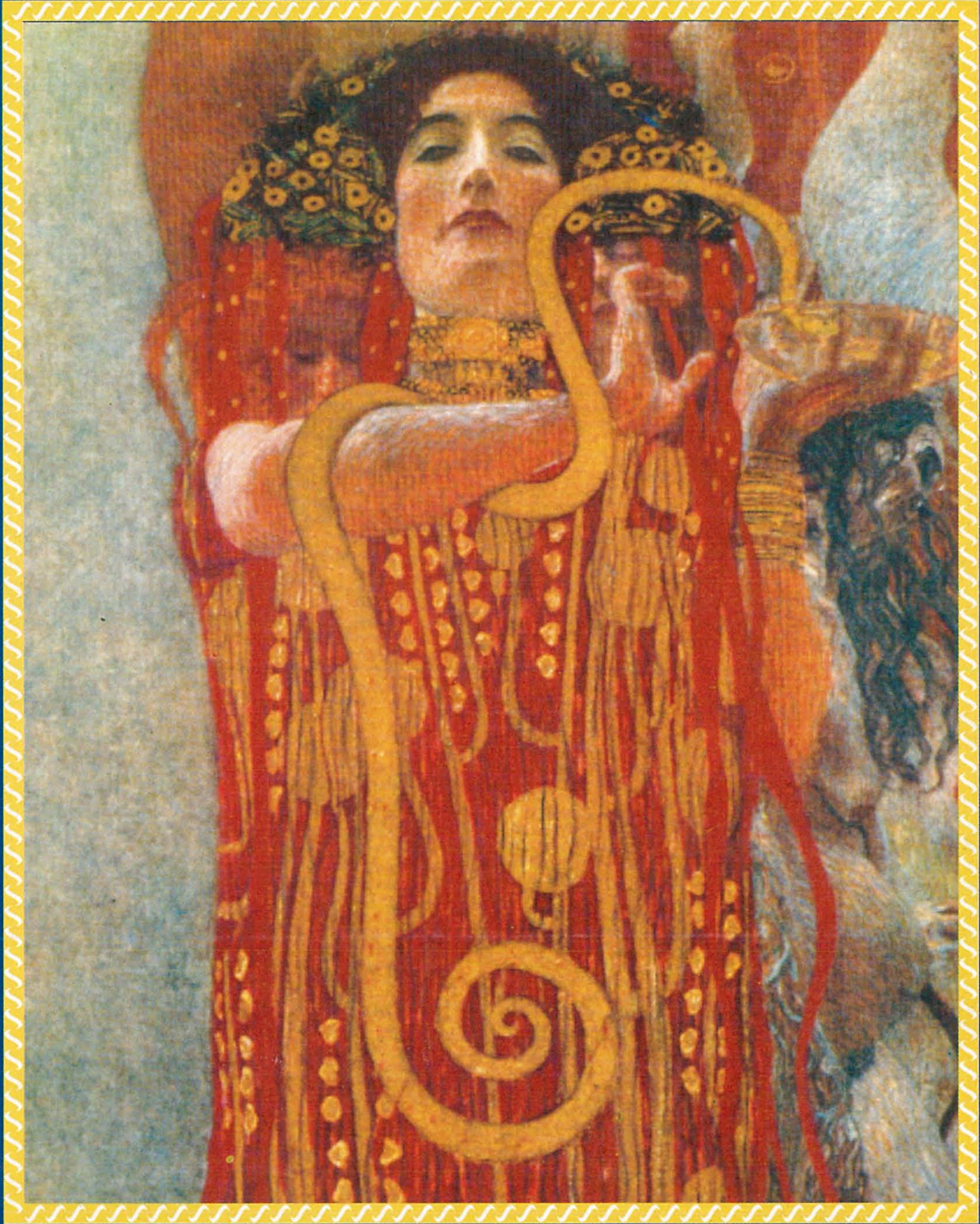
MURMUR



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Issue No.5 - 1996

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Editorial

The Editorial Board is proud to present the fifth issue of "MURMUR"! We have done our utmost to maintain the high standards attained in the previous issues. We have also increased the number of pages and included some distinctive touches which we hope you will appreciate.

At this point, it must be stressed that it is you, the students, who compile this journal. The Editorial Board simply acts like an orchestra conductor coordinating the different processes involved in planning and publishing "MURMUR". Analogously, unless all the adequate instruments are available, no amount of work by the said Board would produce a journal of this calibre.

We would like to avail ourselves of this opportunity to warmly welcome the first year students into the medical realm. As a matter of fact, a number of pages have been specifically allotted for their benefit. The contribution made by the majority of the third year students in answering a 'Book Evaluation Form' was crucial in putting forward suggestions regarding the textbooks used. Past experience has proven "MURMUR" to be indispensable in the integration of the preclinicals with the rest of the medical student body, which is stationed at Medical School.

Net-fever has also managed to permeate "MURMUR". In fact, we are working to produce an Internet version of this publication, which has been baptised e-Murmur. Consequently, "MURMUR" is no longer confined to the local scene, but can now boast an international readership.

Last, but certainly not least, the Editorial Board would like to express its sincere gratitude to the members of the previous Editorial Board, without whose advice and continuous encouragement, this issue of "MURMUR" would not have been published!

Front cover: Hygieia (detail from "MEDICINE" 1900-07 by Gustav Klimt)

In Greek mythology, Hygieia was the goddess of health who was worshipped together with the deified Greek physician Asclepius, her father. The term 'hygiene' is said to be derived from the name of this goddess.

Klimt had no qualms about creating a scandal with "Medicine", a work which, with Hygieia as its central figure, underscores medicine's impotence (rather than praising its merits) in the face of Destiny's indomitable power. Klimt's goddess of health is depicted turning her back on humanity (not visible in the detail illustrated). Her indifference and haughty stance allude to the siren in her, to the enigmatic and magical quality of her person, rather than to any enlighteningly symbolic role with respect to science.

Vienna of "La Belle Epoque" was famous for the exceptional quality and wide scope of its cultural activities and Gustav Klimt was the most representative and most fascinating of the city's painters at the time. True to his revolutionary nature, Klimt was a founding member and president of the Vienna Secession, a group of artists constituted in protest against official academic norms and conservative bourgeois values.

A trait of Klimt's visible in this painting was his cult of Woman in all the plump fullness of her flesh, her femininity, her loving (and fatal) attraction. This trait led him to emphasize the importance of sexuality as a determinig aspect of life, in the same vein of thought as Freud.

MEDICAL ISSUES IN ART

ON THE FABRIC OF THE HUMAN BODY

Alexander Borg (V Year)

It takes courage to change a trend of thought. One has to battle against the powers of ignorance and the reluctance to change long established ideas, regardless of any blaring evidence against their validity. The progress of medical knowledge is a perfect example of the pains that illuminated revolutionaries like Andreas Vesalius (1514 - 1564) had to go through before succeeding in bending the fiercely guarded ancient and fallacious concepts. The writings of Claudius Galen, the ancient Greek physician of the 2nd century A.D., had dominated the scene until the 16th century ... the Christian church ardently protected his teachings from any dissenters. Galen did not dissect human bodies (an illegal practice at that time), but based his anatomical knowledge on the dissection of animals. Well, that explains his many misconceptions, especially when he turned to physiology, but by no means should we underestimate his achievements.

Vesalius, author of the renowned "De humani corporis fabrica", was a young rebel who refused to conform with Galen's writings and decided to base his knowledge simply on what he observed. Vesalius marked the beginning of a new era in medicine. He turned anatomy from a primitive into a highly precise science.

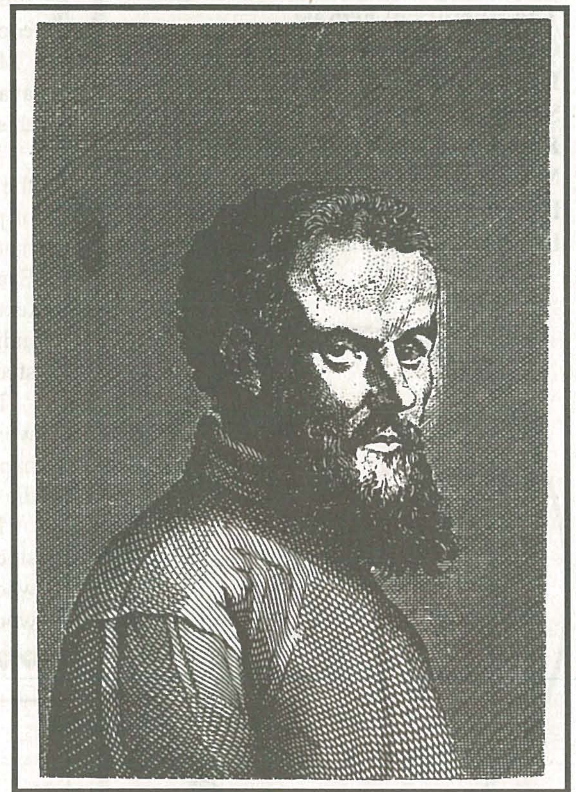

Fig. 1 Portrait of Vesalius

Vesalius was born in Brussels in 1514, (the son of a respected apothecary) under the rule of Charles V, the Holy Roman Emperor. To put you into the picture, this emperor was crowned at the time when Germany was agitated by the religious revolt under the leadership of Martin Luther. For the preceding four generations, Vesalius' family consisted of apothecaries and physicians ... such an environment was surely very conducive to young Andreas' choice of career in medicine. Vesalius travelled to Paris in August 1533 to study medicine. For those interested in medical education, it would be fascinating to have a look into the methods employed at that time: the course lasted four years. There were three major areas of study: *natural subjects (anatomy, physiology, and botany), non-natural subjects (hygiene and regimen of health),* and *subjects contra-nature (pathology and therapeutics).* Teachings were based on the texts of Galen and the Arabic and medieval authors.

Vesalius' tutor, Johann Gunther of Andernach, was very pleased with his student's skill at dissection. Maybe one cannot say the same of the other anatomy teacher, Jacobus Sylvius, an ardent Galenist, who opposed Vesalius' approach throughout

his career. Anyway, things did not go very smoothly: in 1536, war broke out between France and the Holy Roman Empire, and Vesalius had to return to his homeland after completing only three years of his course. There he entered the University of Louvain, where he satisfied his inquisitive nature by smuggling into the city the body of an executed criminal, piece by piece! While still a medical student he also conducted a rare public dissection.

In 1537 he graduated at the famous University of Padua, "*with highest distinction*". Now just imagine that you become Professor of Surgery the day after graduation. Well, that's exactly what happened to Vesalius, at the incredible age of 21! Thus began his outstanding career: in 1538, based on his first public dissection as a Professor, he published the "*Tabulae Sex*" (which has nothing to do with sex!). This consisted of six plates depicting the systems of the human body. They were so popular that many students made pirate copies; copyright legislation was not so well enforced those days. Note, from *Fig.2*, that Vesalius, maybe not having gained enough confidence in his abilities, iterated Galen's mistake concerning the liver: basing on the anatomy of the dog, Galen had declared that man's liver has five lobes!

