murmur 2005

Malta Medical Students' Association
Volume 12 - April 2005

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1 family's true story

Interview with Dr Josanne Vassallo

Multi-disciplinary teams: the way forward?

Maltese doctors in Sri Lanka

The good, the bad, and the downright outrageous
The Top 10 medical student gaffes

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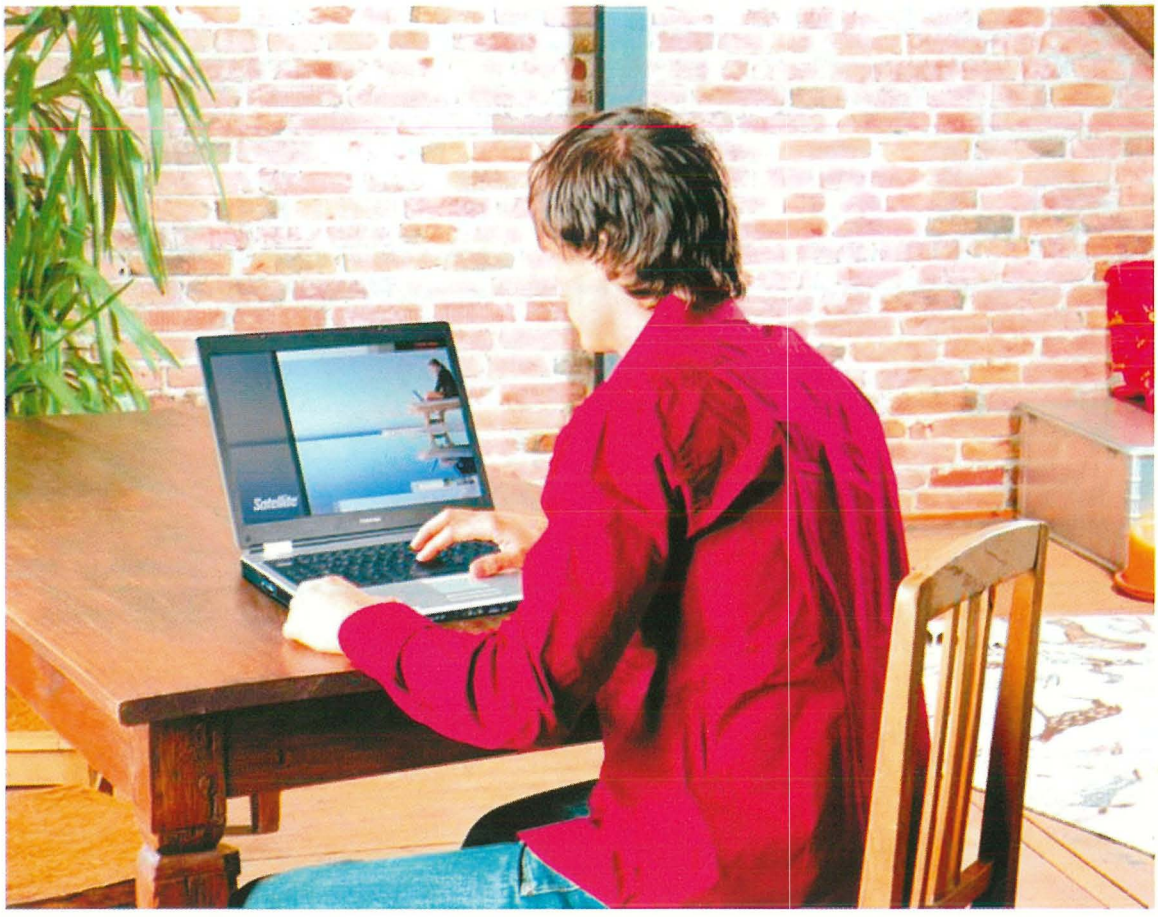

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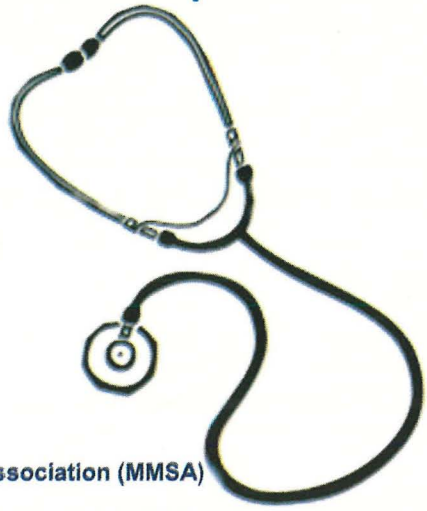

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THANKS
The Editorial Board would like to thank all those companies and individuals who, through their work, helped in the publication of this year's edition.

What's inside?

Editorial
A Year of Firsts...


Another year has passed, bringing with it yet another edition of Murmur. "It's changed!" I hear you say. Well, yes. Yes, it has. For this edition, we've decided to adopt a different layout and format. Don't worry, the content quality you've become accustomed to over the years is still there; we've simply gone for a novel approach to its presentation. This is, in fact, one of the many firsts that the Malta Medical Students' Association (MMSA) is proud to associate itself with over the past year.

As always, Murmur is being distributed to all medical students, but for the first time ever, we're also sending copies to all doctors on the medical registry, providing a showcase for the work we've been doing over the year.

Last May, MMSA and the Malta Pharmacy Students' Association (MPSA) presented a bid to host the first ever World Medical and Pharmacy Students' Symposium (WorldMaPS). The Maltese bid was chosen despite stiff competition from 3 other countries, and 400 medical and pharmacy students will be arriving at our coasts in November for a 5-night conference.

This year also brought with it the first Malta Medical Journal (MMJ) student study competition, highlighting the importance of research at an undergraduate level and allowing our abilities in this field to be recognised. But more about these in the following pages...

The past year has also seen the launch of our new and much-improved website, as well as the booklet, Med.Dic, a useful Maltese-English medical dictionary that has fast become an indispensable companion for many of us on the wards. Our last Training and Development seminar (TRD), held annually, turned out to be our biggest yet, showing that the initiative that started four years ago has not only been continued, but also improved upon.

MMSA takes pride in being an organisation that constantly strives to work closely with its members, namely YOU, the medical students, and we sincerely hope that this edition of Murmur reflects that. We've worked hard to bring you a magazine that we are proud of, and we invite you to see the work for yourselves. Although our thanks go to everyone who has contributed in any way, we feel that special thanks should go to Reuben, the man behind the artwork, to Helena for taking over article coordination when Adriana was away, and to Max for coordinating our hunt for adverts. May we also take this opportunity to congratulate Dr. William Mifsud for his recent appointment as full-time lecturer at the Department of Physiology, at the young age of 24.

Now our talking is over and it's over to you, students and doctors. We want your feedback! We'd love to hear from you, so just drop us a line at media@mmsa.org.mt and let us know what you think of Murmur 2005. For now, we invite you to put the kettle on, sit back, and enjoy...

Nikki Borg
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Adriana Cappello
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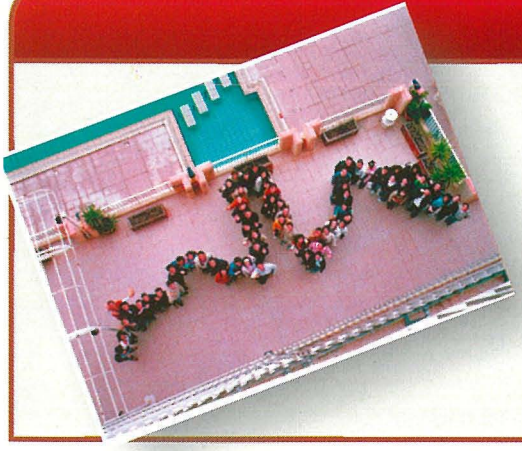
Front Cover



Our thanks go to everyone in first year, who posed for 15 minutes of their break during a Behavioural Sciences weekend seminar at the Halland Hotel – in the rain.

The photo was coordinated by Nikki Borg and Matthew Fenech, and snapped by resident photographer Melvin D'Anastasi, who we dragged out of bed at a cruel 9.00 am after a night's partying at Fuego. Thanks, Melv!

MMSA

The Most Marvelous Student Association

Benedict Vella Briffa
MMSA Secretary General

Some say that MMSA does nothing for them. Are they right? Well, in a sense the association does a lot more for others than it does for medical students. Ask the hundreds of school-children that hosted us in their class-rooms, for example, while we gave them talks on the dangers of smoking and the importance of proper nutrition and exercise. Or the countless youths we approached in places of entertainment across Malta and Gozo, to have a word about their sexual health. Or even the dozens of detained immigrants and their children that have seen groups of us visit them, keep them company, and even give them English lessons.

Does this mean that in its efforts to help others, MMSA has overlooked the very mandate inscribed in its name, that of representing medical students? Are students right to say that MMSA does nothing for them?

I certainly don't think so.

MMSA has been running an exchange programme for the past fifty years or so, for one. This is open to all, and a quarter of us rightly take advantage of these excellent opportunities every summer. Those who did over the past two years will remember that they even got a special discount on their flight ticket. This was thanks to a number of medical students like you, who besides running the busy exchange programme took it upon themselves to negotiate this deal and make the already-appealing exchanges even more accessible.

The older students among you will remember what the medical school relax room looked like not too long ago: bare white walls illuminated by fluorescent lights, a large wooden table with wooden chairs, and little else. It was medical students like you that rolled up their sleeves, picked up a paintbrush and started redecorating, while others secured funding for the project and oversaw the design, purchasing and installation of high-quality lights and furniture. The result is the pleasant room you see today, there for all to enjoy.

These are tangible benefits that MMSA has introduced to its members over the past couple of years, and for the most part they're already taken for granted. They materialised because medical students like you had fresh ideas and dedicated themselves, spending long hours working selflessly for the benefit of all. You could say this about everything that MMSA does, in fact. Even this magazine you read has taken weeks and weeks of hard work by the media team in order to produce; securing sponsorship, running interviews and writing features, editing and proofreading, designing and page-setting, all done by medical students.

Most important of all, however, is the fact that medical students enjoyed doing all these things. They learnt new skills, met new people, became more confident, developed their interests, and generally did things outside the sphere of medicine. Intangible yet important things they gained from MMSA.

The point?

MMSA is not the executive board. It's a population of medical students; all of them, in fact, including you. Everyone should feel a part of it. Anyone who's had experience with student organisations outside of MMSA will tell you that we're one of the very top organisations on campus, in so many ways. MMSA might just as well stand for the Most Marvellous Students' Association. What better reason to get involved?

