Murmurg

An MMSA publication

Here today, gone tomorrow: Is this the best step forward?

Consultants' Interview

issue 15

Diabetes in Malta: MMSA dishes the facts

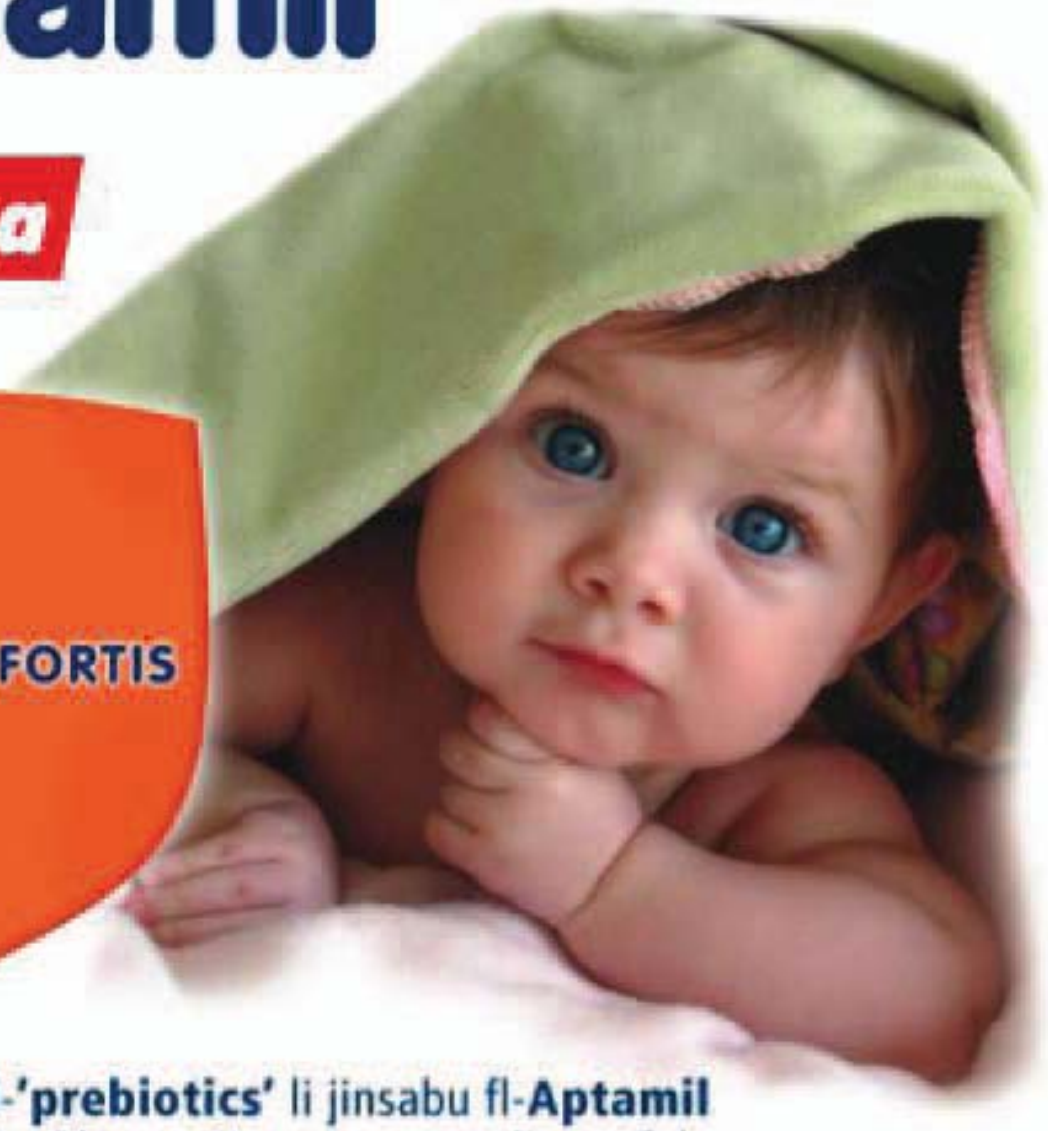
Mater Dei: What's changed?

...And more!

