



NEW VISION

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Graduate Nurses Foundation is an independent academic body for graduate nurses in Sri Lanka. It was built with purpose of providing our contribution to improve Nursing Practice in Sri Lanka.

As nurses, we know, our achievements for professional development are very less. The highest achievement that we had so far was BSc Nursing programme. BSc Nursing Programme was started at the OUSL with collaboration of Athabaska University in Canada in 1994. That was a turning point of Nursing in Sri Lanka, owing to that our nurses are gradually motivate for higher education. At present there are around 250 BSc graduates and 25 MSc graduates in Sri Lanka.



Presentation of the first copy of "New Vision" to Ms. Chandra de Silva, The Pioneer of BSc Nursing Programme in Sri Lanka.

After our graduation, we felt the necessity of motivating our colleagues towards higher education. Because, we can step in to professional development only through the higher education, and ultimately we are able to upgrade quality of our service.

These ideas compelled us to formed the Graduate Nurses' Foundation (G.N.F.). Even though, we are very little in number, we try to give maximum for the profession through our endless effort. So far, we have conducted monthly committee meetings, 5 general meetings and three educational programmes for our nursing colleagues. All the nurses are invited for educational programmes even nursing students.

Even though, it is named as "G.N.F", we offer partial membership for under graduates also. We think, you may have read our newsletter "New Vision". Our effort is to develop "New Vision" among

our colleagues. "New Vision" open a forum for you to discuss and share your knowledge and views with colleagues. Always we are ready to give our helping hand for your professional and personal development. As nurses we should get together and move forward to achieve our goal. That is "To Provide Quality Care Through Higher Education".

Now we are busy with planning to celebrate first birthday of our foundation. It will be due on 24th October in 2004. We hopefully planned one day Educational Programme for you. At the same time we are anxiously waiting to publish your views in our newsletter.

Dear friends, G.N.F. works for you. It is your foundation. Gather around it. Your ideas, criticisms are welcome for further development.

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Students are the youngest, immature and the most vulnerable group in the nursing profession. Students should develop necessary nursing skills, which are based on strong theoretical knowledge in order to become efficient and skilled professionals in the future. It is the obligation of the senior professionals to provide an effective learning environment for the students. As a nurse educator, I strongly feel Sri Lankan nursing students are under immense pressure in the clinical field.

There is an acute shortage of nurses at all levels such as staff nurses, nurse managers and nursing tutors. This shortage affects the nursing students when they are in the clinical areas because there are too few nurses to supervise them and they are required to help with the general workload. This means they spend a large amount of time working alone, doing repetitive tasks and learning little that is new. Students are considered as workers rather than students. So they are unable to develop the necessary nursing skills to meet their educational objectives.

As we are aware, clinical experience is the vital part of nursing education. Nursing students need a comfortable, healthy learning atmosphere for gradual development of their nursing skills in order to make necessary adjustments to become part of the nursing profession.

The quality of nursing education is dependent on the quality of students' clinical experience. The clinical placement experience is

Clinical Experience in Nursing Education

central to the development of nursing practice skills. Learning only occurs if the experience is used productively. Clinical experiences require difficult adjustment for the students as they move from an environment that encourages "thinking" to an environment, which encourages "doing". If there is no supportive environment learning will be reduced.

When we discuss with our students they present long list of problems, which they encounter in the clinical setting. I would like to mention some of them for your consideration.

- Lack of recognition
- Lack of guidance and supervision
- Attitudes of the ward staff regarding students' development
- Lack of learning opportunities
- Theory practice gap
- Lack of related knowledge
- Lack of equipment
- Work load

As senior nursing professionals we should develop some strategies to overcome these barriers and to develop healthy learning environment for the students. I would like to make some suggestions for the improvement of the clinical education.

* **Develop acceptance**

Students need acceptance to the nursing team. The ward staff have a responsibility to treat them as learners; to respect their views; to

talk to the students personally when it is necessary; to treat them empathetically; to provide necessary equipment and support in their learning.

* **Respect the students' dignity**

Lack of respect creates frustration; it is necessary to communicate with them in a friendly manner; avoid insult and criticism; encourage them to learn and provide necessary support.

* **Provide good examples and role models in the clinical setting**

The qualified staff should provide care for patients and practice properly; they can work with students; then the students develop sense of security and interest in the profession.

