ISSN 0332-3242

The Journal of the Eastern Health Board

CONTACTS

Volume 14 No. 1 JANUARY/MARCH 1988

Act of bravery wins award . . .

Mr Peter Sutton, Ambulance Driver attached to the Naas Ambulance Base was presented with a winner's plaque offered by the Association of Chief Ambulance Officers for United Kingdom and Ireland. These awards are presented annually for outstanding performance in the Ambulance Service and are open to competition throughout the United Kingdom and Ireland.

His plaque was presented to him by Mr P McQuillan, Chief Executive Officer, South Eastern Health Board at a ceremony held at the Ambulance Training Centre at St Mary's Hospital on 4 December '87.

Peter won his award for outstanding bravery.

On 4 May '87, a teacher brought four retarded children on an outing to a natural beauty spot known as Poulaphouca in Co Wicklow. This is an area where natural contours and ralleys are utilised to capture water power for electricity generation. The area to which the children were brought is traversed by a main road carried over a natural chasm through which a river courses some sixty feet below the road level. During the afternoon one of the children avoided the attention of his teacher and fell down the cliffside into the river below. His teacher went to his assistance, he himself also slipped and he too fell over the cliffside and was seriously injured.

The injured teacher was not found for approximately 1½ hours, until a passing police car noticed the remaining children playing unsupervised. On investigation they learned that the teacher lay injured some 50/60 feet below and established voice contact with him.

The various rescue services were called in and ambulance crew Peter Sutton (Driver) and Bernard O'Connor (Attendant) responded from their base at Naas. On arrival at the scene local experts were on hand and advised that the injured man could not be reached without the assistance of a helicopter and indeed such method was hazardous and success was not guaranteed.

Peter decided that the injured man could not be left unattended and at extreme personal risk he went over the side of the cliff on a rope and descended to attend the injured man whom he found lying half in water and suffering from severe injuries including fracture of the pelvis. The young boy had drowned in the water and was beyond assistance. Peter splinted the injuries and gave expert attention to the injured man with whom he stayed until the rescue helicopter arrived.

The helicopter rescue of the injured man was extremely dangerous. The pilot had to manouver his allouette machine in reverse between overhanging trees some 30/50 feet

Cont page 2 . . .

Volunteers for disabled group wanted

Action for Mobility (AFM) is a newly formed group of able-bodied and disabled people. It's aims are to encourage and facilitate independence amongst disabled people and to act as a pressure group to lobby on issues affecting disabled persons. AFM has already organised holiday breaks to the Dundalk Drama Festival and to the September Festival in Lisdoonvarna.

Further holiday breaks together with outings to ordinary social occasions, such as the cinema, pubs, the theatre etc, are planned for the coming year. We need new people both ablebodied and disabled to become involved in our activities.

Why not come along and make new friends!

For further information contact Colm Nolan, 12 Roselawn Road, Castleknock, Dublin 15, or Sean Farrell, 8 Elizabeth Street, Dublin 3. Tel 378633.

APOLOGY

The Old People's Development
BETHANY HOUSE
which was featured on the cover of our last issue was designed by
Patrick V Moloney
B.Arch, FRIAI, RIBA, Architect
and not as stated.
We apologise to Mr Moloney for this error.

The late Ronnie Lambe

The death of a pensioner does not normally come as a shock. There is sadness that an old friend has passed away, but the death does not usually have the poignancy of a young person taken in his or her prime. Generally, a pensioner has had a long career and if he has not quite reached the fabled three score years and ten, we are saddened, but after all, we say, nobody lives forever.

Ronnie Lamb was different. He certainly had a long career in the Dublin Corporation, the Dublin Health Authority and the EHB, but somehow he never seemed like someone whose life's work was behind him. He was too active and vibrant for that. In fact, as soon as he retired - and he didn't wait till retirement age to do that - he launched into a new and difficult career of barrister, where already he was making a name for himself.

In his early years in the Corporation, Ronnie was very active in the Local Government and Public Service Union. The oratory acquired in those years no doubt stood him in good stead when he was later called to the Bar.

I do not think he was ever in a dull job in his life. If the job were humdrum before he came to it, he soon changed it. He rose quickly in the Service, and in 1956 when the Health Act 1953, which transformed the Irish health srevices, came into force he was in a senior post in the Public Health Department of the Corporation. The Act introduced institutional and specialist services which involved voluntary hospitals and consultants in providing health services for eligible persons. Ronnie set up these services in Dublin, a task which involved long and tricky negotiations with the voluntary hospital authorities. He was also in charge of the administration of the child health services, the dental services and other public health services.

When he transferred to the Dublin Health Authority he was appointed Senior Administrative Officer over the 'field services' which included general medical services, child health, dental ophthalmic and aural services, and other welfare services.

In 1966, he was appointed acting secretary of the Dublin Health Authority and on the establishment of the EHB in July 1971, he was appointed Personnel Officer.

In his work in Personnel he was ably seconded by his old friend and colleague, the late P I Lyons. Some years before he retired Ronnie was appointed acting Programme Manager, General Hospital Programme.

A few nights before he died, Ronnie attended the Pensioners' Association Christmas Dinner. Always a man who enjoyed a convivial drink, after the dinner he brought Kieran Hickey, Lorcan Hogan, Bunny Byrne and myself to Leinster Cricket Club. I have never seen him in better form as we toasted Paddy Lyons, whose portrait looked down benignly on us from the lounge wall.

It is still hard to believe that he is no longer about. His wife Nancy and his children must miss him sorely. May he Rest in Peace.

JFR

. . . *from page 1*

below the road level to permit his crewman to reach the casualty. When he was attached to the hoist he had to be slowly lifted on to the main road and then loaded on to the helicopter before transfer to Naas General Hospital. For his part in this rescue the pilot has been recommended for merit award.

Conditions were too hazardous for a second pick-up and so Peter had to be hauled back up the cliff-face by rope by the other emergency crews then at the site. Being of not inconsiderable build he sustained several injuries to his person and his uniform was badly ripped by the rope and the undergrowth.

At all times during his mission Peter's actions were motivated solely by his concern for the casualty and with little thought for his own safety.

The young boy's body was eventually recovered by rescue personnel who used a boat to approach the scene. The teacher who had severe fractures to the pelvis and other rib and leg injuries made a satisfactory recovery in hospital.

Launch of health education videos for travellers

The dearth of suitable health education material appropriate to the needs of travellers led to the EHB and the Conference of Major Religious Superiors collaborating in a venture which resulted in the production of six health education videos, an edited version of which was presented at a public viewing in St Brendan's Hospital recently.

Speaking at the launch of the videos, Mrs Dymphna Clune, Chairman of the EHB, mentioned specifically the following topics which were the subject matter of the videos - immunisation, gastroenteritis, chest infections, ante-natal care, nutrition.

Continuing, Mrs Clune said: 'It was decided to concentrate on these particular areas having regard to the experience gained by our staff who have been providing services for travellers in the Mobile Health Clinic, which has been very successful in reaching out with health services which are so important to mothers and infants.'

Mr F Donohue, Programme Manager, Community Care, said that 'Public Health Nursing and other s of the Mobile Clinic measured up to the Board's high expectations, dealing with a wide variety of problems presented.'

'The production of the videos came about as a direct consequence of the desire of the CMRS to be involved in helping the travelling people. The videos were on offer to the other Health Boards for use in their areas.'

Brother Finian of the CMRS said the Conference was delighted to involve itself in a project in which the travellers themselvs actually participated. He hoped the videos would get the widest possible distribution and looked forward to co-operation with other groups who needed support.

New voucher system for DPMA

Over five thousand people in the EHB area who were previously in receipt of Welfare Allowances (in the main, Disabled Person's Maintenance Allowances) have been issued with books of vouchers to replace the weekly cheque. A total of £14 million is paid out in Welfare Allowances each year by the Board.

Mr Martin Gallagher, Finance Officer, talking to *Contacts,* outlined the new system:

'It involved the issue to each recipient of a book of up to 13 personalised vouchers pre-dated for each week. The voucher specifies the Post Office nominated by the payee and is cashable only at that Post Office. Where a person is permanently unable to attend the Post Office to collect the allowance, a permanent agent is appointed. There is also provision to nominate a temporary agent for a limited number of weeks.

Disabled people have experienced difficulty in getting to banks to cash cheques and it has come to my attention that in some cases shops charged a 12p fee for cashing.

With the new system if a beneficiary is ill, no problem will arise with regard to the cashing of the vouchers - an agent can be appointed.

The new system eliminates many of the problems encountered in the past when cheques were lost or received late. The voucher books have in-built security facilities - personalised and security encoded.

The system is devised to maximise efficiency and to facilitate our DPMA client group particularly'.