Those who say that MMSA does nothing for them are missing the whole point. They are MMSA. They are the ones who should take an active role and look after their own interests and those of all medical students. To play on what a certain great leader once said, ask not what your MMSA can do for you. Ask what you can do for your MMSA!

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Spotlight On...
Dr. Josanne Vassallo

Christa Calleja

Dr Josanne Vassallo (endocrinologist, senior lecturer and tutor, MMJ editor, mother of one daughter), talks to us about the problems with practical medical training (or the lack thereof), and the difficulties faced by female members of the medical profession.

As a female doctor have you met any difficulties or prejudices? Have you been treated differently to your male counterparts?

Yes I have. At one time it was common practice in Malta for members of selection boards to ask female candidates for a particular post questions regarding their marital status and whether they intended to have a family, questions which were never put to male candidates. Overseas, I have never encountered that sort of blatant attitude. Another example of prejudice against women wishing to have a professional career centres around the fact that women are not usually seen as the primary breadwinners in a family. It is sometimes believed that they should be perfectly satisfied with a life dedicated solely to their families. Fortunately this sort of prejudice has been almost eradicated in more recent years.

In Malta, is it harder for women to be promoted, when compared to men?

In Malta it is hard for both sexes to progress up the career ladder for the very simple reason that we're a very small country, with a very limited number of job opportunities. Therefore there is bound to be significant competition for the posts there are. New posts are generally only made available when someone retires or occasionally as a result of service expansion. This is one of the reasons why we're facing a brain drain in Malta: young doctors are entering training programmes abroad with the knowledge that they stand a good chance of a consultant appointment shortly after they've completed their specialist training. Their other option is to return to Malta to face the prospect of years working as senior registrars. It doesn't make sense. There are a number of specialties where the last call for applications at consultant level occurred eight to ten years ago. Given this scenario and the concept that married women are not considered the primary breadwinners, women do find it harder to progress in Malta. Furthermore, the responsibility for bringing up children locally is also regarded as being the mother's in comparison to countries such as Sweden where both parents enjoy the same rights and privileges when it comes to raising a family. One can assess the impact of these factors locally by analysing the percentage of women as compared to men in senior positions in different sectors.

> "...no matter what the problems with the system are, you always feel bound to give your patient the best..."

Is having a family compatible with a medical career?

It is compatible but there a number of things one needs to be aware of. First of all, life is going to be much harder. Juggling a 9.00 to 5.00 office job with the responsibilities of taking care of a family is already tough. Pursuing a medical career, having a family whilst you are still in training, working 70 to 100 hour weeks, studying for postgraduate exams and doing research (an essential part of training nowadays) necessitates tremendous discipline, efficiency in organisation and the will to keep going come what may if you want to fulfil your role as a wife, mother and professional. I always tell female medical students to try and sort out as much of the studying process as possible before having a family. For example it is very difficult to study for postgraduate exams when you have young children. As one progresses in one's career, the demands may differ somewhat but a high degree of dedication will always be essential. You are going to have to make a lot of

sacrifices, and if you are not willing to undertake this level of commitment you need to honestly confront the situation and make the necessary choices depending on your priorities. I think this is where counselling and mentoring can be of tremendous help to individuals.

How did you get involved with the Malta Medical Journal (MMJ)?

The Maltese Medical Journal was out of circulation for about 18 months when the Dean of the Faculty, Professor Godfrey LaFerla, together with the newly appointed Chairman of the Editorial Board, Professor Joseph Cacciottolo, set about constituting a new editorial board. Early in 2002, I was approached and asked whether I would be interested in becoming the editor of the Malta Medical Journal, a challenge which I was happy to accept. My background in research and my experience writing and reviewing articles for other journals were an asset. Together with the other members of the Board it became possible to re-vitalise the Journal of the Faculty of Medicine and Surgery. We each have our allotted area of responsibility and we only succeed by working as a team.

How would you say the standard of Maltese research papers compares with that of foreign ones?

We've had a range of submissions from excellent to very poor papers both from Malta and overseas. We have had to reject a number of articles after review by myself as the Editor and our independent reviewers. The main barriers to good science in Malta are lack of adequate research funding, which immediately narrows down the type of research that a person can do, and lack of protected time. There is a wealth of material available but people are so busy with the day-to-day running of the clinical services that they find it difficult to allocate time to research. In spite of this, there is a fair amount going on, and I don't just mean at faculty level, but also at student level, as was evidenced recently at the Corinthia Research Seminar. The level of presentations, especially considering the short time that the students had to prepare for them, was excellent. The MMJ aims to provide all with the opportunity to publish their work, which very often is of relevance to the local scene, and it definitely provides a forum for us to be able to discuss, promote our own work, audit ourselves, institute change, and look at the effect of that change.

Dr. Josanne Vassallo

Would you say that students are being taught clinical skills properly? Shouldn't we have more practical training?

There's always room for improvement, that is definite. Unfortunately, we still have situations where students come for their final MD viva and the unanimous comment by the examiners (and past tutors of these students) is 'where have these students been for the last three years?' They are unfortunately the ones who usually fail their viva. They are students whose theoretical knowledge base is good – but they haven't seen enough patients. I would like to see more interaction between medical students and patients in casualty and on the wards throughout the five years of medical training. Attending a tutorial on the examination of the cardiovascular system is not enough. Each and every student has to then take the initiative to examine countless patients during the clinical years and compare their findings with those reported in the case notes. Students who do this in fact acquire excellent practical skills, but this learning process should not be left until fifth year.

During third year and fourth year we're not examined on clinical skills at all. Do you think we should have clinical exams earlier on in the course? (In third year and in fourth year, students who stay home and study generally do better than those who go to the wards.)

Students who stay at home do better in the theory, but they are the ones who are likely to fail their final MD exam

because of poor clinical skills. I don't really think we need formal clinical exams earlier on in the course. Compared to larger medical schools abroad we are fortunate in being able to provide small group teaching. Unfortunately as the numbers of students increase, problems are emerging. Patients are tiring of constantly seeing students and at times refuse to participate in tutorials.

In fact many people have been commenting on the overcrowding of medical school, with some saying we've reached a stage where consultants and tutors see students as a burden and that few, if any, would be able to name ten medical students. What are your views on this matter?

Unfortunately this does happen. Tutors are finding it difficult to allocate sufficient time to teaching in small groups because of increasing service demands and spiralling student numbers. Tutors are only human, and if you have an acute case to see to, sometimes lectures and tutorials have to be postponed. Due to the limited number of tutors in proportion to the increasing numbers of students, teaching is an addition to the clinical workload. So yes, there are problems with the system. Sometimes, though, there's also a lack of student initiative. Students need to go to casualty and get hands-on experience on the wards before fifth year. You don't need a tutor constantly with you to clerk a patient. You can take a history, examine the patient, and then check your findings with his case notes. Doctors on the wards will be happy to corroborate findings even if they are not actually tutors themselves. I am always amazed at the reaction of fifth year students who are still taken aback when I ask them to clerk a patient fully in outpatients and enter their findings in the case notes. Their obvious lack of self confidence is testimony to their lack of practice. ▶

> **"...tutors should be getting students to clerk patients themselves and to examine patients under supervision, not simply sit by a desk and watch..."**

Students are rarely given the opportunity to clerk a patient under the guidance of a tutor – isn't it obvious they are taken aback when asked to do so?

That's true. In third year tutorials in history taking and examination are held but as I have said before, the process has to be repeated over and over again in the absence of the tutor. Also, tutors should be getting students to clerk patients themselves and to examine patients under supervision in a clinic setting. So yes, there is room for improvement, on both the students' and the tutors' part.

We also rarely have patient examination demonstrated – so perhaps the lack of experience is not because students haven't been on the wards, it's because nobody has taken the time to show us what we should be doing.

In final exams one sees that there is a wide range of clinical skills among students – some have excellent skills, some are very poor. These are all students that have gone through the same mill and system. The demonstrations during your tutorials together with your clinical examination books (which many students are unfortunately not reading) should suffice, if you then go to the wards and practise. Whilst some tutors may be less dedicated than others, there are some very dedicated tutors who have regular contact with their students and yet they will tell you that they have never seen certain students. Aspects that do need to be focused upon however, are the lack of resources, a lack of "training the trainers" programmes and continuing curriculum development and assessment.

One of the methods some tutors seem to have adopted is teaching by humiliation. What do you think of this?

Unfortunately this does occur in medical schools around the world and Malta cannot claim to be the exception. I completely disagree with it; it is definitely not the ideal way to teach and is counter-productive. However, although it still does happen, the situation has improved greatly, and teaching by humiliation is now far less common than it was in the past.

In conclusion, how do you feel about being a female doctor in Malta at the moment?

Medicine is a demanding profession because its practice is both a science and an art. It is tough because no matter what the problems with the system are, you always feel bound to give your patient the best. Although there are problems with the current system, there's been a lot of improvement. At the moment the situation is interesting and challenging. We should be moving to a new hospital and the fate and location of Medical School and the Institute of Health Care are as yet unknown. Service provision ensuring quality healthcare in the face of certain social and financial issues is becoming more difficult. There are, however, dedicated members of both the faculty and the profession who are determined to continue to improve both medical education and healthcare provision. Should we lose this drive to improve and expand, then we may as well give up any aspirations to becoming a centre of excellence.

Earth, swallow me NOW!

Life as a medical student can be dull, right? Yeah, right! Not when you're on the wards and you embarrass yourself outright in front of your colleagues and tutors. We sent our in-house budding journalist (-cum-medical student) Alexandra Camilleri Warne around medical school to collect the very best of the worst faux pas. After collecting dozens of stories, both from victims and from others who had heard the story as it spread, we narrowed our selection to the Top 10. Keep an eye open through the rest of Murmur for our top stories.

After the Waves

December 26th

Disaster struck in south-east Asia, and the world came to a stand-still...

The day after the tragedy, David Paul Galea was at his GP clinic when he received a call from Dr Rachel Attard (better known as Sasha), asking, "David, do you want to go to Sri Lanka?" His first reaction was shock, but he had always wanted to do some volunteer work. He had been postponing it for a while, and now that he's advancing in his studies and thinking of specialising, he had begun to feel that he had missed his chance. Until this came along. No more than half an hour later, he had decided to go.

Daniela Bondin &
Nikki Borg

At 28, David was the eldest of the three doctors who went to Sri Lanka, with the knowledge and experience of four years of practice. He is an SHO in psychiatry, and is leaving Malta later this year for the UK, where he plans to specialise in psychiatry.

Through Sasha, David was in contact with SOS Malta, an organisation that has previously worked in similar situations in places like Albania and with the refugees in Malta. SOS Malta put together a medical team of three doctors – Rachel Attard, Vanessa Saliba, and David – and one nurse, David Grech, who was the only one with previous experience in such operations, having worked in Albania. Rachel and Vanessa, on the other hand, are fresh out of medical school, and work as house officers.