* **Nurses' commitment to teaching and supervisory role**

Charge nurses and other nurses are not trained for student supervision. It is essential to provide necessary knowledge

and skills to supervise and support students more effectively.

Each tutor should have a manageable group of students in the clinical field. If there are 10 to 12 students the tutor can provide proper guidance and supervision in the clinical field. Clinical instructors make valuable contributions for the students' development in the clinical field. Unfortunately there are many problems regarding this post, but I thoroughly believe we should strengthen the post of clinical instructor for the betterment of the nursing education.

As we are aware clinical field provides a variety of learning experiences to the students in order to develop their nursing skills. So it is our duty to strengthen the clinical field and to provide more effective learning environment for the students.

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Tobacco Control

The WHO Framework Convention on Tobacco Control (FCTC) was developed in response to the current globalization of the tobacco epidemic. The spread of the tobacco epidemic is facilitated by a variety of complex factors with cross-boarder effects, including trade liberalization, foreign direct investment, and other activities such as global marketing, transnational tobacco advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes. The WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest standard of health.

WHO-2003

PRE OPERATIVE NURSING CARE MANAGEMENT

Perioperative Nursing includes the nursing functions in the total surgical experience of the patient: preoperative, intra-operative and postoperative. Preoperative phase begins from the time the decision is made for surgical intervention to the transfer of the patient to the operating room.

This phase includes series of steps of nursing care

A. Patient Education

Pre-operative teaching helps the patient to understand the surgical experience to minimize anxiety and promote full recovery from surgery and anesthesia. This can be offered through conversation, discussion, demonstration and audio-visual aids should be over followings

- Teach the patient regarding deep breathing exercises to prevent post-operative chest infections. Use of incentive spirometer helps to measure deep breaths while exerting maximum effort.
- Coughing exercise; promotes the removal of chest secretions.
- Turning; changing positions from back to side-lying (and vice versa) stimulate circulation, encourage deep breathing and relieves pressure areas.
- Foot and Leg Exercises; promotes circulation and muscle tone.

B. Prevention of Complication

- Correct the risk factors; includes poor nutrition, fluid and electrolyte imbalance, obesity, hypertension, pulmonary & upper respiratory tract infections, and diabetic mellitus etc,
- Complete the patient's necessary laboratory tests and other investigations.

C. Preparation of the Operative Area

- Skin; instruct the patient to bathe or shower, using bacteriostatic soap (eg. providone-iodine) or normal soap on the day of surgery while paying special attention to armpits, genital area, between toes, and skin folds.
- If necessary, shaving should be performed as close to the operative time as possible and prevent skin injury while shaving.
- Give light meal in the evening before the surgery and must be kept fasting from 10.00p.m. (or as doctor's order)
- Enemas should be given as ordered.

D. Informed the Patient

- Regarding the operation and anesthesia; kind of anesthesia to be given, post operative drugs and fluid therapy, various catheters and dressings etc.

- Take informed consent. Let the patient ask questions.
- Find out the patient history of allergies; drugs, foods or something else
- Inform the patient that following items are not allowed to use on the day of the surgery, such as lipsticks, nail polish, jewelers and dentures.

E. Preoperative Medication

- Medication will be given to facilitate the administration of any anesthetic, to minimize respiratory tract secretions and changes in heart rate, and to relax the patient and reduce anxiety. Administer medication as ordered to take maximum potency.

F. Admitting the Patient to Surgery

- In the morning of the operating day; total fasting continues (but giving essential drugs with small amount of water), let the patient having mouth care & a bath appropriately, shave & prepare the skin as necessary.
- Patient should wear clean cloths, cap & leggings.
- The pre-operative checklist is the last procedure before taking the patient to the operating room. Prepare the patient according to the checklist. It includes identification and verification of the patient, review of patient records, consent form, and patient preparation (fasting states, kind of pre-medication given, removing of dentures or plates etc.)
- Allow patient to void.
- Complete chart & pre-operative checklist

G. Transporting the Patient to the Operating Room.

- Talk with the patient in friendly manner and reduce anxiety and fear.
- Accompany the patient to the operating room with a operating room nurse and a attendant and maintain patient safety and comfort while transporting.
- Ensure arrival of the patient in the operating room at correct time.

Next phase will be the intra operative phase.

