hand in my dissertation on the Friday, fly to Malta on Saturday and the course started on the Monday. So I had explained this and they still wanted to appoint me, so what I never knew was whether there weren't that many applicants... trying to get information was very difficult.. the lack of briefing, the lack of preparation that we got for what we were expected to be doing.⁵⁵

The employment of more foreign academic staff members had somehow been managed.

They were mostly British and were to teach different aspects of nursing as well as supervise

⁵³ Interview with John Rizzo Naudi.

⁵⁴ Interview with Nancy Harrison.

⁵⁵ Interview with Nancy Harrison.

students.⁵⁶ The expenses for the course were considerably high especially when computed per student and this is another indication that the Government truly supported the initiative.

According to Galea it was not easy to procure the finances because:

Every time you go for the budget; I mean you have... you have to go up all the way to Calvary, every time emm ehe but, but we used to manage... We first had Dupuis [as Minister of Finance] and then we had John Dalli ok? However, we used to manage to persuade that it was a priority of investment.⁵⁷

The actual approval and support was not however manifested in practice as Barbara Burkey was to find out when she first started to work at the University. The Institute of Health Care did not have any official premises and Burkey was allocated an office within the Pharmacy Department that was headed by a close collaborator of Rizzo Naudi who was then also the Head of the Institute of Health Care. Burkey recounted:

The first thing I noticed was I didn't think they were serious because I was given a tiny office which had belonged to quite a senior member of staff but he was now seconded to another part of the University, but I remember being taken into this room that I was going to be allowed to use and all his stuff was there and I was told not to move anything. Opened the drawer and obviously somebody had smoked and... but I was told I couldn't use the drawers, I couldn't use... there was so many things I couldn't use, I wondered how I would work. And then there was no telephone, international telephone at that time... We didn't have anything then... It was a very long way for me. And then I had to have permission to use one of the phones to get overseas and then everybody could hear what you said in the secretaries' office.⁵⁸

This is very similar to what had happened in Manchester where an office had to be used as a teaching room for lack of resources.⁵⁹ Although this might be interpreted as a sign of lack of esteem for the nursing course, it may also have resulted from poor planning. Although it was necessary for nursing to be visually present at the university in order to make a physical statement there was actually no space in a fast growing institution and the Pharmacy Department did not have much else to offer. The fact that Burkey was not allowed the use of the drawers may have been another sign that those who did not agree with the introduction of

⁵⁶ Interview with Nancy Harrison.

⁵⁷ Interview with Louis Galea.

⁵⁸ Interview with Barbara Burkey.

⁵⁹ Hallett, *The 'Manchester Scheme'*, 291.

nursing into tertiary level could not afford to be seen to be against it for fear of being viewed as opposing the government. The individual who had worked at the office allocated to Burkey may have been in this situation and was therefore being difficult. However, this was not as great a hurdle as some that Burkey experienced which could have compromised the course.

7.7 Unforeseen Problems – The Service Contract and the Effect of Nurses’ Absence from the Wards

A problem that had been lurking and that no one could have envisaged was the contract which the undergraduate post registration students were supposed to sign in order to be granted paid study leave. Students were expected to attend university for 14 hours per week and work for 26 hours weekly and through the two month long summer holidays. The conditions of this contract included that each student would bind him/herself to work in government service for four years after graduation. This contract was to be guaranteed by a hypothec by the student and study leave could be terminated if the student did not perform satisfactorily for named reasons including illness. A clause in the proposed contract stated that:

The student may be required to refund all or any part of the expenses... if a) the study leave is suspended or terminated for any reason; b) if he/she fails to complete the course successfully or c) if he/she fails to serve the government as stated.⁶⁰

The contract had not been mentioned in any previous official communications with the students and the latter opposed it especially because the wording of it may have been interpreted in favour of the government or any other government following should it have decided to terminate the course altogether. Students may have also been worried that they would not be academically able to conclude their studies and be penalised financially. Otherwise they would have had to be subjected to medical examinations including those for

⁶⁰ MDH/2297/88 BSc Nursing Course at University of Malta, 28.

mental health in order to be considered for any abatement of the amount due to be refunded.⁶¹

A certificate of mental ill health could then be used by the same employer to recommend a transfer of the employee from his/her position accordingly.

Another point of discussion was the number of years of service to be worked. Nurses following the course had been asked to bind themselves to work for four years after graduation. Agreement had been reached for these years not to be necessarily consecutive, thus allowing for responsibility leave or post graduation study leave. However, the Establishments Secretary had made an exception to this clause.⁶² Discussions were held during several meetings with the authorities and between the students until the issue was not mentioned any longer. The course had been suspended during this time and this may have been a reason for the issue losing its importance. Meanwhile, some of the selected individuals decided to withdraw from the course immediately or resign by December 1988.⁶³ Their places were taken up by another three NOs and a staff nurse.⁶⁴

In the case of the nurse tutors who were also undergraduates there were special considerations since the nursing school timetables had been altered to allow them to attend lectures but their work load had not been changed in any way. They were therefore still performing all the duties that they had been performing prior to the course but were being asked to sign the same contract as the registered nurses working on the wards and attending university.⁶⁵ Discussions continued after students were asked to attend the signing of their deed of contract in March 1989. This deed was not identical to the one agreed upon in January of the same year.⁶⁶ There was another attempt for this signing in May 1989⁶⁷ and a threat from the CGMO

⁶¹ MDH/2297/88 BSc Nursing Course at University of Malta, 28.

⁶² MDH/2297/88 BSc Nursing Course at University of Malta, 29.

⁶³ MDH/2297/88 BSc Nursing Course at University of Malta, 30.

⁶⁴ MDH/2297/88 BSc Nursing Course at University of Malta, 29.

⁶⁵ MDH/2297/88 BSc Nursing Course at University of Malta, 32a.

⁶⁶ MDH/2297/88 BSc Nursing Course at University of Malta, 33.

⁶⁷ MDH/2297/88 BSc Nursing Course at University of Malta, 32b.

that failure to do so would result in a suspension of the paid study leave⁶⁸ commencing very close to the final examinations of the first year. Similar calls for students to sign the deed in December 1989⁶⁹ and February 1990⁷⁰ remained without answer from the students while the authorities of the Department of Health repeatedly approved leave sessions for students to be absent from work in order to sit for examinations and collect data for research units.⁷¹ The deeds were finally signed in November 1992 after the students had graduated and the students were bound to: ‘serve the Government of Malta for a period of four years;’⁷² thereby omitting the need for these years to be consecutive. The students had in effect held the government to ransom until their studies had ended.

The undergraduates may not have realised how powerful their position had been during the course as they may have capitalised on their position in order to negotiate their eventual conditions if not their work – study scheme. Having been trained to obey during the traditional SRN course, they may have felt that they should not ‘abuse’ their power in case there were such repercussions as stopping the course.⁷³ Conversely they might have believed that the government would eventually agree to a waiver of the contract. The cause for concern was never publicised and the reasons for the delay tactics were never uncovered. At the end the students had signed the contract when its consequences became largely irrelevant as they would only have come into effect if the graduates had resigned from work or terminated their studies before graduation. In this case, if they had signed the contract at the

⁶⁸ MDH/2297/88 BSc Nursing Course at University of Malta, 38.

⁶⁹ MDH/2297/88 BSc Nursing Course at University of Malta, 47.

⁷⁰ MDH/2297/88 BSc Nursing Course at University of Malta, 48.

⁷¹ MDH/2297/88 BSc Nursing Course at University of Malta, 49-53; 68-74.

⁷² MDH/2297/88 BSc Nursing Course at University of Malta, 112; 115

⁷³ These students had lived in Malta during the 1970s and 1980s when the Labour Government had taken decisions such as locking out striking doctors and keeping them out for ten years; stopping courses in arts from being offered by the University and stopping the Faculty of Theology from being included in it. The research aspect of the University had also been stopped. (Zammit Mangion, *L-Istorja Ta’ L-Edukazzjoni f’Malta*, 130). There may still have been a lingering fear of the government being in a position to take similar measures. In fact when the CGMO threatened them with a suspension of the paid study leave, one student who would eventually become the first nurse MP wrote to the CGMO protesting against the threatening tone of the letter and underlining the fact that the government of the day had declared itself against oppressive and imposition policies: MDH/2297/88 BSc Nursing Course at University of Malta, 41.

beginning of their studies, they would have had to reimburse the government pro rata for that part of the four year contract which they would have failed to fulfil. In reality, upon graduation, the nurses went back to working in their posts for the next four years. The students had effectively circumvented the government's demands. However, one student had resigned her post of staff nurse during the second year in order to avoid the contract altogether since the four year service had to be consecutive.

Another unforeseen problem occurred because of lack of planning to substitute students on the wards while they were studying. The service had to bear the consequences of the decision to go ahead with the course as promised probably for fear that students might leave the course and give cause for the opposition to criticise this action. The health authorities were in a position where they had to cope with the consequences of their own acquiescence to the political exigencies of granting paid study leave to these qualified nurse undergraduates. Tertiary nurse education brought some disruption in the clinical field and at the School for Nurses as the undergraduate students who were nursing officers or nurse tutors were suddenly all away from their place of work at the same time. Without substitutes, the immediate consequences of beginning this course had actually been a superimposed 'shortage' over the one already occurring in wards rather than the predicted increase in recruitment.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	U	U/E	M/U	B	O	O	A
Week 2	U	U/E	M/U	O	B	O	O
Week 3	U	U/E	M/U	O	O	B	O
Week 4	U	U/E	M/U	B	O	O	A
Week 5	U	U/E	M/U	O	B	O	A
Week 6	U	U/E	M/U	O	O	B	O
Legend - E = Evening = 1.30p.m. to 6.30pm (20 min break). M = Morning = 7.00a.m. to 1.00p.m. (20 min break) B = 7.00a.m. to 6.30p.m. (15 mins, 1 hr, 15 mins break). A = 7.00a.m. to 8.00p.m. (20mins, 1 hr, 15 mins break). U(niversity) – Whole day (Monday) 8a.m. to 5p.m. Tuesday morning – 8a.m – 1p.m. Wednesday afternoon – 1.30p.m. – 5p.m. O = Off Day							

Table 7.1 - Proposed work roster for First Year BSc (Nursing Studies) students - 6 weeks basis - 26hr work weekly.

According to Table 7.1 students were on campus for the first three days of the week beginning on Monday, a day when ward activities resume after the weekend. Their absence from the ward was on consecutive days and would therefore be felt more. The 26 hours of work per week were divided on a shift basis to allow for work and off days including the same number of Sunday duties students had before joining the course.⁷⁴ In this way the students did not miss any of the work conditions they had prior to joining the degree course. No evidence has been found to indicate the basis for students to attend university for three consecutive days but one reason might have been the timetable of pre-existing university courses that were to be joined for some credits. Burkey commented that the sudden change also resulted in the School for Nurses becoming ‘bereft of nurse tutors.’⁷⁵ According to her this had been a bone of contention between the politicians themselves since the Minister for Social Policy and the Parliamentary Secretary for the Care of the Elderly were in favour of the course proceeding while the Parliamentary Secretary for Health who was responsible for St. Luke’s Hospital and the School for Nurses was against.⁷⁶ Burkey said that when Professor Kathryn Vigan from Luther College visited Malta:

We both met Dr together and emm it was in a... it was a disaster. He said he would never give up his nurses [to follow the course] I remember and she was horrified.... This was on a Saturday morning I think when we went to see him. So he was very cross that he was going to be over ruled but he said at that point: “I’m not giving up my nurses.”⁷⁷

He could have been reflecting medical consultants’ reactions to the ‘disruption’ caused by the virtual absence of nursing officers (NOs) on the wards. The tradition of the nun having been the *factotum* of the ward⁷⁸ had been transferred to the NO who was such a key figure in the ward that his/her regular absence must have caused some disruption. The standard of nursing may have been adversely affected by these absences that could not easily be remedied without

⁷⁴ MDH/2297/88, 28. Sunday duties were paid on a double time basis.