Reżistenza kontra l-mard fit-tfal

Aptamil

milupa



IMMUNOFORTIS

Il-**'prebiotics'** li jinsabu fl-**Aptamil**
isaħħu r-reżistenza naturali tat-tfal
kontra l-mard komuni

Murmur 2008 is the official publication of the Malta Medical Students' Association (MMSA) and is distributed free of charge.

MMSA contact details
Address:
Malta Medical Students' Association (MMSA)
University of Malta - Medical School
Block A, Level 0,
Mater Dei Hospital,
Tal-Qroqq,
Msida MSD2090
MALTA
Email: info@mmsa.org.mt
Website: http://www.mmsa.org.mt

Letters the editor should be addressed to "The Editor" and mailed to the MMSA. Alternatively, any comments can be emailed to the editor at: **murmur@mmsa.org.mt**.

Papier plus Studio

Contents

The page turns yet again...

Claire Vella - Editor

It's an honour to write the fifteenth editorial for Murmur – this magazine remains such a vital reflection of our organization's work. This birthday issue of *Murmur* was planned to be a celebration of MMSA's past, present, and future. On page 34, you will find a brief history of this magazine. As for the present – we discuss the move to Mater Dei on page 29 and the delicious ironies of medical student life on page 23; and the photo pages starting from page 16 are full of snapshots of MMSA's work during this last year. Our uncertain futures are also the topic of conversation on our article on page 25.

It is our future as medical students and future doctors which is probably the most interesting issue to contemplate. This past year has been one of monumental importance for MMSA as an organisation and for medical students on a personal level. We are at the doorstep of tremendous change, and it has already begun with our move to Mater Dei, the possibility of new medical schools, and with the ever-increasing amount of Maltese doctors leaving our shores. Whether we like it or not, the realities of being a medical student today are not what they were ten years ago, and whether this difference is for the better or worse... Well, that's up to each one of us to decide!

It is in the face of this change that MMSA must seek to remain united and must strive to better itself as an organisation. I firmly believe that MMSA has such a brilliant reputation on campus not because of the multitude of activities it organizes – even though they play a very important part. Rather, MMSA is what it is because of its members' co-operation, creativity, and sheer drive. We are a tight-knit community, and this is why we have such a unique identity. The times are a-changin', Bob Dylan sang, and it's essential that we embrace the change while retaining the spirit that makes us such a dynamic organisation.

On a lighter note, I would like to take this opportunity to thank anyone and everyone who helped out in the making of *Murmur*. It's been hard work, but completely worth it... I hope you find this magazine a good read!

The Murmur 2008 Editorial Team

Editor: Claire Vella
Article Co-ordinator: Ada Gatt
Cover artwork: Colin Mizzi
Design and layout: Claire Vella
Marketing: Integrated Marketing Services Ltd. and Andrew Busuttil.

The Editorial team would like to thank all the writers and sponsors who made this publication a possibility, as well as everyone who generously contributed photos and artwork. Specal thanks also go out to the MMSA Executive Board for their unfailing support. We would also like to thank Julian Sammut Alessi for the sketch of Mater Dei on page 31 and Matthew Urpani for his comic on page 24.

Message from the President

Matthew Borg - MMSA President 07/08

Once you become a medical student, whether you like to admit it or not, your life really changes. You need to study more, read more, party more, and just when you have that free morning, you join in one of MMSA's activities: sitting in Bieb il Belt taking people's blood pressure, setting up for a party, chalking the quad, or just sitting for endless hours in front of your laptop preparing this year's edition of *Murmur*.

You become medically-oriented, and this is why we form part of such a successful student organisation. We enjoy helping other people, and this is essentially what being a good doctor is all about. MMSA offers a wide choice of activities: helping other medical students through SCOME, other university students through SCORA (and obviously Leisure), the general public through SCOPH, refugees through SCORP.... We manage to reach out to a diverse number of people.

So a big thank you is now in place to all those who help MMSA in any way. It is safe to say we just ended a very successful year for MMSA. Just one month after we got elected last March, we compiled MMSA's activity report for the year '06-'07, and as has happened in the past couple of years we placed first amongst all the other student organisations on campus. We're entering new times now, we're moving our office to Mater Dei, and this brings us much close to University campus, from where, as a University Organisation, we should be working.