Gradually, the increasingly popular anatomist became more independent in his views and severe in his criticism of Galen's supposed infallibility. Vesalius realized fully that Galen's anatomy was derived from that of animals, and that this had often created errors. In another book that he wrote in 1543, the *"Epitome"*, Vesalius wrote: *'(Galen) although easily chief of the masters, nevertheless did not dissect the human body, and the fact is now evident that he described, not to say imposed on us, the fabric of the ape's body, although it differs in many respects'.*

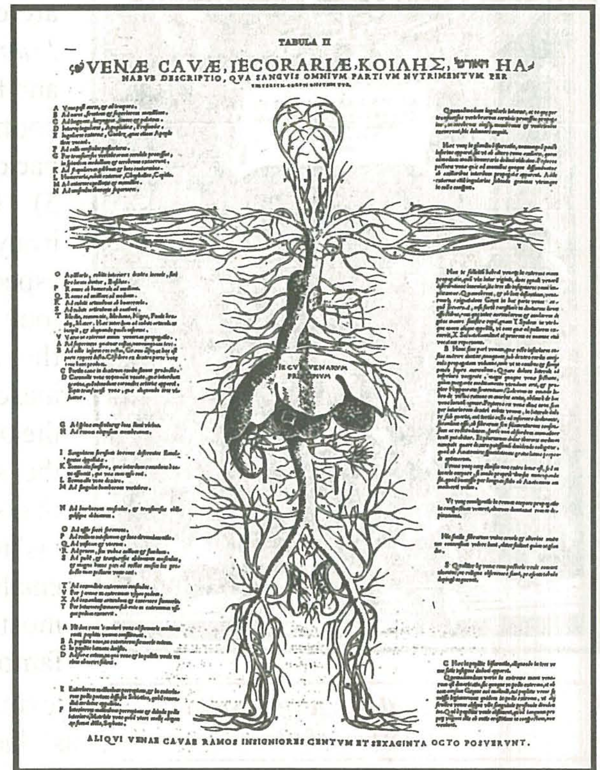

Fig.2. ***The venous system, Tabula II from A. Vesalius, (Tabulae anatomicae sex), Venice, 1538. (Taken from the facsimile issued by Stirling-Maxwell, 1874.) Woodcut (Wellcome Institute Library). 45.8 x 33.5 cm, including text.***

Vesalius' fame escalated further when he was invited to dissect for the students at Bologna, at the age of 25. There he had to work with Matteo Corte or Curtius, a lecturer of sixty-five who just could not get along with Vesalius's teachings. These two men clashed several times, mostly due to the younger man's sometimes arrogant insistence on Galen's errors. Vesalius' publications were also fiercely criticized by his previous teacher, Sylvius, for the same reasons. The latter had also asked Charles V to punish Vesalius for defying the ancient teachings in his writings. Now we come to Vesalius' most important contribution, the *"De humani corporis fabrica"* ("On the Structure/Fabric of the Human Body"), 1543. Have a look at *Fig. 3*, the title page of this book: note that, of all the people attending the dissection, only one observer is referring to a book, emphasizing Vesalius' principle of "forget whatever the others may say, pick up your dissection blade, and have a look yourself ". The Professor of Anatomy, Vesalius himself, is in the centre of the crowd, dissecting and demonstrating. It is also interesting to note that Vesalius himself is carrying out the dissection .... previous

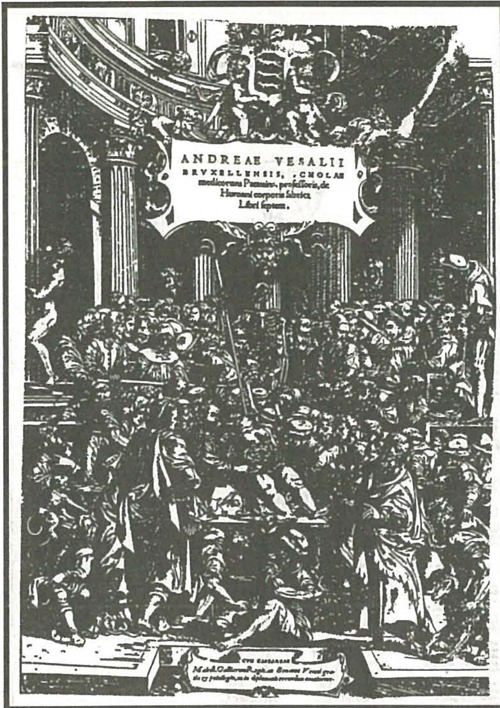

Fig. 3 ***The title-page of Vesalius' Fabrica, 1543.***

teachers lectured from high-placed chairs while the assistants did the dirty work! In Vesalius' own words, in using such a mode of teaching, "less is presented to the spectators than a butcher in his stall could teach a physician". More sure of his expertise, he did not repeat his five-lobed liver blunder (see above), and ridiculed Galen's hypothesis that blood passes across the interventricular septum from the right to the left across minute pores that eluded the naked eye. Decades later, William Harvey discovered that the pulmonary circuit lies between the right and left chambers.

Many a time have I stopped wondering at those pictures hung up in the corridor of the Anatomy section at University, near the the Dissection Hall. They are extracts from Vesalius's *Fabrica*, depicting skeletons and flayed men with a placid countryside scene in the background (see *Figs. 4 and 5*). One feels uneasy at the irony of such a setting, especially with the agonized look on the faces of some of those mutilated men. An inescapable feeling of theatrical drama surrounds the skeleton contemplating the skull in a Hamlet-like fashion *(Fig.4)*. Incidentally, this is probably the most reproduced and most famous of all the *Fabrica* drawings. Note Vesalius' lack of appreciation of the lumbar and cervical lordosis; the pubic symphysis is too high and the hyoid bone on the plinth is certainly not human. The malleus and the incus lie on the extreme right - the tiny stapes was not yet discovered! The patellae's position are not quite right, but let us not be too finicky. *Fig.5* shows a superficial dissection of the muscle man. There is an artistic element to the portrayal of the oversized muscles - probably the plates were intended for the use of artists as well as anatomists. Vesalius left the left inguinal nodes in place. On the left thumb, extensor pollicis longus appears to have a shorter tendon than does the brevis. Some might say that the spermatic cord issues out from the external oblique aponeurosis rather too lateral. Finally, it is still not known with certainty who drew the figures in the *Fabrica*: Titian (the great Tiziano Vecelli himself), Joannes Stephanus of Calcar or Vesalius himself are all plausible candidates, but it is probable that more than one man contributed to the drawings.

These are only two samples of the many plates included in the Fabrica. Fig. 4. is actually Thomas

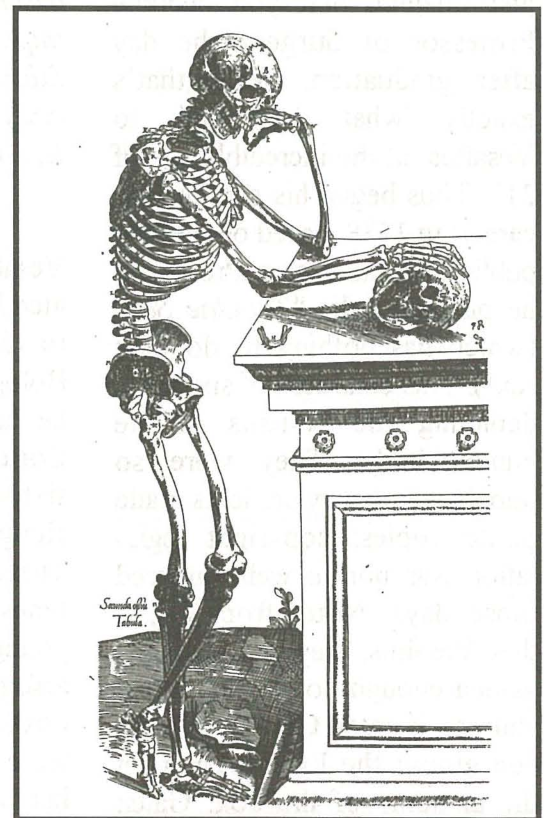

Fig. 4: ***The second skeletal figure (after Vesalius, Fabrica, 1543) from T. Geminus Compendiosa totius anatomie delineatio ...., London, J. Herford, 1545. Engraving (Wellcome Institute Library). 39.0 x 26.8 cms***

Geminus' version (from his work, the *"Compendiosa totius anatomie delineato"*) of Vesalius's original picture. The drawing in the *Fabrica* carried an inscription on the front of the plinth - *Vivitur ingenio caetera mortis erunt* (genius lives on, all else is mortal). Geminus, in 1545, had accurately copied Vesalius' works to make his *Compendiosa*, much to Vesalius' annoyance.

What is so special about the *Fabrica*?

Firstly, the material was based on a critical re-examination of the manuscripts of the classical authors, particularly Galen.

Secondly, Vesalius made it clear that Galen's teachings were based on the dissection of animals.

Thirdly, he pioneered the act of using sufficient illustrations for his text and connecting the illustrations with the text.

On the impact of this book, William Osler wrote: *'Imagine the surprise and consternation of the easy-going professors who held the chairs of anatomy to have a huge volume thrust into their hands filled from cover to cover with descriptions and figures with which they were unfamiliar. And written by a young man of 28....'*

Disillusioned and embittered by the attacks from his enemies, Vesalius retired from academic life after publishing the *Fabrica*. He dedicated himself to the practice of medicine and surgery, and served under Charles V as Imperial Physician until the Emperor's abdication in 1555. His life ended tragically when, in 1564, the ship that was taking him home after a pilgrimage in Jerusalem was wrecked. He was probably going to reoccupy his old anatomy chair in Padua.

The style of anatomical drawings has changed drastically throughout the ages; a very recent development is the use of photographs, like in the work done by McMinn and Hutchings. Artistic drama and emphasis on perspective and depth were abandoned in favour of diagrammatic clarity and keyhole dissections (as done by Henry Gray). In the future, the 3-D computer images and holographic techniques will certainly help the student in appreciating the spatial relationship of structures more than any other medium used before. One cannot help looking back in history and admire the efforts and genius of the old anatomists like Vesalius who, against all odds, started a new revolution in anatomy and medicine.