⁷⁵ Interview with Barbara Burkey.

⁷⁶ Interview with Barbara Burkey.

⁷⁷ This indicates the perception of the authorities regarding nurses and the perceived power they had on the nurses.

⁷⁸ Interview with David Attard.

generating ill feelings in those who would be asked to ‘act up’ regularly for four years with little hope of compensation. The Parliamentary Secretary for Health may have had the option of not allowing any hospital bed to be used for the teaching of these students. This measure had been taken by the Education Committee of the Manchester Royal Infirmary upon the introduction of a nursing programme at the University of Manchester.⁷⁹ Yet there was no attempt to be overt in the opposition probably due to the great support from other authorities which the change had garnered. Burkey recounted that upon meeting Galea:

He told me: “Don’t worry. Get on with what you want to do as you have the Prime Minister behind you.” Now, that was the first time I knew that. He said: “We take things to the Prime Minister and you just carry on as you are and don’t worry about anybody else. What you, what you’re doing is what we want and we will back you, so you must stop being worried about it.”

This may be one reason for the lack of any kind of documented evidence indicating any kind of reaction from the leaders of the clinical area towards these changes that affected the hospitals closely. Moreover, none of the politicians are reported to have complained and there seems to have been a consensus on this initiative. Managers in hospitals may have believed that lodging a formal complaint could have been perceived by the Government and the Opposition as a sign of being uncooperative. Those who had most reason to comment were the very few top managers who had to ensure adequate staffing levels. They may have been reluctant to bring the problem to the fore as one solution could have been that NOs would be stopped from proceeding with their studies due to the exigencies of the service, so a complaint may have worked against colleagues, peers and friends or even relatives. As a result the issue seems to have been shrouded from the public as there is no evidence that it was ever mentioned in the media. It may have either been unnoticed, perceived as being of little effect to the public and/or of such minimal consequence to society as to warrant little mention in public. It may also have been convenient for the Government to conceal any

⁷⁹ Hallett, *The ‘Manchester Scheme,’* 289.

problems arising in order to concentrate on finding solutions to overcome each hurdle that it was facing in its endeavour to launch the BSc (Nursing) course.

Solutions had to be the result of lateral thinking but there were limiting factors that could not be overcome. The problem of replacing these students may have been very difficult because the shortage of nurses was acute and the most needed replacements were in the higher grades of nursing that could not easily be replaced. The concept of overtime in the health sector was only introduced later so there was little choice but to allow the wards to suffer in order for the course to go ahead. There might have been the rationale that these actions could be an investment in the professionalisation of nurses and a concomitant rise in standards of nursing. As a result Malta's image abroad would be improved favouring its eventual accession to the EU.

7.8 Recruitment of Undergraduates

Records of the number of applicants per year have not been found but the number of graduates per year (Table 7.2) indicates that the number of students remained small. The great efforts that had been made to offer nursing courses at tertiary level seem to have been met with little support. The Rector of the University of Malta expressed his disappointment at the lack of new entrants into nursing degree courses in 1990.⁸⁰ There was an apparent return to the situation in the 1960s when calls for applications and entrance examinations yielded very few student nurses.⁸¹

Burkey described a recruitment event for school leavers in which she was one of the speakers about new courses at the University while she was also invited on the public media to talk

⁸⁰ Anon, University Welcomes Record intake of 1,110 Students. *The Times*, 2.10.1990, 17.

⁸¹ There were only twenty student nurses admitted in two courses in 1960: NAM/GMR 2263/60 Report on the Medical Condition and Work of the Medical & Health Department. In 1961 only one course could be started due to the lack of applicants having the minimum requirements for entry: NAM/GMR 2385/61 Report on the Medical Condition and Work of the Medical & Health Department.

about the courses. These talks were highly publicised⁸² but there was a very poor response especially from boys' schools.⁸³

Date of Graduation	Number of graduates
1993	11
1994	11
1995	4
1996	14
1997	14
1998	5
1999	16

Table 7.2 - Number of graduates from BSc course per year (1993 -1999) (Source: Medical and Health Archive (MDH) File Number 2297/88 BSc Nursing Course at University of Malta; No 165)

Calls for applications for nursing courses at the University were also highly publicized in newspapers sometimes including full page adverts.⁸⁴ The poor response indicates that in Malta, recruitment into nursing was not only a question of raising the education levels. The perception that Galea mentioned as having been in need of alteration, had not yet been changed and parents seem to have still maintained their stance that nursing was not desirable as a career for their children. Burkey illustrated this in her description of an encounter during her continuous efforts to recruit students. She said:

Another girl who came had a twin and her twin was going into pharmacy and she came into nursing and I did go to meet her, her mother. And her mother was very cross that she was coming into nursing because it had no respect in Malta the nursing profession, and she wanted her to.. at first... they'd applied to do medicine and they didn't get in so at least they should have got into pharmacy but this young lady wanted to do nursing.

The number of applicants was still small and past attrition rates indicated that there was the risk of losing students during the course of studies.

⁸² Interview with Barbara Burkey

⁸³ Anon, Meeting With Prospective Nursing Students and Their Parents *The Times* 23.7.1989, 32.

⁸⁴ *The Times* 23.8.1989, 24; 7.9.1989, 25; 11.9.1989, 22, *The Sunday Times* 27.8.1989, 11.

Anon. Meeting with Prospective Nursing Students and their Parents' *The Times* 23.7.1989, 32.

7.9 The Practice Element – Another challenge

The practice element in the BSc Nursing course was also problematic as it had to be different for post registration students many of whom had already been in nursing for more than 20 years. The minimum number of hours required for registration had been changed and included mandatory experience in community health settings, obstetric nursing and mental health which may have been lacking in some individuals' course for registration. In the case of community health, some students could never have had the opportunity to learn and work in community health settings as these had not been set up before 1980.⁸⁵ Moreover, male students had been forbidden from entering obstetric and gynaecological settings during the 1980s⁸⁶ while many students had not been allocated to the mental health institution due to their small numbers.⁸⁷ Practice sessions had to be planned so that they occurred during the summer holidays and did not disrupt the service further. Consideration also had to be made to accommodate individual students who were going through special events in their lives such as marriages and parenthood, constraining them to be out of work. The BSc course for post registration students had brought in so many challenges that it is not surprising that it was the only one of its nature offered by the University that seems to have had a need to conceal its existence.⁸⁸

There was also the problem of having registered nurses acting as students within clinical areas in which they would be known as being qualified some even as NOs. Moreover, there may also have been an element of awkwardness in having undergraduate Diploma and traditional course students working alongside NOs and qualified staff nurses who were also students. However, at the time there did not seem to be much importance given to this and all students

⁸⁵ Natasha Azzopardi Muscat, 'Health Care Systems in Transition – Malta'. (Copenhagen: WHO, 1999), 9.

⁸⁶ Interview with Konrad Cauchi.

⁸⁷ Interviews with Denise Galea, Iris Naudi and Quentin Borg.

⁸⁸ An advertisement in a 1989 newspaper described the course as being the first one stating, that it was linked with the University of Liverpool and open to undergraduates only.

seem to have taken this situation in their stride. The determination to succeed may have overcome such feelings of discomfort and unease at the unclear boundaries within roles and the levels of responsibility for procedures performed and actions taken during ‘learning’ experience sessions.

The practice element for the new-entrant undergraduate students that was also the second BSc group was different and had to be planned accordingly. The tutors who had come from the UK had been round the hospitals and institutions at the time. One tutor said:

I was quite shocked by what I was shown. Emm I was never allowed in Mount Carmel apart from the administrative area. I was shown round St. Vincent De Paule and was, was very shocked by the conditions in St. Vincent De Paule.... I mean it really was bad.... you could see people working hard but the facilities were very poor indeed and so that was St. Vincent De Paule..... It was decided that St. Luke’s... [One] arrived six weeks later and it was decided that I would link with St. Luke’s,... because she had a mental health background would link with Mount Carmel...[She] and Barbara would link with the community and I’ve forgotten who would take Boffa [Hospital].⁸⁹

There was the danger that undergraduates would leave the course upon being sent to work and facing these conditions. New solutions had to be found so that the students would have the experience, fulfill their duty to work in health related areas but were not thrown in at the deep end encouraging them to leave the course. According to one interviewee who was also a tutor, Burkey had decided that they would be slowly introduced to the clinical area with a lot of support. In her words:

The first year it had been decided that the pre-reg group would not, were going to work in the community because Barbara was trying to delay them entering the hospital sector and because of the system by which they were employees in the summer then that was when they were going to have their first exposure was over that summer. We did during the first academic year because I arranged lots of activities for them that meant they didn’t actually go into the hospital so we did a lot of public health activities in what would have been clinical time in that first year. So for example I used to produce lots of work sheets for them and they would go and visit tourist sites and do health and safety or I would send them out to different parts of the island to look at people’s nutrition and look at what people put in their shopping bag⁹⁰.... So that was my way, our way of

⁸⁹ Interview with Nancy Harrison. [One] [She] refer to the tutor whose name has been withheld for data protection purposes.

⁹⁰ The nursing curriculum for the first year of the course was based on health and wellness.

giving them practical experience, relating it to what they were doing but keeping them out of the bad areas, and in fact they were good exercises because many of the students had not been to parts of the island so when you split them up and you had some of them going to a village and to a village shop and you had some of them looking at the what was the Dolphin's Superstore⁹¹ which was pretty novel at the time in St Julian's and they all came back together. You could do a really good comparison on what was in people's shopping and what they were buying. And they would talk to the shoppers while they were doing it. When we looked at health and safety and emm they would compare the tourist areas with other areas and do walkabouts and one went up by Swieqi which was a fairly affluent area at the time and found all these syringes and needles and it was an affluent area and there was clearly a problem with drugs even then emm others would be down in the three cities walking around and actually they took their initiative and would go and talk to people in... talk to the local policeman. So actually these activities had a real public health focus but it also kept them out while we had longer to try and prepare for their entry into the clinical.⁹²

The curricula for the university nursing courses also had to pass through the Nursing and Midwifery Board of Malta for approval before legislation⁹³ could be passed to recognise the course as that required for registration in Malta. Legislation to support the BSc in Nursing courses was passed through Parliament after the programme had actually started and just before the graduation ceremony of the first group.⁹⁴ This indicates that there was a period during which students were following courses that were not formally approved and it can only be assumed that responsibility for this was being borne by those who were politically committed to see the Institute of Health Care in full operation. One reason for this may be the urgency to start the courses but there may also have been a need to pilot the courses before legislating for their permanent establishment. One interviewee explained that the Nationalist Party may have been afraid of its own MPs since it had a one seat majority, so one MP who may have opposed the initiative could have used his/her vote as a negotiating pawn to have his/her own way.⁹⁵ Moreover, long drawn discussions and the long time taken for legislation

⁹¹ This was a high class superstore mainly for tourists and upper class people who could afford to shop there.

⁹² Interview with Nancy Harrison.

⁹³ Education Act, 1988 (ACT XXIV of 1988), The Course Leading to the Diploma in Nursing or Diploma in Midwifery Regulations 1992 LN 87/1992 issued in MGG 18.9.1986 No 15,654 MGG 1986 Supplement B 462.

⁹⁴ Subsidiary Legislation 327.31 Bachelor of Science (Honours) in Nursing/Midwifery Studies – BSc (Hons) Degree Course Regulations 3.11.1992

⁹⁵ Interview with Nancy Harrison.

to go through the different stages in parliament would have entailed allowing discussion that may have led to postponement and reconsideration by the cabinet to allow the financing of the course.