Over a very short period of time, the team was immunised in preparation for various outbreaks. As doctors working in a hospital, they had already been immunised against Hepatitis B, and before leaving they were immunised against Hepatitis A, Polio and other diseases.

A few meetings were arranged with SOS Malta, and Sri Lanka was chosen out of all the countries in South East Asia. Sri Lanka gained its Independence from the British Empire in 1948. Tensions erupted in the mid-1980s between the Sinhalese majority in the south and the Tamils in the north. The main religion is Buddhism, followed by Hinduism, and then Catholicism and Islam.

> "the congregation rose in unison and was swept towards the altar, as a van crashed through the door and into the building."

As a Commonwealth country, Sri Lanka had contacted the Maltese Government for assistance. The Government and the Department of Health responded by providing the team with special paid leave, and the Foreign Office arranged their flights, loaded with 6.5 tonnes of medication and medical equipment.

There was an air of camaraderie as all manner of employees at Air Malta volunteered to work against the clock to get the plane on its way. Loaded with cargo and a few journalists, the flight left for Sri Lanka, the teardrop of the Indian Ocean, and landed in the capital city, Colombo, on the 5th of January.

Were it not for the swarm of NGOs infesting the city, Colombo showed no signs of the disaster that had stuck the country's coasts. The next three days, including David's birthday, were spent waiting patiently as customs cleared the medical supplies. The cause of the lethargy was the civil war that plagues the country to this day, with authorities trying to maintain control even amidst a crisis of this magnitude.

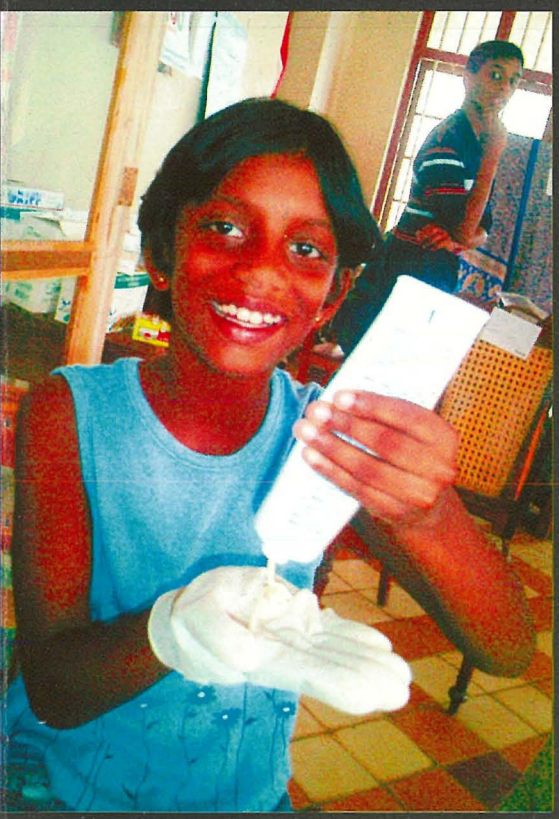
While David worked hard for the cargo to clear customs, Sasha and Vanessa scouted around refugee camps in search of the hardest-hit area. After much deliberation, they settled on Matara, a city in the southern-most tip of Sri Lanka.

Sasha embraces a young child.

Through the help of SOS Malta, a contact was made with a Catholic church just across the road from the beach in Matara. On that fateful day, Sunday Mass was being said just like any other Sunday. "Suddenly," as the priest celebrating the mass describes, "the congregation rose in unison and was swept towards the altar, as a van crashed through the door and into the building." Although the waves were only about three feet high, they engulfed the coast at lightening speed, leaving a trail of devastation in their path.

No television images or magazine shots of the natural disaster could begin to prepare the team for what they witnessed on their journey from Colombo to Matara. For six hours they were driven through perpetual scenes of rubble, foundations and rags. People dotted the terrain, crouching in the foundations of their homes, searching for what little of their belongings had survived the devastation. They stood there, shell-shocked and bewildered, as they struggled to come to terms with the reality they now faced.

Before leaving the airport, the team had got in touch with Sri Lanka's largest tea merchant, who had kindly offered to lend them a number of lorries to transport all the medication from Colombo to Matara.



Upon arrival in Matara, relief efforts were well underway, with foreign NGOs all collaborating to clear the debris and begin reconstruction. The team set up base in a convent that had been used as a school. One of the ground floor classrooms was converted into a rather rudimentary clinic, with shattered windows and a mattress used as a couch. It wasn't a small room – about 10m x 10m – and they divided it into 2 doctors' bases, a nursing station to tend to wounds, the couch behind a screen, and their own little pharmacy, with the medication sent over from Malta.

"Thinking about it," David says, "while working there, I couldn't imagine that a mass of water had gone through the place. For us, although we had seen all the destruction, it still felt surreal. We only experienced the tragedy through other people, and in a sense, you don't truly know something until you've experienced it first hand."

"On one occasion, I was checking a woman's blood glucose level," he continues, "when suddenly she rushed out of the chair and out of the clinic. At first I thought I had scared her, but moments later, the translator ran out, and we heard a dreadful commotion in the street. There had been a warning of a second tsunami in Indonesia, and people rushed into the streets, cars crashed and people got hurt. We, on the other hand, just stood there, in the clinic, the reality of the experience still light years away. Somehow we still didn't believe that it would actually happen, and that's exactly how they must have felt until it actually did strike."

At first everything was haphazard and disorganised. People were panicking, and there was a lack of medical assistance. To organise the situation, they set up a register, whereby patients would get registered before being examined. They worked with translators, who were either teachers or school children who were rather advanced in their English language studies. Fortunately, being a Commonwealth country that received its Independence less than 60 years ago, many people could actually speak English.

"On one occasion, I was checking a woman's blood glucose level, when suddenly she rushed out of the chair and out of the clinic."

Needless to say, examining about 150 patients a day for 6 days a week took its toll on the medical team, but the buzz of enthusiasm provided by the school children helped alleviate their morale. Being there for a whole month, as opposed to just a week or so, they took care to pace themselves, making sure that they found time to relax too. Creepy as it initially felt, they even went for a swim on a few afternoons.

Local doctors, unfortunately, resented the presence of so many foreign doctors who were willing to work for free. Most local doctors do not have great relationships with their patients; they do not take the time to speak to them and explain to them what treatment they were prescribing.

"Doctors there are treated like gods, so whatever they say remains unquestioned. We often saw patients who didn't even know what they were suffering from. They had been prescribed pills and knew when to take them, but had no idea what they were for – they were kept ignorant. We, on the other hand, worked for free and gave them time and explained to them. Although we were seeing many patients a day, we made it a point to give them their time. After having gone through what they did, simply having someone to listen was therapeutic. We empowered them with knowledge and showed them that we cared, and this frustrated some of the local doctors. We had people traveling and getting on buses just to come to our clinic. Had we been there for longer, we might have come across more resistance from the local doctors and maybe even the government."

For a while, David joined an Irish team at a refugee camp. The Irish team was considerably larger than the Maltese one, but was nowhere near as organised. They were working with medication still packed in boxes, while the Maltese had a convent to set up in. Otherwise, there were few or no other medical teams.

David, Sasha and Vanessa knew each other

well, having worked together on various MMSA projects during their student years. Although just out of medical school, Sasha and Vanessa performed "brilliantly", in David's words. "They were thrown into the deep end with no supervision, except for the little help I gave them for the first few days. It was great that we knew each other so well, because we felt comfortable consulting each other and asking for second opinions."

During their stay, they met a number of great people, particularly a retired British business consultant called David Pope. Evidently, the man was beyond wealthy, yet he had an immense love for the people and helped the orphanage greatly. One day, he pulled up in his limousine, flustered but relieved to have found David. He wanted him to go back to the orphanage with him because he was concerned about a young woman suffering from a severe skin condition.

Upon arriving at the orphanage, David saw that she had nodules all over her body, she was mentally deficient and had a slight kyphosis. Immediately, he knew it was neurofibromatosis. The prognosis was not good, and he explained this to David Pope, who was devastated when he found out that he couldn't help her. Rich and powerful as he was, he suddenly felt so small because he realised that wealth cannot always buy the most meaningful and treasured things in life.

From a purely medical point of view, the general situation was better than expected, with no alarming outbreaks. The majority of cases were chest infections, exacerbations of chronic diseases as a result of neglect and loss of medication, and wound infections.

Ironically, many of the injuries were actually sustained in the re-building process. From a psychological point of view, there were many convergence disorders, and many physical complaints that after some talking, turned out to be psycho-somatic.

There were also a number of cases of post-traumatic stress disorder. David recalls one girl in particular who stopped speaking altogether. She was injured during the tsunami, and was hospitalised as a result of her injuries. During her stay in hospital, she even missed her mother's funeral. Eventually, once she was discharged, she returned to school, only to find out that her best friend had passed away, too.

Impressively, the people responded with a ▸

Tears in the eyes of a child - David examines a young boy at the clinic in Matara

▲ All smiles - Sasha and two children at the clinic

fighting spirit. Shocked as they were, they tried to get back on their feet, with Buddhists, Hindus, Catholics and Muslims coming together to salvage lives. A Catholic priest who had lost his home was hosted by a Buddhist. The Maltese team themselves lived with a Buddhist family during their stay. The huge cloud's silver lining was the unity and humanity arising out of tragedy. More than anything, the locals were angry at the sea. It was so calm before the waves struck, that they felt deceived by something that they had relied on for their livelihood. Fishermen didn't want to live by the sea anymore, simply because they feared for their families' safety and well-being.

Emotionally, the people remain, and will remain for a while, severely scarred. In the weeks and months after December 26th, they were overwhelmed by the buzz of activity around them, with NGOs flying in from all corners of the earth. Now that such organisations are beginning to leave and life is calming down again, they are going to find themselves having to stand on their own two feet. It is now that there is a need for a psychological programme that is culturally appropriate and ongoing.

Sri Lanka is a beautiful country, and tourism plays a vital role in its economy. Unfortunately, after the tragedy, tourists were put off travelling to the affected countries. The only way for the economy to pick up again is to encourage people to go to these countries. In reality, the chances of another tsunami striking in that region are no higher than in any other island with similar geological surroundings.

Reflecting on his stay in Sri Lanka, David comments that the month they spent there was too short. "After a month, I was torn between a feeling of exhaustion and a feeling that my work there was just getting started, and my desire to stay on was stronger than my exhaustion. Perhaps three months would have been more appropriate, yet somewhat daunting."