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Confidentiality

"I will respect the secrets which are confided in me even after the patient has died"

Geneva declaration

QUALITY OF CARE : PATIENT SAFETY

Health care interventions are intended to benefit patients, but they can also

cause harm. The complex combination of processes, technologies and human interactions that constitutes the modern health care delivery system can bring significant benefits. However, it also involves an inevitable risk of adverse events. Today more countries, including Canada, Denmark, the Netherlands, Sweden, and other countries are taking a serious look at the problem. New Zealand has carried out a feasibility study on research into adverse events in public hospitals. Sri Lanka Health Service should consider this trend to protect patients as well as improving the quality of care.

Extend of Adverse Events

Various studies have investigated the extent of adverse events. The Harvard study found that 4% of patients suffer some kind of harm in hospital; 70% of the adverse events result in short-lived disability, 14% of the incidents lead to death. The Institute of Medicine report estimated that "medical errors" cause between 44 000 and 98 000 deaths annually in hospitals in the United State of America – more than car accidents, breast cancer or AIDS. The United Kingdom Department of Health, in its 200 report An organization with a Memory estimated that adverse-events occur in around 10% of Hospital admissions, or about 850 000 adverse events a year. The Quality in Australia Health Care Study (QAHCS) released in 1995 found an adverse-event rate of 16.6% among hospitals patients. The hospitals for Europe's Working Party on Quality Care in Hospitals estimated in 2000 that every tenth patient in Europe suffers from preventable harm and adverse effects related to his or her care (WHO 2001).

Adverse events exact a high toll in financial loss as well. The

total national cost of preventable adverse medical events in the United States of America, including lost income, disability and medical expenses, is estimated at between US\$ 17 000 Million and US\$ 29 000 million annually. Added to this costs is the erosion of trust, confidence and satisfaction among the public and health care providers. The situation in developing countries and economic in economic transition merits particular attention. The poor state of infrastructure and equipment, unreliable supply and quality of drugs, shortcomings in waste management and infection control, poor performance of personnel because of low motivation or insufficient technical skills and severe under functioning of essential operating costs of health services make the probability of adverse events much higher than in industrialized nations. Despite of highest health states, most Sri Lankan people experience this situation every day, however reporting and analyzing of adverse events are in the lower level. WHO figures suggest that developing countries account for around 77% of all reported cases of counterfeit and substandard drugs. It also reported that at least 50% of all medical equipment in most of these countries are unusable, or only partly usable, at any given time, resulting in neglect of patients or increased risk of harm to them and to health workers. In the newly independent States, about 40% hospital beds located in structures originally built for other purposes. This makes facilities for radiation protection and infection control extremely difficult to incorporate, with the result that such facilities are often either substandard or absent.

Where and Why Adverse Events Occur

Who studies reveal that most of the current evidence on adverse events comes from hospitals,

because the risk associated with hospitals care are high, strategies for

improvement are better documented and the importance of patient trust is paramount. But many adverse events occur in other health care settings, such as dispensaries nursing homes, pharmacies and patient's homes. Every point in the process of care giving contains certain degree of inherent unsafely: side effects of drugs or drug combinations, hazards posed by a medical device, substandard or faulty products entering the health service, human shortcomings, or system (latent) failures. Adverse events may therefore result from practice, products, procedures or systems. Immunization, which is given to healthy individuals, poses a particular challenge. With the decline in prevalence of vaccine-preventable diseases, concern about potential adverse events following immunization may have a negative impact on national immunization programmes and preventive health care in general.

Current conceptual thinking on the safety of patients places the prime responsibility for adverse events on deficiencies in system design, organization and operation rather than on individual providers or individual products. Adverse drug events in the Utah-Colorado Study in the United States of America provide a dramatic example, 75% of them being attributed to system failures. Similarly, most adverse events are not the result of negligence or lack of training, but rather occur because of latent causes within systems. For those who work on systems, adverse events are shaped and provoked by "upstream" systemic factors, which include the particular organization's strategy, its culture, its approach towards quality management and risk prevention, and its capacity for learning from failures.

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Infection can be considered as a major problem in clinical setting. It increases cost of care in one hand, and on the other hand, patients and their families are also affected.

Critically ill patients are commonly immuno-compromised and they are easily caught by infections. In case of in children and elderly patients, they are at the greatest risk of infections. Hand washing is the primary means of preventing the spread of infection. Prophylactic antibiotic therapy and abuse of antibiotics have contributed to the development of resistant micro-organisms, and therefore specific drugs therapy are essential in preventing and treating the spread of infection.