7.10 Conclusion

The introduction of nurse education into tertiary level seems to have come totally from outside of the institution responsible for nurse education as there is no evidence to support any move towards tertiary education prior to Rizzo Naudi's declaration.⁹⁶ According to Rizzo Naudi, the previous Minister had called upon nurses to further their studies in order to become doctors but had not made any provisions to facilitate it.⁹⁷ The declaration may have been one of rhetoric rather than commitment especially when considering that it was made in 1978 and not mentioned any more thereafter. During 1978, there was a sudden shortage of doctors brought about by striking doctors being locked out of the medical service and may have been mentioned as a tester for reactions to a situation where nurses would be asked to take more responsibility in the absence of doctors. However, no evidence has been found regarding any plans in this direction. There was once more an outside force affecting change in that the introduction of nursing into tertiary level brought with it the influence of the British systems both in course curricula and in delivery systems.⁹⁸

The move towards upgrading nursing education to a tertiary level may have been *the* one that would hasten the way to professionalisation of nursing in Malta. Although offering the first course to already qualified nurses many of whom were NOs and Nurse Tutors, came as a coincidence, it may have been the single factor that had its ramifications within the grass roots of nursing in the wards as well as in the nurse education environment. The NOs were in a

⁹⁶ Anon. New Packages of Services for the Elderly *The Sunday Times* 29.11.1987, 52.

⁹⁷ Anon. University Budget Carried *The Times* 20.11.1986, 24.

⁹⁸ Interview with Nancy Harrison.

position not only to introduce some innovation in practice but also and perhaps more importantly, to contribute towards an environment that would be more receptive to concepts of nursing such as patient allocation and individualised care. Graduate Nurse Tutors could be in a position to contribute in the gradual transition from the School for Nurses to the Institute of Health Care with an upgrade in material and research based tuition for all levels of nursing courses. The result may have inadvertently given Maltese nurses a chance to take part in future decisions earlier than they would have done had the first course been for undergraduates only. As it happened, the first BSc graduates were also experienced nurses who could contribute to future discussions and take part in multidisciplinary conferences that would affect the future of nursing in Malta as a profession.

The events leading to the successful introduction of nursing at tertiary level in Malta may be an example of political influence, determination, collaboration between political and academic leaders and lateral thinking to overcome challenges. Political decisions and fortuitous circumstances may have contributed to a deviation in the plan from its original route. It, nevertheless, appears to have achieved its aim.

Chapter 8

CONCLUSION

8.0 Introduction

This chapter outlines the contribution of the thesis as a description of how nursing in Malta was organised and how changes occurring within and without it affected the process of professionalization. This study aimed to investigate how nursing in Malta changed between 1964 and 1996 in education, organisation and management and how it moved towards professionalisation. The impact of changes on nursing as a budding profession in the wake of Malta's first years as an independent state was explored. Factors such as the effects of political expediency, emancipation of women and the decline in the number of nuns in hospitals together with technological changes and tertiary education were discussed. The study presented the way nurses in Malta conducted themselves in reaction to changes – imposed and circumstantial. This behaviour may be interpreted as a unique way of coping that may have both hindered and facilitated the process of professionalisation.

8.1 Contribution of the Thesis

This study is the first to outline the history of nursing in Malta after Malta achieved independence and therefore gives visibility to Maltese nurses in society during the period 1964-1965. This work provides an identity to modern nursing in Malta and should help nursing in Malta to evolve and grow as advised by Lewenson and Krohn Hermann.¹ It also provides an initial preservation of evidence that may be lost with time. This is especially so with the oral history interviews with former nurses.

¹Sandra Lewenson and Eleanor Krohn Hermann (eds) *Capturing Nursing History* (New York: Springer Publishing Company; 2008) 2

A lack of literature pertaining to the subject brought with it difficulties in finding sources of information. Diverse sources of data that had not been tapped before were sought and their use provides data for future study. The small amount of information gleaned from such sources as the Government Gazette and the daily newspaper indicates that nursing was not given much importance by society. It also shows that nurses were silent for a long time and this may have been the result of a lack of education but also that they were performing their work irrespective of conditions imposed upon them.

This study uncovers some reasons why, in Malta, the image of nursing was poor and remained so for a long time. The nurse emerges as a worker who was probably one who had been a hospital attendant and therefore not very knowledgeable, and who needed to be supervised at all times. Obedience without question and a lack of autonomy was the order of the day. The kind of work nurses carried out consisted mainly of fundamental care practices without therapeutic intent, along with cleaning duties, work roles that were unlikely to enhance their image.

The reaction to imposed measures may have been typical of a people who had just emerged from a long period of colonisation since it was minimal at best. The authorities regarded themselves and were regarded as knowing what is best. This may have been a symptom that was also present in the whole of Maltese society so that initiatives towards professionalisation of nursing were slow in coming from within nursing as well as from without. The nurses did not protest and went on with their work without questioning the imposition of new policies from above. Maltese nurses seem to have lacked professional awareness or chose to obey rather than stir trouble. The lack of professional awareness may have resulted from a lack of education in critical thinking but the decision not to react may have been the 'natural' one taken by people who have adapted to colonialism in such a way

as to be unable to protest. They may have been behaving in a typical Maltese way especially since they did not perceive any financial gain in reacting.

This thesis demonstrates the unique way nursing in Malta was organised from 1964 to the late 1996. The nuns and later on the nursing officers were at the helm but not in the highest administration as the major decisions were taken at the Health Department. The lowest grade of nurses who were not very knowledgeable far outnumbered the qualified nurses so that patient care had to be given by them. The few qualified nurses depended on the former hospital attendants for support and cooperation. This is the first attempt to describe nursing in Malta in any way and may inform future research. It is possible therefore, that this research and the reporting of its findings may offer insights which move nursing forward along the continuum of professionalisation. Although the official opening of St. Luke's School for nurses and the introduction of nurse education at tertiary level were definite instances that spurred on the process of professionalisation, the resultant changes in nursing in Malta were so gradual that one can speak of a continuum of professionalisation. There were also instances where actions taken actually brought about a hindrance in professionalisation causing a delay in the process. The 'upgrade' of health attendants to nursing without much training and the continued practice of offering multiple entrance opportunities are two examples of these actions. Nursing remained generally one that was trained in practice while not having a high level of theoretical knowledge so that nurses were not perceived as knowledgeable enough to be considered as professionals by society.

8.2 Limitations of the Study

Although all efforts were made to ensure rigour in the research process underlying this study, it still has several limitations. One such limitation is the broad approach of the study undertaken in order to give an overview of nursing in Malta and the depth in which particular

aspects had to be studied to find plausible explanations for the outlined changes. Several factors acting together may have been inadequately described so that the full complexity of the situation may not always be captured and may not be explicit.

Another limitation may result from the fact that some potentially informative archives were not available for study. Therefore there may be information that is lacking and which would have given the results another direction had they been tapped. A lack of previous work in the subject area could have affected this as well. The snowball sampling method used to recruit respondents for the oral history data may have resulted in themes not being uncovered. In requesting interviews with foreign nurse tutors an attempt was made to capture the facts of nurse education at tertiary level.

8.3 Researcher reflective process

The extensive background reading into the historical events the Maltese experienced under different dominions but more importantly for this work, under the British rule allowed the researcher to delve deeply into the colonised mind as described by various authors such as Edward Said², Carmel Borg and Peter Mayo.³ The anthropological studies of the Maltese by Jeremy Boissevain⁴ deepened the author's understanding of how the Maltese cope with situations. This enhanced the hermeneutic interpretation of the evidence provided by participants and found in the archives. During the course of this study, the researcher moved away from previously held beliefs that history consists of a narrative, and move instead towards the realisation that history is a multifaceted narrative. This is in contrast with quantitative research where statistical data can lead to definite conclusions even though there

² Edward W. Said, *Culture and Imperialism* (New York: Vintage Books; 1994)

³ Carmel Borg & Peter Mayo, *Learning and Social Difference: Challenges for Public Education and Critical Pedagogy* (New York: Routledge, 2016)

⁴ Jeremy Boissevain, *Saints and Fireworks: Religion and Politics in Rural Malta* (Malta: Progress Press; 1993); and *Factions, Friends and Feasts: Anthropological Perspectives on the Mediterranean* (New York: Bergahn Books; 2013).

is always some space for interpretation. This realisation contributed to a gradual maturity as a data collector, analyser and interpreter. There was also an increased awareness in the researcher regarding the effect of gender, age and other personal characteristics such as ability on producing a historical narrative. Awareness of these characteristics as well as the experience of the times under study developed in the researcher a critical stance towards the emanating information.

8.4 Main deliberations of the thesis

Malta gained Independence from Britain in 1964 after more than 150 years of being a British colony and many more centuries under various rules. The Maltese had coped with colonisation by going about their life as subservient people but carrying on with their own business as much as possible, assisted by a network of personal relations and acquaintances that would be useful from time to time.⁵ Maltese nurses may have had similarly passive reactions to changes occurring in at their place of work.

Health services in Malta prior to Independence had been led by Maltese health authorities without much direct intervention from the British, but the way they operated strongly emulated that of the British. After Independence this strong following of the British system remained. However, individual politicians responsible for health became more powerful as they became more involved in the everyday running of the Department of Health.⁶ The setting up of a School for Nurses and introducing nursing at tertiary level were changes in nurse education that really brought about a position for nursing on the continuum of professionalization. Although these were defining changes in the process of

⁵John C. Lane, The Election of Women under Proportional Representation: The Case of Malta, *Democratisation* 1995 (2) 2:154. Jon P. Mitchell, An Island in Between: Malta, Identity and Anthropology. *South European Society and Politics* 1998 (3) 1:145.

⁶Edward Warrington, The Fall from Grace of an Administrative Elite: The Administrative Class of the Malta Civil Service and the Transfer of Power – April 1958 to September 1964. *Journal of Maltese History* 1 (2008), 48-66.

professionalisation of nursing in Malta, their effect was gradual indicating a continuum rather than a process occurring in stages. The singular way that the Maltese authorities brought about change and the unique manner of Maltese nurses' reactions also affected the process of professionalisation.

8.5 Change or no change?

A 1957 report on the health services in Malta had expressed the necessity for more qualified nurses if nursing was to be equipped for the care of patients in modern times.⁷ The delivery of nursing was being made by Hospital Attendants (HA) who far outnumbered registered nurses in Malta.⁸ Standards of care were the responsibility of nuns, members of the congregation of the Sisters of Mercy who effectively ran all the hospitals in Malta.⁹

In 1969, the Maltese government amended the Medical and Kindred Professions Ordinance¹⁰ allowing hospital attendants to be called nurses and be accepted in the newly created Roll of Nurses. HAs had therefore become 'nurses' overnight, a change that was in effect slightly felt as the actual delivery of nursing care had long been performed by HAs. The designation of the title 'nurse' was detrimental to the perception of nursing in society. The title had been exclusively reserved for SRNs, giving them prestige. HAs were called '*servjenti*' in Maltese from the Italian word for servant. The change in title that may have been aimed at raising the profile of nursing so as to encourage recruitment may have had the opposite effect in that nursing may have become devalued on being seen as an occupation requiring little preparation and having to deliver care under constant supervision. It compromised

⁷ NAM/GMR/1999/1957 Leslie Farrer-Brown, Harold Boldero & James B. Oldham, *Report of the Medical Services Commission* (Malta: Department of Information, 1957) 27: 106-109.

⁸ Farrer-Brown, Boldero & Oldham; Report of the Medical Services Commission, 27:106-109.

⁹ Alexander Bonnici, *Is-Sorijiet tal-Karita' u l-Hidma Tagħhom f'Malta*. (Malta: PEG; 2002), 326.

¹⁰ MGG Supplement A 1968, ACT XXIII (1968) The Medical and Health Department Constitution Ordinance Cap 148, 235.

autonomy for nurses that may have been developing through the slowly increasing number of qualified registered nurses.