"As an experience, it affected me possibly more than I even know. I learned that in life I need to give something back, and I hope I'll have more opportunities to do so in the future. No matter what choices you make in life or how successful you are, like David Pope, there's always time to help someone. Fundamentally, we owe it to ourselves and we owe it to the world. In most experiences, you gain more than you actually give, no matter how much you work. It's important, sometimes, to just grab the opportunity when it comes along. It's good to think straight and think things through before taking decisions, but sometimes you just have to take the chance, shutting off your brain and listening to your heart. At the end of the day, no matter how it turns out, every experience is a good experience."

When asked whether he'd do it all again, David's reply was short and confident: "Definitely! Maybe I wouldn't have spent my birthday there, but other than that, I'd do it all again in the blink of an eye."

The Editorial Board would like to thank David for taking the time to tell us his story.

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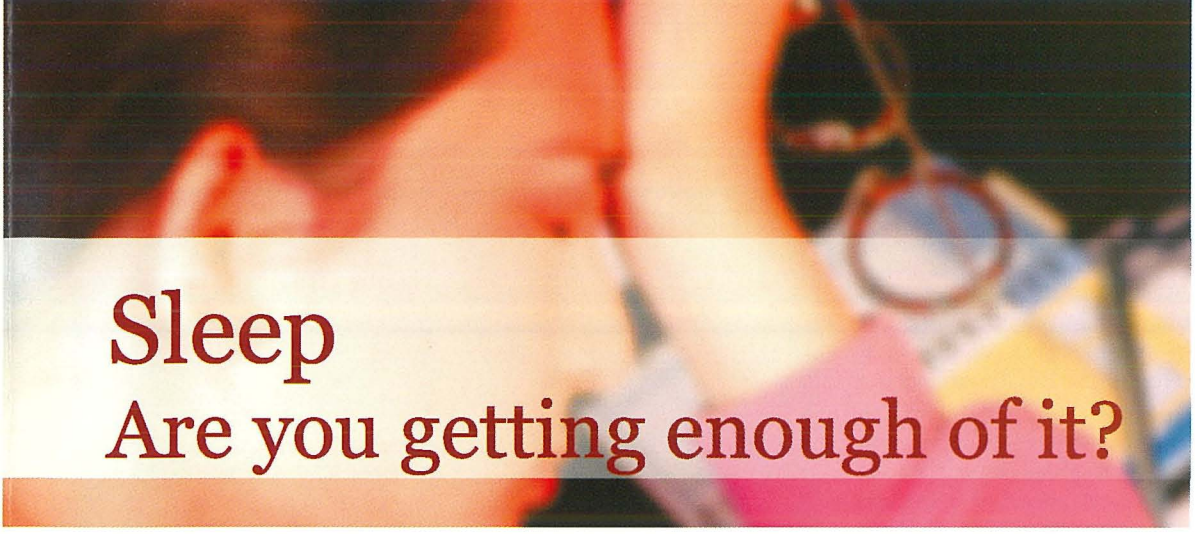

Sleep
Are you getting enough of it?

Laura Azzopardi

Did you know?

Before Thomas Edison's invention of the light bulb, people slept an average of 10 hours a night; today Americans average 6.9 hours of sleep on weeknights and 7.5 hours per night on weekends.

If you had to keep a sleep diary, what would it be like? Nine straight hours every night, up and fresh in the morning, or a few hours just before dawn and a quick nap after lunch? Whatever makes you tick, sleep is one thing you just cannot do without. You can try stretching those hours, because you're on holiday or because it's the night before your medicine exam. But no matter how much you cheat your body, the god of sleep will catch up on you and before you know it, you're drowsing off. And yes, it can happen even on your medicine books.

The natural circadian rhythms of the body have a role in the regulation of several vital functions, including temperature regulation, hormone levels and heart rate. Thus, a certain number of hours of sleep each day are essential to revive brain cells and other body systems. Most adults need between seven and nine hours of sleep each night for optimum performance, health and safety. An overall lack of the necessary amount of sleep will accumulate a "sleep debt". In the short term, this sleep deprivation has major effects on judgement, cognition and behaviour, and is associated with decreased productivity and safety issues in the home, on the job and on the road. When chronic, sleep deprivation will also affect overall health, and has been linked to problems such as obesity and high blood pressure.

Sleep deprivation - we've probably all been there, done that. The bad news is that once you are a junior doctor, it does not get much better! Several studies have indicated that sleep deprivation is an inevitable consequence of a junior doctor's work. With the traditional schedule of more than 70-80 hours a week, with some shifts longer than 24 hours, sleep deprivation is no surprise. Interns are often "forced" to work such marathon shifts, and cannot get a medical license if they don't do it.

> "Interns are often 'forced' to work marathon shifts, and cannot get a medical licence if they don't."

The good news is that junior doctors deprived of sleep retain their medical knowledge, according to a study on British juniors after a night on call, with an average 3-5 hour sleep. However, the doctors under study tended to lose their ability to make quick, accurate decisions. Indeed, junior doctors following a schedule of over 80 hours a week, made 35.9% more medical errors than those working on a less demanding schedule. The study found that a night on-call impaired their ability to answer clinical questions correctly - and eroded their confidence in their abilities. But the sleep-deprived junior doctors eventually got to the right answers - partly because of their loss of confidence – after realizing their answers might be wrong and double-checking them. In addition, the study found that those doctors who had the longest periods of unbroken sleep answered the most questions correctly. Overall energy and confidence levels were found to be low.

Besides work performance, there seems to be an added risk of car accidents as junior doctors drive home. A nationwide survey of 2,737 interns in the US was conducted by the Divisions of Sleep Medicine at the Brigham and Women's Hospital and the Harvard Medical School in Boston, to investigate the impact of extended work hours and fatigue on junior doctors. The study found that the majority of interns routinely worked more than 30 consecutive hours, and they reported that they were awake 96% of their time in the hospital on average. Also, during the 12-month study period, interns reported working an average of 80 hours or more during 46% of work weeks and 100 hours or more during 11% of work weeks.

As a result, study participants reported a total of 320 accidents during the 12-month study period, including 133 that required treatment in the emergency room, property damage of more than $1,000 or the filing of a police report. Slightly more than 40% of the 320 ▸

crashes occurred on the commute from work. Interns also were more than twice as likely to fall asleep while driving with the chance of having an accident on the road more than doubled, while the risk of a near miss increased nearly six-fold.

According to studies, 21 hours of wakefulness decrease psychomotor performance and ability as much as a blood alcohol content of 0.08%, the US legal limit for blood alcohol for ordinary drivers. In other terms, young doctors working the long shifts required by hospitals are so drowsy when driving home, they run the same risk of a car accident as someone who is legally drunk.

In conclusion, junior doctors often need to endure long hours of sleeplessness during their internship. Besides affecting a doctor's performance in hospital, this sleep deprivation makes it pretty unsafe to get behind the wheel of a car and drive drowsily to home. Moral of the story? Do not get chronically sleep deprived – learn to catnap as you have done in the lectures.

AAAARGH!!!

A man carrying a baby went inside a doctor's clinic and frantically asked the doctor to examine his baby who had a very bad rash on his buttocks. The doctor, trying to calm the father down gave him a cream and told him "aghmel il-cream mal-patata". A few days later the father returned and with a disappointed look on his face told the doctor that he had followed his instructions-he had mixed the cream with mash potatoes and fed it to the baby several times. Surprisingly, the rash hadn't yet disappeared...

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a year in pictures

MMSA last year

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World AIDS Day

▲ Prof Laferla models the latest in authentic MMSA fashionwear (Consultants' Party 2004)

Multi-Disciplinary Teams

Kristelle Vassallo

What exactly is a multi-disciplinary team? We've all heard the words 'multi-disciplinary team' before, but do we really know what they imply? Murmur headed down to the breast clinic to ask Mr. Caruana Dingli to explain exactly how such a team works...

K: Could you please explain what a multi-disciplinary team is?

CD: Multi-disciplinary means having professionals from different specializations working together as a team.

K: How does this differ from the conventional method?

CD: The conventional way in which medicine works is that everyone works independently, referring to each other when they encounter something that's not in their line of expertise. In a multi-disciplinary team, each member gets used to each other and the sum of their expertise is more than that of the individual's.

AAAARGH!!!

Ah the joys of taking blood. We've all mastered the technique of taking it, yet for some transferring may be a problem as what happened in the case of an over-zealous student who applied too much pressure to the vacutainer and ended up with blood everywhere- including her face, her labcoat, the patient and her fellow students!

K: Who are the members of the team at the breast clinic?

CD: The team is made up of surgeons, radiologists, pathologists, breast care nurses, oncologists, radiographers and physiotherapists.

K: Is there a team-leader?

CD: Yes, the surgeon is the leader. Traditionally, in other countries where they have similar teams, like in England, it is usually the surgeon who is the leader of the team. This is simply because we are the first port of call. Patients are usually referred to us, not to a pathologist or an oncologist straight away. We have to make the diagnosis and then we plan the management with the whole team.

K: How does such a team work at the breast clinic?

CD: The team works in two functions. One is a meeting that we have every fortnight, which everyone attends in order to discuss particular patients. The other function is our work at the breast clinic itself and then we refer to the people who are on the team. We see patients every Monday.

K: So the whole team isn't present on Mondays?

CD: No, there'll be the surgeons and the breast care nurses.

K: I see, so not everyone has contact with patients?

CD: No, no…in fact sometimes, the radiologist wouldn't even have seen the patient. If the patient needs a mammogram, they don't need to see the patient but simply to report on the films. Also, the pathologist doesn't usually see the patient. However a particular case is presented at the meetings, so that we can see the films, get the histology report and we can discuss all aspects of the case.

> "The conventional way in which medicine works is that everyone works independently..."

K: So the meetings are really the hub of the team?

CD: Yes. The only thing is that though we tend to discuss all the difficult cases and the cancer cases, not every breast patient is discussed at the meetings, as then it would take forever. The meetings are there, more to discuss those cases that are not quite the routine, which might need changes in the management.

K: How long has such a team been in play at the breast clinic?

CD: I don't know exactly but about 2-3 years, more or less. It was something that built up gradually. It didn't start suddenly. However we've been having the fortnightly meetings for about two years now.

AAAARGH!!!

Embarrassing episodes do not just happen to students at medical school but also start in the years before (to the unlucky ones that is!) Imagine the tutor's surprise, when on showing the students how to distinguish between a male and a female pelvis from the bones, was then asked how the distinction could be made if the flesh was still there....

K: Are there any other such teams in hospital?

CD: (long pause)… I suppose if I have to think so long, it means that there aren't. No, no there are some, probably in paediatrics, oncology but I don't really know.

K; Do you see such teams as the best system for hospital?