The staff in the Community Care Programme contacted the organisations representing the handicapped, and also all welfare payment recipients, to explain the proposed system.

Nora Greene of Community Care pointed out that the new arrangements would facilitate liaison between Community Care personnel and the Post Masters in their areas, and this, on an on-going basis, should help to identify and sort out at an early stage any problems for the recipients. It could be hoped that Community Care Area Headquarters would be alerted if any one normally in receipt of an allowance did not turn up - a welcome extension of the Board's caring network.

The response from both the organisations and individuals was very favourable.

Other health boards have expressed interest in implementing the system too, and this will give our Board an opportunity to recoup some of the development costs for the project'.

Little Sisters thank staff for their donations

The Christmas Collection from the staff of the EHB and St James's Hospital for the Little Sisters of the Assumption to enable them to provide extras by way of food and fuel for needy families in the areas of Rialto, Ballyfermot and Ballybrack was quite successful this year, realising £884.05 + 1 US dollar.

Among sums received were £140 from one anonymous subscriber, £110 from Mr John Malone who organised the collection in St James's Hospital and £100 from Miss Carmel Taaffe who looked after the collection in Cherry Orchard Hospital.

Sr Angela Lennox of Rialto Parish Centre has written to thank the staff for their generous contributions.

Changes in Central Supplies Stores

Changes have been recently made in the areas covered by the Central Supplies Stores based at Cherry Orchard, St Brendan's and St Ita's Hospital.

Set out below are details of these changes - column 1 shows the location of each Group Stores, column 2 shows the services area in respect of each store and column 3 gives the names of the Supplies Officers for each location.

Group Stores	*Service Area*	*Officer-in-Charge*
Cherry Orchard Ballyfermot, D 10. Tel 264702 exts. 220/251/ 256/287	South of River Liffey incl CC Areas 1, 2, 3, 4, 5, 8, 9 & 10 and Counties Kildare & Wicklow	K Whelan, *Group Supplies Officer* L Mullen, *Deputy Group Supplies Officer*
St Brendan's Rathdown Rd, D 7. Tel 381001 exts. 359/424 425/510	North of River Liffey incl CC Areas 6 & 7 but excluding CC Area 8	P Byrne *Group Supplies Officer* B Madden *Deputy Group Supplies Officer*
St Ita's Portrane, Co Dn. Tel 436337 exts. 380/383	St Ita's Hospital, Portrane & CC Area 8	M Delaney *Group Supplies Officer* P Gavin *(acting) Deputy Group Supplies Officer*

As from 1 January '88 the Welfare Stores, James's Street has moved to Group Stores, St Brendan's Hospital

MS M QUAIN, Historian to the Faculty of Nursing, RCSI, writes on the Jubilee Nursing Service (the predecessor of our present day Public Health Nursing Service), which is 100 years old this year.

THE JUBILEE NURSING SERVICE

It is one hundred years since the Jubilee Nursing Service was founded. A sub-committee was formed to co-ordinate the day to day development of the service. This consisted of:
- the Duke of Westminster, representing Her Majesty the Queen;
- the Rev Arthur Lewis Babington Peile, Master of St Katherine's Hosp;
- Sir John Paget and Mr Rathbone.

It was in the early years that the following letter was sent by Florence Nightingale to the Duke of Westminster in 1896:

'Dear Duke of Westminster,

Good speed to your noble effort in favour of District Nurses for town and 'country'; and in commemoration of our Queen who cares for all.

We look upon the District Nurse, if she is what she should be, and if we give her the training she should have, as the great civiliser of the poor, training as well as nursing them out of ill health (Health Missioners), out of drink into self-control, but all without preaching, patronising - as friends in sympathy. But let them hold the standard high as nurses.

Pray be sure I will help all I can, though that be small, here and will, with your leave, let you know.

Pray believe me, your Grace's faithful servant.

Florence Nightingale

Throughout the years, we may safely say that the nursing staff lived up to the ideals expressed by Florence Nightingale. The nurses were welcomed and trusted by the people, therefore, they experienced no difficulty in entering the homes of their patients. No matter how poor the people were, or what conditions they lived in, they were never humiliated. The staff set to work quietly to improve their lot and to educate them by word and example and, on the whole, they achieved amazing results. It was very rewarding but needed much patience and tact.

Each nurse planned her daily round of visits to suit the needs of the patient. Geography was a very important factor. While following the basic routine recommended by the Institute as far as possible, it was accepted that nobody could do so in toto. These basics were as follows: (i) diabetic patients, (ii) midwifery patients, (iii) new cases, (iv) acutely ill patients and injections administration early in the day to ensure the patients' comfort, (v) surgical dressings, (vi) general nursing care and bed baths, (vii) TB patients - these to be paid early in the afternoon round, (viii) child welfare visits, (ix) school medical service.

On looking at the foregoing list, it is easy to understand why flexibility was so necessary. Naturally, patients living adjacent to one another were treated when the nurse was in the vicinity. It must be borne in mind that a bicycle was the only means of transport and speaking personally, I recall one particular day when I cycled forty miles and treated two patients.

There was another very important duty to be fulfilled by jubilee nurses ie to care for their own health. Hence, only two visits were paid. It was due to the fact that I had eaten very little food since the previous day so it was vital that the omission should be corrected. When explaining this to the inspector, she advised me to enter the mileage in the Time Book which I did.

Admittedly, that was due to exceptional circumstances but there were other occasions not very dissimilar except that I had more visits to show for the effort.

Invariably one had to cycle into strong winds and on the return journey, very often the wind had changed. This had to be accepted.

Child Welfare visits could be fitted in at odd times during the day. Indeed it was a simple matter to check a reasonable number while carrying out routine work. Nevertheless, it was important to see those who were not so accessible in order to ensure that any incipient abnormalities were treated as soon as possible.

Visits were paid to schools at regular intervals. The teachers were very co-operative and insisted that one should call at any time.

Personally, mine took place usually on Friday afternoons in order to cause as little disruption as possible. By visiting one school weekly and checking a couple of classes, all the children were checked regularly.

On returning home and after a meal, the records called for attention. These consisted of: General Register, Time Book, Daily Visit Book, the Institute Midwifery Register, LA Midwifery Register, TB Register, Child Welfare Cards - all children under five years of age, the Donation Book.

With all this accomplished, nurse was at liberty to relax by the fire with a book or whatever she wished, and, in due course, she retired to bed fervently hoping that she might be allowed to remain there until morning.

NON-MARITAL BIRTHS STUDY PUBLISHED

The Federation of Services for Unmarried Parents and their Children have published a study of women who gave birth outside marriage in Ireland during the twelve months of 1983.

Non-marital births are now no longer a curiosity in Irish society, but constitute 9.6% of all births in the country.

This book is a valuable step towards understanding the background to unmarried parenthood and in shaping public responses that are adequate and appropriate.

Background

The study was undertaken in the context of a rising illegitimate or non-marital birth rate accompanied by a falling total birth rate. In 1953, non-marital births constituted only 2% of all live births in Ireland, but by 1983, the year of this study, they represented just under 7% of all live births.

Objectives

The broad objectives of the study were:

- to describe selected social characteristics of women who gave birth outside marriage in Ireland in 1983;

- to study the amount and type of contact by the women with medical and social work agencies during their pregnancy;

- to document the women's plans regarding their children in the light of current trends regarding non-marital births and adoptions.

Summary of main findings

Information was collected on 4,049 women which represented 89% of women who had non-marital births in Ireland in 1983, and the main findings of the study are -

- over one third, or 37% of the women surveyed were teenagers and 55% were aged between 20 and 29 years;

- 7% of study women were, or had at some stage, been married;

- 80% of the putative fathers were unmarried;

- over half - 55% of the women resided in the EHB area;

- disproportionately more women, 55%, were from the lower social classes (semi- and unskilled manual), and 43% of the study women were unemployed when the data were collected;

- half the women in the study received antenatal care late in their pregnancy, at twenty weeks or later, and 4% did not receive antenatal care;

- 19% of women had a previous non-marital birth;

- 13% of study women were cohabiting for a year or more before the birth;

- 72% of women had contacted a social work agency before the birth, of whom 22% contacted more than one agency;

- the majority of women, 76%, planned on keeping their children, while a further 18% had decided to place their children for adoption, and

- 83% of parents and 80% of putative fathers had knowledge of the women's pregnancies.

Conclusion

This first national study of women who give birth outside marriage has provided information on the characteristics and circumstances of the group, as well as important insights into the difficulties many women face.

The report concludes, however, that further study is necessary to determine how many women are really alone and vulnerable and how many have the economic and social support they need.

Beatification of Eithne!