Most of the critically ill patients require the placement of central or peripheral vascular access lines for hemodynamic monitoring. Insertion of intra-vascular devices is the commonest cause of septicemia. Further, the respiratory tract, Urinary tract, wound sites, and blood can be identified as common sites where occur infections in the critically ill patients.

Antibiotic resistant organisms such as staphylococci, streptococci, pseudomonas, enterobacteriae, tuberculosis etc. are mainly contributed to occur infections in severely ill patients. Liberal use of broad spectrum antibiotics also results such infections. Further, certain diseases include diabetic mellitus severe trauma, renal failure, chronic lung diseases and leukemia predispose the patients to an increase the risk for infections.

Diagnostic test findings and physical assessment help to identify patients with infectious diseases. However symptoms may be masked or absent if they are immuno-

suppressed or are currently receiving antibiotics. White blood cell count is elevated due to viral or mycoplasmic organisms and WBC differentials will assist in differentiating the type of infection

INFECTION CONTROL

(eg. neutrophils increased due to bacterial infection). Culture and sensitivity studies identify the organisms and reveal the appropriate antibiotic to use for the treatment.

Strategies in Patient Care Management

1. Obtain diagnostic test studies to identify the source of infection.
 - They are valid only if the specimen is properly collected, transported, and processed. Strict sterile techniques should be followed in collecting specimens for culture studies.
2. Administer drugs as ordered.
 - Antibiotics appropriate to the organism should be given at specified time.
 - Evaluation of the patient's kidney and liver functions is essential to determine the correct dosage.
 - Resistant organisms may require use drug of choice & frequent adjusting the dosages of drugs.
3. Wear gloves and other attires to avoid in contacting blood and other body fluids as necessary.
 - Precautions should be taken to protect the patient and the nurse, and should prevent contamination in suctioning, dressing changing, urine handling, and blood specimens collecting

4. Wash hands thoroughly under running water with using soap or antiseptic lotion for a minimum 1minute. This is the primary means of preventing transmission of infection.
 - Antiseptic soaps and longing washing time should be used in high risk clinical areas and in invasive procedures.
 - Hands should be washed between contacts with different patients, between different procedures on the same patient, and before and after gloves are worn.
5. Adhere strictly to protocols for **catheter insertion and care** to markedly reduce catheter- related sepsis.
 - Use of any catheter (urinary or vascular) must be essential for care, not merely convenience for the medical and nursing staff.
 - **All connection sites** are potential sources of contamination. The catheter should be manipulated only after hand washing or donning gloves.
6. Decrease risks of infection by following below methods.
 - Avoid sharing of equipment between patients to prevent cross infections and spills, especially blood and other excreta, should be removed immediately.
 - Equipment such as monitor parts, oxygen inhalation and ventilator parts should be carefully decontaminated using effective disinfectants.
 - Persons with active infections, specially upper respiratory tract infections and skin lesions should be restricted from patient contact.
7. Care for infection sites properly.

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Consciousness

It is extremely important for a nurse to necessary knowledge, skills, and attitude to identify a person or a patient's nature of nature of consciousness as far as nurses' practice is concerned. Bates (1996) discusses consciousness as an individual's states of awareness of the self and environment. Usually it is expressed when stimuli is given. So if a person is fully conscious he/ she is awake, alert, oriented in time and place, understands spoken words reads written words and express ideas verbally.

The consciousness also involves the ability to initiate movements and modifying the motor response (Lindsay et al, 1998). However, normal consciousness is displayed by responding to stimuli and showing appropriate behaviour, and speech. Importantly, patients who are asleep can be aroused (awake) and then they would do activities in normal manner. On the other hand, in context of psychiatry a person's consciousness is a state of mind that would refers to the person's mental experience at a given movement (Trethowan & Sims, 1983). So in these situations not only state of consciousness but also content of the consciousness expresses the person's quality of awareness. The quality of consciousness changes from moment to moment. For instance, if a person is fatigue consciousness is lower, whereas if a person is threatened she/he concentrates more or high. Consciousness is also changes with age. But it seriously changes due to disease process.