We're coming closer to the end of our term, and wrapping up for quieter times. Just like Christmas Day: one family member spots your sphygmomanometer and in no time at all you've got a long queue of relatives, all wanting to be tested (and then heading off for a huge meal). We all need and look forward to a break. It's time for everyone to hit the books and then the beaches. It gives everyone time to unwind and relax, and take their minds off their studies and career and hopefully gear up for another successful year!

Attention MMSA Alumni!

Dear Fellow MMSA Alumni,

MMSA has lately been working to strengthen its connection with our alumni, with hopes of achieving the goal of making your connection with MMSA a lifelong one that will be mutually beneficial.

We believe that what you have collectively accomplished during your past terms on Executive Board is in large measure responsible for the ever-growing tradition, and universal reputation of MMSA as one of the strongest student associations on campus. For this reason we value your opinions and advice. This has lead to our decision to create an official alumni community.

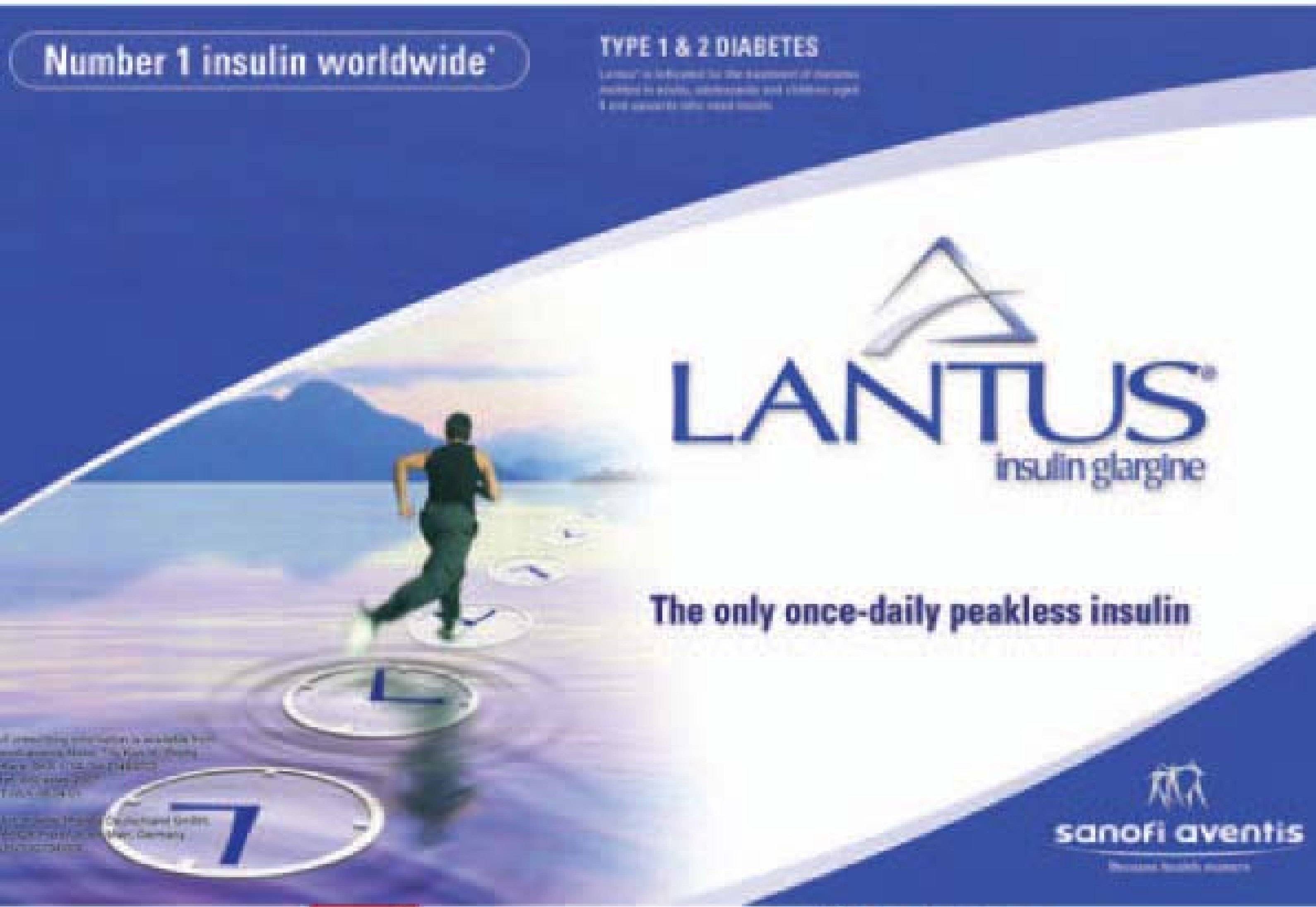
If you are interested, please send an email to **alumni@mmsa.org.mt** and help us form our Alumni Community.