Nevertheless, there may have been less impact on the general public than may be implied as Maltese people had already been used to being ‘nursed’ by HAs upon becoming patients. Patients tend to place all those who assist them under the name of ‘nurse’ irrespective of education and training levels.¹¹ Moreover, the Maltese seemed to be resigned to accept all that is provided by the authorities having little choice as there was only one system available for them. No evidence has been found to indicate that the government had consulted the nurses before changing the legislation and discussions had only been held with the union representing the HAs.¹² There may have been a need to appease the union and its members to avoid discontent as well as some degree of paternalism behind this action. SRNs may have accepted their lot without much comment in a mode of behaviour that was common amongst the colonised

SRNs went on doing their job in silence accepting the decisions taken about them. Reasons for this may include a lack of knowledge of the wider implications of the measure so that they were not really aware of what it meant, a lack of readiness to speak up in view of their minute numbers and lack of support, a lack of motivation to act when they knew that most of them would not be nursing for long due to the marriage bar and a lack of motivation in the awareness that their career prospects were very slim since only nuns could occupy higher positions. The change from ‘attending’ to ‘nursing’ may have really begun in the late 1970s when more SRNs began to qualify and when the number of enrolled nurses who had been through a two year course began to increase. Although boundaries were unclear, the added

¹¹ Anne Crowther & Susan McGann, Professionalism and Prestige, a British Perspective on International Nursing Organisation in the Twentieth Century, 3. Presentation based on the historical archives of the Royal College of Nursing (RCN). Available at:

http://www.who.int/global_health_histories/seminars/presentation25.pdf [Accessed 23 September 2016].

¹² Registered Nurses did not have a Union at the time.

knowledge was reflected in the way nurses acted in their work especially with the introduction of technology. A combination of factors and events lead to the introduction of nurse education at tertiary level and the emergence of a new meaning for nursing care that would slowly replace 'attending.' The significance of education in nursing care standards had been established.

The management of nursing in Malta was also to change in the period under study (1964-1996). The nuns had been at the helm of Maltese hospitals since 1871, supervising all workers including nurses. They were not all necessarily registered nurses but they kept constant watch on the nurses throughout the day and night. In 1967, only one of them had had formal education in management.¹³ However, their disciplined manner and the discipline they fostered among their subordinates contributed to an image of control and level headedness that instilled confidence in patients and their relatives. The fact that they were religious, and therefore presumably believed to be near to God added an aura of righteousness and possibly assimilated power. Patients and their relatives felt safe resigning themselves to the care of the nuns. In Malta, nuns did not need to raise any kind of funds. This might have made them dependent on the authorities and generally acquiescent had they not demanded autonomy from the outset.¹⁴ This may explain the element of acquiescence when the authorities implemented changes that they may otherwise have protested against such as the changes in working hours for students and the transfer of nurses between wards and hospitals in the latter part of their contribution. The tensions reported elsewhere between the religious and the secular¹⁵ were never really apparent in Malta not least because of the Maltese way of accepting authority at the time. The gradual decline in numbers of the nuns

¹³ Bonnici, *Is-Sorijiettal-Karità u l-Hidma Tagħhom f'Malta*, 343

¹⁴ Alexander Bonnici, *Is-Sorijiettal-Karità u l-Hidma Tagħhom f'Malta*, 326.

¹⁵ Barbra Mann Wall, "We Might As Well Burn It": Catholic Sister-Nurses and Hospital Control, 1865-1930. *U.S. Catholic Historian, History and Gender* 2002 (20) 1:27.

led to a natural death in their role in nursing in Malta, thus avoiding confrontation that may have come due to the general secularisation of Maltese society during the 1970s.

The real change in the transition between the religious and the lay in nursing management may have been the loss of autonomy. The new elite were more amenable to the health authorities and to the medical profession as they did not have the Mother Superior or the congregation to which to adhere. The individual's opinion and personal agenda for career progression may have been forces that led to a higher degree of acquiescence than that of the nuns. The absence of a leader which the nuns had in the Superior and the lack of unionisation that may have substituted the role of the congregation left Nursing Officers (NOs) to their own devices. They may have been more highly trained for nursing but their training had been geared towards obedience and maintaining cleanliness and order. The only exposure they had had to management systems were those demonstrated by the nuns and they could only try to emulate them. However, their lack of spiritual power rendered them to be less revered and their authority was thus diminished. This was compounded by the fact that lay NOs had fixed rota and were therefore not supervising all the time like the nuns. Being promoted from among peers who had long been their working colleagues also contributed to a lack of authority and self confidence. This is because in such a small community the probability that former peers are also acquaintances or relatives was increased. Dissent and opposition from subordinates could be expressed more freely due to the familiarity that had been fostered before promotion. Familiarity also encouraged favouritisms and could possibly have discouraged disciplinary actions. The order and discipline were slowly eroded, affecting the image of nursing negatively.

During the 1970s and 1980s Maltese society became increasingly tolerant of favouritisms according to party allegiances.¹⁶ These favouritisms could have resulted in a threat to the lay NOs' authority who could not really exercise the discipline of the nuns. Party allegiances placed individual nurses in a position where they could influence decisions about disciplinary actions and promotion, indirectly undermining the NO's power. However, there is no evidence of much comment on this state of affairs that may have been yet another demonstration of the Maltese way of dealing with the 'ruler'. Moreover, due to the small size of the island, networking was very dominant and kinship brought together people who interacted within different circles in what Richards called 'an overlapping and coincidence of roles'.¹⁷ Authority over subordinates could therefore be somehow threatened while new ideas may have gained support or found opposition as a result of previous relationships.

Decisions to add new health services and expand others were taken by politicians and health authorities so that emerging specialities such as coronary care could be introduced. No evidence has been found to indicate nurses' involvement in these decisions. The introduction of medical technology brought with it an extended role in the nurses' duties while offering more treatment options to patients with increasing demand for beds. In 1977, doctors in government employment went on strike and were 'locked out' of government hospitals. This brought a sudden change as Maltese nurses had to take on more responsibility and act as translators for foreign doctors who were brought to take their place. The doctors' strike lasted for ten years and brought with it a sudden closure of private hospitals. There was an unprecedented surge in the demand for acute beds that brought with it a shortage of nurses began to be acutely felt but once again nurses did not protest and continued to work in all prevailing circumstances. This reinforced the image that nurses could and would take on

¹⁶Jeffrey Richards, Politics in Small Independent Communities: Conflict or Consensus? *The Journal of Commonwealth & Comparative Politics* 1982 (20) 2:159.

¹⁷ Richards, Politics in Small Independent Communities, 158.

responsibilities as necessary but not the autonomy. This may have hindered professionalisation of nursing. The nurses' lack of assertion may also have led to a further lack of definition of nursing's specialized knowledge base so that nursing professionalisation was hindered. The era of unquestioning obedience came to a close with the emergence of the Malta Union of Nurses in 1976. Collaborative decision making and actions to preserve the nurses' conditions resulted in nurses being more vocal. This has been associated with enhanced professionalisation.¹⁸ The first courses in management were organised in 1981 as post registration courses that would later be a requisite for application for promotions. In this way there was a great change from 1967 when there was a single nun with academic qualifications in administration to 1980s when many nurses who been instructed in management. The role of education as a basis for improved practice had been acknowledged.

8.6 Real change towards professionalisation

Perhaps the two main milestones that brought change in nursing occurring during the period under study were the official opening of the School for Nurses in 1965 and the beginning of nurse education at tertiary level in 1988. The opening of the School for Nurses made an impact on the image of nursing as a learned occupation while the introduction of nurse education at tertiary level brought with it the initial awareness that nursing could be a theoretically based occupation and even a profession.

The School for Nurses followed schools of nursing elsewhere in its regulations¹⁹ and system of teaching theoretical and clinical nursing. Recruitment into nursing was a perennial problem throughout the period under study (1964-1996). In the earlier part of this period

¹⁸Karen Lucas Brader, Professional Nurses in Unions: Working Together Pays Off. *Journal of Professional Nursing*. 1997 (13) 2:103.

¹⁹ Barbara Mortimer, The History of Nursing: Yesterday, Today and Tomorrow. In: Barbara Mortimer & Susan McGann (eds) *New Directions in Nursing History: International Perspectives*, (London: Routledge; 2005),10; Gerard Fealy, *A History of Apprenticeship Nurse Training in Ireland* (Oxford, UK: Routledge; 2006) , 30; Janet C. Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta (1859-1996)* (Alberta, Canada: The University of Alberta Press, 1998),151.

adequately educated people who would willingly work as nurses were scarce due to the general lack of education and the poor perception of nursing. Requirements for recruitment were not standardised and the multiple ways of entering nursing contributed to differences in academic level that would be reflected in student and pupil nurses' academic and professional performance. It would also compromise the process of professionalisation of nursing due to unclear standards of knowledge. The common practice of influential individuals and politicians recommending their acquaintances or members of their constituency irrespective of aptitude or adequacy compounded the problem.²⁰ However, there was little comment on this behaviour that seems to have been accepted as the norm.

The school offered apprenticeship style training for registered and enrolled nurses through which students were trained to carry out procedures, perform tasks and generally do what they were asked to do without question. This was similar to other countries' systems such as the UK,²¹ North America²² and Canada.²³ Much of the work on the wards was actually carried out by learners resulting in varying standards of care. In this system, Malta seems to have been following other countries but may have differed during the time when the great majority of individuals carrying out nursing tasks were the less trained HAs who could not effectively supervise students

Nurses qualifying through this system were instructed and examined on the medical model nursing, both in theory and in practice.²⁴

²⁰Pirotta and colleagues stated that there is a persistent 'standard practice for appointments and promotions [that] is essentially a recommendation from party headquarters.' Godfrey Pirotta, Isabelle Calleja, & Cesar Colino, *Sustainable Governance Indicators: 2014 Malta Report*. Bertelsmann-Stiftung (ed.) (2015). Available at: www.sgi-network.org/docs/2014/country/SGI2014_Malta.pdf [Accessed: 12 February 2016].

²¹Ann Bradshaw, The Covenant of Care, *Journal of Medical Ethics* 1999 (25) 478.

²²Martha Scheckel, 'Nursing Education: Past, Present and Future.' In: Roux, Gayle & M Halstead, Judith A. (eds.) *Issues and Trends in Nursing: Essential Knowledge for Today and Tomorrow* (Sudbury, MA: Jones and Bartlett Publishers, 2009), 33.

²³Ross-Kerr, *Prepared to Care*, 146.

²⁴Betty Kershaw, 'Report of visit by Betty Kershaw 19.06.89-29.06.89' Unpublished Report; author's archives.

The move towards founding nurse education at tertiary level was another instance of Malta following other countries such as the UK. However, it came relatively early considering that it was initiated in 1988 when in other countries such as UK and Australia nursing courses at university level were still few in number.²⁵²⁶ It was also somewhat accelerated and implemented in a shorter time than the two years recommended by experts brought over to make recommendations for the purpose.²⁷ Political commitment and the determination of individuals who contributed to its implementation may have been reasons that facilitated the change. Although seemingly overly ambitious and probably unique, the simultaneous embarkation on diploma and degree level of nurse education resulted in effectively closing down the School for Nurses and establishing nursing at a solely university level. As in other instances of changes being implemented in nursing, there was little overt opposition to these measures.

. A major hurdle was the very low number of students applying for the first undergraduate course that demanded a change in direction so that the course was offered to nurses who were already registered . The initial group of students was atypical in that it consisted of post registration students including nurse tutors and nursing officers. As a result there was a confusion of roles on the wards where they needed experience. Nurse tutors suddenly became learners for part of the week on the same wards as their students, while nursing officers left their wards to enter those of others as students. Preregistration undergraduate students on the wards became supernumerary and their role as observers became sacrosanct. Their need to be supervised at all times was also established and they could therefore no more be assigned work for which they were not academically prepared. Nurses working on the

²⁵Jane Brooks, The first undergraduate nursing students: A quantitative historical study of the Edinburgh degrees, 1960–1985, *Nurse Education Today* 2011, 6:633

²⁶ Linda Shields & Roger Watson, The Demise of Nursing in the United Kingdom: A Warning to Medicine. *The Journal of the Royal Society of Medicine* 2007 (100) 2:70.

²⁷ Janice Crackett & Denise Donnelly, Report on the Nursing Services, Nurse Education and Nursing Management in Malta, 1988, 14.

wards hardly commented on any of these measures, accepting the added burden of having less support while needing to supervise students. They were also not graduates themselves so there was a quasi identical situation to that of the early 1960s where students had to work alongside and ‘learn’ from those who were not as learned as they were.