CD: It isn't always necessary probably, because in some fields it isn't so important to involve the pathologist and radiologist. For example, if a patient comes with a hernia, at the end of the day the surgeon doesn't need the input from other specialists except from the anaesthetist of course, and from a physician if the patient has concurrent medical conditions. You have to be careful not to use up resources and time for things that could work well without having a team.

> "... I think we feel that we are doing our work better and that must be a good sign."

K: How does the patient benefit from this and how has it affected patient care at this breast clinic?

CD: We haven't actually measured it because it's difficult to measure the outcome. What you have to measure is morbidity and mor-

tality. This is very difficult to measure over a short time and with small patient numbers. So really I can't give you a scientific reply to tell you whether or not we have improved mortality. However, I think we feel that we are doing our work better and that must be a good sign.

K: Do the patients know that so many people are treating them?

CD: Yes, we often tell them. For example, recently a particular patient had a mammogram, which showed some microcalcifications. The radiologist in isolation actually suggested repeating the mammogram but wasn't too sure whether or not it was too risky to wait a few months before operating. The patient noticed his indecision. This is the type of patient who is very anxious. Once we had discussed her case at a team meeting we were able to recommend that she wait six months and then have another mammogram. Knowing that we have discussed her case as a team, she is unlikely to feel the individual's anxiety about whether or not to take the risk of waiting. In this way we share the responsibility. This is very important because not only do you have a better outcome as different people are giving an input, but even medicolegally; you feel that it's been a decision taken by a team and you don't stand alone. I mean you don't think of this all the time but it is there at the back of your mind.

K: Just one last question: In short, what is the main aim of the multi- disciplinary team?

CD: The aim is to improve the quality of care in all its functions, not just medically in the sense of giving longer survival but also when it comes to the quality of life. Patients get better prosthesis, better attention from specialists and more support. And so we want to improve the quality of life and we want to improve the medical survival. I see a distinction between someone living longer and someone having a better life.

AAAARGH!!!

While dissecting their anatomy project the professor told the students: "Now we are going to need to take out some tissues". You can imagine the look on his face when a student went up to him with a paper napkin!

D.L.T.

Petramay Cortis

You really must be wondering what D.L.T. stands for right? Well, unfortunately (for you) I'm not here to give you one, single, desired truth... I'll explain to you how D.L.T. was born, and how some medical students, dental students and a recently graduated doc would interpret it... but more than that I cannot do! Happy reading!

To start at the beginning, I promised our gracious editor that I would take care of the now-traditional vox pop for this year's edition of Murmur. At the time (sometime in November), it sounded great... a good excuse to chat up hunks on campus! But then Christmas festivities came along... and then exams... and then a well-deserved break... and by that time, our lovely article coordinator was starting to freak out! (And who would blame her!

During a boring lecture I wrote down the numbers 1 to 26 on the back of my notepad... admittedly, at that point, it was simple doodling. Then the brainwave... I asked my equally bored best friend to circle four numbers... they were 4, 12, 20 and 26. Those were equivalent to D.L.T. and Z. Since Z looked a bit too cruel, I scrapped it and presented medical and dental students with D.L.T. to interpret (as when found on a patient's file)! Here's what you crème-de-la-crème came up with!

Obligingly, there is a real medical definition to D.L.T. "DLT stands for DOSE LIMITING TOXICITY. It is medical terminology used in oncology (study of cancer) and is determined by phase 1 studies." This was courteously provided by Rebecca E. Galea Camilleri (1st year MD). Thank you for saving my face!

Other first year students came up with a couple of interesting interpretations: "Dreading Leaving Theatre" is what Paul Cacciottolo (MD student) came up with (he's apparently got hypochondriacs on the brain). And John Paul Cauchi (also MD student) decided it meant "Definitely Loves Throttles"–now I wonder what he had in mind! While Maria Abela (BChD student) thought that the good-souled patient was a "Donor of Lung Tissue", David Sladden (MD student) assumed that the "Dude Likes Trauma" (now the patient is a sadist!) and Michael Bonello (3rd year MD) chose to think of the patient as a "Dainty Little Twit"!!

Marwan Obeid (2nd year MD) thought his patient had a "Dangling Left Testicle" and Shawn Agius (3rd year MD) argued it was "Dorsi Lateral Torsion". Tessa Bugeja (3rd year MD) wondered whether the dear patient needed "Dramatic Laxation Tests" (whatever those may be) and Samuel Aquilina (4th year MD) opted in favour of "Drunken Liver Therapy!"

And the Top 10 are...

Andrew Busuttil
Dead Left Toe

Lara Callus
Drainage Leaked Through

Jonathan Cutajar
Dysfunctional Little Testicles

Mark Aquilina
Devastating Lamellar Testiculitis

Jonathan Mamo
Delayed Laborious Treatment

Glenn Garzia
Drunk Last Tuesday

Chris D'alfonso
Definitely Looks Terrible

Mark Camilleri
Denies Lesbian Tendencies

Tiziana Schembri
Didn't Like Tuna

Glorianne Bezzina
D-unemployment Lawyers' Tachycardia

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Imagine

Nikki Abela

When refugees land on our coasts, they are rarely greeted with much sympathy. Our first thought is often the financial (and other) burdens they place upon our society. What we don't think of, however, is the story that lead to their arrival here. Nikki Abela and John Cauchi interviewed a couple from the Democratic Republic of Congo, Sonna and Maidi, and got their true story.

Imagine not being able to leave the house for fear that your wife may be abducted and your possessions may be stolen.

Imagine not being able to go to work, every day fearing the moment that they will drag you away to fight.

Imagine, as a last straw, having to leave your country and all that you own, not only to be unaccepted in the next country but to be thrown into prison where you are beaten repeatedly.

Imagine leaving prison, yet still not managing to free your eldest son and having to move on to the next country without him so as to ensure the safety of the rest of your family.

Imagine not even knowing what country you are going to, yet willing to risk all your life savings to get on a small, rickety boat to take you somewhere, anywhere away from here.

Doesn't this depict a scene from hell? Now imagine you are black. Would that change your reaction?

Sonna*, a teacher, and Maidi*, a professor, lived in Congo with their three children, before a civil war broke out. "Congo has been Independent since 1960", John explains, "yet somehow we have never had an election. We have had a number of dictators who sold our rich land reeking with precious minerals to foreign companies, leaving our people poor. Rebels emerged and tensions erupted. They forced all men, and young boys too, to go and fight. I was scared to leave the house and go to work for fear that I would never come back or even worse, to find that they had taken my wife and children."

"... they left their house in the dead of night, making their way through the forest, and across the river..."

On the 20th October 1999, they left their house in the dead of night, making their way through the forest and across the river to a town close to Congo, and from there on to Libya. It was lucky that they decided to leave when they did because shortly afterwards, all hell broke loose. In Libya they were granted refugee status and had been living there for five years when one afternoon, Jean*, their adopted, youngest son went out to watch a football game on television. He was arrested without any explanation and his parents suspected it had something to do with his skin colour. Maidi endured the extent of this racism when he went to fetch his son from prison and was arrested and repeatedly beaten. "They tied my hands and legs in cuffs and struck me with a stick. I could not walk for two weeks. Sonna was able to speak to some people in positions of power in Libya, and luckily I was released after twenty days. We never managed to free Jean.

"Soon after we returned to the refugee camp, one refugee had set fire to a building, so all

MMSA Members teaching English to refugees in the Hal-Far Detention Centre.

the refugees were thrown out of the camp in retaliation. With nowhere else to go, we managed to get onto a half-sinking boat destined for Europe. We had no idea where it would take us; all that we knew was that we had to get out of Libya and we had to do it fast."

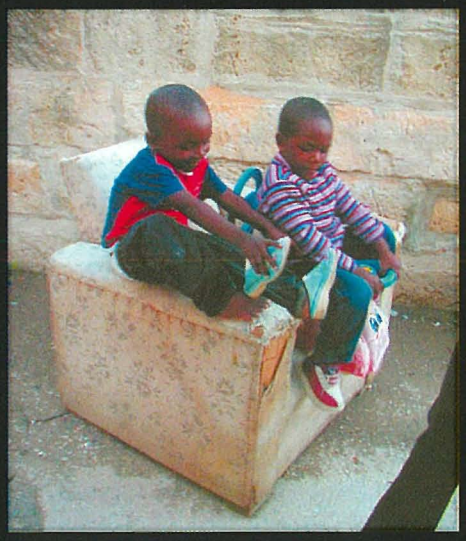
After a two-day boat ride, they found themselves in Maltese waters. Two days cramped on a small boat on the verge of sinking with hardly anything to eat. They have been here for six months now, but until they are granted refugee status they may not apply for a job, much less attempt to contact Jean.

We Maltese claim to be a hospitable society. We love programs like 'Tista Tkun Int' and reach far into our pockets to help the tsunami victims on the other side of the globe. Yet when people right on our doorstep, are desperate for our help they fail to touch our hearts. When we hear that irregular migrants have reached our shores, the first thing that comes to mind is the weight on the tax-payer's pocket. Who in their right mind would spend their life savings to get onto a boat whose chances of making it to another shore looks very grim at best, destination unknown, with no job to go to, where they know they are going to be discriminated against and having to leave their son behind in a prison where he is tortured?

Next time you're sitting at home, sipping a warm cup of coffee, surrounded by the luxury of a family and freedom, thinking about the financial burden refugees impose on our country and believing that we should send them back to their country to face their own problems, stop for a moment and use your grey matter. What sort of life do you think an illegal immigrant has here? I can assure you that while it is much better than the life that they had to escape from, it is far from bright. They live a life with problems so foreign to us that we cannot even begin to understand them, let alone relate to them.

Yet migrants are not asking us to pull them out of their pit, they do not want a "ready-made" life. They are here simply to exercise their basic human rights. All they ask of us is the power to do so.

**Names have been changed to protect their identities.*



▲ Two refugee children keeping themselves happy in the Hal-Far Detention Centre.

2 minutes with... Chris D'alfonso

1. Can a medical student find time for other events apart from their studies? Is it true that the medical course means years of intensive studying, with no social life?

Although being a medical student does mean many hours of sitting down with a book, it definitely leaves room for other things. I have found that all this work has helped the creative side of me. I've been into music for some years now, but only recently have I started compiling my first album "Blueprints". Recording my work has been a dream of mine for a few years, which is only now becoming a reality.

2. How did you get into this business of writing and recording songs?

For the past 3 years I've been playing with the band, Reckless Abandon (our last concert was held at Baystreet to promote World AIDS Day). I don't really know how I started writing, but each song I've ever composed represents a "checkpoint" in my life, a moment where I penned what I was experiencing. One aim I have is to bring out a positive message through my music. I actually started "Blueprints" because of all the support of my friends and family. I released a single early last year, which I had recorded at home, and that was a huge success. Soon after, we had made our first music video as a band. One thing led to another, and now I find myself in the studio everyday.