We really appreciate your support towards this new venture, and look forward to being in contact with all of you.

Matthew Mercieca Balbi

Alumni Coordinator 2008-09
Malta Medical Students Association

alumni@mmsa.org.mt
www.mmsa.org.mt



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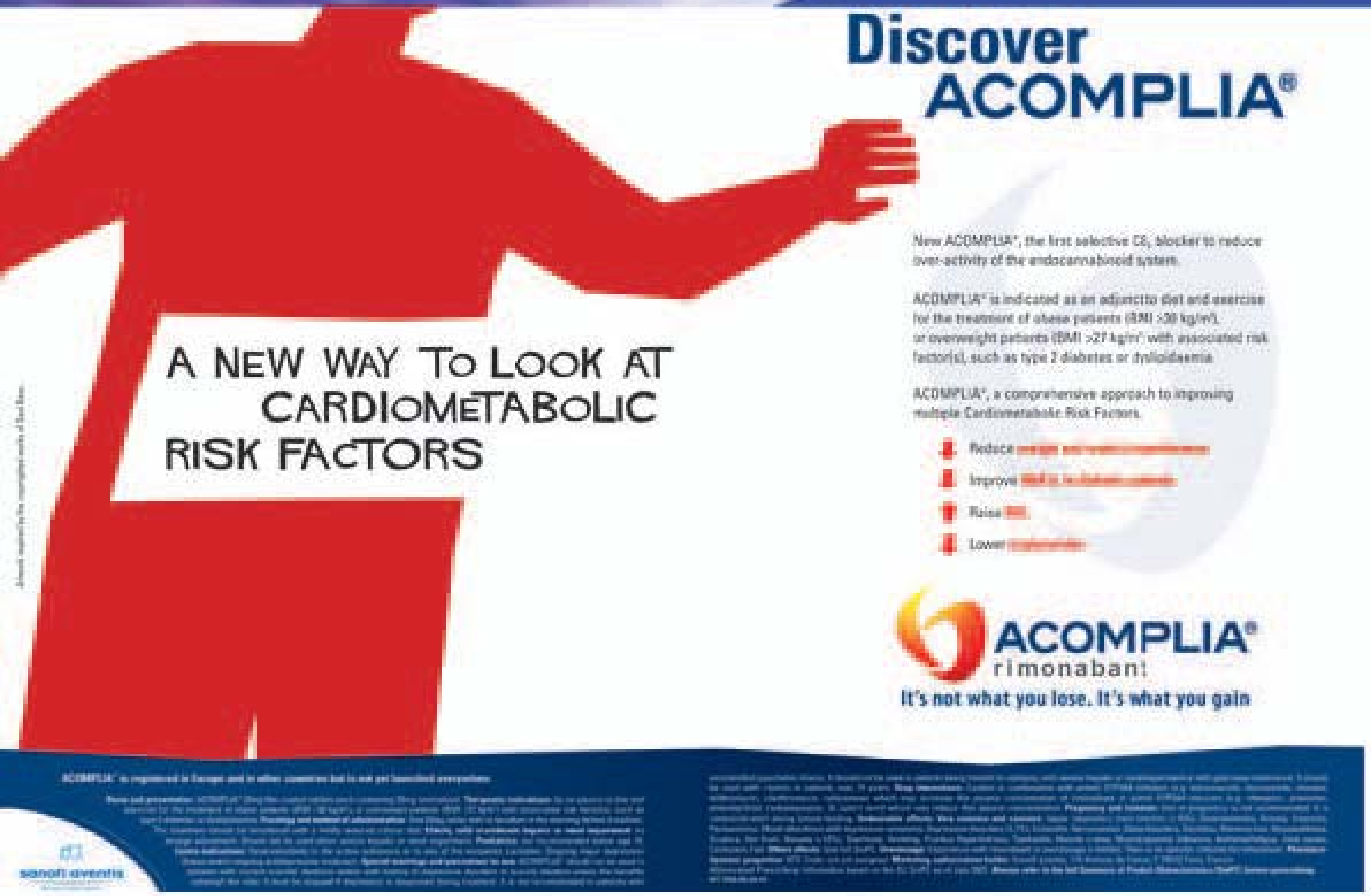

