

7. *Daydreaming fanciful thinking* (hallucinations) may be interrupted or replaced by an active interest in an activity, planned to keep the patient in touch with reality.

8. *Lack of confidence or loss of ego* can be overcome by the development of assurance, through accomplishment, by the patient. Such performance must be skillfully guided to avoid failure.

9. *Hyperactive or maniac actions* may be directed into constructive channels and dissipated or redirected into acceptable behaviour through participation in a selected work program.

10. *Depressed* patients may be stimulated and interested by giving them activities involving variety and colour.

These are only a few of the problems which therapist must be able to meet. One patient may suffer from not one but many of the conditions listed under both physiologic and psychologic disturbances. Each factor in the combinations of factors must be recognised and given its place in a directed program of purposeful activity. This may require a number of activities for the patient or a single procedure may meet the needs of several factors simultaneously.

From the foregoing you will readily understand why the occupational therapist is a jack of all trades and thus master of therapy. She or he must know the meaning of the diagnosis, the normal precautions for such an illness and understand the significance of additional precautions mentioned in the prescription by the doctor. Thus an occupational therapy student must study anatomy, physiology, pathology, bacteriology, neurology, orthopedics, kinesiology [science of muscles], psychology, psychiatry, special conditions such as heart, eye, and burns. With the medical background there must be a knowledge of games and recreational activities for individuals and groups. Then come the crafts—weaving, bookbinding, metalwork, pottery, sewing, embroidery, basketry, knitting, crocheting, and the many minor crafts or divisions under each of these. A knowledge of projects which may be carried out in a ward is also essential such as marionettes or dramatics. Very often the therapist must make her own apparatus or appliances as they must be adapted to the needs of a particular patient. As far as possible adaptations are discouraged but now and again are necessary, especially for some types of cases such as contracture of the fingers after a burn.

And now you must be wondering just where all this fits into your problems as nurses. In the first place we occupational therapists make it a point never to give bed patients activities which may be messy and soil the bedding. We also do not want the patient to have activities which will be a nuisance when the doctor comes on his ward rounds. So our first aim is not to increase in any way the work of the nursing or other hospital staff. But we do claim to lighten the duties of the nurse, for we are able to help keep the patients happy and occupied so that much of unnecessary demand of service from the nurses on the part of the patients is removed. The nurse and the occupational therapist co-operate for the welfare of the patients. The occupational therapist and her O. T. Shop welcome the nurse at any time she is free and are always ready to teach her any craft or help with her sewing and related problems. We cannot guarantee a cup of tea but you will have a welcome. We will help with parties and functions and add a bit of life and sunshine when things become too dreary, not forgetting that we are all there for the good of the patients and the institution.

A Case of an Extensive, Infected, Second Degree Burn Treated at the Rahima Hospital, Arabian American Oil Co. Saudi ARABIA.

It was on the 30th of August when the Arabian summer was in its zenith. Our O.P.D. Clinic was packed to capacity. At 10-30 a.m. our routine was disturbed by an exceptional sight. A seventy year old ("Bedouin," named tribe of the Arabian Desert) was being wheeled into the clinic on a stretcher. He was a wiry

dirty man clad in filthy clothes. But more filthy were his limbs and back, which were coated with a thick moist layer of pus and camel dung (excreta of the camel) the smell of which filled the place dispelling the crowd faster than gathering around him. Only the Clinic Doctor remained to examine him.

History : The patient, Sayed Ibn Mali had sustained severe burns when his "Barsati" [hut] caught fire ten days back. A fellow bedouin treated him with camel dung.

Examination : showed extensive second degree burn over

1. The whole of the back.
2. The dorsa of both hands.
3. Both ankles and feet.

They were secondarily infected and covered with pus and dung. temp: 99.5; pulse 100; Resp 24; B.P. 90/40. The routine treatment for burns of our Company Hospital was ordered. It has been carried out by two Male Nurses who proceeded with the following technique:—

As the patient was too weak to be given General Anesthesia, Quarter grain of Morphine Sulphate was injected. A thorough preliminary soap and water bath was given to cleanse him. Then the First Nurse scrubbed the back using Tr. Soap Sterile water and sterile gauze. The scrubbing was repeated four times which extended about six inches beyond the outskirts of the burn. All the dead skin and debris were removed. The second Nurse then dressed the scrubbed wounds with vaseline gauze, dry gauze, sterile mechanical waste, and sterile cotton wool in the order by layers. To keep the dressing in position and to ensure compression to the oozing surface of the burn an elastic bandage was applied around his chest. The same process was repeated for the extremities. Special care was given while dressing the toes and fingers, to see that vaseline gauze and gauze were kept in between the toes and fingers.

After Care : After this operation the patient was put in bed. On admission Temp 99.5; pulse 100; rather feeble: Resp 24; B.P. 70/40. The condition caused anxiety to Doctors and Nurses. The Body was kept warm with blankets and electric cradle, fluids forced by mouth. Penicillin 500,000 units Q. 3.H. started. Plasma 250 c.c. was administered B.I.D. to replace fluid loss and protein. Patient was moved from side to side Q. 2 H. gently. At 8 p.m. Temp. 102; Pulse 118; Resp. 24; B.P. 100/65.

Second Day : Temp. came down to 99; Pulse 92; Resp, 22, general condition improving 1500 Units of A.T.S. was given I.M. Plasma and Penicillin continued as before. Vitamines and Iron were started by mouth. Urine examination showed Albumin Plus. On examination of blood Haemoglobin was low therefore Liver Extract 2 c.c. I.M. was given daily and iron by mouth continued. Urine examination continued daily. Albumen cleared after four days.

Fifth Day : T.P.R. normal, taking light diet. Penicillin and Plasma continued.

Sixth Day : Dressing changed. wound was found to be clean and wound surface was covered with epithelium over the greater part. Again dressed with vaseline gauze. Penicillin and Plasma continued.

Ninth Day : Penicillin and Plasma discontinued. Regular diet started. Patient allowed to sit up.

Fifteenth Day : Dressing changed. Only two or three spots of granulation were noticed on the back and over the left posterior ankle. They were touched with Silver Nitrate 20% and dressed with Hypertonic Saline. As far as the burn was concerned the patient was almost recovered.

As the patient was too old and weak he was retained in the Hospital for a fortnight more, and was discharged after he had attained almost normal condition.

It is very clear that Penicillin plays a great part in the prevention of sepsis of any wound.

I Wilson, R.N.,

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