3. What came first: your passion for music or your passion for medicine?

I think the same rule applies for both musicians and doctors; "it's in your blood". I can't recall not having a passion for music, or not being interested in medicine.

4. What do you aspire to do in the future with regards to your singing career?

'Singing career' is a term that scares me. It would be great if my music takes off, but it's not really what's important. My songs have a story to tell, and my hope is to bring a smile to the weary, and to stir people's thoughts about the significance of their life and the presence of God. I have toyed with the idea of finishing medicine and going full time into music. Only time will tell.

"Blueprints" will be released this summer. You can listen to sample songs from the album at *www.shipwrecksounds.com*. For more information Chris can be contacted via the following email address: *info@shipwrecksounds.com*.

▶ Cover of Chris D'alfonso's debut album "Blueprints".

MMJ
Student Study Competition

Tessa Bugeja

This year, the Malta Medical Journal (MMJ) organised the first Student Study Competition. Medical and dental students were invited to submit proposals for a study. Eight of these were selected to give a ten minute PowerPoint presentation, on Saturday 19th February, at the Corinthia Palace Hotel, Attard. That morning I spent ten minutes behind a podium and microphone, but now allow me to share the rest of the experience with you...

On Friday afternoons I always tend to be in a more pensive mood than usual. As I sat on the bus, watching the rain outside, as well as listening to the ailments of the dear and not so dear) lady passengers in the background, I thought of the presentation I was to deliver the next day. Butterflies had long since settled in my stomach: the horrendous gut feeling that something would definitely go wrong, despite all odds, had been with me for a couple of days. Such are the days when one's feelings surpass the realm of logic...all too familiar to the proverbial medical student in May and June. But for the sake of putting my nerves on hold, and giving my sympathetics a well-deserved break, I decided to think positive. The experience had not been that daunting after all! I had had my first bout of research experience, with all the pitfalls that a first-time experience in anything you could imagine, is bound to bring along with it.

This is the era of competition, and 'marketing' has never been more of a buzzword. The only way to make people who take joy in thinking of themselves as the busiest people in tertiary education participate in such an event, would be to portray it as simple. Most of us spend our life talking, and wish the day were just a little longer to let us finish what we've got to say... in the name of common sense – what are ten minutes?! No feat by any standards! Although admittedly, in more domestic terms, this is what I thought when I saw the call for proposals. Yet, making it to February would entail going through a selection process. I believe that this was really the crux of the matter. There was a standard to achieve, and interest to create, and yes, some skill in convincing the editorial board in a score of words that my study was worth selecting. To be or not to be? To take on the challenge and see where it took me, or opt out and shy away? It took me a long time to decide, but when I came across an interesting enough idea, I decided to take it on board. I'd give it a go, and see where it got me!!

> "... as I read on, as the picture began to unfold, as the chick cracked out of its shell, things began to fall into place."

And get me it did. When I received notification that my proposal was accepted, I had mixed feelings of satisfaction and incredulity. In exaggerated terms, I had plunged into the world of research. Before this date, it had never been something I imagined I could do. It had always been an associated feature of doom and gloom. Possibly, the erroneous impression that research and clinical practice are segregated, made the former an obvious reject. The idea that research must be something big, a milestone in science to be of any use, conveys the impression that this is no ground for the undergraduate!

It was now too late for afterthoughts. This was it, and to quote Dr Vassallo, I had to "get cracking". You probably remember your kindergarten attempts to put a jigsaw puzzle together. Then you'll probably understand my mental turmoil in the initial stages. But as I read on, as the picture began to unfold, as the chick cracked out of its shell, things began to fall into place. Being a study on the factors influencing the likelihood of having a male or female child, it was really a study on probability. Fascinating as it was all turning out to be, I was now on an adventure. One moment it was genetics, the next environmental biology, then electrophysiology of gametes, as well as Darwin. It was a question of viewing one subject matter from so many perspectives, or to view so many subject matters from one perspective! Unknowingly, this was a venture into Ian Pirsig's world, where science does

away with compartments, and becomes a single entity.

Following this, I was into demographics, for the actual data collection. Then for the statistics! And what an unprecedented joy to finally comprehend the significance of statistics...albeit a nonstatistical one! Then I had to put all the odds and ends together. This was the process of bringing together all the jigsaw puzzle pieces, to form one picture.

And now it felt good. Whatever picture it was, it was my picture. To say that it was the picture would be pretentious: allow me to share with you that there are limitations and shortcomings to my work. But the sound of lecturers criticising the Women's Health Initiative came as such sweet music to my ears it could have been the Almighty who designed it for the sake of consoling me!! Condensing all my work into ten minutes does away with the myth behind the legend recounting St Augustine's attempt at containing the earth's oceans in a hole in the sand. Yet, deny it though we do, we are all blessed with the innate ability to discriminate: and there it was in its prime. I rehearsed the presentation till all I could breathe, speak, dream, was it.

▲ Prof Cacciottolo delivering the opening speech during the finals of the competition at the Corinthia Palace Hotel

.....Was anyone wondering why I was so nervous?!....

....As I sat on the bus, it dawned on me that my experience in research was really about learning from first hand experience. Topping it all with the event organised by MMJ, this has been a most enjoyable experience. Hopefully, other undergraduates, like me, will have the opportunity to research, and present their findings to an enthusiastic audience. May there be many others to follow!

AAAARGH!!!

One student was rather concerned when she asked to perform a rectal examination but was less worried when she was told that patient would not feel her as she was sedated. As the student began her examination the patient started screaming at the top of her voice: "Hallini! X'qed taghmilli?! Qed tweggaghni!" (Leave me alone! What are you doing to me? You're hurting me!")

#6

AAAARGH!!!

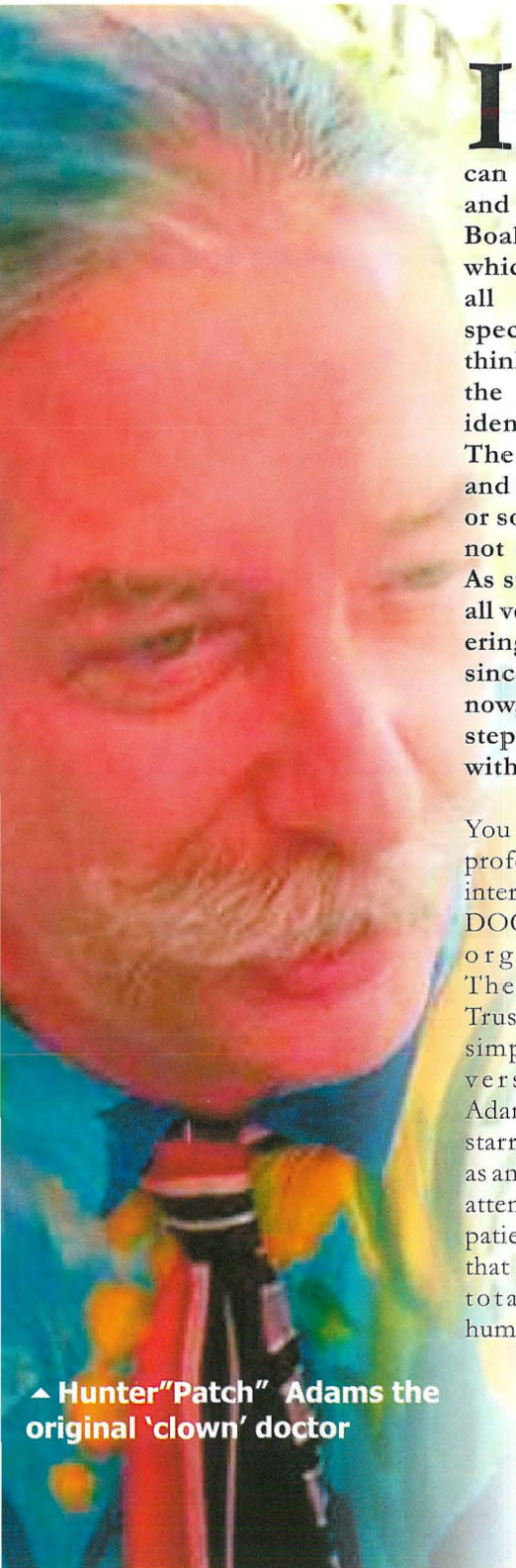
One student was very happy with the protective screen used in surgery against radioactivity. This was evident by the face-making and tongue-pulling she enjoyed through the clear panel while trying to amuse her fellow students. This would have been fine if only the audience did actually consist of her friends, as opposed to a rather baffled (and not very amused) surgeon...

#3

Prescribe: Humour

Clown doctors help the medicine go down

Jonathan Mamo



▲ Hunter"Patch" Adams the original 'clown' doctor

In a clinical setting both doctors and patients exchange roles as actors and audience. But how far can one delve into the methodology and use of theatre in hospitals? In Boal's 'Theatre of the Oppressed', which is now being used as the basis for all community based theatre, the spectator is allowed to free himself to think and act freely. The characters in the clinical 'farce' explore an often identified problem in an unsolved way. The spectators and actors put forward, and invite, the proposal of suggestions or solutions. Audience participation is not only essential but also inevitable. As strange as this may all seem, this is all very conservative especially considering that all of this has been going on since the time of Hippocrates. But now, a group of people are taking it one step further; to better the quality of life without the medical knowledge.

You don't have to be a doctor or a trained professional to do this. Anyone who's interested can train to become a CLOWN DOCTOR. The program, organized by the Theodora Children's Trust in the UK, is very simply the organised version of "Patch Adams" – the 1998 film starring Robin Williams as an aspiring doctor who attempted to treat his patients with a medicine that modern science had totally disregarded: humour.

Given that laughter is the best medicine it is rather surprising that this organization is the ONLY one of its kind in the whole of the UK. Clown doctors have to be sensitive but resilient, spontaneous but willing to play by the hospital rule book, capable of being funny in an intrinsically sad and depressing environment. Whatever happens whilst the clowns are 'on duty', they are only allowed to display happiness.

The chosen few who manage to complete the course which is held in partnership with King's College, London follow training programs that include both medical and artistic workshops. The participants undergo rigorous medical training in subjects as diverse as child development, infection control, pain management, physical and psychological illnesses, child protection, the knowledge of how to deal with the death of a young person and the structure of hospital paediatric services. Regarding the artistic skills, the candidates learn to develop improvisational and entertainment skills, juggling, magic, story-telling, mime, and

AAAARGH!!!