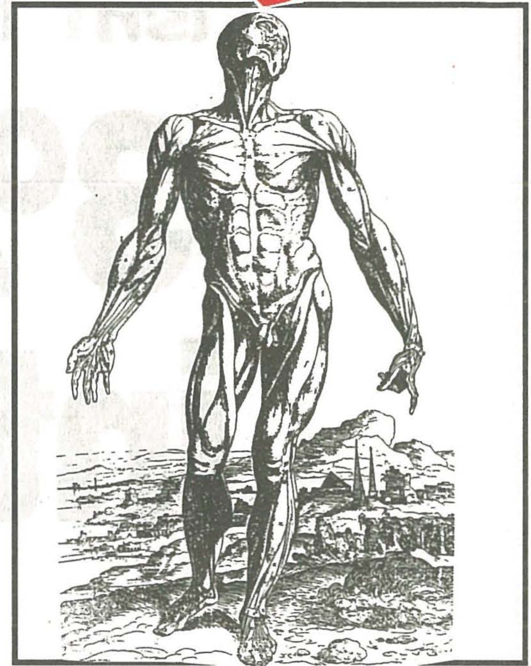

Fig 5. ***The first muscle figure from A. Vesalius, De humani corporis fabrica ...., Basle, J. Oporinus, 1543. Woodcut (Cambridge University Library). 35.0 x 21.0 cm.***

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FRESHERS' PAGES

Course Structure

Jean Agius (III Year)

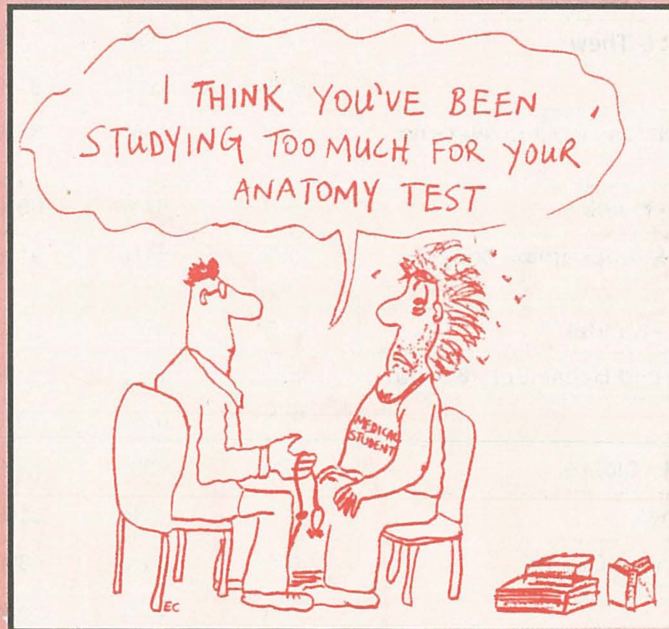
Brief Outline of the Course

The course of medicine and surgery lasts five years and can be said to be made up of 2 parts. The Pre-Clinical years ie, the first and the second year (until February) are spent at the Medical Buildings at Tal-Qroqq and basically involve the study of anatomy and physiology (the study of the NORMAL structure and biological function of the human being).

These years serve as a foundation for the following three and a half years: the Clinical Years. These start from March of the 2nd Year till the 5th Year, and are spent at Medical School. During these years students are assigned to wards and intensive study is done on Disease - its prevention, management and cure. After the 5 year course, students graduate and are then required to work as housemen for 2 years at St. Luke's Hospital.

Now, let's proceed to the main events happening during the pre-clinical year until December, it is quite easy-going but it is important not to slack as just after the progress test held in January, studying will have to gain momentum since the subjects start getting harder and time starts running out. Besides the lectures, a number of tutorials, living anatomy sessions and dissections will be held, and it is advisable to attend and try to gain as much as possible out of them. Another progress test is held at Easter time and yet another one at the end of the 1st Year. Note that only the latter is a failing test, in the sense that those who do not pass, will have to do a resit.

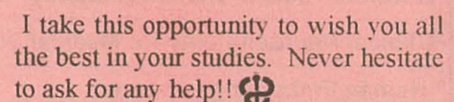
Second year (up till February) is similar to first year, the only difference being the stress due to the oncoming intermediate final exams, held in February. So, I suggest that during the summer between the first and second years, while obviously taking the necessary break, one does not let go of the books. Another helpful tip is that in summer, one starts preparing or even completing the anatomy dissection and physiology project which will eventually have to be presented in February as well.



The Medical Library

Besides the main University Library, which holds an ample collection of physiology and anatomy books, there is also the Medical Library. The Medical Library, which forms part of the Medical School at Guardamangia. has over 22,000 books and bound volumes of periodicals covering the general and specialized aspects of clinical medicine, surgery, pathology and dental science. The Medical Library is a depository of the World Health Organisation (W.H.O.) and as such it receives a copy of all W.H.O. publications. One important reference work at the Medical Library is 'Medline' (formerly Index Medicus) which is the indexing service controlling all aspects of medical literaure. This is available on compact disc via a computer terminal and it offers rapid literature searching as well as a current awareness service. It will be a great asset while compiling the physiology long essay at the end of the pre-clinical years.

The following. are the hours of service at the Medical Library:



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Mon. & Thur. : 9.00am to 7.00pm
Tue., Wed., Fri. : 9.00am to 5.00pm
Sat.: 9am to noon
16th. June - 30th. September
Mon. &Thur: 9.00 am to 4.45pm
Tue., Wed., Fri.: 9.00am to 1.15pm
Sat: 9.00am to noon

The Library remains closed on public holidays, on Holy Saturday and during the first fortnight of August.

I take this opportunity to wish you all the best in your studies. Never hesitate to ask for any help!!

The Book Evaluation

The Editorial Board

The information for this book evaluation was compiled with the help of the III year medical students who graded the readibility, amount of figures, detail and clinical relevance of the various anatomy and physiology books used in the preclinical years.

This, we hope will help the I year students in their purchase of books.

	Readability	Figures	Detail	Clinical Relevance	Usage by Students
* Review of Medical Physiology - Ganong	88%	59%	52%	71%	88%
* Human Physiology - Schmidt & Thews	60%	68%	81%	65%	88%
* Biochemistry - Stryer	84%	86%	81%	50%	84%
* Textbook of Biochemistry with clinical correlations - Devlin	78%	71%	85%	91%	47%
* Neurotrasmitters and Drugs - Kruck	93%	61%	65%	73%	81%
* The Biochemical Basis of Neuropharmacology - Cooper	46%	51%	91%	59%	84%
* Principles of Neural Science - Kandel	74%	86%	97%	78%	78%
* Essentials of Neural Science and Behaviour - Kandel	92%	95%	62%	72%	41%
* Genes V - Lewin	57%	83%	90%	67%	28%
* Molecular Biology of the Cell - Alberts	72%	90%	92%	80%	47%
* Molecular Cell Biology - Darnell	71%	78%	81%	43%	22%
* Textbook of Medical Physiology - Guyton	100%	83%	93%	93%	16%
* NMS Physiology	73%	50%	58%	58%	16%
* Cell Biology - Sadava	78%	61%	90%	44%	22%
* Basic Histology - Junqueira	78%	64%	86%	70%	94%
*Atlas of Functional Histology - Wheater	94%	99%	65%	45%	81%
* Clinical Anatomy for Medical Students - Snell	99%	87%	70%	95%	97%
* Last's Anatomy - McMinn	62%	41%	100%	55%	78%
* Clinically Oriented Anatomy - Moore	96%	94%	76%	96%	53%
* Gray's Anatomy	50%	82%	100%	60%	44%
*Grant's Atlas of Anatomy - Argur	85%	93%	70%	42%	56%
*A Colour Atlas of Human Anatomy - McMinn	86%	97%	87%	47%	78%
*Clinical Neuroanatomy for Medical Students - Snell	90%	86%	81%	94%	100%
* Human Embryology - Larsen	81%	96%	97%	92%	75%
* Medical Embryology - Langman	93%	88%	76%	80%	72%

Book Evaluation Cont. .... Some Practical Hints

- Don't buy all the books which the lecturers suggest. Browse through them in the library and ask for the opinion of other students.
- Schmidt and Thews is a translation from German. Although its English is not as good as that of other books, it has a very rich presentation of cardiovascular physiology. Other areas of physiology are poorly represented.
- Regarding the biochemistry textbooks, Devlin contains clinical correlations which Stryer lacks, yet most lectures are based on Stryer.
- Molecular Biology of the Cell and Molecular Cell Biology are expensive and used only for reference purposes.
- NMS Physiology is excellent for revision.
- Moore has sufficient detail, stimulating figures and very interesting clinical details.
- Gray's is strictly a reference book and not to be used for study purposes, unless you have nothing more interesting to do!
- Sadava is used only in the first two weeks of the 1st year.
- Larsen's Embryololgy looks very inviting, but has a tendency of going into too much detail.
- If you still have some money to spare, the MCQ (Multiple Choice Questions) books are ideal revision tools.

What is MMSA?
Neville Calleja (MMSA Secretary)

I still remember very vividly the first days of my first year in the MD Course. One of the meetings which was fitted in our Orientation week was with three MMSA people; Alex Gatt, Ludvic Zrinzo and Marie-Klaire Farrugia. All three were praising the MMSA's countless efforts, however I still had doubts what the letters MMSA standed for.

I doubt whether you freshmen, starting your MD this October, will react any differently upon your first exposure to MMSA. So let me explain in a nutshell what MMSA is all about.

The MMSA the letters, by the way, stand for Malta Medical Students' Association, is one of the countless students' associations within the University. We can even claim that our association is one of the most long standing student bodies in the University. You automatically become a member of MMSA as soon as you receive your letter of acceptance into the MD Course: no fees are involved!

You will read about the Exchange Committee and Medical Education Sub-committee on the following page. But that is not all there is to MMSA. MMSA also provides you with your entertainment, organising fun activities all year round. One which particularly concerns you at the moment is the Welcome Party. We organise it especially for you freshmen to get to know us, the veterans, and in which we try to provide you with useful hints for your integration into the medical world.

But MMSA is not a self-perpetuating organism, MMSA is YOU! MMSA has remained alive only thanks to the perseverence and dedication of medical students who were willing to utilise some of their sweating for MMSA and, therefore, for their colleagues. So do continue the tradition: roll up your sleeves and get moving in the life of MMSA . Your experience shall be gratifying. If you are the inquiring type and would like to get to know more on MMSA, do not hesitate to contact me or anyone of the Committee. Remember: your contribution, whether great or small, is always appreciated in MMSA.

THE EXCHANGE COMMITEE
Andrew Cassar (National Exchange Officer)

The student exchange scheme organized by the exchange committee is undoubtedly MMSA's most time and money consuming effort. It is also very popular with medical students, being an experience that is difficult to forget.Every summer about forty students go on an exchange in a European country (till now at least) ranging from Scandinavia to the Mediterranean.

The same number of foreign students are hosted by us, mostly in July and August. While on an exchange, which lasts a month, the student attends ward-rounds, out-patient sessions etc, just as he does in Malta. This is called a "clerkship" or "elective". This year we have also introduced "research electives", in which a student spends a month (or more) doing research work. The host country offers free board and accomodation. Board usually consists of hospital or university canteen meals, and, lodging, depending on the city and country, ranges from hospital dormitories to student apartments. The host student association usually also organizes a social programme, which may include parties, cultural visits, camping, hiking, etc...