According to neurological explanations, normal consciousness occurs with the integration of activity of ascending reticular activating substance of brain stem and neural connection between areas in the cerebral cortex. Actually, ascending reticular activating system extends from spinal cord, medulla oblongata, and midbrain to thalamus. From there, there are 2nd order neural connection to cortex. (James, 2000). Therefore, these structures to be intact in order to a person to be awake. If a person is arousal, he does eye opening spontaneously motor responses, and does verbal communication. But the content of consciousness is maintained by cerebral cortex. Hence, if there is a damaged to the brain stem affecting the ascending reticular activating substance or damage to areas of the cerebral 'hemispheres' results in alteration of normal consciousness Graicy & prema (2002) divide 5 categories of alterations of consciousness.

Alert	- To verbal stimuli patient responds immediately and appropriately. He is awake
Lethargic	- Patient is drowsy but arouses easily. He is inattentive, prefers to sleep. But, if he aroused, he is oriented to person, place and time.
Stuporous	- Arouses with difficulty and cooperate minimally. Verbal responses are inappropriate. Patient spends more time for sleeping.
Semi-comatose	- Patient does not ability to response to verbal stimuli. For pain stimuli motor responses are little and non purposeful.
Comatose	- No response to verbal or painful stimuli. No verbal activity to be seen

Altered levels of consciousness are examined with Glasgow-Coma Scale (GCS).

Eye Opening

Spontaneously	4
To speech	3
To pain	2
No response	1

Best Verbal Response

Oriented and speaks	5
Disoriented	4
Inappropriate Words	3
Incomprehensive sounds	2
No response	1

Best Motor Response

Obeys commands	6
Localizes pain	5
Flexion-withdrawal	4
Flexion- Abnormal	3
Extension	2
No response	1

Total marks = 15

How you assess the patient.

Eye opening	-	1. Spontaneous	2. To speech
		3. To pain	4. None.

Pressure should applied to supra-orbital nerve or finger nail bed to assess 3 & 4

Verbal responses

Oriented	- Knows place, date, time and his name
Confuse	- Talking in sentences but disoriented in time and place
Inappropriate words	- Utters occasional words. No sentences can be made.

Incomprehensive sounds- Graons, grants, No words.

Motor responses

Obeys commands	- Tell the patient to hold your arms. Patient holds arms
Localizing to pain	- When pressure is applied to supra-orbital groove, patient responds by bringing hands towards the pressure (pain).
Flexion to pain	- When pain is applied to nail-bed with a pen patient flexes arms.
(A). Flexion withdrawal	- When pain is applied patient tries to take his hands away
(B). Flexion abnormal	- Patient tries to bend his arms abnormally. Reaction is different.
Extending to pain	- when pain is applied to nail-beds patients hands go outwards, specially from wrists. eg. extra pyramidal tracts damage. None.

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QUALITY OF..... continued from Page 4**Strategies to Enhance the Safety of Patients**

WHO recommends several strategies for enhancing the safety of patients includes three complementary actions: Preventing adverse events; making them visible; and migrating their effects when they occur. This requires: (a) increased ability to learn from mistakes, through better reporting systems, skilful investigation of incidents and responsible sharing of data; (b) greater capacity to anticipate mistakes and probe systemic weaknesses that might lead to an adverse event; (c) identifying existing knowledge resources, within and outside the health sector; (d) improvements in the health care delivery system itself, so that structures are reconfigured, incentives are realigned, and quality is placed at the core of the system. In general, national programmes should build around these principles.

Despite growing interest in the safety of patients, there is still widespread lack of awareness of the problem of adverse events. Capacity for reporting, analyzing, and learning from experience still seriously hampered by lack of methodological uniformity in identification and measurement, inadequate adverse event reporting schemes, undue concerns over breaches in confidentiality of data, the fear of professional liability, and weak information systems. Understanding and knowledge of the epidemiology of adverse events—frequency of occurrence, causes, determinants and impact on patient outcomes, and of effective methods for preventing them are still limited. Although there are examples of successful initiatives for reducing the incidence of adverse events, none has been scaled up to embrace an entire health system.

Practices relating to quality management in health care differ from one country and culture to another. There is a need for international standardization of terminology in definition, common methods for measurement, and compatible reporting of adverse events. These could be achieved by building on WHO's experience in the methodology of intercountry comparisons.

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INFECTION CONTROL continued from Page 4

- Dressings should be changed frequently as necessary to keep clean & dry, and cover each wound with a separate dressing to prevent cross contamination.
- Aseptic techniques should follow thoroughly.
- 8. Separate patients if possible to prevent cross infection.
- 9. Teach patients regarding following,
 - Risk factors & causative agents contributing to the infection.
 - Specific drugs regimen for treatment.
 - Importance of informing others about infection if it will have a major health effect, such as hepatitis-B, herpes & AIDS
 - Specific measures to prevent and control infection & proper disposal of contaminated materials.