A group of students went to check on a patient with very bad peripheral vascular disease. As they walked in the cubicle they noticed that he had both legs amputated. Later on, on trying to make conversation with him they asked him if he still smoked and instead of answering them he lifted his hands to show them his missing fingers!!

AAAARGH!!!

A female patient who happened to be a member of the M.U.S.E.U.M. visited a doctor, who examined her with a stethoscope and asked her to breathe in through her mouth: "Min halqek" (through the mouth). The patient persisted in breathing in through her nose and the doctor was forced to repeat his instructions –"minn halqek". After repeating this several times the patient (holding tightly onto to her faith) said in a huff – "Min tridu johloqni? Mhux Alla halaqni!!" (For our English-speaking readers, 'Min halqek' can also mean 'who created you', to which the patient replied 'God of course!').

balloon sculpture. The apprentice clown doctors then learn how to adapt them to each child's needs in widely differing situations.

We think of clowns as characters that bombard people with their jokes, their clashing clothes, and also their vivid make-up, but with the clown doctors everything is toned down. At their simplest, these people give children who are ill the chance to laugh. They improve the quality of life of the children and bring something that is usually not only lacking but even extinct in some hospitals – Humour.

It has been suggested that laughter lowers the levels of steroid chemicals in the blood which are associated with stress, boosts the immune system and increases tolerance to pain. The details are not that important but the results are! Sometimes children will relax with a clown and allow things to happen that they would otherwise have been resistant to, such as taking medication. As much as possible clown doctors are not used as a distraction for treatment such as during an injection, because then children may associate clowns with unpleasant procedures. The recovery of a number of children was found to be speeded up by regular visits from the clown doctors. The anticipation of the sessions, the sessions themselves and the recollection of it are all of great importance. The clown doctors use their improvisation and entertainment skills to involve each patient as much as possible, ensuring that the child is not confined to the role of spectator but can participate in the magic and the activities. The clown doctors can also involve the families and the hospital staff giving the atmosphere on the ward an air of joy and hope. They can be an invaluable help to the hospital staff, and they build relationships that support families and help them cope with their experiences in hospital.

With their lavishly decorated white coats, giant stethoscopes and thermometers, clown doctors are a gentle parody of the system; the spoonful of sugar that helps the medicine go down.

The Future of Medicine

Richard Pullicino
David Sladden

Picture it: the year is 2307 and on this bright and terribly hot summer day, one rather normal ıother, somewhere on planet Earth, oes into labour. On August 12th 2307 er son is born; she names him Aaron nd she holds him proudly. For Aaron is ntering the new age of medical technolgy. He is being born into the golden age f scientific discovery.

/e are about to embark on a journey ırough Aaron's life; we will follow him osely and hereby record the medical events f his life.

eb 3rd 2318

aron is ten years old and enjoying airırfing on his anti-gravity scooter for the rst time since the snowstorm at Christmas. he purring engine suddenly squeals and ıokes and as his hydrogen runs out so does is lift, and he dramatically crashes down on ıe pavement.

aron's cries of pain alert his mother, who as quite a rough time getting her big boy ıto her miniature car. Whimpering, Aaron olds his semi-flexed elbow with the other and, unable to move his arm. They arrive at ıe Emergency Booth and after entering her IN code Aaron's mother sits him on the ıclined chair and closes her crying son in ıe booth.

fter a quick scan the computer screen rompts for the next command: 'Press 1 for aser Fusion of the broken clavicle.' She oes so and soon Aaron's crying stops. In ıct he feels no pain as the laser fuses the roken ends of bone – he emerges as good ; new.

Sept 11th 2336

Aaron is furious to learn that a job he had applied for a month earlier is now out of reach. The interviewer seemed to like Aaron as a prospective employee, and had he not failed his DNA screening he would be on his way to a much higher wage. Not only is his insurance premium sky high but he can't even get the job he wants – all because of one oncogene. This is starting to frustrate Aaron - something good had better happen soon.

Oct 24th 2338

Aaron is 31 and time is pressing. He checks his mail everyday eagerly awaiting the brown envelope – why they use such outdated, inefficient means of communicating is beyond him!

Finally the long-awaited letter from the NGA arrived. It read "The National Genetic Authority is pleased to confirm a procreative match for Mr. Aaron Smith. Attached please find a photograph, genetic map and personal qualities of your designated partner." Aaron is going to get married, and what a perfect match she is! Of course, it goes without saying that a 92% genetic counter-match will satisfy all you seek in the opposite sex.

April 2nd 2340

Aaron's stem cells have just been extracted from a bone marrow sample this morning and are now being transferred to an incubator where 'Organ U56' will be grown. As Aaron gets home from the clinic he kisses his beautiful wife and rubs her extended abdomen, ecstatic at the thought of his child growing in there.

May 28th 2340

Now 3 months pregnant, Aaron's wife is feeling the strain, and eagerly waits as Organ U56 is transplanted into Aaron.

June 5th 2340

Aaron has recovered from the implantation of his custom grown 'Uterus number 56' and is now tremendously excited at the thought of the responsibility he is being entrusted with, now that he is about to receive his unborn child within him. His wife – relieved at the reduced weight and stretch-marks – looks proudly at Aaron lying in recovery with a huge belly under the sheets.

July 5th 2340

Aaron wears his extended belly with even more pride than the 'I Love Beer' t-shirt that he was so fond of wearing a few years ago. After following the battle for gender equality whilst growing up, Aaron is one of the first males to express their new-found rights here in Malta.

Aug 28th 2340

The yellowish sac-like shell produced by all recent fetuses encoded with the appropriate gene has been removed from Aaron and sent to the compulsory incubator where the growing child will be monitored, given appropriate nutrition and vaccines for all possible illnesses. The baby is kept there

for an additional four months and the 10-month- old is sent to his parents, healthy enough to face the world of antibiotic-resistant pathogens and fluctuating climates.

Dec 30th 2340

Finally the one- month- old baby boy arrives on his parents' doorstep, swathed in a bundle of lines and delivered by the traditional jet, Stork. The sun sparkles off the titanium wings of the jet as it rises away from Aaron and his baby boy. Aaron's wife reads the attached certificate. It says:

"Offspring No. 6684240.
Hair: Light Brown,
Eyes: Deep Blue,
IQ: 147
Other: Artistic talent no. 247 – water-colour and oil on canvas."

Aaron looks at his son with the widest smile of joy and tells his wife, 'I think we made the right choices honey; it was well worth the extra money for these beautiful blue eyes. They are a rare luxury indeed.'

Wow, what a future indeed! Medics are being replaced by something that resembles a telephone booth more than a human being. When Aaron broke his clavicle all that his mother did was press a few buttons and, hey presto, his clavicle was repaired and healed with no major consequences. Talk about being instantaneous!

What we are talking about is not a dream, and even if CASPAR (Computer Assisted Surgical Planning and Robotics) is still in its infancy it is already proving its point. Today systems like NeuroMate™ and ROBODOC™ make surgery as precise as possible and allow for very small incisions. Not only do they provide consistent quality, but repetitive motions can be carried out without fatigue.

Unfortunately, at the moment there are some points to consider with a Utilitarian attitude, in order to consider whether these systems are of an overall advantage to both patient and hospital. These machines are currently pretty expensive and global costs will most definitely sky-rocket. Not only that, but operation time is increased, thus decreasing the amount of patients that can be operated on a particular day, which would in turn increase hospital costs.

"Today systems like NeuroMate™ and ROBODOC™ make surgery as precise as possible..."

In the future we may see the surgeon as a pure technician. But will abolishing the doctor-patient relationship, pre-/post-operative assessment and care be of overall benefit to the patient? Physically this would seem the case, but what about psychological trauma? No machine or drug can fully replace man in this matter. Human beings have innate social mechanisms like pro-social behaviour (altruism, empathy and even norms) that help in psychological healing and such mechanisms cannot be effectively duplicated by any machine whatsoever, unless the machine itself contains the appropriate pattern of values to be considered a human being.

Medicine may not be all that beautiful in the future. Society-classified gene defects that run in your genetic code that you could have easily concealed or you were not even aware of in the first place can become more public. Employers are always conscious about the money that they invest in their employees, therefore knowing the employees' genetic code will be of great advantage to them. Lying in your interview will definitely not help you in this case because before meeting your interviewers you would have been already screened and classified about certain aspects of your life such as behaviour, life span and susceptibility to diseases. Insurers would probably take a similar stance and you may find that your insurance premium is four times greater than that of your neighbour. Talk about being non discriminatory! Such technological advances open the floor for immense ethical debate regarding patients' rights and data protection.

Your DNA will become more transparent both to yourself and others. People, seeing that they can avoid risks in the personal decisions of their life, will try to use this information for their own benefit. With an insatiable appetite to play god, we will be able to choose our partners, like Aaron did with his wife, by using a computer (which would never make mistakes like HAL in Stanley Kubrick's film 2001: Space Odyssey) making the best choice for us in light of our genes and other calculated risks.

As they play god, humans are very careful that every factor is taken into consideration so that things always go as 'planned'. Their 'planning' may indeed involve selfish desires, including the ability to choose the characteristics of their children in the same way that they order food from a menu. This would invariably lead to what some might call Gene Cleansing since certain genes will be selected against over time. To some, this may seem to be a very advanced form of artificial selection. However it is still a potential option that medicine could offer in the future.

It is without doubt that technology will play an important role in the future of medicine. The patient, who is the central pivot in health care, will be the one to benefit most since, not only will he receive outstanding treatment, but also an increase in the range of life-changing decisions. The options will not only affect the decision-maker, but also the predestination of future generations.

The future's bright. Or is it?

FUN PAGES

Did you know?

The human heart creates enough pressure when it pumps out to the body to squirt blood 30 feet.

The strongest muscle in the body is the tongue.

Women blink nearly twice as much as men.

It's physically impossible for you to lick your elbow.

Our eyes are always the same size from birth, but our nose and ears never stop growing.

Almost everyone who reads this will try to lick their elbow.

ere's the final word on nutrition and health. It's a relief to know the truth after all those conflicting medical studies.
The Japanese eat very little fat and suffer fewer heart attacks than the British or Americans.
The Mexicans eat a lot of fat and suffer fewer heart attacks than the British or Americans.
The Japanese drink very little red wine and suffer fewer heart attacks than the British or Americans
The Italians drink excessive amounts of red wine and suffer fewer heart attacks than the British or Americans.
The Germans drink a lot of beers and eat lots of sausages and fats and suffer fewer heart attacks than the British or Americans.
ONCLUSION Eat and drink what you like. Speaking English is apparently what kills you.

Why?!

Ever wondered.....why women can't put on mascara with heir mouth closed?