(or farewell from 1 James's Street)

It wasn't exactly St Peter's in Rome, just the end room in the James's Street Staff Restaurant, but they sang the praises of Eithne with a rousing gusto equal to that at any beatification ceremony. And rightly so.

A friend to us all, Eithne possesses the virtues of kindness, loyalty, cheerfulness and unselfishness combined in a genuinely unassuming nature. She's just plain *good*.

The speakers at her retirement presentation were hard pushed to find a flaw in her, with the exception of Vincent Treacy. He hinted at a murky incident in the pool in St Mary's wherein Miss Banks attempted to drown the then Treasurer of the Astra Theatre Group, one Dolores Kennedy, under the guise of saving her.

But, drawing a veil over that, Mr Hickey, CEO, said she epitomised all that was best in a public servant and she could truly be described as a gentle lady. On behalf of the staff he presented her with a colour TV and other goodies.

Eithne, who had not been expecting such a large crowd or such lavish tributes, was in a state of slight shock. She thanked everyone and when the food was demolished they were all invited over to Kenny's. This establishment was already in full swing, it being a Friday night, so we all heaved ourselves in and the crack was great. Some of the party then adjourned for a meal to one of Dublin's more select clubs, a centre where the learned commune in tranquillity. Sad to relate, they now look at Joe McEvoy in a new light.

We think Eithne will remember her send-off!

Homeless Person's Unit opens

Our picture shows Mr Kieran Hickey, Acting CEO, EHB, Mr Gerry Kenny, Supt CWO, Mrs Dymphna Clune, Chairman, EHB and Bishop Desmond Williams at the Opening of the Homeless Person's Unit in Dublin's Charles Street West by Mrs Clune.

The new Centre, Mrs Clune stated, would play a pivotal role in the development of a comprehensive service for homeless men, women and children. She outlined the current situation where the homeless are housed in various city hostels and said that consideration would have to be given to opening another hostel for boys and youths similar to that opened in Percy Place last year. She paid tribute to the valuable service given to homeless persons by the staff of the EHB and drew attention to the fact that 1987 had been declared International Year of the Homeless. It was, therefore, appropriate that the Centre should be brought into service in that year.

Referring to the demands being met by the staff of the Unit, Mrs Clune said that in the eleven months up to the end of November 1987 a total of 1,600 individuals or families contacted the Unit and 1,000 of these received direct financial or other assistance from the Health Board. About 200 individuals or families are assisted each week.

Bishop Williams joined with Canon Carmody, Rev Desmond Bain and Rev Alan Martin in an ecumenical blessing of the new Unit.

Our picture shows (l-r) Mr F Donohue, Programme Manager, Community Care, EHB; Dr J Robins, Asst Secretary, Dept of Health, and Alice Leahy, Secretary of Trust, at a presentation of a report on the work done by TRUST for the homeless.

TRUST issues report on it's work for homeless

Just before Christmas 1987 TRUST, founded in 1975, presented a report on its work for homeless people at a reception held in the TRUST premises at Bride Road, Dublin 8. The reception was attended by a large number of people among whom were Bishop Desmond Williams, Auxiliary to the Archbishop of Dublin.

The philosophy of TRUST is based on two central principles:

- the recognition of every individual's right to be treated as an autonomous and unique human being, and

- the need to restore the dignity of individuals whom society has labelled deviant and undesirable.

In a foreword to the report on the nature of homelessness, Professor James McCormick, Dept of Community Health TCD said:

'The word homelessness sounds self-explanatory, but in relation to the population which either sleep rough or use hostels and night shelters, homelessness is merely a symptom of a much more deep-seated set of problems. For this reason the solution to these problems is much more complex and difficult than the provision of housing.

If these problems have any common factor it has to do with a failure to become, or to remain, a part of the wider community. The homeless, in this restricted sense, are people who have rejected the conventional values of society or who, because of deviant behaviour, have been themselves rejected. It is not surprising that many have been in prison or mental hospitals or both. In a society which is intolerant, imprisonment or admission to a mental hospital are usual responses to deviance. In the view of most people these unfortunates are failures, failures who are largely to blame for their own misfortunes, failures whose very existence is an embarrassment and shame.

The reality is of course different. Once set on a downward path, often as a result of things over which they had no control, such people may readily enter a spiral which ensures that they become more and more distanced from their fellow citizens and have less and less in common with those who have loving families, houses and a regular income. They have little reason to trust others, who treat them with distain, they have little to look forward to and little to remember with pleasure.

It is not, therefore, surprising that there are no simple solutions to their problems. The provision of a flat does not solve their difficulty. What is needed is a slow and painful rehabilitation which has as its main objective restoring a sense of personal worth. That is why the philosophy of TRUST centres, not on the important medical, nursing and social service which it provides but upon the restoration of human dignity to those whom the rest of the world appears to despise.

This takes time, patience and a realisation that rewards may be meagre and delayed. Nonetheless the rewards are real and although primarily valuable to the individual are also valuable to the community, in that the work of TRUST makes a contribution to keeping people out of institutions'.

Many individuals give freely of their time, skills and transport to help TRUST. Two areas where extra assistance are always welcome are clothing and funds. Thanks to the generosity of TRUST supporters it can provide a range and quality of clothing for homeless people.

Direct donations of good quality clothing or funds can be sent to Nurse Alice Leahy, TRUST, Bride Road, Dublin 8, tel 758372.

'On your reckoning, would I be better off taking the pension or staying on and havin' to give to all those collections?'

AIDS IN EUROPE

Country	No. Cases	Rate/ million pop.
ICELAND	4	16.95
NORWAY	49	11.91
SWEDEN	141	16.94
DENMARK	176	34.42
IRELAND	26	7.35
U.K.	1067	18.93
W.GERMANY	1400	22.79
NETHERLANDS	306	21.44
BELGIUM	255	25.67
LUXEMBURG	7	19.13
SWITZERLAND	299	46.16
FRANCE	1960	36.18
SPAIN	508	13.39
PORTUGAL	67	6.74
MALTA	6	17.19

Country	No. Cases	Rate/ million pop.
FINLAND		
U.S.S.R.	4	0.01
E.GERMANY	4	0.24
POLAND	2	0.06
CZECHOSLAVAKIA	7	0.46
AUSTRIA	93	12.28
HUNGARY	5	0.47
ITALY	1025	18.03
YOGOSLAVIA	11	0.48
ROMANIA	2	0.09
ALBANIA		
BULGARIA	3	0.33
GREECE	49	4.96
TURKEY	21	0.50
CYPRUS	3	4.65

WHO 4th Nov. 1987

AIDS - the challenge for schools

by Dr H Johnson, Dr Z Johnson

Since the first case of Acquired Immunodeficiency Syndrome (AIDS) was reported in the United States in 1981, the Human Immunodeficiency Virus (HIV) that may lead to AIDS in those infected has precipitated an epidemic unprecedented in modern history *(See fig.1 - AIDS in Europe).*

Given the absence of any truly effective cure for AIDS and the absence of a vaccine, control of this epidemic must depend on an alternative strategy. Because the virus is transmitted almost exclusively by behaviour that individuals can modify, educational programmes designed to influence relevant behaviour would appear to be the only weapons available that offer any hope for effective control of this epidemic in the immediate future.

Despite the relatively short time since the 'discovery' of this 'new' disease, the current wealth of knowledge concerning the disease is vast. However, the key features of AIDS and the spread of HIV have been well known for many years. More recent research has generally just 'fine tuned' existing information. It is likely that any *truly dramatic* breakthrough in current knowledge about AIDS will involve the discovery of an effective 'cure' for this exceptionally complex infection, or the development of an effective HIV vaccine. No one knows whether such developments will occur before or after the year 2000.

In Ireland, at the present, there are only 36 known cases of AIDS. It takes 7 years on average (the incubation period) for the virus to nibble away at the person's immune system before the immune system starts to collapse and infections and cancers take root. HIV infection also leads to many other complications. Dementia is a particularly tragic feature especially in a 30 or 40 year old. Such AIDS cases only represent the tip of the iceberg in terms of the number fo people actually infected and in the carrier phase of the infection. Carriers outnumber AIDS cases by 50 or 100 to 1. It is clear that the AIDS plague is already well entrenched in Ireland, but relatively few in the community have yet seen or personally known individuals in the full blown stage of the disease. Media coverage of the problem in other countries can give the impression that AIDS is an issue in Los Angeles, New York or Africa etc. To a young Irish school leaver, the risk of becoming infected tonight or tomorrow with HIV might well seem a ludicrous idea!

AIDS research highlights two inescapable facts.

Firstly, intimate sexual contact, whether homosexual or heterosexual, with an infected individual carries a high risk of HIV transfer.