As part of the Standing Committee on Professional Exchanges (SCOPE) within the International Federation of Medical Students' Associations (IFMSA) the exchange committee gets into contact with foreign exchange committees mostly during the General Assembly (GA) of IFMSA (in August of every year). During the GA, MMSA makes contracts with different countries stating the number of students being exchanged between the two countries. Towards the end of the year the exchange committee issues the applications for clerkships and research electives for the following summer. Applicants have to pay a small registration fee and a deposit (usually Lm2 and Lm20). The exchange committee assigns the posts to the applicants according to a point system as stated by the MMSA statute. The applications are exchanged with the respective countries during the Exchange Officers' Meeting (EOM) of IFMSA in early March.

The main purpose of exchange is that of broadening the working knowledge of medical students. The experience we gain during our student years is limited but by attending clerkships in other countries a student can get to know how things work in other hospitals besides St. Luke's.

THE MEDICAL EDUCATION SUB-COMMITTEE
Maria Vella (Officer of Medical Education)

I guess one of the major concerns of a medical student is to be able to get through his/her studies at university as easily and effectively as possible. This is precisely what the role of the Medical Education Subcommittee is all about.

How do we actually go about to fulfill this? First we collect information from the medical students of different years via the questionnaires, meetings and in the annual seminar organized by the committee then, after properly processing the results, we liaise with our professors and discuss with them what could be done in order to improve the issues which would have been raised. Like this we, as medical students are able to take an active role in our own medical education. .

We also get a lot of help and ideas from I.F.M.S.A. *(The International Federation of Medical Students' Associations)* of which the Maltese Medical Students Association and particularly the Medical Education Subcommittee is an active member. Infact, the S.C.O.M.E. *(Standing Committee on Medical Education)* director was in Malta twice this year and, on one occasion he organised a workshop in a P.B.L. (Problem Based Learning) set-up for both clinical and pre-clinical students.

Besides Medical Education Evaluation, the Medical Education Sub-Committee is also active in other areas. This year we are taking up a new initiative, the Public Health Project, in which we go out into the sixth form schools and actually talk to people about the major public health issues in the offing at the moment, namely:

- A.I.D.S. and Sexually Transmitted diseases.
- Drug abuse and alcohol abuse.
- Nutritional problems (anorexia and bulimia included).

In this article I tried to just give a small insight of what is actually going on in the Medical Education subcommittee, hopefully enough to arouse the curiosity of a good number of you, who would also consider playing an active role in helping us further shape up at our own Medical Education.

Experience of a Maltese Exchange Student in Groningen

Gert Attard (III Year)

THE HOST

On arriving at Groningen station on the 30th June 1995, I was met by my host Jose Festen - a 1.7m tall hearty blonde who was waiting for me inspite of my 2 hour delay. She then accompanied me to her apartment, where I was to spend the next month, and introduced me to the other four students with whom she shared the flat.

THE SOCIAL ASPECT

Ingrid, another student, met me at the hospital at the indecent hour of 9.00am on the following Monday morning. She handed me a yellow bag containing various sheets with information and welcome messages and a white tub full of *dropjes* which the Dutch feel must be forced down into each visitor's mouth. I naively accepted them and politely tossed 2 into my mouth. The sudden feeling of burning and pain which devasted me ensured that I would never dare try one again. That evening Ingrid kindly invited me to a party where I met the other exchange students. In all we were 9 students with roots ranging from Brazil to Egypt. We embarked into deep philosophical conversations discussing the diversity of our cultures. Misunderstandings and clashes abounded as a direct result of the acute cultural shock we all suffered in each others' presence but it all paved the way to potentially good friendships.

The evening which was undoubtedly the best of them all was my first Donderdag night. Mahrouki, the other party animal in the student group, together with myself were taken to an end-of-exam party by Jose. We danced, sang (screamed),

sweated and inebbriated ourselves till the early hours of the morning in an overcrowded, smoke congested room whilst a punk Dutch band blasted our cochleae to pieces.

The ever-hospitable Dutch hosts filled our free time with all sorts of activities from visiting an island called Schiermonnikoog on a thunder-storm riddled day to sailing round the Paterwoldsemeer in 3 neat boats. We filled our remaining time with trips around Groningen, a day off to Utrecht and a fair share of time just moping around.

DE FIETSEN

On the first day, our host pulled each of us aside, asked for a 50 Guilder deposit and gave us the keys to the many locks which would however not be sufficient to protect the bike we were to ride for the next 4 weeks. One must understand that the bike is second only to the heart which pumps blood around the human body on the *'List of things required to survive in order of priority'*. (The brain was voted off this list by the All Blonde Society - a very powerful organisation in this city - as they claimed that they did pretty well without using it). My bike suffered a flat tyre within the first week as did all the other students' bikes. So I was offered another bike which had been turned down by all the others. This *fiets'* seat had been set to accomodate a 1.95m tall Dutch guy and would not budge even when challenged with hammers, spanners and screw-drivers. Jagged bits of rusty metal stuck out at points vantageously chosen to cause as much damage as possible to the rider's attire and flesh. The last

straw was that the brakes did not work. As a result of this, I spent an entire day tipping over onto the riders around me when having to stop at the lights, countless crashes into poles and being abused by all due to the careless driving. This culminated in my being unable to stop when heading for one of the many canals and inevitably ... SPLASH! The bike had to be fished out. After a week, my original bike was finaly ready to be used and I passed the ill-fated bike to Mahrouki. That night he had it stolen and that cost him his dear 50 Guilders deposit. In Holland, they say that a bike is not a bike till it has been stolen and I even heard that 80% of Dutch ride stolen bikes!

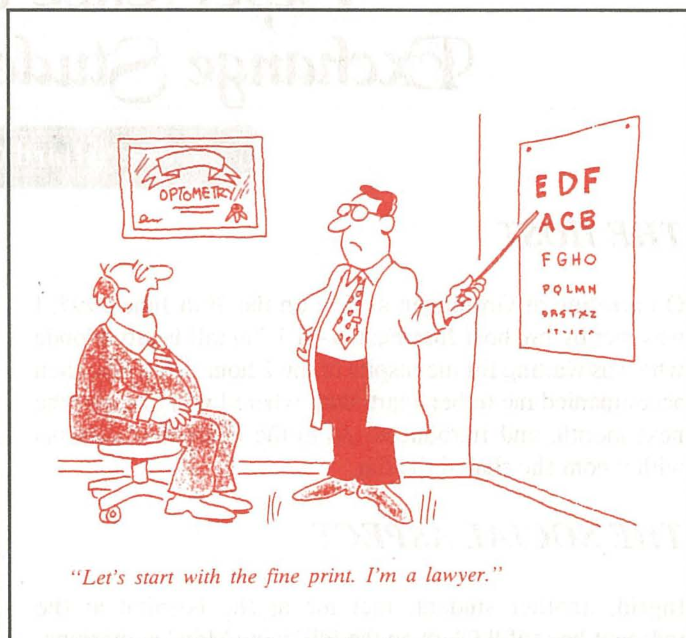
THE WORK ITSELF

Since I was a 19 year old inexperienced 1st year medical student, I was assigned to fulfill my clerkship in the anatomy department. The first week was a great experience. The department was organising an afternoon cadaver course for 40 or so American physios and on realising my potential, I was asked to give them a hand with identifying muscles and other structures. I prepared myself with a quick revision from the texts. It was the first time I got to see so many dissections on one area and be able to handle them for so long. However, having just completed my exams back home, I was finely tuned on the subject and was a great fascination to the Americans who heaped praises ranging from *"this guy is fantastic"* to *"here comes the anatomy king"* over my head and landed me with a self-ego which was inflated to bursting point.

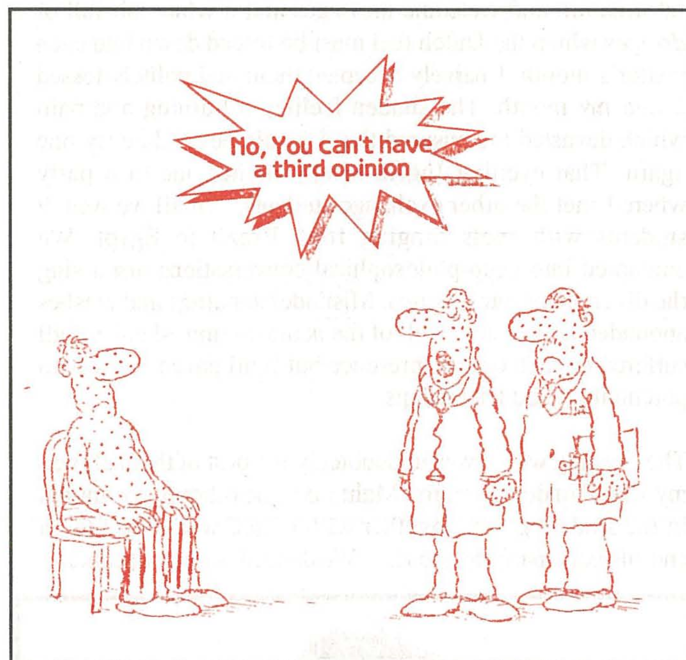
A FINAL NOTE

Groningen is surely the place to go for an exchange in the summer months. All the Dutch speak English well and are both kind and helpful. My sole disappointment was that most of the students left the city in the second week of July on vacation so the atmosphere did calm down a bit. However it was great just sitting downtown relaxing, drinking a beer and having other students you'd never met just come up to you and sit down for a chat.

Last but not least, I would like to thank all Groningen, especially the Exchange Comittee for the wonderful experience!



"Let's start with the fine print. I'm a lawyer."