The move towards tertiary education entailed a change from the medical model to a more holistic model of care together with a problem solving approach. The importance of research had also been emphasised within the curriculum. The move towards tertiary level may have improved people’s perception of nursing but the simultaneous increase in choices of careers mediated low recruitment rates. However, the concept of the nurse as a university graduate became gradually known within society and nursing could find its place along the continuum of professionalisation. Education had been consolidated. There might also have been a leap in the general population’s perception since the concept of nursing as a learned profession was instilled enabling society to eventually begin to accept it.

8.7 Going it alone – with a little help from abroad

The development of nursing in Malta generally followed and was heavily influenced by that of the UK. Between 1964 and 1996, there were many instances where measures were adopted from abroad and resources brought in to implement them. The whole system of nurse training was based on the British system that was also adopted elsewhere. In the case of tertiary education there was the assistance of two British universities.

In the clinical area, nursing administration and organisation of work systems also followed those in the UK. A British Matron was brought to Malta during the 1960s²⁸ to implement a system that was similar to those in the UK. The introduction of the enrolled nurse course and the grade of enrolled nurse were also in keeping with the British system. However, the

²⁸Interview with Olivia Gatt. The exact date of employment of the British matron could not be ascertained from the available documents as she was not listed in the Staff Lists consulted i.e. those from 1957 to 1996.

implementation of this measure was in a very different manner and acted as a barrier to professionalisation of nursing as it introduced a second level of nursing²⁹ affecting the image of nursing as an occupation requiring little educational preparation.

The effect of colonisation on nursing in Malta may have brought about a remaining perception that what was British had to be good for Malta. This may have been an oversimplification that resulted in changes of direction sometimes even verging on the opposite to those intended. . Experts and individuals implementing change who were purposely brought to Malta contributed greatly to the changes in nurse education. However, the details of execution of these changes in Malta may have been affected by the Maltese ‘modus operandi’ so that results were reached in a more tortuous way than previously envisaged.

8.8 The Maltese ‘modus operandi’

In 1964, Malta was granted independence from Great Britain after 164 years. The ties and the systems that had become a way of life in Malta could not suddenly be halted so it may have been natural for the Maltese authorities to seek resources from Britain. The history of Malta and the Maltese people is one of being under the reign of other countries and the Maltese people seem to have accepted this domination probably in the understanding that Malta could not thrive without economic activity with other countries and the protection they could provide.³⁰ They learnt to appease their rulers, adopted the latter’s ways and comply with them while still going on in their ways as they felt would benefit them best, sometimes adopting unique ways.

²⁹The multilevel system of nursing is considered to be a barrier to professionalisation of nursing: Fataneh Ghadirian, Mahvash Salsali & Mohammed Aki Cheraghi, *Nursing Professionalism: An Evolutionary Concept Analysis, Iranian Journal of Nursing & Midwifery Research*. 2014 (19) 1:6.

³⁰Brian W. Beeley & William A. Charlton, *Maltese Patterns of Dependence: An Historical Perspective; Scottish Geographical Magazine*, 1994 110:113.

Developments in nursing during the period under study came about generally upon the initiative or the personal endorsement of politicians, mainly the minister responsible. The nurses do not seem to have expressed opinion on the decisions taken.

The change in status from HAs to SENs seems to have made little difference in the way nursing in Malta had been organised before and may have been perceived as being cosmetic only. Registered nurses who were very few may have had little motivation to complain as it was not really affecting their pocket or their career progression. They either did not discern or preferred to keep silent at the fact that such a seemingly meaningless change was in effect devaluing their profession. In this way, the Maltese *modus operandi* had come into effect; the politician initiated a change and the people accepted the government's actions as long as their pockets were not affected.³¹

The government's ubiquity encouraged individuals to ask for favours but it also discouraged criticism as this could potentially result in deep enmities.³²

During the early part of the period 1964-1996, Malta lacked a critical mass of registered nurses who did not have a union so they could do very little to affect their professional status in terms of lobbying with the politicians who could affect changes. This is perhaps why the change in title from Hospital Attendant to Enrolled Nurse was allowed to happen with little if any comment from nurses. A prolonged *status quo* followed, which indicates that nursing was not really top priority in governments' agenda. A transfer of power from the nuns to the lay nurses came as a result of further lobbying from the Unions and a simultaneous decline in the number of nuns. No evidence has been found of much planning for such a transfer. Nor

³¹Jeremy Boissevain, On Predicting the Future: Parish Rituals and Patronage in Malta in Sandra Wallmann (ed) *Contemporary Futures: Perspectives from Social Anthropology* (London; Routledge, 1992) 75. Boissevain contended that the Maltese have a tendency to act or react to a situation if they have an egoistic motivation. In this case Maltese nurses may have decided that reacting would not be in their best interests given that they were still not going to gain much in terms of career progression and pay.

³²Richards, *Politics in Small Independent Communities*, 159.

has any evidence been found regarding any reaction from nuns, nurses or the general public. The *modus operandi* of top down change instigation seems to have been accepted by all.

The same *modus operandi* is evident in the move to introduce nurse education to tertiary level in 1988, demonstrating the power of the politician and the perpetuated perception that nurses were still not sufficiently well versed in their affairs to be consulted on how to implement changes that were to affect their profession. There may have been some condescension in the fact that no nurse is recorded to have contributed to the proposed change. Experts in the field who had been commissioned for advice had not been heeded and the government pushed for implementation immediately rather than taking time to prepare as advised. This may be an indication of how binding a political commitment can be; once the promise has been made all efforts need to be made to carry it out irrespective of the difficulties arising. Solutions may have verged on the unorthodox and ingenious. In Malta they did not raise much comment and the uphill struggle was allowed to go on. It may have been the single most important act to move nursing forward along the continuum of professionalisation.

8.9 The influence of extraneous circumstances on professionalisation

Events leading to a positive move towards professionalisation of nursing in Malta were mostly extrinsic as the nurses themselves do not seem to have had great expectations. The increasing technology that was being used in health care mandated a more academically prepared nurse who could absorb information, analyse it and use it effectively in her work. The progress made by society in achieving higher levels of education made this possible as more people could be found to take up the level of study needed for the complex role expected of the nurse in modern times. The rise in education may have been most timely in the move towards professionalisation. The emancipation of women and the global move

towards accepting married women as workers outside of the home was also a coincidental occurrence that gradually improved quality and quantity in nursing in Malta. When more women went into the labour market the choice for recruitment increased. The removal of the marriage bar put a stop to the haemorrhage of nurses that had been taking place before and the number of nurses in employment continued to increase. As a professional group, nurses were on the way to establishing a professional body that would be ‘basically intellectual, carrying with it high responsibility, learned in nature, practical as well as theoretical, with a technique that can be taught through educational discipline, well organised internally and motivated by altruism.’³³

Malta’s aspiration to be admitted into the EU was also advantageous as it spurred the government to reach a pre determined standard in health and in nursing. This coincided with the move nurse education in Malta had made to embark on a project that was similar to the UK’s Project 2000 so the concerted effort of two separate teams with invaluable inputs from experts from the UK enhanced the process of professionalisation of nursing in Malta.

The determination to embark on tertiary level nurse education was also important in the endeavour to enhance the process of professionalisation.. However, the recruitment of Barbara Burkey who would implement the change was also advantageous as she happened to be committed, hard working and well prepared to face opposition even from unexpected angles. A conviction that this was the right direction and perseverance to pursue it may also have contributed to the professionalisation process.

³³ These were the characteristics of a profession put forward by Abraham Flexner in 1915: Abraham Flexner, “Is Social Work a Profession?” in *Proceedings of the National Conference of Charities and Corrections*. (Chicago: Hildermann Printing; 1915), 579

8.10 Factors hindering the professionalisation of nursing in Malta

The process of professionalisation of nursing in Malta was hindered by various intrinsic and extrinsic factors. One major extrinsic factor hindering professionalisation was the public perception of nursing in Maltese society at the time of this study, which was generally low. Being seen as employees who were constantly under supervision was not conducive to an image of professionalism. A failure to be recognised by society as a profession is highly detrimental in any attempt to achieve that status.³⁴ The gender distribution of nursing as a female dominated profession was another hindering factor in professionalisation aggravated by the marriage bar that resulted in many female nurses being young and relatively inexperienced. As a consequence the majority may not have had the motivation to take initiatives towards professionalisation since they would not be able to reap any benefits. Another outside factor hindering professionalisation of nursing was the general education of the public that was generally low especially in women and therefore hindered recruitment of new nurses both in quality and quantity. Professionalisation could not be contemplated while the general education in Malta was low.

Within nursing, the medical profession delivered a substantial portion of lectures to student and pupil nurses so the body of knowledge that was the basis on which nurses were instructed was mainly medical based. Another intrinsic factor hindering the process of nurse professionalisation in Malta was the lack of change in curriculum studies. Evidence based changes that had been made in other countries such as the UK had not been adopted in Malta; a fact that was somewhat atypical to what had happened before. One contributing factor may have been the ten year long doctor's strike of 1978 that had resulted in the loss of mutual

³⁴Margaret Moloney, *Professionalisation of Nursing: Current Issues and Trends*, 2nd edition, (London: J.B. Lippincott Company; 1992), 8.

recognition of registration between UK and Malta.³⁵ Meanwhile, new practices had been introduced in the clinical field as a result of technological developments. There was a theory-practice gap that was in itself, the result of post-education within the broad base of the profession.

The School for Nurses became seemingly insulated from the UK probably due to lack of changes in nurse education and in the management of the school. In clinical nursing management specific preparation for management roles were only introduced in the 1980s. These factors hindered the process of professionalisation of nursing in Malta. There was a resulting lack of leadership that was exacerbated by political intervention in measures such as discipline and deployment so that autonomy was further diminished.

One intrinsic factor that may have affected the process of professionalisation was the confusion of borders between supervisory nurses' work and that of the lower grades. Tasks were carried out by those who were available and this resulted in the lower grades performing tasks which the supervisory nurse would have done had s/he been available. The benefits of the higher qualified nurses could not be well discerned and the resulting association of knowledge with performance could not be made so that the profession took time to find itself on the continuum of professionalism.

Maltese nurses do not seem to have been proactive in overcoming these barriers and actions were often taken by outside forces such as politicians and unions. There may have been a lingering colonised mentality that expected others to provide for them. There may also have been an element of the Maltese behaviour that allows occurrences to happen unless they affect them personally.

³⁵Interview with John Rizzo Naudi.

8.11 Conclusion

Nursing in Malta after colonial times has been through many changes that were often extrinsic to it in their origin but had both positive and negative effects on the process of professionalisation. The way nurses reacted to these changes was probably influenced by how the Maltese people had reacted to their various colonisers, namely by accepting the change without much comment unless it was going to affect their personal security or financial situation. Two major changes affecting the process of professionalisation of nursing in Malta were associated with education, namely the official opening of the School for Nurses in 1965 and the introduction of tertiary level nurse education in 1988. These changes were to place Maltese nursing on the continuum of professionalisation from where it could move depending on the incidence of enhancing factors such as political endorsement or barriers such as a lack of professional associations. The process was an ongoing one. Nursing in Malta (1964-1996) generally followed the British system while adopting a unique '*modus operandi*' that may have contributed to a delayed professionalisation.

This study outlined the changes within and without nursing in Malta that brought about an initiation into the process of professionalisation. Further study may increase Maltese nurses' awareness of how they may push forward towards professionalism.