Secondly, sharing an injection needle with an infected abuser of illicit drugs carries a high risk of HIV transfer. The risk from any such single encounter is massively increased as such encounters are repeated with other, potentially infected partners.

In both above situations, the risk of HIV transfer can be somewhat reduced, but never eliminated.

Thirdly, AIDS and HIV carriers are generally young individuals. The average age of known Irish AIDS cases is in the 20s and 30s (see table).

Given the known incubation period of some 7 years, it implies that the initial infection occured during the teenage years and early 20s.

Hence, HIV infection is primarily an issue relevant to schoolgoing children and school leavers.

Given that health education is the only current option for the control of HIV spread, how can the message of responsible behaviour be effectively transmitted to such a young, and clearly experimenting audience?

Clearly, any approach in this area will depend on close co-operation at local level between the medical profession (especially Community Medicine), the educational profession, and parents. The Department of Health recently advised Directors of Community Care to initiate such a process, and to initially target this year's school leavers. To assist such a process, specialists and registrars in Community Medicine (the authors, Dr C Heyes, Dr D O'Flanagan, Dr M Hynes, Dr P Doorley and Dr J Barry) devised an information package (slide format) on AIDS. Topics include a review of the discovery of AIDS, the clinical features of AIDS, the antibody blood test, HIV transmission and at risk groups, prevention strategies, and statistical data on world and Irish trends of the disease. The package is comprehensive and produced in modular format to permit tailoring to meet the needs of the audience. The Health Education Package is currently being piloted throughout the EHB area and is targeted at school management and staff, and parents. It is hoped that the package would update the audience on accurate AIDS information in a cohesive fashion, and simultaneously dispel the myths that have mushroomed around the topic of AIDS. The response has been very positive to date. The scope and content of a school educational package would then be determined locally and be consistent with parental values.

Prevention (ie health education) is the only realistic AIDS control strategy at present. An unwillingness to grasp the nettle relevant to this year's school leavers may result in a painful and pathetic sting for tomorrow's young adults.

IRELAND - AIDS cases to date (31 Dec '87)

Age Group (Yrs)	*MALE*	*FEMALE*	*TOTAL*	*%*	
(1	*2*	-	*2*	*(6.1)*	*
1 - 4	-	-	-	-	
5 - 9	-	-	-	-	
10 - 14	*1*	-	*1*	*(3.0)*	*
15 - 19	*2*	-	*2*	*(6.1)*	
20 - 29	*7*	*2*	*9*	*(27.2)*	
30 - 39	*13*	*1*	*14*	*(42.4)*	
40 - 49	*2*	-	*2*	*(6.1)*	
50 - 59	*3*	-	*3*	*(9.1)*	
) 60	-	-	-	-	
TOTAL	*30*	*3*	*33*	*(100.0)*	

** NOTE: Infection by HIV in very young children was via infected mothers in pregnancy or haemophiliacs who received blood products prior to blood screening and heating.*

Máire O'Leary

Outline of a paper by MAIRE O'LEARY, Vice-President, Council of Ireland, St Vincent de Paul, originally given to the Social Study Conference 1987 at Inchigéala.

NEW POOR

The experience of poverty

The new poor . . .

These are people who have been living on incomes far in excess of the poverty line. Their style of living matched their income. Suddenly, because of job loss, business failure, illness or personal addiction such as gambling or alcohol people find themselves joining the ranks of the new poor.

The new poor are not an easily identifiable group. They are, and feel isolated in the society in which we live. People do not recognise them as being poor, they do not wish it to be known that they are poor. Because of the SVP image of helping the traditional poor, the very decision by a new poor family to contact us greatly adds to the burden of guilt they are already experiencing.

By the time they have made contact with the Society, they have reached their lowest ebb, we find them suffering from what I can only describe as mental paralysis, guilt and most of all shame.

The first reaction to their new situation is one of total disbelief. At first they regard their situation as very temporary, and hope to find new employment immediately. Hope fades as time passes, the accumulated savings or redundancy money diminishes. The awful reality of their plight usually dawns on them at the same time as a cash crisis arises.

At this point ***fear*** is the overriding emotion that grips the family. They fear all outside contact - the door bell, the phone, the post, visitors.

They avoid friends and the extended family because they do not want others to know of their needs. They 'put a brave face on things' for the neighbours - they may even pretend to go to work every day - just to show that things are normal. This stress can place enormous strain on the emotions and interpersonal relationships within the household.

First encounter with family . . .

The first encounter with the family is very important for both parties. We try to appreciate the difficulty and trauma they have experienced in asking for our help, we try to respond quickly to their request for help. It is desirable to meet the couple together and in their own home if at all possible. This meeting sets the tone of the whole relationship with the family which must be a trusting and open friendship. This sounds so simple but is so hard to achieve, requiring patience and tact and never standing in judgment, or asking the why or the wherefore of the situation.

Accepting things as they are and never expressing shock or other emotions, we must listen to the story of the past and then work together towards the future. What I have just said inevitably sounds pious and almost patronising - the difficulty is that what I have described is essential to achieve and yet so difficult. It taxes even the most experienced to actually maintain the sensitivity and genuine Christian care needed to be successful.

For some couples this meeting may be the first time that they have verbalised their problem, to themselves and to one another, in a rational way, without accusations, self-pity or mud-slinging. We can find ourselves acting as a catalyst, and by talking through things together, solutions can emerge, sometimes from the couple themselves.

At this stage it may be possible to identify a list of priorities and some strategy for dealing with them. As a first step we can guide people towards the Dept of Social Welfare for benefits they may be entitled to but are not aware of.

The helper may become the vic

I cannot overstress the importance of listening, listening and hearing what is being said, what is not being said, what they are trying to say. Taking time, watching tears flow, drinking tea, discussing the weather, drinking more tea, chatting with the children, all the while trying to put the jigsaw together.

We try to be balanced in our judgment of their situation. Our decision to help and the extent of that help is of course a value judgment on our part, but I know of no other way to assess the situation. We check out any information we are given, as discreetly as possible, always respecting confidentiality. We advise the family that we require their permission to carry out this detailed research.

There is a need for total honesty, by this I mean, not raising hopes in an unrealistic fashion and then failing to deliver. It is better to work together being acutely aware of just how fragile people are at this time. If at all possible we encourage people to do most of the work or reorganisation themselves, but of course this is not always possible.

This is where the mental paralysis I mentioned earlier manifests itself. Avoidance is the most evident factor

Aim of SVP for new poor

The objective of the SVP in attempting to help the new poor is to try, in so far as is possible, in the given circumstances, to enable the family to adapt to their newfound circumstances and to help them to rediscover their own ability to cope and all that this involves -

- the regaining of self-esteem
- regaining a level of dignity
- redeveloping confidence

Progress of debts . . .

- the head of household loses his income,
- the outgoings of the household remain as they were,
- the income of the household, whether it is PRSI or State Assistance simply does not cover these outgoings,
- in my experience, all bills and commitments, with the exception of food and fuel are completely ignored,
- banks, building societies and other financial institutions do not like to be ignored - their letters become stronger and more threatening,
- ostrich-like behaviour comes into evidence at this stage, and everything is ignored; the invitations to come and discuss the financial difficulty are continuously buried - however, these things have a way of surfacing - in the shape of threats of legal action, eviction notice, repossession of goods, a call from the sheriff.
- This whole process has taken time to evolve - regrettably it is time that is not well used by the newly impoverished,
- it is at this critical stage there is a cry for help - many do not know where to go for help.

Finance . . .

It is interesting to note that in almost every case, the new poor appear to be unable, without help, to clarify the exact amount of indebtedness in financial terms. It is not that they are incapable of such a calculation, it is just that they cannot face the reality of the gravity of the situation. It is like taking blood from stone to extract this information.

They will say things like -

'I owe the bank £4,000, the ESB £100, the building society £2,000 and there are a few more bits and pieces'.

When the actual sum is calculated it looks more like -

Bank	£5,200
ESB	140
Building Society	2,500
Fuel	200
Other domestic bills	400
Borrowings from fam/friends	2,000
Total	£10,440

not the £6,100 as was first indicated.

A difference of £4,340 and growing.

As the figures get higher, there is a strong tendency to ignore everything but the first digit, such as £8,760 becomes £8,000, and the £142 telephone bill is £100, you can imagine the cumulative effect of this on any calculation. Debts are always described by rounding the figure downwards.

Banks . . .

Banks are a significant lender in the personal sector. However, financial services can be complicated for the layman to understand. It would be desirable if the banks, using everyday language, could quote the price of their money in a standard format. In Britain and N. Ireland the banks are legally obliged to do this.

The financial naivety of many borrowers and their lack of knowledge, through no fault of their own, of where to turn for financial advice is frightening.