Ever wondered.....why doctors call what they do "practice"?

Ever wondered.....why they sterilize the needle for lethal njections?

On Boot's Children Cough Medicine: "Do not drive a car or operate machinery after taking this medication."

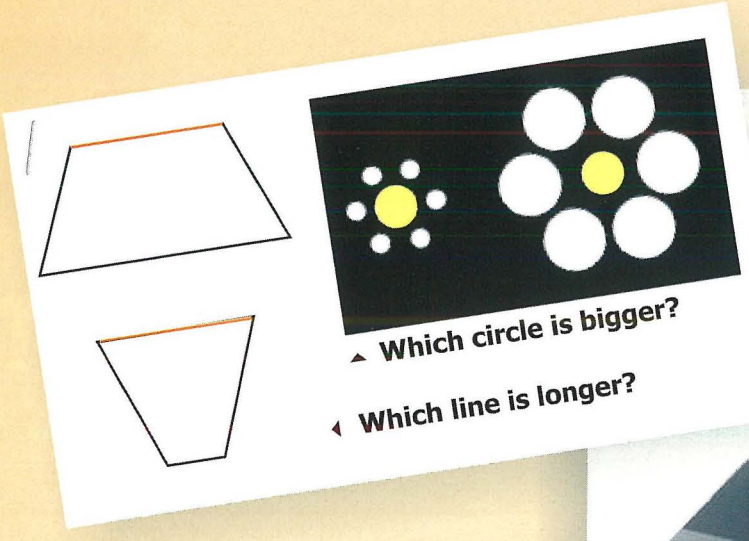
On Nytol Sleep Aid: "Warning: May cause drowsiness"

"Nurse, get on the internet, go to SURGERY.COM, scroll down and click on the 'Are you totally lost?' icon."

AAAARGH!!!

A student was asked to interpret an ECG in front of a patient, and diagnosed ST depression. He was quickly interrupted by a shocked patient who exclaimed in dismay: "Dott, minbarra l-problema ta' qalbi ghandi depression ukoll?!?" ("Doctor, apart from my heart problem am I also suffering from depression?!?")

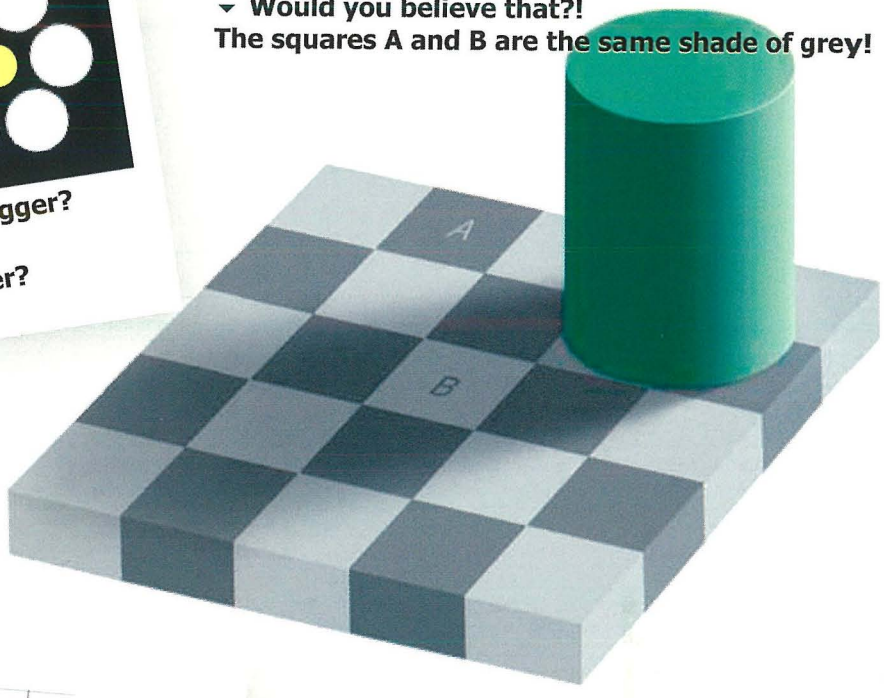
#2



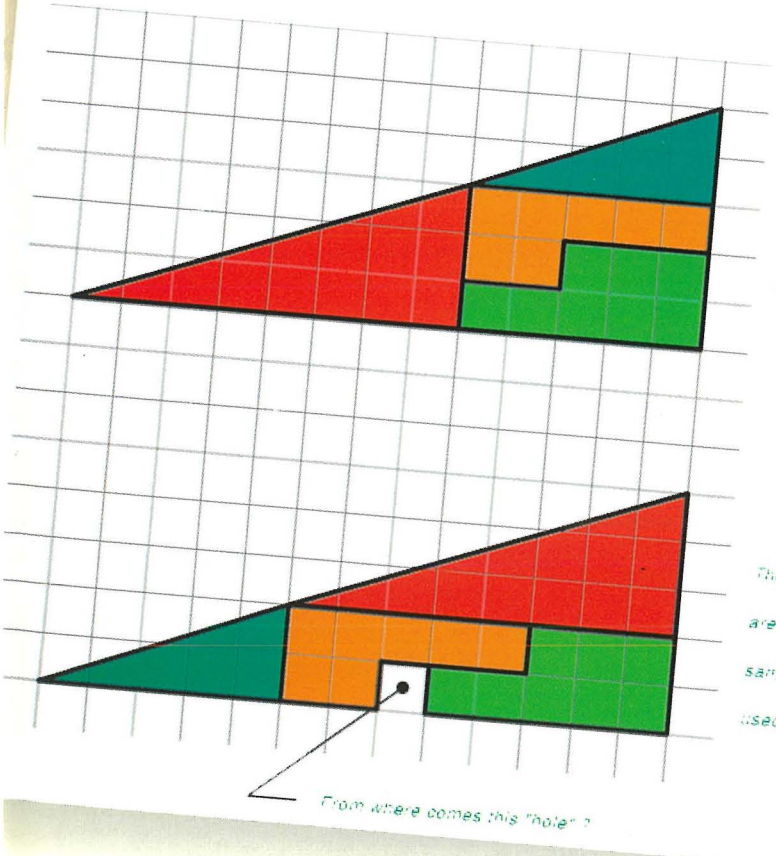
▲ Which circle is bigger?

◀ Which line is longer?

▼ Would you believe that?!
The squares A and B are the same shade of grey!



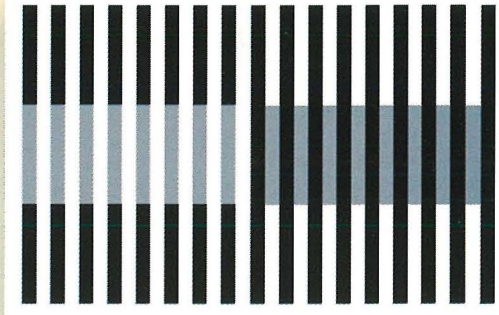
HOW CAN THIS BE TRUE ?



Below the four parts are moved around

From where comes this "hole" ?

The short grey lines are the same colour ▼



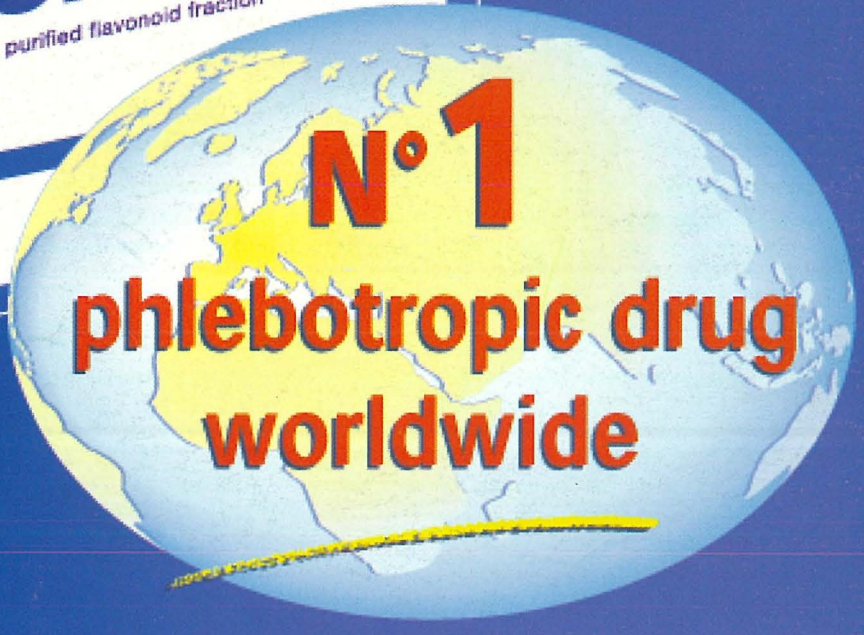
I cdnuolt blveiee taht I cluod aulaclty uesdnatnrd waht I was rdanieg. The phaonmneal pweor of the hmuan mnid. Aoccdrnig to rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, the olny iprmoetnt tihng is taht the frist and lsat ltteer be in the rghit pclae. The rset can be a toatl mses and you can sitll raed it wouthit a porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe. Yaeh, and I awlyas thought slpeling was ipmorantt!

daflon® 500mg

Micronized, purified flavonoid fraction

Micronized

A micronized form
and a comprehensive mode of action
for a better clinical efficacy



Chronic venous insufficiency

2 tablets daily

Hemorrhoidal disease

up to 6 tablets daily

Presentation and composition: Micronized, purified flavonoid fraction 500 mg: diosmin 450 mg; hesperidin 50 mg. **Therapeutic properties:** Vascular protector and venotonic. Daflon 500 mg acts on the retum'vascular system: it reduces venous distensibility and venous stasis; in the microcirculation, it normalizes capillary permeability and reinforces capillary resistance. **Therapeutic indications:** Treatment of organic and idiopathic chronic venous insufficiency of the lower limbs with the following symptoms: heavy legs; pain; nocturnal cramps. Treatment of hemorrhoids and acute hemorrhoidal attacks. **Side effects:** Some cases of minor gastrointestinal and autonomic disorders have been reported, but these never required cessation of treatment. **Drug interactions:** None. **Precautions:** *Pregnancy:* experimental studies in animals have not demonstrated any teratogenic effects, and no harmful effects have been reported in man to date. *Lactation:* in the absence of data concerning the diffusion into breast milk, breast-feeding is not recommended during treatment. **Contraindications:** None. **Dosage and administration:** *In venous disease:* 2 tablets daily. *In acute hemorrhoidal attacks:* the dosage can be increased to up to 6 tablets daily. *As prescribing information may vary from country to country, please refer to the complete data sheet supplied in your country.*

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