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Chemotherapy for Elderly Patients with Advanced Cancers

Elderly patients with advanced cancers must be allowed to balance the potential risks and benefits of treatment when deciding whether or not have chemotherapy. The response rates to aggressive chemotherapy are similar in younger and older patients. Disease related survival is often similar, although the older age group has more deaths due to comorbid illness. Factors complicating chemotherapy in the elderly are the physiological changes of ageing, the presence of comorbidities and polypharmacy. Deterioration in renal or hepatic function may force the doses of the chemotherapy to be adjusted. Organ toxicities may be more problematic in the elderly, but in most tumours, the efficacy of chemotherapy is not age dependent. Chemotherapy, where indicated for advanced cancer, can therefore be safely and effectively used in selected elderly patients.

Source : Australian Prescriber –2004.

An oily essence in tobacco was discovered in early 1800s and named

between puffs or of the exhaled by a smoker, causes a serious health risk.

represents about half of all US doctors and is a strong opponent of smoking. In

substantial adverse effects on a person's heart and lungs.

LIFE WITH A HEAVY SMOKER IS MORE RISKY THAN LIFE WITH AN HIV INFECTED MAN

nicotianine. Later it was recognized as the main active ingredient of tobacco and called as nicotine. Nicotine, however, is only a small component of cigarette smoke. It contains more than 4700 chemical compounds other than nicotine. Today scientists have identified 43 cancer-causing substances in cigarette smoke. In recent times, scientific research has been providing evidence that years of cigarette smoking vastly increases the risk of developing fatal medical conditions.

Smoking is responsible for more than 85 % of lung cancers. Apart from this, tobacco smoke is associated with cancers of the mouth, stomach and kidneys. In addition, smoking is thought to cause about 14% of leukemia and cervical cancers. Smoking, it is believed, is responsible for 30% of all deaths from cancer and clearly represents the most important preventable cause of cancers.

Passive smoking, the breathing in of the side stream smoke from the burning of tobacco

A report of American Environmental Protection Agency revealed the dangers of the side-stream smoke. According to the report of this type of smoke contains more smaller particles and is therefore more likely to be deposited deep in the lungs. In this case, environmental tobacco smoke has been identified as the highest risk category for causing cancer. As an illustration of the health risks in the case of a married couple where one partner is a smoker and one a non-smoker, the latter is believed to have a 30% higher risk of death from heart disease because of passive smoking. The risk of lung cancer also increases over the years of exposure, and the figure jumps to 80% if the spouse has been smoking four packets of cigarettes a day for 20 years. Not only this, but the lives of the kids of a heavy smoker is also at utter risk. It has been calculated 17% of cases of lung cancer can be attributed to high levels of exposure to second-hand tobacco smoke during childhood and adolescence.

The American Medical Association

their journal, they published a review of studies of smoking over the past few years. In that report, they suggest that people who smoke cigarettes are continually damaging their cardiovascular system, which adapts in order to compensate for the effects of smoking. However it further states that people who do not smoke do not have the benefit of their systems adapting to smoke inhalation. Consequently, the effects of passive smoking are far greater on non-smokers than on smokers. There is no doubt that smoking has a great impact on smokers' health. But many scientific researchers have provided evidence that the impact on non-smokers' health is far greater.

A more recent study by researchers at the university of California has shown that second-hand cigarette smoke does more harm to non-smokers. Leaving aside the philosophical question of whether anyone should have to breath someone else's cigarette smoke, the report suggest that the smoke experienced by many people in their daily lives is enough to produce

Passive smoking is a grave health problem to the society. Non-smoking spouse of the smoker, innocent kids, and all the others of the society have to spend health risky lives because of one person's bad habit. Therefore some type of immediate action needed against passive smoking, and to establish smoke free homes, work places and public places. Changing of attitude of the public by convincing the adverse effects of smoking to the health is the most cost effective way of reducing smoking. Specially in countries like Sri Lanka almost all females are non-smokers. They have the right to live in a smoke-free home. Therefore, they should select the non-smokers as their partners. If the spouse is an HIV infected person, it is easier to protect from getting aids, than avoiding passive smoking. Although the kids of a HIV infected father have no risk of HIV, the kids of an smoker have a great health risk.

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