Recently in England, the Finance Houses Association launched a Money Advice Services Trust. Through this, banks, building societies and other financial institutions contribute to a central fund that pays for ***money advice services to people in debt.*** Similar help is urgently needed in Ireland.

The use and availability of credit cards has added to the credit boom. There is an air of unreality about plastic money.

Two other issues which also require scrutiny are those of -

**** Irish banks taking unlimited personal guarantees for business borrowing without regard to the personal assets of the guarantor;***

**** the practice of taking a guarantee from the spouse, who very often is not made fully aware of the implications of what is being signed for.***

ictim . . .

involved. Avoiding facing the facts and figures involved; avoiding taking any action to help themselves; avoiding the obvious requests contained in letters from banks, finance houses, building societies. Everything is ignored. I cannot offer an explanation for this behaviour, it is a recurring pattern among the new poor.

Decisions on the part of the SVP to help financially must be economically sound, based on full knowledge of the real situation. Having shared such intimate difficulties as the exact financial problems within the household, the hopes and aspirations of the family and all that this entails, there is a tendency on the part of the family to become totally dependent and hand over the problem to the helper. As I am sure you are aware, the tendency is there for the helper to become the victim . . .

We may have to advise families to sell their homes and seek alternative accommodation. We can help them through this most difficult phase of their lives by being supportive in so many ways other than financial. Our response to the needs of the new poor cannot always be positive in the financial sense.

Building societies and repossession . . .

Contrary to their benign image, building societies are extremely active in the use of the law to pursue mortgage arrears, being second only to the Collector General of the Revenue Commissioners, in the number of Civil Bills they issue each year.

It would be helpful if the building societies developed a more active and discriminating policy towards arrears and re-possession. They need to identify more quickly the defaulters, who while not initially the authors of their own misfortune, fail to make real attempts to alleviate it. Many of those in arrears can get back to normal payment with some temporary help from the building societies.

In cases where repossession is the only alternative, I would appeal to the societies to consider full repossession, but allow a rent-back situation. So much trauma and pain could be avoided by such a solution in selected cases.

Education . . .

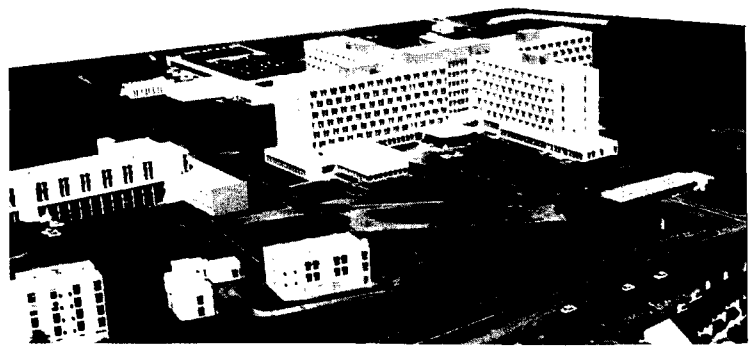
People must be helped to evaluate personal choices in regard to the disposal of their income.

What we can do . . .

Perhaps the harsh financial climate of recent years and the harsher climate of years to come will evoke a more compassionate attitude to those who have suffered, those who are suffering and those who may, in the future suffer, from the types of problems I have outlined.

CATHERINE DEANE, Acting Gr. V, Accounts Section, EHB, lived for a time in a hospital in Brittany and found their methods of providing the various services, particularly accident & emergency, most impressive.

INSIDE A BRITTANY HOSPITAL



Le CENTRE HOSPITALIER DE LA BEAUCHEE, Brittany

Catherine Deane, A/Grade 5 in Accounts, was sent to the Centre Hospitalier de St Brieuc in Brittany as part of the EEC Exchange Programme for Young Hospital Administrators. The programme was from 27 April last to 20 June.

She spent the first few weeks getting to know the run of the hospital and reading up on the general structure of the French health care services. She also attended meetings. These included the weekly meetings of heads of the various departments as well as their monthly meeting with the management team. At a twice-yearly meeting of representatives of all the hospitals in the north/west region of France she was on familiar ground as the discussion centered on financial problems. They were particularly concerned about the implications of reformed budgetary procedures; the *prix de journée.* system based on cost per patient was replaced by a global budget which meant that each hospital was given a lump sum on which they had to manage. This made individual departments within the hospital more aware of and responsible for the budgetary implications of their actions.

In that region of France similar size/grade hospitals use the same computer packages. However, they are first researched and developed. Catherine was at a forum, attended by people from the hospitals, at which information was exchanged on the benefits of the various packages before being introduced in the hospitals. Several systems, such as personnel management, finance, and patient administration, are now running successfully.

Catherine was based for ten days in a 200-bed annex to the main hospital. It was located sixty miles away and it specialised in rehabilitation and re-education. She then returned to St Brieuc where she spent three weeks between the two main hospitals there. Her host, M. Mano, the *Directeur Adjount* had prepared a very detailed programme for her. He had arranged for her to spend at least a half-day in each of the various services of the hospitals, both administrative and medical. She was encouraged to ask questions and, in the administrative offices, she sometimes participated in the work.

The medical services appeared to be of a higher standard than our own, with high-tech equipment much in evidence. The general standard of accommodation was far superior to ours; in a public hospital there, the largest ward had three beds and most were single rooms with bathroom, television and telephone.

In geriatric institutions the standand of services again were of a high level and geared to the needs of the individual. However, France has virtually no community-based services although it has an increasing elderly population.

She found the accident and emergency service most interesting. Unlike our own service, all emergency calls are monitored by a physician in the emergency control centre. He decides on the level of the emergency and sends out the appropriate personnel. This could be just an ambulance or a fast car with a doctor, or the fire brigade. A doctor can be brought quickly to the scene of the accident and diagnose and treat the patient there. The fast ambulance contains a mini-intensive care unit. Catherine spent a day with this service and was very impressed with its effectiveness.

The public hospitals in the French regions are run by a board consisting of public representatives, representatives of local insurance funds, medical personnel and other qualified persons. The local mayor is usually the chairman. The decisions of the board are implemented by the *directeur* of the hospital and the management team. The *directeur* plays a much more significant role in the running of the hospital than his Irish counterpart; he/she is totally responsible for all aspects of the service, unlike here, where nursing is the responsibility of the matron and medical care is under the doctor, etc. She was most impressed at the sheer professionalism of the administrators. It brought home to her the need to improve our educational standards and to develop specialised courses for administrators.

The French health service is financed by national health insurance and most people are insured. The patient is reimbursed by the insurance fund whether he receives treatment in a public or a private hospital. At present some 30% of the country's 600,000 beds are in private hospitals or clinics. Both systems are developing side by side; the public hospitals are often of as high a standard as the private and offer a wider range of services.

Catherine considers that by providing free hospital services to about 80% of the population we have perpetuated the growth of public hospitals. With the cutbacks in the health services, many people are now buying private health insurance and increasing the demand for private beds.

Looking back, she says the attachment was of great value to her. 'It provided me with the unique experience of living and working in a totally French environment.' Her command of French improved dramatically. She travelled extensively in Brittany and spent some time in Paris. She also made friends there and visited their homes. It was a worthwhile experience.

THE MENTAL HEALTH ASSOCIATION OF IRELAND

DEVELOPMENT OFFICERS

EASTERN HEALTH BOARD REGION

The MHAI is a national voluntary organisation, with local associations throughout the country. Its aim is twofold — to help those who are mentally ill and to promote mental health. Through its affiliation to the World Federation for Mental Health, it is in touch with trends and developments in countries throughout the world.

The Eastern Health Board's community psychiatric services are developing rapidly. To ensure their maximum effect it is most important that all appropriate voluntary resources are mobilised in supporting roles so that every person who needs it should have ready access to these services.

In line with these developments the EHB proposes seconding two staff members to work as Development Officers with the MHAI for an initial period of two years.

The Development Officers will be required:

- *to strengthen and encourage existing local mental health associations and to promote and develop their work by fostering community participation in psychiatric rehabilitation projects*
- *to facilitate the formation of new local MHAs where necessary*
- *to liaise with all relevant organisations, groups and individuals involved directly or indirectly in the provision of mental health services and to encourage the further development of these agencies where appropriate*
- *to assist in the identification of suitable mental health projects in the community and to help develop a greater awareness of mental health needs within the area*
- *to foster the development of an active mental health education programme by the direct involvement of schools and community groups and by making available to educationalists and others in the area, resource materials such as playlets, films and literature on health related matters*
- *to encourage the promotion and evaluation of standards and quality of services in the community psychiatric system*
- *to work with other Health Board professional staff providing mental health and social services in the area.*

The successful candidates will have a high level of organisational skills, enthusiasm, a record of proven performance in relevant areas and will probably be in the age group twenty-five to forty-five. The salary is negotiable and will be commensurate with experience. The successful candidates will continue to be pensionable employees of the EHB. The posts are confined to permanent staff of the EHB and are open to all disciplines.