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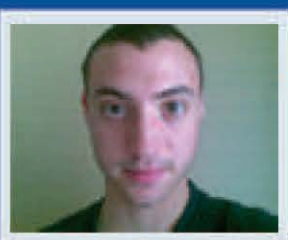
10% of Maltese people have diabetes. What is MMSA doing about this and what strategies can we use in the future to decrease this incidence? **Chris Giordimaina, on behalf of the SCOPH team,** discusses the data the organization gathered last year.



Chris Giordimaina

Diabetes in Malta: A Study by MMSA

In 2005, 10% of the Maltese population had Diabetes, 90% of which was Type 2. This is an alarmingly high figure, especially compared to the average of other European countries, which is put at being somewhere between 2% and 3% (2).

For several years now, the Malta Medical Student Association (MMSA) has been organizing an annual event to commemorate World Diabetes Day. The event takes place in Valletta, where passers-by are offered a free check of their blood glucose, blood pressure, and body mass index (BMI). However, apart from offering these services (as well as advising people on how to eat right and keep healthy), MMSA also keeps a record of the results which people get with regards to their blood glucose, blood pressure and BMI. This article will discuss this data (collected in 2007) and examine any trends visible.

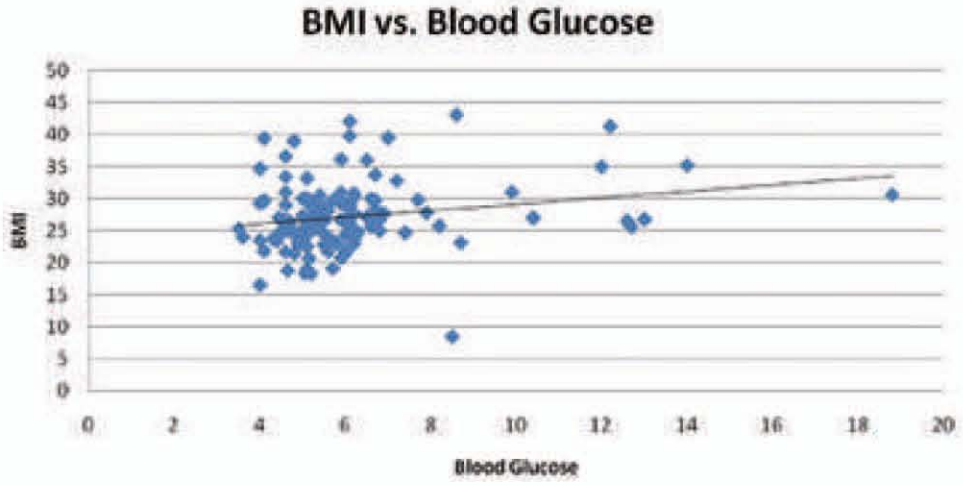


Fig 1 - A graph of BMI vs blood glucose (mmol/L)

Last year we had two opportunities to gather data. One was the opening of the Mater Dei hospital on Saturday 30th June and Sunday 1st July. The other was the World Diabetes Day held in November. For the purpose of this article (and since they were held so close together) they will be treated as one thing.

One of the clearest things you can notice from the data we've gathered is a positive correlation between BMI and blood glucose levels (Figure 1). This is roughly in concordance with other studies which have been published in the literature about this (1). It further reinforces the idea that the public must be encouraged to eat healthily and exercise regularly in order to maintain a healthy BMI.

Luckily enough, our averages (Table 1) show that overall the Maltese population has very good values for blood glucose, blood pressure and BMI. It is noteworthy however, that Maltese men have significantly higher blood glucose on average than their female counterparts. This might be indicative of a tendency of Maltese men to overindulge in food while under-indulging in exercise.