Controversy in Medicine:- Voltaire (1694 - 1788)

"The art of medicine consists of amusing the patient while nature cures the disease"

"Doctors are men who prescribe medicines of which they know little to cure diseases they know less in human beings of whom they know nothing"

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MED-SNAPS

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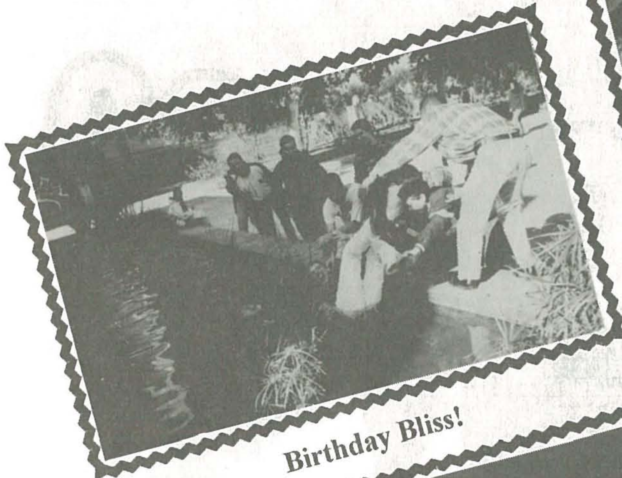
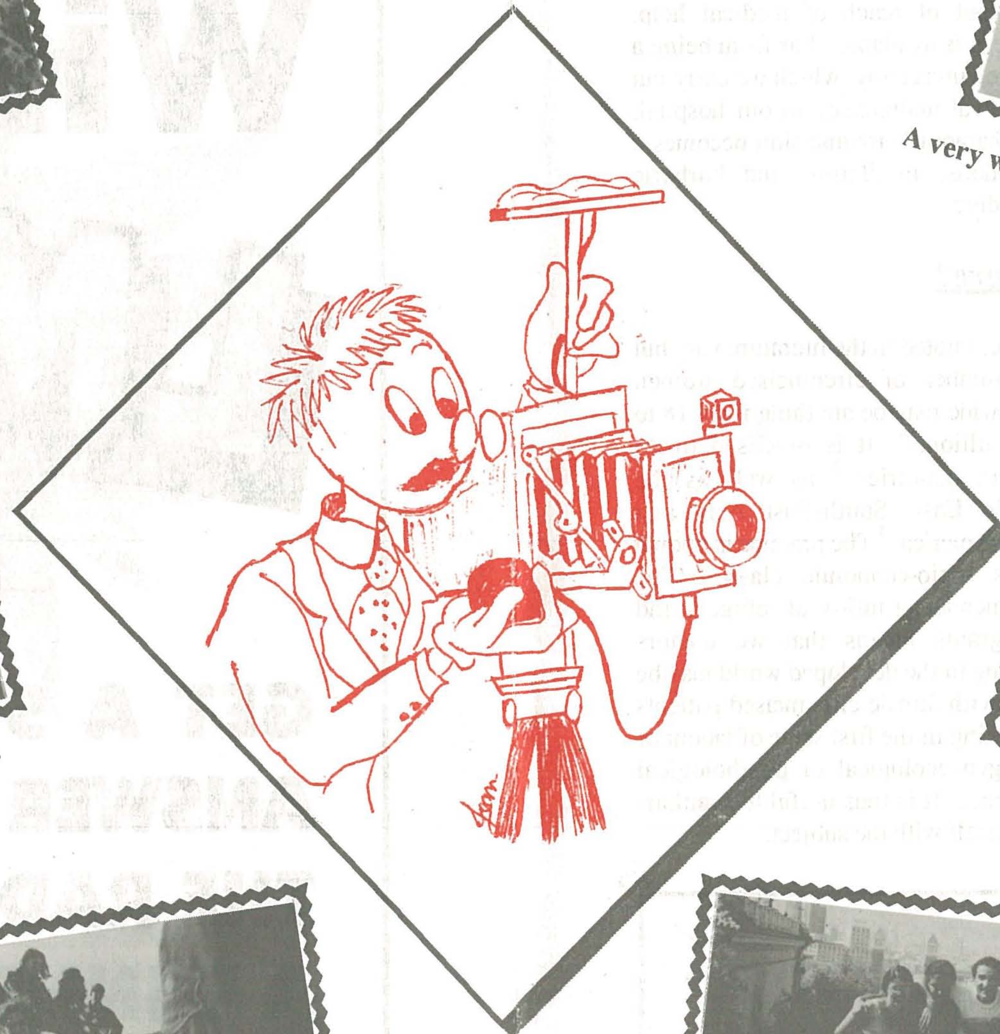

Birthday Bliss!

Spin the bottle- it`s Mireille`s turn......



A very well-attended sports-day?!

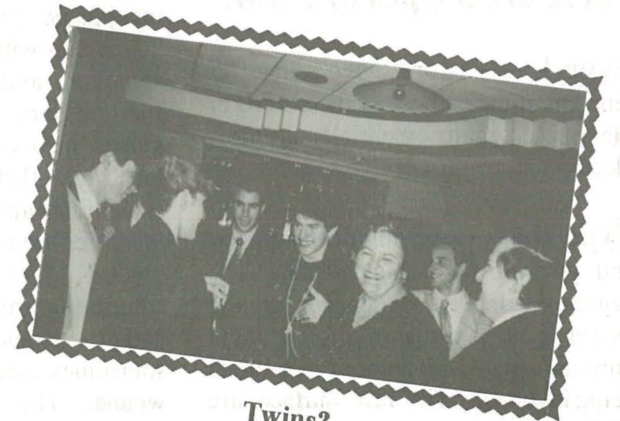
4th Years "cleaning up" Sta. Marija Battery Comino.

The G8 summit.

A Chinese New Year`s Eve

Stuck in the mud!

GA `95- Maria and Veronique must have got stuck somewhere?!


Twins?

THE HORRORS OF FEMALE GENITAL MUTILATION

Ian Galea (V Year)

We all know what male circumcision is, but few of us have heard of its female counterpart, a traditional practice in underdeveloped countries. It has long been known as female circumcision but the term **"female genital mutilation"** is being increasingly used instead to indicate its radicality.

The first time I read about female genital tract mutilation (FGM) was in an issue of "World Health" [1] and I remember cold shivers passing down my backbone. Considering that there are millions of circumcised women worldwide and the tradition is still practised rampantly, it becomes an important public health problem.

What is it?

The circumcision, scientifically known as infibulation, is usually performed between 4 and 10 years of age, although sometimes it is performed on infants or postponed to until just before marriage.

There are 3 types of FGM:

Type I ----- or "*sunna*", involves removal of the prepuce of the clitoris or the whole organ, essentially a clitoridectomy.

Type II ----- excision of the clitoris and part of the labia minora. The degree of this FGM depends on the extent of the excision of the labia minora, usually the anterior two-thirds being involved. The raw surfaces are stitched up. The urethra and vaginal introitus are not covered up.

> **"Long ago my sister died after a circumcision. She couldn't pass urine and was not taken to a doctor. One of my daughters, circumcised the pharaonic way, had the same trouble, together with a fever. The doctor did a de-circumcision". - *A married woman, 47 years old, illiterate.***

Type III ----- or "*pharaonic*", involves removal of the clitoris, labia minora and majora. The raw surfaces of the labia majora are stitched up to cover the whole of the vulva with a hood of skin, leaving a hole near the posterior fourchette for the passage of urine and menstrual blood. Patency is preserved with a sliver of wood. The extent of this operation depends on the size of the posterior opening.

How?

To add insult to injury, the procedure is carried out under the worst conditions imaginable. The operator is usually a lay person with limited knowledge of anatomy and surgical technique. Incisions are made with unsterilized knives, razors or pieces of glasses. No local anaesthetic is used. The girl is screaming and moving. No aseptic measures are taken. Bleeding from the clitoral artery is halted with clumsy sutures. Suturing is done with thorn or catgut. Homemade poultices are sometimes used to help closure of the wound. The girl's legs are bound together for some time afterwards. Most importantly, the circumcision is done out of reach of medical help, where it is available. Far from being a simple vulvectomy, which we carry out for vulval malignancy in our hospital, the pharaonic circumcision becomes a hazardous, mutilating and barbaric procedure.

Where?

Figures quoted in the literature vary but the number of circumcised women worldwide may be anything from 18 to 100 million.[3,4] It is practised in 26 African countries [3] as well as the Middle East, South-East Asia and South America. [4] The practice is known across socio-economic classes. The ever-increasing influx of refugees and immigrants means that we doctors working in the developed world may be faced with female circumcised patients presenting in the first stage of labour or with gynaecological or psychological problems. It is thus useful to familiarize oneself with the subject.

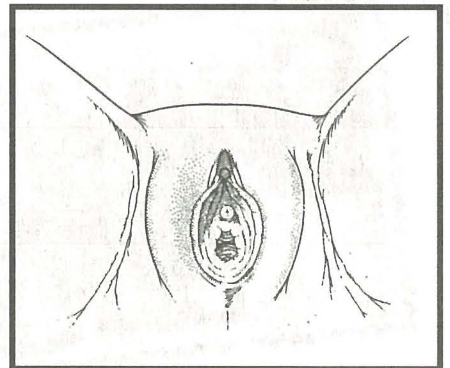


Fig. 1: Type I FGM

Why?

The reason underlying FGM is as elusive as ever. It is uncertain when it was first practised but it certainly preceded Christianity and Islam.[2] It is done irrespective of one's religion (Muslim, Jewish, Christian, indigenous African) and it seems that it is socially driven.[5] Unfortunately there are misconceptions among the people themselves: 50% of male respondents in a survey conducted in Sudan expressed the belief that female circumcision is a Muslim religious requirement.[1]

The fact that such a drastic practice is pursued so fervently must point towards an underlying deep-rooted scope, which may have faded in places. Researchers have come out with two motivational reasons:[3]

cultural identity - This may mean zilch for us but one must consider that these ethnic groups are forced with colonialism and stronger majority cultures.
individual status - Female circumcision is the physical marking of the marriageability of women, because it symbolizes social control of their sexual pleasure (clitoridectomy) and their reproduction (infibulation). Again this may mean nothing for us but not for these women for whom circumcision is the key to social and economic security. Men will only marry circumcised women.

Medical consequences

A. Immediate

Severe haemorrhage and pain can lead to shock and death. Chronic low grade bleeding due to imperfect haemostasis can lead to anaemia and failure to thrive. Since aseptic technique is non-existent, local infection is the rule and a septicaemia may follow in its steps. Acute retention of urine in the first few days with cystitis and pyelonephritis can occur.

" I have been circumcised pharaonically. My daughter, who is 17 now, has not been circumcised. I told her she didn't have to be grateful to me for anything in her life, except that she is uncircumcised".
- A married woman, no age stated.

B. Long term gynaecological

The picture of the full pharaonic circumcision is unsightly, at least for us. However, the girl concerned will not perceive it in this manner. The vulvar scarring will vary with the operator's surgical acumen. An uncomplicated type III FGM will consist of a midline scar below the mons that gives way to a small posterior opening. It can be complicated by painful stitch neuromas, recurrent stitch abscesses, keloid formation and dermoid cysts for which the patient may seek medical help.

Since urine has to percolate through a tissue canal under the infibulation and cross the vaginal opening before reaching the exterior, chronic urinary obsruction can lead to stones and scarred kidney from a chronic pyelonephritic process. Pooling of urine in the vagina leads to an atrophic vaginitis and vaginal stones. Sometimes there can be prolonged dribbling of urine due to external urinary sphincter disturbance.

Haematocolpos can occur with the onset of menstruation due to a narrowed vaginal introitus. The occluded vagina is especially predisposed to infections such as Candida. Chronic pelvic infection causes pelvic and back pain, dysmenorrhoea and possibly infertility.

C. Coital

Needless to say, circumcised women have immense sexual problems. The mechanical factor is paramount. Sometimes the pharaonic opening can hardly admit a pencil, let alone an erect penis. The opening may not overlie the vaginal introitus and stenosis from scarring may be present. Dyspareunia is very likely.