If this post interests you, **please write** in confidence, setting out how you meet these requirements, to reach the undersigned not later that **Friday, 8 April 1988:**

The Chief Executive Officer
Mental Health Association of Ireland
Mensana House, 6 Adelaide Street
Dun Laoghaire, Co Dublin

National Council for the Aged Report

Is boarding out an option for care of the elderly?

The National Council for the Aged has published a report on boarding out schemes for the elderly in Ireland. The report was prepared for the Council by Robbie Gilligan, Dept of Social Studies, Trinity College, with the assistance of Susan Keogh.

Despite the constraints of time and depth on the study and of the level of knowledge of what is described as the ate of the art' in this country, certain conclusions are offered by the report. It is strongly contended that boarding out seems to represent a very attractive policy option in the field of long-term geriatric care for a number of reasons:

1. It may be cheaper to provide a place in boarding out care than in residential care.
2. It involves no capital cost to the public authorities.
3. It permits a more effective use of resources than does institutional care. A boarding out place is created and survives only to serve a specific need. If the need ceases it becomes redundant and no further cost is incurred.
4. A boarding out place is more mobile than a place in institutional care. It may be possible often to find a placement in a remote district near to the old person's residence but far from the nearest institution.
5. It represents a service ideally suited to use in rural areas which increasingly pose a challenge in terms of adequate provision of health and social care.
6. It can enable the ideal of community care to be given very concrete expression by allowing whole families share responsibility for, and contribute to, the welfare of elderly members of *their* community.
7. It can enable old people to remain within the district that is familiar to them and minimise the disruption they experience in their move from home.
8. It can enable old people to receive a degree of personal attention that, given the best will in the world, may not be attainable in institutional care.
9. It enables the old person to remain in touch, through the caring family, with the routine, rhythm and cycles of ordinary life in the community.
10. It helps keep the needs of dependent old people, by their visibility in neighbours' houses, more prominent in the minds of the community.
11. It helps children, who may otherwise be deprived of it, to have direct personal contact with old people and to contribute to their care.

The report goes on to say:

'No policy option is without possible risks or disadvantages. Among those associated with boarding out may be (i) the possible isolation and vulnerability of an old person, (ii) an unsatisfactory motivation or behaviour on the part of the carer or (iii) the carer's possible lack of competence to cope in certain emergencies.

We would suggest that, given adequate precautions, at least some of these difficulties can be avoided and those that remain are not confined to boarding out and may also arise if the old person is living alone, with his/her family or in an institution.'

The recommendations of the National Council for the Aged on the report are:

1. The Minister for Health should invite each health board to further promote and develop adult boarding out schemes in order to broaden the range of options available for the care of dependent elderly people in the community.

2. The Minister should ensure that adult boarding out receives full consideration in the forthcoming review of services for the elderly to be carried out by the Department of Health. Particular reference should be made to establishing methods of assessing and evaluating the potential scope of boarding out in the provision of care for elderly people.

Voluntary Researchers wanted

Many people want to help the less fortunate but don't know how to go about it. They may be keen to help disabled people, for example, but may be unsure of their own effectiveness. There is a reluctance to intrude unless there is a specific invitation. They wish to give more than a cash donation.

The KEY ASSOCIATION is looking for volunteers who will give some time to contribute to a scheme which will create employment for mentally and physically disabled people.

This scheme will involve the collection of family history details for storage on computer. The volunteers will spend some time (as much or as little as they choose) in the National Library, Dublin, the Public Records Office etc, collecting information of births, marriages, deaths and wills. After sufficient information is stored it should be possible to offer a service to those researching their family roots. Any profit from this enterprise will be used for the benefit of the disabled.

Initially volunteers will be given a briefing on the procedure for conducting family history research. Thereafter they may work with a group, or individually, to build up a stock of information. All contributions of time, no matter how small, will be of use - and much better than cash!

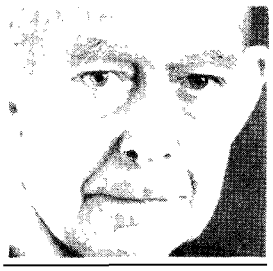
If any readers are interested in contributing to the scheme will they please contact:

Michael swords
46 Hazel Avenue, Stillorgan
Co Dublin
Tel 886702 after 7 pm
OR
Unit 5G
Chapelizod Industrial Estate
Tel 266044

Interested in job-sharing?

Contact
ANNETTE WILLIAMS
Grade 111
Community Care Office
Clonskeagh
Tel 698222

A COUNTRY PRACTICE



DR PADDY CUSACK, former County Physician of Monaghan, gives a witty commentary on his experiences.

The first county physician was appointed in 1943 - before that there were assistant doctors attached to county hospitals who did not necessarily have any higher degree. I do not remember the date that the first county surgeon was appointed - it was well established in 1934, and may have dated from the early 1920s.

The first county surgeon I knew was Mr McMullen in Cavan - an excellent surgeon, absolutely first class. The next one I knew was John James McArdle in Monaghan - also an excellent man and very experienced. He had a Fellowship of an American College. At the time that he was appointed, his terms of appointment made him absolute superior in the Hospital - he was in charge of nurses before matrons assumed that responsibility.

I got the job of county physician in Monaghan after selection by the Local Appointments Commission - the duties specified for the post were very wide.

I had an option of two appointments - one Clonmel, the other Monaghan. I rightly selected Monaghan - the people there I found pleasant and co-operative.

The county surgeon

At the time, I was in every way junior to the county surgeon. The appointments at that time were permanent, provided that at the end of the first year, immediate superiors certified that the year's work had been good.

At the beginning, I had a slight resentment of the county surgeon. In one early case, we failed to agree about a caesarian section - a disaster ensued, the first fatality, not for the mother, but the child. There were no subsequent differences between us - the county surgeon accepted my word as physician and did caesarian sections on the spot, without question. I cannot laud too highly John James McArdle . . .

Duties of a county physician - idiotic rules

A county physician in my early days had to sign a book and attend the hospital each day before 9 am in the morning. I fulfilled this duty by going in at one minute past midnight and often stayed there until 2 am, ensuring that everything was all right for the night -being there when it was necessary to be there, rather than just conforming to idiotic rules. I saw everybody and could assess the condition of patients - strict adherence to a book of rules never really bothered me . . .

Hospital experiences

One night as I stood outside the door of a ward in rubber soled shoes, I heard an old man whispering to a nurse 'Mother of God, you're an angel . . .'. I was very impressed - that nurse was great - she subsequently worked in obstetrics and when we were once stuck for a pharmacist she helped out.

A county physician had to be a GP, an obstetrician, a physician, assistant to the surgeon and an anaesthetist. Most hospital private work went to the county surgeon.

On one occasion, a patient with whom my contacts had been fortunate, in that he had survived my medication, said to me 'Isn't it a strange thing, doctor, you appear to be a very able man - isn't it a strange thing you never went on to take out your degrees to be a surgeon?'

I thought this very funny because I had more senior degrees than the surgeon. My degrees were MRCPI, DA, and LM (the Coombe).

Skills of an anaesthetist

At one time, I was the only qualified anaesthetist outside Dublin and worked with the late Mr de Wytt, the great orthopaedic surgeon.

The skills and personality of the anaesthetist matter tremendously to a patient who is about to undergo an operation - it is the duty of an anaesthetist to come in on the night before surgery, usually about 9 pm to 10 pm, or perhaps a few days earlier, so that he becomes acquainted with the patient, thereby inspiring trust. He fully examines the patient before the operation.

The anaesthetist has total control of the operation and the surgeon should always stop when the anaesthetist says so. The anaesthetist is the absolute boss in the theatre - he must tell the surgeon how long he may continue with the operation. I, on many occasions told the surgeon, 'You have twenty or thirty minutes to get out if we are going to have a live patient'. McArdle always agreed with me; so did de Wytt.

Some temporary surgeons differed with me - I never gave more than one anaesthetic for any surgeon who did that. Doctors differ and patients die. If I found that surgeons were reasonable men and did what they were told, I would continue to work with them.

'Resuscitation of the new born'

I think I was the first person to suggest mouth-to-mouth resuscitation for new-born infants who weren't breathing. A paper I wrote about it *Resuscitation of the new born,* was published in the Irish and the British Medical Journals (c. 1950). It struck me as sensible to blow air into the child to help it breathe properly - the procedure is now standard practice. Other more technical papers, by me, were also published in the 1950s ...

. . . from page 11

Such assessment and evaluation should take both medical and social dimensions into account.