It is important to note that from the data collected, the average age of the people who stopped for the check was 55.2. This could indicate that it is mainly this age group >>

Average	Male	Female
Age (years)	55.1	53.6
Blood Glucose (mmol/L)	6.4	5.9
Systolic blood pressure (mmHg)	134.4	130.3
Diastolic blood pressure (mmHg)	81.6	81.5
Body Mass Index	26.3	26.8

Table 1 - The average blood glucose, blood pressure, and BMI recorded during the Mater Dei opening and WDD 2007

which shows the highest interest in their health. It is therefore a good initiative which SCOPH has taken this year to begin health and nutrition talks in schools, and it is strongly recommended that the importance of regular checkups (even in the young) be stressed during these talks.

Another important thing to keep in mind is that these tests were performed by medical students, the majority of which were pre-clinical (38 preclinical students as opposed to 34 clinical during WDD). This could lead to the results (particularly blood pressure reading, which is the reading which requires the most skill to take) being somewhat inaccurate, as the first and second year students might not have the clinical experience required to perform these tests correctly. That said, it is worth mentioning that MMSA holds an annual Training and Resource Development seminar where its members are taught, among other things, the skills necessary to gather accurate data.

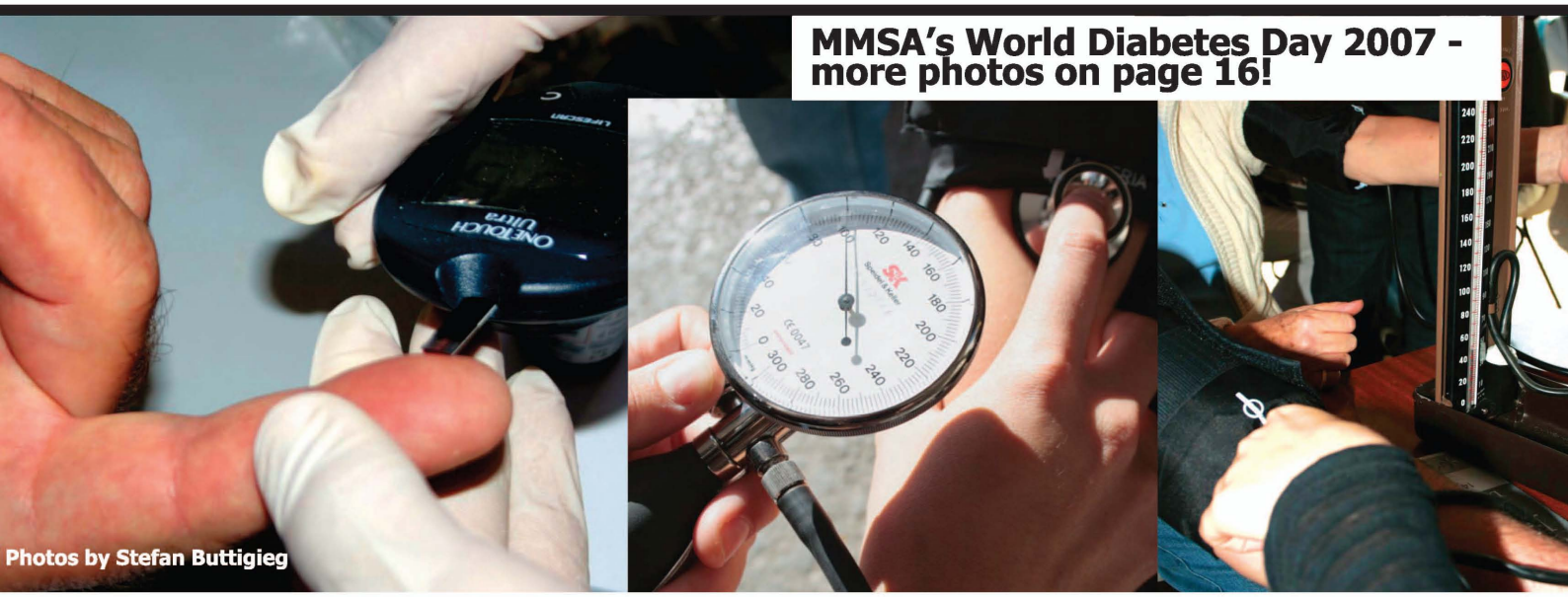
Note that even though certain factors were not taken into account when collecting this data (such as the time of the last meal eaten, etc), the sample size (841 people) is large enough to eliminate these problems.

It is recommended that in future World Diabetes Day events organized by MMSA, the diabetic incidence should be recorded. This will not serve only to give an indication of the incidence of diabetes in the Maltese population (other, more accurate studies using clinical data are available for this), but it will help put the obtained results into perspective.