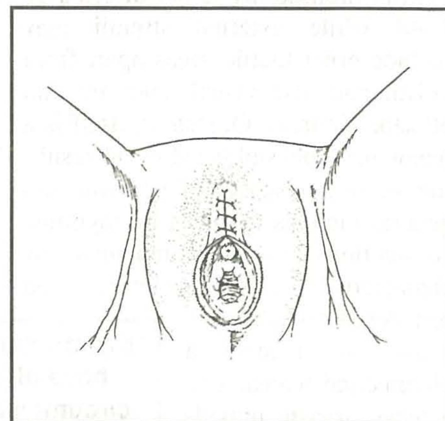


Fig. 2: Type II FGM

Two of the three primary genital erogenous areas are absent in circumcised women: the glans of the clitoris and the labia minora. This leaves them with the controversial "G spot" in the anterior wall of the vagina[10] and the body of the clitoris -- structures which can be only stimulated by penile thrusting. This reduces their capacity for masturbation, interferes with foreplay and elevates orgasmic threshold.

The only erectile tissues the woman is left with are the body and the crura of the clitoris (which buffer penile thrusting against the pubic rami) and the bulbs of the vestibule (which elongate the vagina on tumescence). These structures can be accidentally damaged during a crude female circumcision. Moreover the secretory capacity of the lower one-third of the vagina is reduced due to chronic urine pooling. Intercourse is undoubtedly less comfortable.

It is not known whether FGM influences the ability to achieve orgasm. The psychosomatic theory of sexual stimulation involves two possible inputs: central arousability (or libido) and, external stimuli

Central arousability is not affected by FGM while external stimuli may include other tactile areas apart from vulval and also visual, auditory and olfactory sources. Orgasm in itself is a major neurophysiological event resulting in initial spasm of perineal and general muscles followed by rhythmic contractions and accompanied by characteristic cardiorespiratory and somatosensory changes.

Thus in theory a circumcised woman can achieve orgasm provided she is able to balance the degree of mutilation through other sensory areas or emotions and fantasy.

D. Obstetric

Unattended infibulated women are bound to run into obstetric problems. The likelihood of obstructed labour is much greater with a resultant high maternal and perinatal mortality. Severe post-partum haemorrhage may occur from tears in the vagina, perineum or scar tissue. Rectovaginal and vesicovaginal fistulae are common sequelae. An increased incidence of local infection or abscesses result in neonatal infections.

In the hospital setting, inadequate vaginal accessibility prevents diagnosis of labour and monitoring of the first stage. In preparing for a Caesarean section, emptying of the bladder by catheterization is also impossible.

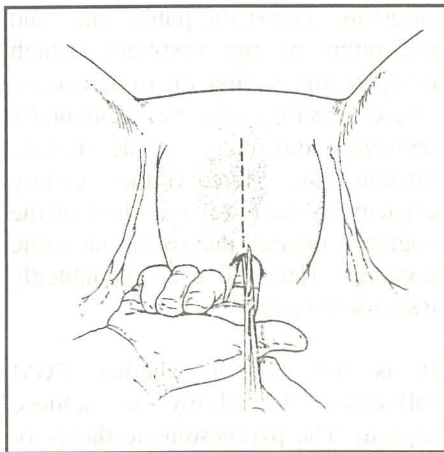


Fig 3: Type III FGM

Deinfibulation is indicated if the vulval opening is narrow: this avoids the unnecessary risks of a Caesarean section by giving normal vaginal delivery a try. A mediolateral episiotomy might be required and a low forceps might have to be resorted to. Caesarean section is indicated if there is foetal distress, vulvo-vaginal infection or the mother resists deinfibulation. Operative intervention including Caesarean section must always be done with the patient's consent.

> **"My mother, sisters and wife have all had pharaonic circumcisions. So will my daughters. This has nothing to do with Islam but sometimes society governs people's lives". - *A married man, 33 years old, teacher.***

Preferably deinfibulation is carried out antenatally.[7] It involves an anterior episiotomy. The scar is infiltrated with local anaesthetic, a finger is passed through the opening under the scar up to the pubis, and the tissue is cut in layers in the midline, over the finger, with scissors, until the urethral meatus is visualized.[6]

Recently in Malta we have seen two infibulated women presenting in the first stage at Labour Ward. One was a clitoral circumcision while the other was a pharaonic type requiring anterior and mediolateral episiotomies.[11]

The women might ask for a reinfibulation. This they do for three reasons: for cultural purposes, because they feel "naked" and because it is thought to enhance sexual satisfaction for the male partner. Faced with such a situation, involving delicate medicolegal issues, we must follow the law of the country we're operating in.

In Britain, under the Prohibition of Female Circumcision Act, 1985, the minimal amount of reparative surgery should be done which will allow a moderate reinfibulation that leaves the vaginal introitus open so that intercourse is not impeded. The Royal College of Obstetricians and Gynaecologists expects its Members and Fellows worldwide to accept this principle.[4]

In Malta there is no legislation specifically prohibiting female circumcision.

E. Psychological

No studies have been done on the psychological effects of FGM but clinicians working in places like Sudan say that most infibulated women have a syndrome of chronic anxiety and depression arising from worry over the state of their genitals, intractable dysmenorrhoea and the fear of infertility.[3]

A medicolegal issue

Specific legislation has been enacted in Britain, Sweden, Belgium, the Netherlands and some American states.[2,3,8] France has no specific legislation as yet but twenty cases or so have been brought to the French court. However most excisionists have been set free or received light sentences. The court could only pin it to violence against children under 15.[8]

Egyptian President Hosni Mubarak backtracked on his promise to ban FGM and is now looking at ways to ensure that circumcision is carried out by qualified doctors and under proper medical supervision. Mubarak had promised his ban upon international pressure during the recent population conference in Cairo but resistance in his home country, especially from religious quarters, was too strong.[9]

The Vienna Declaration of the World Conference on Human Rights held that traditional practices such as female circumcision were violations of human rights.[3] The UN, UNICEF, WHO and

FIGO have issued various statements on the subject.[2,3] The WMA has also recently condemned FGM.[2]

Right or wrong?

Public health efforts should now be directed in two directions. First, education of the professionals involved so as to be capable to deliver the most appropriate clinical care and psychological support to already circumcised women. Secondly, the controversial issue of *de novo* infibulation. A doctor must abide by the laws of the country he's operating in. But then, is it ethically correct to prohibit female circumcision by legislation? We consider the procedure to be a mutilation but people living in countries where FGM is illegal are having their children circumcised in their homeland. **Is it ethical to impose one's attitudes on other's cultural beliefs?**

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Letters to the Editor

Dear Editor,

Various occasions have arisen when your consultant asks you a brilliant question that you're sure you should know the answer to, but don't. What can you do? Here are some suggestions:

- Would you please repeat the question?
- Ignore the consultant and act like you didn't hear the question.
- Repeat the question aloud to buy time.
- Ask for clarification of the question.
- Say "I don't know."
- Say "I'm not sure what you're after." (You know so much you need more specificity).
- Be bold (i.e. stupid) and say "I don't think that's relevant."
- We didn't cover that in class.
- I haven't had that rotation.
- That rotation was bad.
- The doctor was on vacation when I was on that rotation.
- I was sick that day.
- I didn't get good notes from the note pool.
- The day for that lecture they closed the medical school for heat.
- Start a conversation on an unrelated topic.
- Feign illness.
- Get 'hypoglycemic' and pass out (gets attention, but no sympathy).
- Say "I'm sorry, my wife is about to deliver and my head is elsewhere".
- Talk constantly so you are dismissed from the room.
- Threaten to quit medical school (gets attention and sympathy).
- Have a Tumour or Mortality Board Meeting to attend.
- Keep asking the consultant questions.
- Memorize some obtuse fact and ask the consultant that question.
- Ask the consultant about his favourite sport or car.
- Talk vacation with the consultant.
- Excuse yourself to answer a long distant call.
- Excuse yourself to go to a Post-Mortem Exam.
- Feign hearing deficit.
- If the consultant has an accent, feign difficulty understanding him/her.

I hope you found these ploys entertaining. Maybe some time they will turn out to be useful!

Yours sincerely,
Neville Calleja

Dear Editor,

What a wonderful person Mrs. Mary West is! As far as the Medical School administration is concerned, she is a clerk; but for us students, she plays various other important roles: she is our adviser, counsellor, helper ... and her oft-sought-for office is our refuge. I think Maltese medical student life would certainly be a shade drearier without Mary!

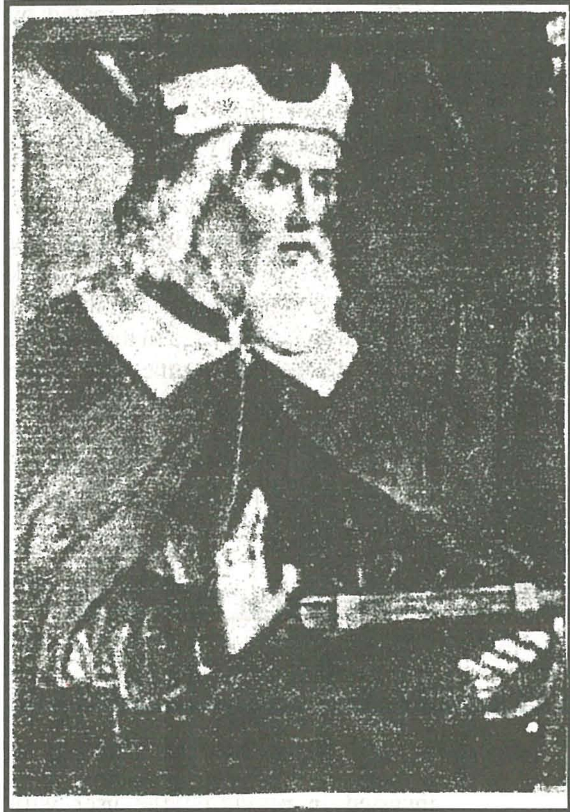
Mary's role was not imposed by anyone - it simply evolved out of necessity. In a way, this evolution is an acknowledgment of the soundness of MMSA's cries for a psychological counsellor specializing in medical student needs, and it fulfills them to some extent.

So, Hail Mary! And may these words ring bells in the right heads!