3. The Minister should prepare and publish guidelines governing the operation of boarding out schemes for the elderly. These guidelines should include a working definition of boarding out and should cover matters such as:

(a) Procedures for the adequate supervision of boarding out schemes in relation to the selection, deployment and training of staff.

(b) Procedure for the selection and matching of persons to be boarded out with families who are acting as carers.

(c) Appropriate levels of payment to families acting as carers.

4. Health boards should seek the assistance of voluntary bodies, where appropriate, to help identify:

(a) Elderly persons who would be suitable for and likely to benefit from being boarded out;

(b) Families who would be suitable for recruitment as carers.

5. The Minister for Health should ensure that any review of legislation or regulations governing institutions caring for the elderly should include reference to boarding out schemes, making the distinction between such schemes and private nursing home care, which is also in some instances subvented by health boards.

TONY COYNE WILL BE HOLDING AN EXHIBITION OF FRAMED PRINTS OF OLD DUBLIN IN THE PUBLIC LIBRARY, RAHENY, DURING THE FIRST THREE WEEKS OF MAY. ANYBODY WISHING TO PURCHASE PICTURES MAY CONTACT HIM AT TEL. 740940 (evenings).

Lucozade Nurse of the Year Awards

Our picture shows l-r, Dr Rory O'Hanlon, Minister for Health, Nurse Paula Hurrell, winner, Lucozade Nurse of the Year, John Costigan, Product Group Manager, Beecham of Ireland and Biddy Butler, President, INO.

The winner of the 13th Annual Lucozade Nurse of the Year Award is Paula Hurrell, a staff nurse caring for geriatric patients in St James's Hospital, Dublin.

Born in Tralee, Co Kerry, Nurse Hurrell did her general training in the Mater Hospital, Dublin; her medical and surgical training in the Bons Secours Hospital, Tralee, her private nursing in the Lansdowne House Nursing Home and her gynaecology, paediatrics and theatre training in the Tralee Regional Hospital, Kerry.

The winner of the special category Lucozade Student Nurse of the Year is Teresa Heffernan, who is studying an integrated course at James Connolly Memorial Hospital, in conjunction with Our Lady's Hospital for Sick Children.

Born in Youghal, Co Cork, Ms Heffernan is married and lives in Castleknock.

When she has completed the course in general nursing she intends to train as a midwife and as a public health nurse.

Pictured l-r are Dr Rory O'Hanlon TD, Minister for Health, Student Nurse Teresa Heffernan, winner, Lucozade Student Nurse of the Year, and John Costigan, Group Manager, Beecham of Ireland Ltd.

The Awards were presented by the Minister for Health, Dr Rory O'Hanlon TD, at a ceremony in the Royal College of Surgeons in Ireland.

The winners will attend an international nursing conference of their choice.

The other finalists for the Lucozade Nurse of the Year Award were Martin Duffy, Community Psychiatric Nurse, St Brigid's Hospital, Ardee, Co Louth and Trudi Fennell, Ward Sister, Regional Hospital, Cork.

The other Student Award finalists were Sr Robin Dalton from the USA who is a third year student at Portnacula Hospital, Ballinasloe, Co Galway and Paulette Hanrahan, a second year student at the Limerick Regional Hospital, Dooradoyle, Co Limerick.

Speaking on behalf of the sponsors, Mr John Costigan, Product Group Manager, Beecham of Ireland Ltd, noted that since the awards scheme was initiated 13 years ago, thousands of nurses have been nominated for the Awards.

He pointed out that all six finalists exemplified the highest standards of excellence in the nursing profession. This was evident in the citation for staff nurse Paula Hurrell which stressed 'her dedication to caring for the older members of our community'. Student Nurse Teresa Heffernan 'had proved to be an outstanding student both in her academic work and in her practical nursing duties'.

In his remarks he paid particular tribute to two former presidents of the Irish Nurse's Organisation, Ms Maeve Keane and Ms Ita O'Dwyer, for their support and guidance in developing the awards scheme.

The awards are organised by Lucozade in association with the Irish Nurse's Organisation. Candidates are nominated by their colleagues in the medical and paramedical profession as well as by the public generally.

Health bus launched

Long travelling time in an ambulance can be very uncomfortable for old people attending hospital - to cope with the problem the EHB has introduced a new service, the Mobile Day Hospital, which brings the hospital to the people, not the people to the hospital. The service caters for the elderly in outlying areas.

The Mobile Hospital - a converted coach - contains a doctor's consulting area, a physiotherapy area with exercise bars, a bath and toilet facilities. Meals are provided for people attending. It is the first service of its kind in Ireland.

The new service was launched recently by the Minister for Health, Dr Rory O'Hanlon, at St Mary's Hospital, Phoenix Park.

In introducing the Minister, the Acting CEO of the EHB, Mr Kieran Hickey, said the Minister had many major issues on his mind, but had always shown a keen interest in the Mobile Day Hospital Project with its objective of bringing hospital services closer to the community and primary health care.

The Minister, launching the Mobile Day Hospital described the new service at St Mary's as an exciting concept which sought to overcome two weaknesses identified in the organisation of our health services.

'Firstly it helps to bridge the gap between the hospital and the community in caring for elderly patients. Secondly it tries to bridge the artificial divide which is created by the division of responsibility for services for the elderly between different programmes of the health board . . .'

The Minister said the conditions to be treated include stroke, arthritis, post-hip surgery and Parkinson's Disease and expressed the hope that the service would prolong the active life of patients in the community, thus enabling them to continue to make an important contribution to community life, maintain their independence, raise their aspirations and enlighten friends and relatives to the benefits of this type of care.

Mrs Dymphna Clune, Chairman, EHB, said: *'In the north of County Dublin the areas of perceived need are centred at Swords and Skerries. In the case of Kildare the areas are Carbury and Maynooth. The Mobile Day Hospital will call to each of these four locations every week with Friday being reserved for research and evaluation. The Mobile Clinic will be the point of first referral from the family practitioner for specialist assessment and investigation.*

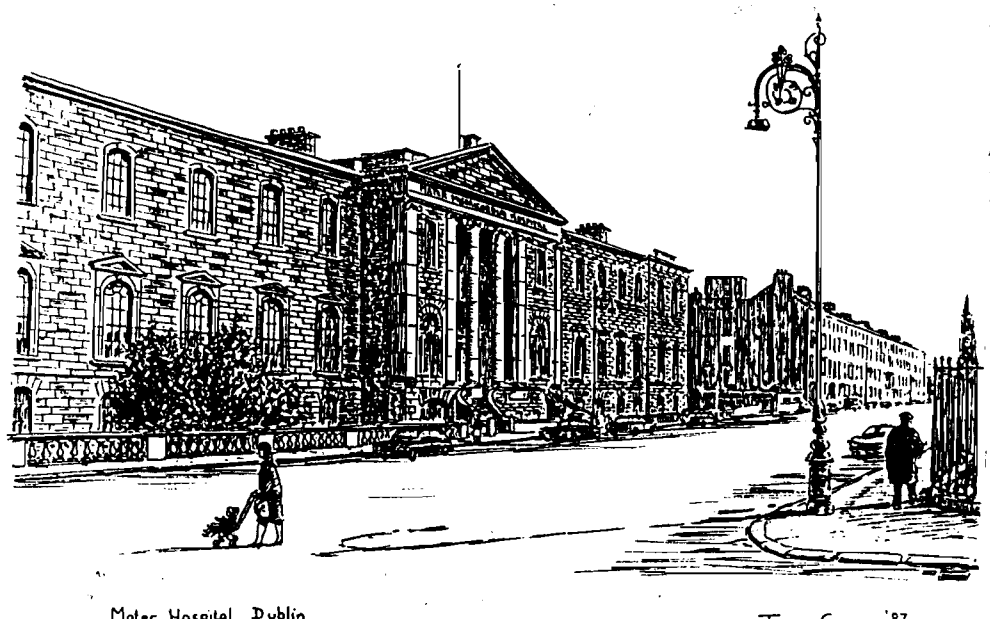
The medical officer will be supported by a para-medical team and patients will be referred back to their GP with a full report.

A very close liaison will be maintained with the primary care team in the community and it is our hope that this service will provide easier access for patients and will be fully utilised'.

SKETCH PAD

Sketch by Tony Coyne

Text by Davis Coakley



Catherine McAuley, founded the Congregation of the Sisters of Mercy in Dublin in 1831. Her initial aim was to form a group of women not formally bound by vows who would teach school-age children, who would train girls for domestic work, and who would visit the sick and poor in their homes and in the city hospitals. She had started this work in 1827 but she came to the conclusion that a religious foundation would bind members of the organisation more closely together and that it would increase the likelihood that the work would continue to develop after her death.