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2 Oral History Interviews

Conducted by author

<i>Date of Interview</i>	<i>Pseudonym applied to interviewee</i>
3 rd November 2012	Noella Delia
3 rd November 2012	Ingrid Tanti
30 th January 2013	Tina Ingham
10 th June 2013	Iris Naudi
18 th July 2013	Konrad Cauchi
24 th July 2013	Denise Galea
5 th August 2013	Gerard Spiteri

9 th August 2013	Quentin Borg
24 th October 2013	Eliza Camilleri
10 th December 2013	Jesmond Tanti
18 th January 2014	Bernard Dimech
4 th February 2014	Nancy Harrison
11 th February 2014	Benjamin Walters
14 th February 2014	Keith Holmes
19 th May 2014	David Attard
10 th June 2014	Kevin Abela
1 st July 2014	Olivia Gatt
19 th March 2015	Nicole Nelson
9 th April 2015	Nathalie Caruana
16 th April 2016	Edward Urpani

Name of Elite interviewee

25 th February 2013	Hon. Prof. John Rizzo Naudi
8 th November 2013	Ms Barbara Burkey
3 rd December 2013	Hon. Dr Louis Galea
23 rd March 2015	Dame Prof. Betty Kershaw

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APPENDIX I

REFERENCING GUIDELINES - STYLE SHEET

These are the styles adopted throughout this work for the layout of text and bibliographies and footnotes. The style sheet is based on the approach used in the School of Arts and Languages and Cultures and as advised by the supervisors of this work.

Layout of Text

- All work is double line spaced.
- Longer quotes and citations (more than two lines) are single line space and indented. Indented quotes do not have ‘quotation marks.’
- Pages are numbered in the top right-hand corner.
- Times New Roman font size 12 has been adopted for the main part of the essay and bibliography. Times New Roman font size 16 has been adopted for Chapter titles and Appendices.
- Large margin (one inch – 2.54cm) has been used around all work.

Bibliographies

In view of the fact that different historians may apply various referencing styles for bibliographies, for this work the following style has been adopted and has been applied consistently throughout the thesis.

1. Books

Surname, Forename. *Full Title of Book in Italics: Including Subtitles and Dates After a Colon with Each Important Word Written with a Capital*. (Place of Publication Nearest to Student: Publishing House; Date of Publication).

E.g.:

Thompson, Paul. *The Voice of the Past: Oral History*. (Oxford: Oxford University Press; 1984).

2. Essays in Books

Surname, Forename. ‘Full Title of Essay in Single Inverted but not Italics: “Double Inverted Commas are for Quotes Within the Title.”’ In: Surname, Forename (ed. [eds. if there is more than one editor]), *Full Title of Book in Italics*. 2nd edition. (Place of Publication Nearest to Student: Publishing House; Date of Publication), pp. 123-456. [the page numbers of the essay in the book have been included].

E.g.:

Zapf, Dieter & Einarsen, Ståle. 'Individual Antecedents of Bullying: Victims & Perpetrators.' In: Einarsen, Ståle; Hoel, Helge; Zapf Dieter & Cooper, Cary L. (eds.), *Bullying and Harassment in the Workplace: Developments in theory, Research and Practice*. 2nd edition. (London: Taylor & Francis Group; 2011), pp. 177-200.

3. Article in Journals

Surname, Forename. 'Full Title of Article in Single Inverted Commas but not Italics: "Double Inverted Commas are for Quotes Within the Title."' *Full Title of Journal in Italics* Volume: Number of journal in year or in series (Year in Brackets), pp. 123-456.

E.g.:

Brooks, Jane & Rafferty, Anne Marie. 'Dress and Distinction in Nursing, 1860–1939: "A corporate (as well as corporeal) armour of probity and purity."' *Women's History Review* 16:1 (2007), pp. 41-57.

4. Malta Government Gazette

Malta Government Gazette Edition number Date, p. [number]

E.g.:

Malta Government Gazette No. 11,603 21st January 1964, p.149

5. Internet Sources

Surname, Name; Surname, Name. 'Full Title of Article in Single Inverted Commas but not Italics' (Date) Available at: Internet link [Last accessed on date].

E.g: Demiranda, Michael A.; Dogett, A. Mark & Evans, Jane T. 'Medical Technology: Contexts And Content In Science And Technology' (2005) Available at:

[Http://People.Wku.Edu/Mark.Doggett/Medtechprimer6.0.Pdf](http://People.Wku.Edu/Mark.Doggett/Medtechprimer6.0.Pdf) [Last accessed on 19 June 2016].

6. Footnotes

Footnotes have been prepared as per similiar rules described in bibliographic referencces but with three differences:

- In footnotes, the forename is listed before for the surname: 'Mary Smith' not 'Smith, Mary.'
- An entry only appears once in the bibliography, but may have to refer to the same work several times in footnotes. When the same book, article or essay has been mentioned more than once in the footnotes, the full citation has been used for the first time and thereafter the 'short form' citation has been used.

- In the footnotes, there is a need to indicate the specific page or pages from where the information has been extracted. For each footnote, the exact page from the book is specified and signified by a comma followed by page number. For journals, a different format has been adopted – date (Volume) Series Number: page.
- In footnotes, the dates for newspaper references are listed in the numerical format e.g. 13.6.1964, however dates for internet references are listed as [number] [month] [year], e.g. 13 June 1964.

Books – First citation:

Henry Frendo, *Maltese Political Development 1798-1964: A Documentary History* (Malta: Frendo; 1993), 905.

Books – Second and subsequent citations:

Frendo, *Maltese Political Development*, 7.

Essays in Books – First citation:

Jeremy Boissevain, On Predicting the Future: Parish Rituals and Patronage in Malta. In: Sandra Wallmann (ed.) *Contemporary Futures: Perspectives from Social Anthropology* (London: Routledge; 1992), 75.

Essays in Books – Second and subsequent citations:

Jeremy Boissevain, On Predicting the Future, 75.

Articles in Journals – First citation:

Jeffrey Richards, Politics in Small Independent Communities: Conflict or Consensus? *The Journal of Commonwealth & Comparative Politics*, 1982 (20) 2:155.

Articles in Journals – Second and subsequent citations:

Richards, Politics in Small Independent Communities, 162.

APPENDIX II

BIOGRAPHIES OF THE TWENTY FOUR INTERVIEWEES

Benjamin Walters

A medical doctor who qualified in the 1960s and who pursued a career in the Medical and Health department occupying various senior positions at the Health Department.

Bernard Dimech

A state registered nurse who qualified in the late 1960s. He occupied various administrative posts in the public service. He was also a nurse tutor in the 1970s and 1980s at St. Luke's School for Nurses.

David Attard

A state registered nurse who qualified in the early 1960s and who occupied various administrative posts within the public service. During his career he worked in practically all the clinical settings in Malta and Gozo.

Denise Galea

A state registered nurse who qualified in the late 1960s and who dedicated all her career to the care of the elderly. She occupied various administrative posts in the public service.

Edward Urpani

A state registered nurse who qualified in the early 1970s and who occupied various administrative posts in various clinical settings. He also worked as nurse tutor for a short period of time. He was also active in industrial relations.

Eliza Camilleri

A state registered nurse who qualified in the early 1970s and who pursued a career in teaching nursing. She became a lecturer in nursing at the Institute of Health Care in the 1990s obtaining a doctoral degree later in her career.

Gerard Spiteri

A registered mental health nurse who trained in the UK in the 1970s and who worked in the mental health setting upon his return to Malta. He occupied various administrative posts in the public service.

Ingrid Tanti

An enrolled nurse who pursued the enrolled nurse course in 1970s through the nursing class in the secondary school. She currently works in an Care for the Elderly setting.

Iris Naudi

A nurse and midwife who qualified in the 1960s who worked mostly in the community in the private sector. Worked as a midwife with the Public Service in the 1970s.

Jesmond Tanti

Commenced his career in the public service as a health assistant in the 1980s who moved on to become an enrolled nurse and then a state registered nurse. He worked in various acute health settings and he qualified with a Master's degree.

Keith Holmes

A state registered nurse who commenced his career as an enrolled nurse in the 1980s. He pursued further training in his speciality to become a clinical nurse specialist. He also worked for some time in the private sector.

Kevin Abela

A state registered nurse who qualified in the early 1970s and who occupied various administrative posts within the public service and he worked in both the acute and elderly care settings. He served for some time on the Nursing and Midwifery Board as a registrar of the board.

Konrad Cauchi

A State Registered Nurse who qualified in late 1960s and who spent most of his career working in the mental health setting both in the hospital and community settings. He also graduated with a post-graduate diploma and Master's Degree in Mental Health.

Nancy Harrison

A nurse lecturer from the UK who was actively involved during the first phase of tertiary education in Malta in the 1990s. She returned to the UK in 1996. She is currently a senior academic in a UK university.

Nathalie Caruana

A state registered nurse and midwife who qualified in the late 1960s and who worked in various clinical settings. She later became a nurse tutor and was actively involved in nurse education.

Nicole Nelson

A nurse lecturer from the UK who was actively involved during the first phase of tertiary education in Malta in the 1990s. She returned to the UK in the mid-nineties and retired from work.

Noella Delia

An enrolled nurse who pursued the enrolled nurse course in 1970s through the nursing class in the secondary school. She currently works in the mental health setting.

Olivia Gatt

A state registered nurse who qualified in the late 1960s and who occupied a number senior administrative posts within the public service particularly within the Health Department. During her career she worked in both the acute and elderly care settings.

Quentin Borg

A State Registered Nurse who qualified in late 1960s and who spent most of his career working in the mental health hospital setting. He also graduated with a post-graduate diploma in Mental Health and occupied various administrative posts in the public service.

Tina Ingham

A nurse lecturer from the UK who was actively involved during the first phase of tertiary education in Malta in the 1990s. She returned to the UK in 1996.

ELITE INTERVIEWEES

Ms Barbara Burkey

Ms Barbara Burkey, SCM, SRN, MSc (Nursing), M.Q.R. was born in Liverpool on 6th June 1942. Following the establishment of a formal link with the University of Liverpool, Ms Barbara Burkey, who a lecturer at the University of Liverpool, was identified as the first Coordinator of the Nursing Studies Division in 1988. After setting up the new B.Sc. (Honours) course in Nursing Studies for newcomers to the profession, Ms Burkey also proceeded to develop an undergraduate degree programme for qualified staff, together with a number of other courses such as the diplomas in nursing, midwifery and psychiatric nursing amongst others. She also helped develop a Nurse Tutors course for lecturing staff on the IHC's Nursing programmes and a post qualification diploma to master's programme in Nursing and Midwifery Education.

She left her mark on nursing and midwifery practice in Malta by unfailingly promoting the professional image of nursing and the quality of care given to health service consumers. She left Malta to the UK in 1995.

Ms Barbara Burkey was granted Midalja għall-Qadi tar-Repubblika (M.Q.R.) on 13th December 2001, Malta's highest award in recognition for her contribution to nursing and midwifery in Malta and service to the Republic of Malta.

Dame Profs Janet Elizabeth “Betty” Kershaw

Dame Janet Elizabeth Murray "Betty" Kershaw, DBE, FRCN, CStJ, née Gammie (born 11 December 1943), was Professor of Nursing and Dean at the School of Nursing and Midwifery, University of Sheffield from 1999 to 2006. She served as Head of the Manchester College of Midwifery and the Director of Nursing Education at the Stockport, Tameside and Glossop College of Nursing.

Kershaw received an honorary doctorate from Manchester University in 1995 in recognition of her contribution to nursing education. Professor Kershaw was created Dame Commander of the Order of the British Empire in 1998 for services to nursing education. Her recent international consultancy work includes projects in Colombia, China and Malta on the modernization agenda for nursing. She has ongoing commitments to the Department of Health Leadership Project including advising on how the program develops black nurses for leadership positions.

Prof John Rizzo Naudi

Prof John Rizzo Naudi K.O.M., M.D., B.Sc., F.R.C.P. (Edin.) (born on 25 December 1925) graduated as a Doctor of Medicine from the University of Malta in 1952. He served in Malaysia from 1953 to 1961. He was appointed Lecturer in the Department of Medicine in 1966 and a Consultant Physician in the Department of Health in 1968. In 1988 he was appointed Professor of Medicine in the Faculty of Medicine and Chairman of the Institute of Health Care, University of Malta. In 2010 on his recommendation the Institute of Health Care was raised to the status of a Faculty, the Faculty of Health Sciences with ten departments including Nursing, and Midwifery.