Yours truly,
Ian Galea

STRESS RELIEVER

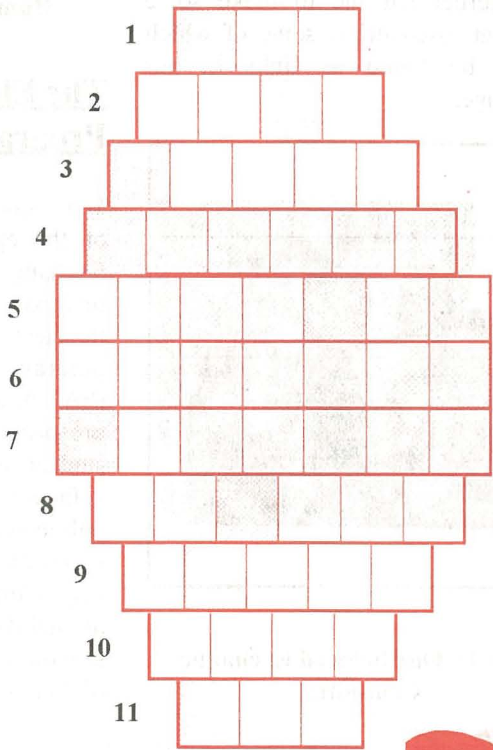
Erika Grech (III Year)



"WHENEVER A DOCTOR CANNOT DO GOOD, HE MUST KEEP FROM DOING HARM"

Who said these famous oft-quoted words? - Solve the following puzzle to unravel his name using the letters in the shaded boxes.
(Hint: Each clue leads to the name of a fellow medical student)

1. Well-known Irish footballer ... Rush
2. Elvis Fan
3. The golden fleece
4. Diving and abseiling enthusiast
5. Pectoralis Major
6. Computers-know-it-all and budding poet
7. The patron saint of Ireland
8. Brings to mind Vienesse waltzes
9. Anagram: Keira
10. Windsurfing fanatic
11. As in Pictionary: Sounds like - 'bat'



1. Ian 2. Jean 3. Chris 4. Stuart 5. Gregory 6. Neville 7. Patrick 8. Johann 9. Erika 10. Gert 11. Pat
HIPPOCRATES

MMSA goes Net-wards!

Neville Calleja (III Year)

Those of you who are growing to be Net-freaks, please note: MMSA now has its homepage on the big and mighty Net. We are at http://www.cis.um.edu.mt/Assoc/mmsa. Dr Martin Schranz and myself have been at it these past few months, together with Thomas Ganslandt, a fellow medical student from the University of Muenster, who is the webmaster back home and is responsible for the maintenance of the MedWeb. Thomas was here on an elective and, in the meantime, he introduced us to the vast realm of creating Webpages. MMSA can never thank him enough and wishes him the best results possible in his oncoming finals.

Few of us can deny the potential of the Internet as an educating medium. The value of the pooling of information into one massive single source can never be overestimated. My ventures through the Internet led me to make some excellent discoveries, some of which are to be found as links in our homepage.

Fig. 1: Our beloved Exchange Committee.

The MMSA homepage covers the following aspects, mainly:

- **The Elective and Exchange Programme**
- **Medical Education**
- **eMurmur**

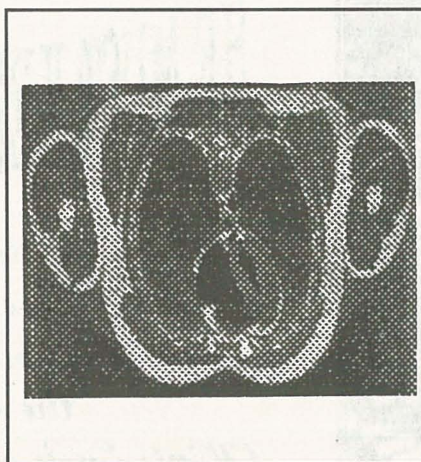


Fig. 2: Cross section through the thorax. Found at the Visible Human Project Homepage.

The Elective and Exchange Programme

When one accesses our homepage, one of the options is The Elective and Exchange Programme. This opens up on a page with information about both the elective program and the exchange program, frequently asked questions (FAQs), and links through which the prospective elective or clerkship student can see what Malta is all about. A facility to apply for electives in Malta online is also under construction and will soon be available, I hope. Links to very informative sites about Malta from around the world are to be found in this section, complete with a detailed map of Malta compiled by the US government. One of my favourite sites in this section is the site created by Grazio Falzon, an emigrant living in Canada, I believe. His site truly reflects his love for the Island and truly underlines the beauty of our homeland.

By the way, for all those of you who, like our beloved President, are diving addicts, we even provide a link regarding diving schools in Malta. But what you must surely see in the Elective and Exchange Programme page is the photo of our modest Exchange Committee members. (NB Please observe the expression on Andrew's face reflecting his opinion about the whole business !)

The Medical Education

The fruit borne by long hours of eye-drying Net surfing lies in this section. The time employed in scanning the Net for good medical sites has been invested in providing the user with good links which should provide him with the material he/she requires. We

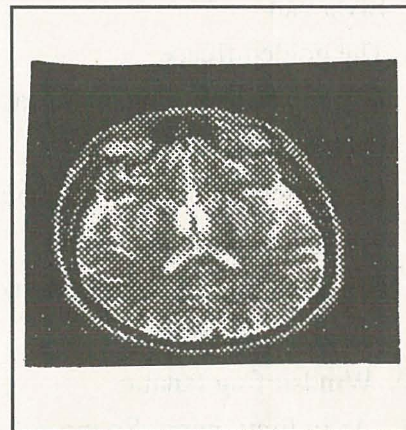


Fig. 3: An MRI section through the brain of a patient affected with Creutzfeld-Jakob disease. Found at the Whole Brain Atlas.

have also managed to provide our own link to Medline. Gone are the days when when you had to book the Medical School Library CD-ROM system to access Medline: Medline is now available on your humble computer system just a local call away, with all the time in the world for downloading and printing your abstracts!

These links are to be found in the Campus Info page under Medical Education. One link I would never erase is that to a page packed with links compiled by a good soul of name John McNulty, of whom I know nothing more than the name. This section of the name 'Anatomy on the Internet' is a true treasure trove for the medical student, especially the premedical ones. So now, after a strenuous tutorial on cadaver sections with our beloved Prof Camilleri Podesta', one can go home and review these sections on the Visible Human Project Homepage. Or, how about the tedious brain sections? The Internet has its own tutorials on brain sections, too. Have a look at the Whole Brain Atlas where you get MRI sections of all of the brain together with pathology of the brain. Ever wondered what makes a Creutzfeld-Jakob patient spastic: an MRI section of such an unfortunate guy is there for you to assess! You can also have a look at the Radiology Atlas to see how the trachea should lie in the classical thoracic radiograph.

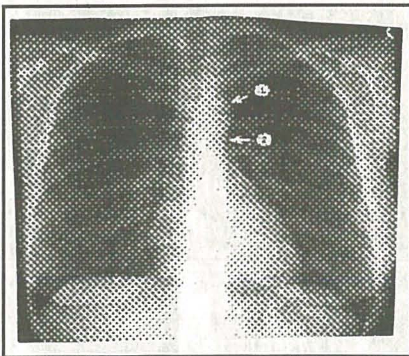


Fig. 4: A thoracic radiograph. Found at the Radiology Atlas site.

Another good link is that of the Virtual Hospital. Even though it takes pretty long to access, (NB I recommend to you that you choose to access it during a Euro '96 match in which Italy is playing, like I did) your patience will be amply rewarded with the material available in this section.

Other interesting links are to be found under a section of a specifically chosen name, namely 'Other interesting links'. Browse through this page to see how life ticks on in other medical schools around the world. Have a look at the European worldwide Medical Students Associations (EMSA) Homepage and feel the pulse of medical students all over Europe. Other medical student site links are available such as Pittsburgh, Muenster and Ege. However, a distinction goes to the Interactive Medical Students Lounge. This is a site packed with information and links which interests medical students, not only regarding the usual boring textbook material, but also humorous sites about, for example, medical bloopers and anecdotes, and personal sites of medical students worldwide.

Fig. 5: Have a laugh at the Medical Bloopers site.

Online Tutorials

We have also just started to provide our own cases on the Internet thanks to Dr Schranz and his investment in a digital camera. The first one was put in June sporting a thoracic radiograph complete with the traditionally Maltese handwritten label. A case description accompanies each case enabling the medical student and practitioner to widen his experience.

eMurmur

In this section, we intend to put up the best articles published in the MMSA's official publication, the Murmur, thus opening it to a wider circulation than the printed 500 copies which are circulated mainly in Malta. Moreover, this opens up an opportunity to foreign medical students and physicians to contribute articles to eMurmur and therefore also to Murmur.

So, those of you who thought that the Internet is only a massive source of dirty pictures, think twice. You can quite well see that you can benefit from the Net, both as a medical student and as a physician. And, mind you, our page is not the only site around for medical information; splendid systems such as extensive databases like CancerNet are out there just waiting to be tapped. So, get moving and buy that blessed modem. Get a good Internet subscription and you will surely grow to appreciate your moody comp much more!

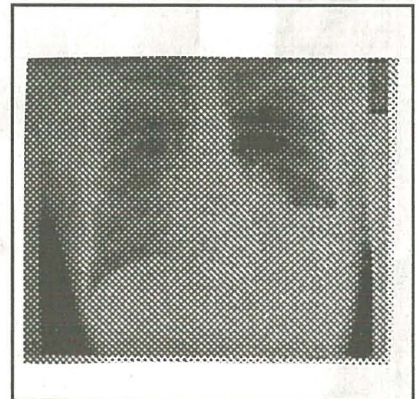


Fig. 6: Our own first case in the section "Online Tutorials"

EMOTIONAL ABUSE IN CHILDREN

Etienne Ciantar (III Year)

When considering child abuse, we almost exclusively think of a physically injured child or a minor who has been sexually abused. Physical and sexual abuse are two important types of child abuse which the doctor must be fully aware of when treating a child-patient. Yet there is another type of abuse which we rarely take account of: **emotional neglect**.

Emotional abuse may be obvious in the form of open hostility or rejections. It may occur in less obvious ways such as the failure to recognise the child's emotional need for affection, security and care. All forms of child abuse and neglect involve emotional abuse. The issue of emotional abuse is gaining ground in many jurisdictions around the world.

The main problem in assessing emotional abuse is the actual difficulty in recognising it. How severe must the family's failure be to refer to their children as victims of emotional abuse? Similarly different societies react differently to emotional and psychological harm which children may be subject to. One cannot deny the fact that in Malta, the children are regarded as the nucleus of the family; yet, some still regard it as a right of the parent to punish or even humiliate the child for any wrongdoing. Should that be regarded as emotional abuse or is it necessary part of the psychological growth of the child?

The difficulty in defining emotional neglect could therefore explain the latency of many legislative bodies to take action against this abuse. Yet it is important to realise that the emotional neglect of a child may have severe consequences. In extreme cases, there may even be a "non-organic failure to thrive". Additionally a markedly unfavourable upbringing may also give rise to "deprivation dwarfism", although in this case the emotional abuse is usually also supplemented by the insufficient provision of food. In the less severe cases there are problems of psychological development and of emotional behavioural adjustment, such as poor self-esteem, unresolved anger, conduct disorders and academic failure.