The Dublin hospitals could not cope with the victims of the cholera epidemic of 1832. Several emergency hospitals were opened and the newly formed order was given charge of one in Townsend Street. Here they did heroic work and their experience convinced them of the need to found a hospital of their own. In 1851 they purchased land to build their Mater Misericordiae Hospital after nearly twenty years of planning.

The site occupied fifteen acres at the top of Eccles Street which was then unfinished. Francis Johnson, the famous architect who lived in 64 Eccles Street had planned a large eliptical circus to finish the street. This would have formed a focal point in Georgian Dublin situated on this high ground but the scheme was never put into effect. John Bourke was the architect of the new hospital and he visited hospitals in Great Britain and the Continent before designing the Mater.

The first patients were admitted to the new hospital in 1861. Five years after it opened another epidemic of cholera broke out in the city and the Sisters and their hospital played a major role in caring for the unfortunate victims, the majority of whom perished.

ISSN 0332-3242

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Volume 14 No. 1 JANUARY/MARCH 1988

St James's Social & Sports Club

New Committee '88/'89

The following committee was elected at the Club's recent AGM:

Chairperson: Eibhlis Purcell, Salaries Sect, 1 James's Street
Secretary: Helen Bohan, Emmet House
Treasurer: Patricia Kelly, St Mary's Hosp
PRO: Caroline Whelan, St Mary's Hosp
Committee: Alice Hogan, Comm. Care HQ, Area 6; Ronan Segrave, River House

The following were co-opted on to the committee:
Fiàcra McGuirk, Comm Welf, Park Hse
Ciaran Johnson, Bank Reconciliation, 1 James's Street

The Club continues to thrive, and looks forward to an active, happy, and successful year.

We wish them well, and hope to bring readers regular reports of events.

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Pensioners' Associati NEWS

T. Ragan

Many of you who have retired from the service of the EHB, James Connolly Memorial Hospital, and St James's Hospital and who are members of the Association will appreciate the credit due to those who set up the Association in January 1980.

In all there are approximately 1,000 - 1,200 on the Pension Payrolls of the above bodies and yet, sorry to say, the paid-up membership of the Association barely reaches 400.

The whole purpose of setting up the Association was to ensure that contact should not be lost with friends and colleagues of working days and that the often traumatic effect of ceasing a day-to-day routine of 20, 30 or 40 year's duration should be lessened somewhat by using and joining the Association and thereby still maintaining the friendship of erstwhile colleagues.

As membership of the Association includes all grades and all ranks, a source of information and well of expertise is readily available to help those in need of advice concerning all the health and social services currently available. Indeed advice and direction is often sought and readily given in matters such as income tax on occasions, matters of a confidential and personal nature. In general terms the Association is there to provide a general information service to it's members.

On the social side the Association arranges two 'outings' a year - one a full-day trip and the second a half-day trip. Those who have availed of the outings will testify to the general enjoyment of the trips. The highlight of our social activities is the Annual Christmas Dinner where members are able to meet and chat with friends and colleagues in a most friendly setting. A committee of 25 manage the affairs of the Association and this committee meets regularly every month. An Annual General Meeting is held in April each year and various reports are submitted for discussion. Our Hon. Auditor's report is also submitted to AGM for discussion. In the main, our funds are disbursed by donations to an agreed charity and the subsidising of our Annual Dinner.

The Constitution of the Association (Art. II) states that *'no fee or emoluments - other than reimbursement of outlay on telephone calls, postage etc. may be paid to or accepted by members of the Management Committee for work undertaken on behalf of the Association or on behalf of it's members'.*

Finally, the annual subscription is only £2, and I would ask those on pension who have not yet joined the Association to do so now and forward the subscription to the Pensioners' Association, c/o Central Registry, EHB, 1 James's Street, Dublin 8.

Volunteers for disabled group wanted

Action for Mobility (AFM) is a newly formed group of able-bodied and disabled people. It's aims are to encourage and facilitate independence amongst disabled people and to act as a pressure group to lobby on issues affecting disabled persons. AFM has already organised holiday breaks to the Dundalk Drama Festival and to

Wicklow Town

4 on a Team: Scramble

Like to enter?

£15.00 per person (includes food)

1st Prize: *Weekend flights to Paris & London*

PRIZES GALORE!

Details: Ring Andy Kavanagh (EHB) at 0404-68400 (9 - 5)
OR
Jimmy Rathbone tel 562201 after 7pm

INTER HOSPITAL SOCIAL CLUB '88

MIXED FOOTBALL

(6 girls and 5 men)

Like to enter?

Details from Jimmy at 562201 after 7pm

FOR SALE

OPEL KADETT 1.2 1983

Excellent condition.
Serviced regularly.
One owner.

£4,950 o.n.o.

Tel 537951 ext 2885/2718

The late Ronnie Lambe

The death of a pensioner does not normally come as a shock. There is sadness that an old friend has passed away, but the death does not usually have the poignancy of a young person taken in his or her prime. Generally, a pensioner has had a long career and if he has not quite reached the fabled three score years and ten, we are saddened, but after all, we say, nobody lives forever.

Ronnie Lamb was different. He certainly had a long career in the Dublin Corporation, the Dublin Health Authority and the EHB, but somehow he never seemed like someone whose life's work was behind him. He was too active and vibrant for that. In fact, as soon as he retired - and he didn't wait till retirement age to do that -

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SOLUTION CROSSWORD 66

ACROSS: 1. Illegible; 6. Stag; 10. Tenet; 11. Eradicate; 12. Mattock; 13. Tingled; 14. Cherry Orchard; 18. Sewing machine; 20. Acrobat; 23. Ourself; 24. Municipal; 25. Idler; 26. Hoed; 27. Rowan Tree.

DOWN: 1. Intimacy; 2. Lengthens; 3. Get your own back; 4. Breakdown; 5. Exact; 7. Trail; 8. Greedy; 9. Piano accordian; 15. Common law; 16. Driveller; 17. Perforce; 19. Warmth; 21. Range; 22. Toper.

ACROSS

1. *Sailor must confound the deceivers (10)*
6. *Strange cold sticky mass (4)*
10. *Anxious German woman at end of mounting high tension (7)*
11. *Particular gamble, I and Albert follow (7)*
12. *Long ago at home boys meeting ran wild (2,5,4,2)*
14. *Dead seers upset the person to whom the message is sent (9)*
17. *Are national armies initially a centre of conflict (5)*
18. *Mask a part of a helmet (5)*
19. *The sacking of Sidney, back with holy book (9)*
20. *Dealers way to swap kings (6,7)*
24. *Foreign nobleman concealed botched goal (7)*
25. *Silly name in front of one flower (7)*
26. *Consumes assorted light meals (4)*
27. *Judgment of fools delivered about the beginning of May (10)*

DOWN

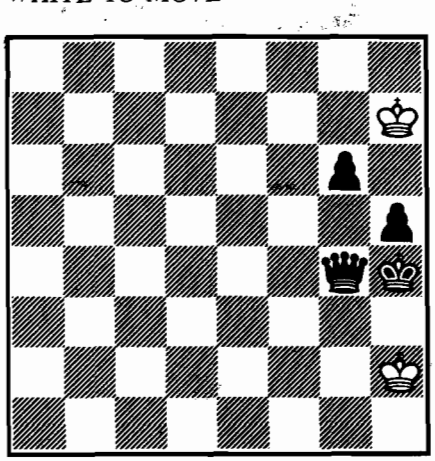
1. *It's sure to be found in goods a fence handled (4)*
2. *I am climbing twice around US town (5)*
3. *Hear Edward in gently cheerful fashion (14)*
4. *Symbol seen in visit to temple at Ephesus (5)*
5. *Strive against or start suppressing electrical appliances (9)*
7. *See, it's about . . . uh . . . uh . . . wasters (9)*
8. *Two learners into do-it-yourself and two more in day that showed what seven do (10)*
9. *Embellishment of scenery with restructured naive sets (14)*
13. *Runner shoves a can all over the place (6,4)*
15. *Disgrace to Diana's honour (9)*
16. *Treacherous Ted is crazy and promises to pay (9)*
21. *Degrade a headquarters (5)*
22. *A good man to love - no beginner - will keep you warm (5)*
23. *Fitting assembly for hunting (4)*

Winner: Barry White, Personnel Dept, EHB.

Entries to Crossword, *Contacts*, 1 James's Street. £5 to first correct solution opened on Friday 27 May '88. Prizes for Crossword and Chess Problem sponsored by Astra and St James Social & Sports Club

Chess Problem

WHITE TO MOVE



White is two pawns in arrears.
What is the continuation and who wins?

Entries to Chess Problem, *Contacts*, 1 James's Street. Prize £5. Closing date Friday 27 May '88.