He was elected Member of Parliament from 1976 onwards. He was appointed Parliamentary Secretary for the Care of the Elderly in 1987, with a special portfolio for Tertiary Medical Education, and again Parliamentary Secretary for Health in 1992. In 1995 he was appointed President of the first Standing Committee for Social Affairs in the House of Representatives and Member of the parliamentary delegation to the Parliamentary Assembly of the Council of Europe in Strasbourg.

As Co-Founder of the Institute of Health Care, University of Malta he modernized the training and professional preparation of nurses and other professions allied to medicine, by creating Bachelor's Degree and Masters programmes in the University for Nursing Studies amongst others. The President of Malta appointed him Chancellor of the University on 8 November 1995. In 2001 he was honoured by the State, when he was made Companion of the National Order of Malta.

Dr Louis Galea

Dr Louis Galea LLD (born 2 January 1948) is a Maltese politician who has been Malta's representative on the European Court of Auditors from 2010 to 2016. Galea was Secretary General of the Nationalist Party from 1977 to 1987. A lawyer by profession, he has devoted most of his energies to politics and has contributed in no small way to increasing and maintaining the Party's organisation and efficiency. Galea has been a member of the Nationalist Party's General Council and Executive Committee since 1972 and was a member of the Administrative Council from 1975 to 1987.

Dr. Galea was first elected to Parliament in 1976, and re-elected in 1981, 1987, 1992, 1996, 1998 and 2003. Following the 1987 election he was appointed Minister for Social Policy. In 1992 he was appointed Minister for Home Affairs and Social Development. He was appointed then Minister for Social Development (1995-1996) and Minister for Education (1998-2008) and Speaker of the House of Representatives of Malta (2008-2010). Louis Galea studied at the University of Malta and is a lawyer by profession. For ten years between 1999 and 2010 he lectured on social and labour law in the Department of Public Law of the same University. Dr. Galea has been honoured by the Kingdom of Spain, and the Republics of France, Bulgaria and Cyprus.

APPENDIX III – INTERVIEW GUIDE

The following interview guide was used for nurses:

Age last birthday

Motivation to enter nursing.

When training started.

Conditions for entrance at the time. Minimum age, qualifications.

Do you remember your first day at the nursing school? How was it? And your first day as a student on the wards?

Can you describe your typical student day on a ward? How did you learn? (theory/practice divide).

What kind of exams did you have at the time? Practicals? Written? Who were the examiners?

Which ward /s did you work at as a staff nurse? What were the most common conditions of patients in this/these ward/s?

Can you describe a typical nurse's day on this ward? Or a nurse's week? How were shifts organised then? Any special procedures you remember? Why were these carried out?

How was the management of the ward at the time? Consultants, Nuns, nurses?

Did you have an association or union? What was their role? Do you remember any representation for better conditions of work? How and why would shifts be changed at the time?

Can you remember any particular experience?

Are there any patients you still remember? Why?

Can you mention any changes you observe? In nurses, nursing, or nursing management of patients?

The following interview guide was used for former matrons, ministers, parliamentary secretaries, university rectors, university lecturers:

Positions held:

What was the connection between your office and nursing?

What was your role during this time?

Can you outline your efforts towards the management of nursing while you were in office as a?

Were there any influencing factors towards these propositions, suggestions and their eventual implementation or modification?

Did nurses react to your proposals or implementation? What kind of reaction was this? Were any changes made as a result? Did you need any changes in the Law to affect your propositions? If yes, how did these come about?

Were there any incidents of note?

APPENDIX IV

RESEARCH ETHICS COMMITTEE APPROVALS

Dr Natasha Azzopardi Muscat
Chief Medical Officer
Department of Health
15 Merchants Str
Valletta
24th September, 2011.

Dear Dr Azzopardi Muscat,

I am a nurse and a PhD (Nursing) student at the University of Manchester. For this degree, I intend to study the **History of Nursing in Post Colonial Malta (1964-1996)**, through documents, interviews with influential people and oral history of nurses in employment during this time. The Ethics Committee of the University of Manchester have requested a formal endorsement of this proposal from the Maltese Health Authority stating that there are no objections to my carrying out this study.


I am enclosing a copy of the research proposal submitted to the University of Manchester Research Ethics Committee.

I would appreciate having a favourable answer. Thank you

Yours truly



Catherine Sharples

Approved

20/10/11

DR. NATASHA AZZOPARDI MUSCAT
Chief Medical Officer



**Secretary to Research Ethics Committees
Room 2.004 John Owens Building**

Tel: 0161 275 2206/2046

Fax: 0161 275 5697

Email: timothy.stibbs@manchester.ac.uk

Compliance and Risk Office
University of Manchester
Oxford Road
Manchester, M13 9PL

Ref: *ethics/11158*

Prof. Christine Hallett,
School of Nursing, Midwifery & Social Work,
6.327 University Place.

21st March 2012

Dear Mrs Sharples, Prof. Hallett and Dr Brooks,

Research Ethics Committee 4

[Sharples, Hallett, Brooks: Nursing in Post Colonial Malta (1964-2004) (ref 11158-resubmission)]

I write to thank Prof. Hallett for coming to meet the Committee on 1st February 2012 and to confirm that it gave the above research project, after the submission of amendments / clarifications, a favourable ethical opinion.

This approval is effective for a period of five years and if the project continues beyond that period it must be submitted for review. It is the Committee's practice to warn investigators that they should not depart from the agreed protocol without seeking the approval of the Committee, as any significant deviation could invalidate the insurance arrangements and constitute research misconduct. We also ask that any information sheet should carry a University logo or other indication of where it came from, and that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a university computer or kept as a hard copy in a location which is accessible only to those involved with the research.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by the end of January 2013.

We hope the research goes well.

Yours sincerely,

Dr Deborah Bentley
Secretary to University Research Ethics Committee 4

UNIVERSITY OF MANCHESTER

COMMITTEE ON THE ETHICS OF RESEARCH ON HUMAN BEINGS

Progress or Completion Report Form on an Approved Project

The Committee's procedures require those responsible for projects which have been approved by the Committee to report on any of the following:

- * Any incident, accident or untoward event associated with the project (*Please note that if the incident constitutes an accident or dangerous occurrence, the usual Health and Safety reporting mechanism must still be used*)
- * Any variation in the methods or procedures in the approved protocol
- * A termination or abandonment of the project (with reasons)
- * A report on completion of the project or a progress report 12 months after approval has been given.

The report should be sent to the Secretary to the Committee, Dr T P C Stibbs, Room 2.004 John Owens Building, University of Manchester, Oxford Road, Manchester M13 9PL (*tel:* 0161-275-2046/2206).

Project: *[Sharples, Hallett, Brooks: Nursing in Post Colonial Malta (1964-2004) (ref 11158-resubmission)]*

APPENDIX V

**LETTERS OF PERMISSION ‘SISTERS OF CHARITY OF ST.
JEANNE ANTIDE’**

Sr. Marie Salvina Bezzina SOC
Sisters of Charity
51, Triq Hal-Tarxien
Tarxien. TXN 1090
MALTA.
8th August 2014

Dear Sr Marie Salvina,

I am a student currently following a PhD Degree in nursing at the University of Manchester, UK. In partial fulfillment of this course I intend to study the history of nursing in Malta during the period 1964-1996. It is therefore necessary to include the contribution of the Sisters of Charity during this time.

I am therefore asking for permission to be able to access the Archives of the Congregation of the Sisters of Charity in Malta, to collect data relevant to the development of nursing in Malta during these years. I understand that there may be data that is sensitive even to date and bind myself to access documents that are accessible and to treat any sensitive material with due sensitivity.

Data will be used to outline the history of nursing in Malta and to confirm data yielded from interviews from nurses and other persons who contributed towards the development of nursing between 1964 and 1996.

Thank you,

Yours truly,



Catherine Sharples
MSc Health Science (Nursing), BSc (Hons) (Nursing), SRN

Email: catherine.sharples@postgrad.manchester.ac.uk

From: Sr Maria Teresa [segroma@onvol.net]
Sent: Tuesday, August 12, 2014 8:20 AM
To: Catherine Sharples
Subject: message

Ms Sharples.

I am writing to you on behalf of Sr M. Salvina who is away at the moment on a short visit. She has passed me on your letter requiring information about the nursing school. Even if several of our sisters have studied in the Malta Nursing School for Nurses and other have been tutors we have very little information in our archives. What we have we would very willingly show it to you for your information. If you would like to fix an appointment with me, here at Tarxien, since I am in charge of our archive in Malta I would be very willing to show you the very little information we have. Wishing you all the best in your studies

Yours sincerely,

Sr Maria Teresa DeMarco, SdC.

Our telephone No; 21694451

APPENDIX VI

INVITATION LETTERS SENT TO POTENTIAL PARTICIPANTS

Letter of information for Influential/Elite Persons.

Participant Information Sheet

Nursing in Post Colonial Malta (1964-1996)

The purpose of this study.

The purpose of this study is to outline the professional development of nursing and nursing practice in Malta during the period 1964-1996. There is little documented evidence of how nursing in Malta was carried out, managed and developed during this time. The study seeks to find out about these aspects and also about how factors such as educational reforms, industrial evolution, emancipation of women among others affected nursing in Malta.

Approval

Approval for this study has been granted by the University of Manchester Committee on the Ethics of Research on Human Beings and the Health Department (Malta).

Participation in the Study.

You have therefore been invited to participate in this study by sharing any information or memories you have that may have affected nursing during this time. Your agreement to participate in this study would greatly contribute towards achieving the aim of this study by detailing your contribution towards the development of the nursing profession and nursing practice, during an interview. This participation is fully optional and you can refrain from participating at any time while also making restrictions on how information is used.

Your Participation

Interviews will be conducted at a place that is convenient for you and you may choose to have a family member or friend present. The interview will take about one and a half hours but you may stop at any time you wish.

It will be carried out in English or Maltese according to your wish, by Ms Catherine Sharples, a nurse at Mater Dei Hospital, who is undertaking a Doctor of Philosophy with the University of Manchester's School of Nursing, Midwifery and Social Work. This project forms part of the work towards that qualification and is therefore being supervised by Prof Christine Hallett and Dr Jane Brooks, lecturers at Manchester University.

Use of the Interview.

Interviews will be audiorecorded if you consent and these recordings will be listened to by those directly involved in the study. Parts of the interview, in written form will be reproduced as part of the research. Anonymity for this cannot be guaranteed due to the position you held that may have affected nursing in Malta. You will be asked whether you would like to complete a deposit agreement agreeing to your interview being deposited at the Archive of the University of Malta under conditions you make for its storage and future utilization. You may wish to decline to have your interview so preserved in which case it will be destroyed upon the end of the study for which it is being conducted.

Further information and contact details

For general and specific information about the project, or advice on participation contact Catherine Sharples. Catherine can be contacted on _____*, on email catherine.sharples@postgrad.manchester.ac.uk

If you are unhappy about any aspect of the project contact the senior supervisor of the project Prof Christine Hallett, School of Nursing, Midwifery and Social Work, University of Manchester, Oxford Road, Manchester, M13 9PL, email: Christine.Hallett@manchester.ac.uk

Catherine Sharples

* To be notified

Information letter for nurses

Participant Information Sheet

Nursing in Post Colonial Malta (1964-1996)

Thank you for your interest in my project

The purpose of this study.

The purpose of this study is to outline the professional development of nursing and nursing practice in Malta during the period 1964-1996. There is little documented evidence of how nursing in Malta was carried out, managed and developed during this time. The study seeks to find out about these aspects and also about how factors such as educational reforms, industrial evolution, emancipation of women among others affected nursing in Malta.

Approval

Approval for this study has been granted by the University of Manchester Committee on the Ethics of Research on Human Beings and the Health Department (Malta).

Participation in the Study.