In essence, one must acknowledge the fact that society has the duty to ensure that its young citizens attain the full potential in terms of emotional and psychological requirements. Sometimes parents who fail to meet the emotional needs of the children were themselves victims of emotional neglect as children. The doctor has the opportunity of having direct contact with society, and he/she must avail him/herself of this opportunity to ensure that the vicious circle is stopped.

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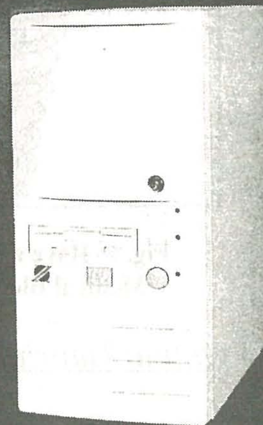

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POET'S CORNER

LIFE - THE GREATEST GIFT

The day has just broken, Lord
and I have just awoken.
- Think my friend, keep
Jesus' love as a gift and as a token.

The sun outside the window is a sign
of Your shining light.
The trees, the flowers and the plants
gifts in which we delight.

The river flowing along the rocks,
Oh! Thank you Lord for all Your love,
We know oh Lord we're not one in a flock,
but an abode for Your Holy Dove.

But then turn to the depressed world,
Especially those of the countries third,
It's sad to see them in this way.
But we're sure You're amidst them - never astray!

But alas give me a break,
Never let me turn away,
For brother in one we were one day,
And forever so we remain I pray.

Oh Lord this instant somewhere,
desperate cries for help I hear,
Many die - but should we care
Or should we walk away unfair?

The gifts of the world - the gifts of life,
Made to be equally shared
But is it so? - or should it be so?
or I am living in a world of "no"?

We pray as one: our day's sure to be won
So brother, make haste - there's no time to haste
Today's the day, tomorrow's too late
The world's family is at bay - Truly I say!

Alistair Pace 17-10-93

Deep Moods

As the reverberating notes of the subtle piano,
spread over the crystalline pictorial atmosphere
of a sandy beach,
the seagulls will perceive the beauty
of this everlasting sphere:
God knew what nature means to our moods.

The seagulls cry, the plover on the crusty rocks,
a splendid breeze creating subtle benevolent waves
and the sun low down on the horizon
almost touching the golden path,
are the deep moods which immerse you
in a reflective feeling.

Then one looks back and sees the tall shivering palms
and sighs with relief as he remembers the joy of living,
remembers how lucky he is to be here
remembers the deep moods of life.

Then comes the dark night where only the moon stands still,
the sound of the mild wind which curves round the palms,
sculptures figures and patterns on the sand and then
fades away in the depth of blackness and thoughts.

We wander and wade on this beach, looking back
to see our own footprints on this world.
Sometimes the markings are doubled sometimes alone
sometimes with a melody of the past,
which reminds you the piano of the deep moods......

Melvin J.Gouder 10-3-96

ĊELLA T'IŻOLAMENT

Kamra mudlama.
La bibien u lanqas twieqi.
Riħa t'egħluq
Taqtagħli nifsi.

Fil miftuħ
Jurini d-dinja ta' barra:
Fejn in-nies tidħaq.
Fejn in-namrati jitgħannqu.

Irrid nibki;
Dmugħ ma fadallix.
Irrid ngħajjat;
Maħnuq.

Tgħid jasal il-jum
Meta jeħilsuni?
Għalfejn in-nies tidħaq?
Għalfejn in-namrati jitgħannqu?

Neville Calleja 9-8-93

PROFESSOR ROGER ELLUL-MICALLEF WOLFRAM ANTEPHOL: SCOME PAST AND PRESENT

Interview by:

Marie-Klaire Farrugia & Amaris Falzon (V Years)

Statuesque. Knowledgeable. Ambitious. An echoing voice demanding audience. Judging by the two SCOME personalities we confronted with our questions, the above are assets for anyone aspiring to become more than just a name in the expanding field of medical education. Twenty-eight years after his participation in the Standing Committee On Medical Education (SCOME), Prof. Ellul Micallef meets the current SCOME Director, 26-year-old Wolfram Antephol, under the gaze of MMSA's first Officer on Medical Education, Ian Galea.

Just over three years ago, Wolfram was merely one among the mass of platinum-blonde students attending Kiel Medical School in the North of Germany, like them, oblivious of the IFM SA (International Federation of Medical Students' Association). The addiction to Committee work began growing as he joined the German Medical Students' Associations (GeMSA) and became involved with IFMSA matters, but the vent which liberated his power of action was being part of the organising committee which orchestrated the 1993 Workshop and General Assembly (GA) together with the Danish Medical Students' Association. During the same GA he was introduced to the Medical Education Sub-Committee, and it was not long before he was nominated SCOME Director. His two-year term saw the introduction of innovative and challenging projects such as the Book-Aid (through which medical books are being collected for some poor Eastern European countries) and the IFMSA-EMSA (European Medical Students' Association) Workshops on Medical Education which took place in Maastricht, the Netherlands, and in Brazil only recently.

From left to Right: Marie Klaire Farrugia, Ian Galea, Prof. R. Ellul Micallef, Wolfram Antephol, Amaris Falzon

The roots of Prof. Ellul-Micallef's participation in SCOME also lie in an IFMSA General Assembly he recalls clearly: Vienna, 1967. At the time, MMSA was an active member of IFMSA. When or how membership lapsed remains an unresolved mystery. Prof.'s belief is that this is to be blamed on the tumultuous phase when the University was undergoing a "tremendous social and educational upheaval", with the consequent loss of most of its staff -- Prof. Ellul-Micallef himself spent 6 years teaching in Kuwait. The meeting in Vienna concealed more than one budding professor: Ian Fraser from Edinburgh, then IFMSA President, is today a Consultant Obstetrician and a known activist in the World Federation for Medical Education. Wolfram worked with him only a few months ago at the last meeting of the Association for Medical Education in Europe (MEE). Mike Simpson, another of the 1967 SCOME ensemble, is now Consultant Psychiatrist at Guy's Hospital in London.

But who was Roger Ellul-Micallef the student? He succeeded George Vella (currently deputy leader of the Opposition) as National Exchange Officer of MMSA, and boasts the arrival of around 200 elective students

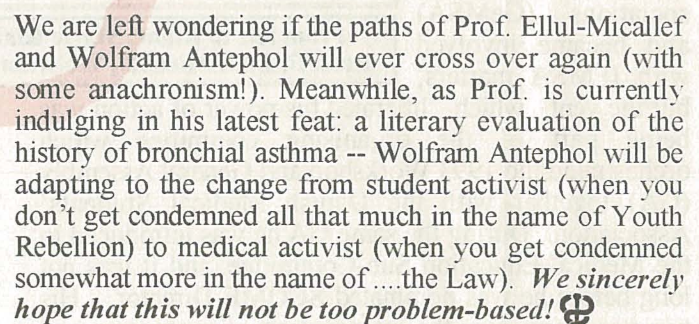
during his term (*any comments, Andrew?*). His next post was that of MMSA President - "single-handed" as all the other final years were understandably headfirst in their books.

This is where the link between international activity and the students seems to break down: when the examination phenomenon rears its head and all good intentions fizzle into oblivion. Both Prof. Ellul-Micallef and Wolfram have found it difficult to involve all students and to spread the spirit of participation beyond the confines of the main committee. Wolfram believes it is probably easier for him to find support in his medical school, where the number of students is proportionally much larger. One of his secret weapons is parties: just like he accepted the post of SCOME Director at one of the GA parties (*we hope you were sober, Wolfram!*), so he maintains that students' enthusiasm for team work grows when they meet in a relaxed atmosphere. Wolfram insists that it is not impossible to cope with both studying and other activities. Despite everything he has been through in the past three years, he has still managed to graduate as a doctor last year. And his medical career may not merely stop here. In no time, he was offered a post in Medical Education in the Cologne Medical Faculty. He is currently based in one of Europe's major reform faculties in Linkoping, Sweden. Wolfram and his team from Linkoping were in Malta last December, when they carried out typical **Problem-Based** tutorials with both the second and fourth year medical students.

Prof. Ellul-Micallef's medical career certainly did not stop at square one. Today, he holds as many posts of varying prestige as there are beads on a rosary, the latest innovation being his election as Rector of the University of Malta. Last year, he completed a three-year term as chairman of the Committee on Higher Education and Research for the Council of Europe, which discusses issues such as access to universities, standards required and standardization of courses. *Has experience within IFSMA been a determining factor in achieving his status?* Not directly, although contacts established then did come in useful in the long run.

This explains why Prof. Ellul-Micallef is eager for MMSA to renew its activity within IFMSA - he has even offered to "stand up and plead their case". Wolfram, however, has assured our altruistic Rector that MMSA has already made a name for itself through the Maltese delegations attending the last four major IFMSA meetings. He is confident that we will be elected to full membership status, and is looking forward to seeing a General Assembly being organised in Malta. He has particularly appreciated the Maltese contribution in the field of Medical Education. The tireless Ian Galea saw the creation of a Sub-Committee on Medical Education, inspired by his participation in the first Workshop on Medical Education held in Maastricht. He has been succeeded this year by the promising Maria Vella, who is carrying on his valuable work on Lecturer Evaluation. The Sub-Committee organised highly informative Medical Education Seminars in the past two years, enabling more students to become involved by getting to know about alternative modes of learning and practising medicine as a student, and allowing them to make suggestions about what aspects of Medical Education (and Educators) they envisage need a brush up or outright change. Although participation was far from universal both times, it must be said that students who showed interest gained a worthwhile update on what Europe envisages as the future of Medical Education, as well as innovations to be introduced by the local team.

Medical Education today is being faced with challenging alternatives to the teacher-centred, discipline-based course that is recycled year after year *ad nauseam*. A "trial-run" of a problem-based or integrated course is difficult to organise, especially as constant lecturer-student co-operation would be required. Wolfram found this a hard nut to crack at his Medical School in Kiel, but eventually convinced one unconventional lecturer to change his traditional lecture-programme (taking a risk, since his lectures were voted by the students to be the best) to assume a problem-based nature. The students were then able to compare the outcome of these "new-age" lectures with that of the rest of their lectures, which were still in the usual format. Student feedback acclaimed the new approach as a welcome improvement on traditional teaching methods, so that more lecturers are now being invited to take the challenge. *Would Prof. Ellul-Micallef risk such an overhaul in our medical system?* Whatever format the lectures take, they should not be the mainstay of learning medicine -- **more and more time on the wards** is his advice.



We are left wondering if the paths of Prof. Ellul-Micallef and Wolfram Antephol will ever cross over again (with some anachronism!). Meanwhile, as Prof. is currently indulging in his latest feat: a literary evaluation of the history of bronchial asthma -- Wolfram Antephol will be adapting to the change from student activist (when you don't get condemned all that much in the name of Youth Rebellion) to medical activist (when you get condemned somewhat more in the name of ....the Law). ***We sincerely hope that this will not be too problem-based!***

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