You have contacted me in response to our advert asking for help from nurses who worked in Malta during the 1964-1996 period. I would like to invite you to participate in this study by sharing any information or memories you have that may have affected nursing during this time. Your agreement to participate in this study would greatly contribute towards achieving the aim of this study. Please take time to read the following information carefully and feel free to discuss any part of it with others. If you agree to participate, I would like you to take part in an interview during which you will be asked about your memories of nursing during the 1964-1996 period. This participation is fully optional and you can refrain from participating at any time while also making restrictions on how information is used.

Your Participation

Interviews will be conducted at a place and time that is convenient for you and you may choose to have a family member or friend present. The interview will take about one and a half hours but you may stop at any time you wish, for a rest, to continue on another day as you wish or to withdraw from the study altogether. The latter will not affect you in any way.

The interview will be carried out in English or Maltese according to your wish, by Ms Catherine Sharples, a nurse at Mater Dei Hospital, who is undertaking a Doctor of Philosophy with the University of Manchester's School of Nursing, Midwifery and Social Work. This project forms

part of the work towards that qualification and is therefore being supervised by Christine Hallett PhD and Jane Brooks PhD, lecturers at Manchester University.

Use of the Interview

Interviews will be audiorecorded if you consent and these recordings will be listened to by those directly involved in the study. The interview can be carried out without recording if you so wish although it would be more difficult to write down all you say. Parts of the interview, in written form will be reproduced as part of the research. You will be asked whether you would like to complete a deposit agreement agreeing to your interview being deposited at the Archive of the University of Malta under conditions you make for its storage and future utilization. You may wish to decline to have your interview so preserved in which case it will be destroyed upon the end of the study for which it is being conducted. If you wish to remain anonymous, your wish will be respected and a pseudonym will be used for referral.

Further information and contact details

For general and specific information about the project, or advice on participation contact Catherine Sharples. Catherine can be contacted on _____*, on email - catherine.sharples@postgrad.manchester.ac.uk

If you are unhappy about any aspect of the project contact the senior supervisor of the project Christine Hallett, School of Nursing, Midwifery and Social Work, University of Manchester, Oxford Road, Manchester, M13 9PL, email: Christine.Hallett@manchester.ac.uk

Catherine Sharples

* To be notified

APPENDIX VII

CONSENT FORM

Title of the project: Nursing in Post Colonial Malta (1964-1996)

If you are happy to participate please complete and sign the consent form below

**Please
initial box**

The nature of the research and what I will be asked to do as an interviewee was explained to me.

☐

I was handed an information sheet, which I have read and understood.

☐

I consent to take part in this study as an interviewee and I understand that I am free to withdraw from this study at any time without giving any reason, and without detriment to myself.

☐

I agree that the interview will be conducted at a place and time convenient to me.

☐

I understand that I can choose to be accompanied by a relative or friend during the interview.

☐

I confirm that I am a nurse and worked in Malta at some time during the 1964-1996 period.

☐

I consent to my interview being recorded on audiotape.

☐

If I have any concerns about the study or the conduct of the interview I know that I can contact Christine Hallett, Senior lecturer, Faculty of Medicine and Human Sciences, University of Manchester to express my concern (Email: Christine.Hallett@manchester.ac.uk)

Signed

Date

NAME (BLOCK LETTERS)

Address for correspondence:

Telephone Number

Witnessed by

Date

NAME (BLOCK LETTERS)

Name and Address of researcher who will collect the form.

Catherine Sharples (Staff Nurse)*Official address* * **Malta.**

I confirm that I have fully explained the purpose and the nature of the study and any risks involved.

Signed

Date

NAME (BLOCK LETTERS)

* To be notified

APPENDIX VIII

DEPOSIT AGREEMENT

Nursing in Post Colonial Malta 1964-1996

Clearance Note and Deposit Instructions

The purpose of this “deposit agreement” is to ensure that the storage and future use of your interview is in strict accordance with your wishes. The Maltese Copyright Act (Chapter 415) (2000) prescribes the need for written permission for any future use to be made of your contribution.

This does not restrict any use you may wish to make of your interview but does allow us to ensure that it is preserved as a permanent public record and resource for use in research, publications, education and broadcasting.

If you agree to this interview being used for any of these purposes please tick the appropriate box/es and sign underneath.

I agree to my interview being used for		
	Yes	No
Research purposes		
Educational purposes		
Reference in radio or television broadcasts		
Reference in publications		
I agree to my name being mentioned		
I wish to apply a time restriction before my contribution is released		

This time restriction is _____ years (up to 30 years).

Signed _____

Print Name

Address _____

Telephone No _____

Date of Recording ____/____/____2012

Place of Recording _____

Signature of Project Work

APPENDIX IX

RECRUITMENT ARTICLE¹

The Study of the History of Nursing in Malta

Catherine Sharples

Have you ever imagined how nursing was carried out when the Central Sterile Supplies Department (CSSD) did not exist? You may remember or have probably heard how surgical swabs had to be cut out on the ward by nurses, made into packs and packed in stainless steel containers resembling drums which were then taken for sterilization by direct heat. Special packs such as the dressing pack did not exist and had to be assembled as necessary each time they were needed. Student nurses had to learn lists of items needed according to the procedure to be done and how these were to be placed on special trays and trolleys to be taken by the bedside as necessary. Common examples were the dressing trolley, the enema trolley, the intramuscular injection tray, the neurological tray and the catheterization trolley. Nurses spent a lot of their time preparing these before the procedure, assisting during the procedure itself, cleaning up afterwards and ensuring that items are packed and resterilised by direct heat according to need. Syringes and needles for injection were boiled in special containers on the oven hob of the ward pantry. Since they were used very frequently this was done several times per day and care had to be taken not to forget them while they were being boiled away. Special care was taken to check that needles had a fine point as they could get easily broken. Checking involved using dry cotton wool to wipe each needle checking that no fibres remain attached to a broken needle point. If this occurred, the needle was discarded and replaced by a new one.

Did you know that until the introduction of urinalysis sticks some thirty years ago urine testing had to be done on the ward using laboratory spirit lamps, testtubes and different solutions to test for glucose and proteins using heat? Blood glucose testing on the ward could not be done as there were no testing sticks or meters. Nurses had to make sure that samples were gathered and appropriately labelled everytime a urine test was needed.

Can you imagine how it must have been like nursing without the assistance of modern drugs and technology? Bed rest made up a large part of the care needed in many illnesses. This did not only predispose patients to complications but contributed greatly to the dependency of patients on nursing personnel. The organisation of care had therefore to be different in order to cope and manage care of the large numbers of patients in the wards.

¹ Published in "Il-Musbieh" September 2012 – A Malta Union of Midwives and Nurses (MUMN) Journal

Collecting information of how nursing care was carried out in the past is interesting. However, it is not done for interest's sake only. Knowing where we came from and analysing how we are here now can assist us when making decisions in the future.

Many people I meet ask me why researching the history of nursing in Malta is needed. My response is usually because without knowledge of where we come from we cannot know who we are and what we stand for. I liken this situation with that of the African slaves who were taken to America and who could not know their roots beyond the time of their arrival in the United States. Lynaugh (1996, p1) described history of nursing as “..our source of identity, our cultural DNA”. The virtually inexistent recorded history of nursing in Malta has resulted in a lack of knowledge of our roots as a profession, the development of the profession and the realization of the constant changes that have occurred and are occurring in the nature of this profession in Malta. If we do not know our past, its analysis would be impossible and factors that have affected nursing in Malta cannot be identified. Knowledge of these would put the profession into a better position to mitigate against negative influences and make provisions to enhance the factors that bring about positive results for the profession and therefore for the patients.

Talks on the history of nursing in Malta invariably mention the times of the Knight Hospitallers or Malta's contribution as ‘the nurse of the Mediterranean’ during World War I. However, little is said of how this nursing was carried out. Less has been written on how nursing was organised and carried out during World War II and hardly any information is recorded on nursing in Malta after the war. This has left Maltese nurses lacking knowledge regarding where they come from and how the world affects their profession.

Many of us have actually experienced such changes in practice as ward routines, extended roles for nurses and tasks that have become obsolete. History is the collection and analysis of facts and the factors affecting them that assists us to know what we are becoming as a result of what we are and what we are no more. For example the much romanticized image of the nurse as handmaiden to the doctor has slowly receded in the wake of the professional nurse being responsible for decision making in care.

I believe we are now at a time when we can venture to record the history of nursing in Malta and the movement of nursing towards professionalisation. It is time to attempt to analyse and understand how nursing was affected by such factors as public needs, industrialisation, secularization, gender emancipation, the contribution of unions, political expediency and tertiary education. It is also interesting to note how day to day nursing was carried out in Malta in the past, the changing role of the nurse in Malta and the interpersonal relationships.

Recording the history of nurses in Malta is a mammoth task, not only because it covers a long time span but also because information needs to be sought and gleaned from sources that are not related to nursing. These include diaries or letters of nurses or patients describing aspects of nursing, notes kept by nurses, records kept by religious institutions regarding their own

members who were carrying out nursing duties, and records and reports of the Medical and Health Department. Laws affecting nursing are also a source of information. The oral histories of nurses themselves are a great source of information on how nursing education, practice and management were carried out in the past and how they changed over time.

There is such a lot to discover and analysis should lead to finding ways of enhancing the profession and exploring possible scenarios of care in all environments, armed by evidence of how nurses reacted to the different circumstances under which they were working and influenced patient outcomes. The resulting narrative should not only be useful for researchers in the future but provide a record of past Maltese nurses' contribution towards the nation's health and the professionalisation of nursing in Malta.

References

Lynaugh, J. E. (1996) Editorial *Nursing History Review*, 4 p.1.

Call for Nurses

If you were nursing in Malta until 1996 then you can help me. I am a nurse and currently reading for a PhD at the School of Nursing, Midwifery and Social Work at the University of Manchester. I intend to find out and record how nursing was organised and carried out between the years 1964 and 1996, and how it developed during this time. This will be done by gathering from documents and from interviews with nurses who worked in Malta during these years.

If you are willing to take part in this study and contribute memories and information I would be pleased to hear from you. Please contact me on 99373562 or on email catherine.sharples@postgrad.manchester.ac.uk or my academic supervisor Christine.Hallett@manchester.ac.uk

Your decision to contact me regarding this study will not affect any of your rights to withdraw from it at any time

Thank you

Catherine Sharples

APPENDIX X

TRANSLATION OF TITLES IN MALTESE

Maltese Publication Titles	English Translation
<i>Estimi tas-Saħħa.</i>	Health Estimates.
<i>Fil-Gżira Taparsi Jikbru l-Fjuri.</i>	Flowers Bloom in the Isle of Pretence.
<i>Ghadma Minn Ghadmi.</i>	Flesh from Flesh.
<i>Is-Sorijiet tal-Karita' u l-Hidma Tagħhom f'Malta.</i>	The Sisters of Charity and their Work in Malta.
<i>Iż-Żmien Nofsani Malti.</i>	The Maltese Middle Ages.
<i>L-Elezzjonijiet f'Malta 1849-1992.</i>	Elections in Malta 1849-1992.
<i>L-Emigrazzjoni Maltija: Is-Seklu Dsatax u Ghoxrin.</i>	Maltese Emigration: The nineteenth and twentieth centuries.
<i>L-infermiera: Forza għall-bidla.</i>	Nurse: A Force for Change.
<i>L-Istituti ta' Hajja Kkonsagrata f'Malta.</i>	The Institutes for Consecrated Life in Malta.
<i>L-Istorja ta' L-Edukazzjoni f'Malta.</i>	The History of Education in Malta.
<i>L-Istorja tal-Knisja f'Malta.</i>	The History of the Church in Malta.
<i>L-Istorja tal-Kostituzzjoni f'Malta (1942-2004).</i>	The History of the Constitution in Malta (1942-2004).
<i>Rajt Malta Tinbidel.</i>	I saw Malta Change.
Publishing Houses	
<i>Pubblikazzjoni Indipendenza (PIN)</i>	Independence Publications
<i>Klabb Kotba Maltin (KKM)</i>	Maltese Book Club

Newspapers*Il-Hajja*

The Life

In-Nazzjon Tagħna

Our Nation