The data collected by MMSA is vaster than that given here. This year, there are plans to organize this data properly and make it available to members on the MMSA website. Once the data is properly sorted it will be possible to examine trends of blood glucose, blood pressure and BMI over the past 8 years to give us an indication of where blood glucose, blood pressure, BMI and ultimately Diabetes is going in our country.

References:

1. H E Bays, R H Chapman, and S Grandy The relationship of body mass index to diabetes mellitus, hypertension and dyslipidaemia: comparison of data from two national surveys. Int J Clin Pract. 2007 May 1; 61(5): 737–747.
2. WHO Regional Office for Europe, Highlights on Health in Malta. 2005 [updated 2004 October 28]. http://www.euro.who.int/document/e72500.pdf



MMSA's World Diabetes Day 2007 - more photos on page 16!

Photos by Stefan Buttigieg

Andrew Busuttil

Paul Cacciottolo

FROM THE *Heart*

Prior to 1995 not much was done with regards to cardiac services, apart from the monthly visit by foreign consultants to operate or see patients. All this changed, to our present situation, where only the patients with rarer conditions are sent abroad, much like in other specialities. The start of the cardiac services department, and its transformation to what we have today - an efficient, hardworking team of people offering the Maltese population excellent service - turned the old system upside-down.

Every year Murmur picks a consultant, or two, to interview.

This year Professor Albert Fenech and Mr Alex Manchè were chosen. Together, they have set up the cardiac services department and have, in about ten years, converted this from its inception to one of the top centres for cardiology in Europe.

This is what they had to say about Murmur's questions.

Professor Albert Fenech

Why did you return to Malta?

I returned permanently in 1995, but I started coming as a visiting consultant in 1988. There used to be 4 cardiologists who would come over for a week at a time, four times a year, do interventional cases, at first diagnostic but then therapeutic.

What differences did you encounter?

The biggest challenge was that there was no resident cardiosurgical or invasive cardiology team on the island, which meant that acute emergencies had to be handled medically, and one had to wait for either the patient to get better, for the team to come or to be transferred abroad. Sadly, some patients didn't make it because there weren't the facilities available. That was one of the main reasons we set up the unit: it felt awful that patients would only get interventional treatment 8 weeks in the year.

And challenges?

St. Luke's wasn't designed for cardiology or cardiac surgery. We had to shoehorn the service into what we had there. We modified the old Angio Suite facilities – modernized it and digitalized it, but mostly we had people who were keen to work in cardiology, keen to specialise.

What did you start out to do originally with regards to cardiac services?

My brief was to introduce the interventional service. There were 5 doctors practicing cardiology prior to the set up, and they were running the non-invasive procedures really well. However, unless you have the interventional side it kind of limits your capabilities. We needed to set up the interventional service as well as the cardiac surgery side – one without the other is like a boat with only one oar!

Where do you see it going?

We planned Mater Dei with the future in mind; a hospital to accommodate our needs for 50 years. We have the facilities but we don't have the staff for them yet, though hopefully that will resolve itself within the next year. We still don't have a dedicated cardiac theatre, or a standby theatre. We also need doctors; we need more cardiologists on the island. We hope to have a cardiology service that just takes in and assesses the cardiology cases to take a load off the general medical side.

Do you see any pros or cons to working here?

One used to have to go abroad to specialise in a subject. Going abroad is a good thing because you get to work with different teams and get fresh ideas, but in terms of actual clinical experience, everything you need can be gained over here. The cons were the salaries. People were not motivated to stay here because the salaries were abysmal. Now with the new deal, things may improve. We also need to address this stupid retirement issue: retiring at 61 is a waste of resources. It's also an obscenity that one's pension is capped unless you're an MP. I happen to think that doctors actually do a more useful job to the country, but that is a contentious issue [he grins].

How does being in the public eye affect you and your work?

Cardiology is different from most other specialities in that most of our patients are awake, and also because heart disease ranks high in anxiety levels of people. Being in the public eye is a good thing because I can reassure people they're coming into a good unit, resolving anxiety in a disease process were anxiety itself determines the outcome. Doctors should be in the public eye – it's a bad move for the medical profession to consider strike action as that immediately takes away any esteem for the professionals. There's a lot that can be done with arbitration instead. Plus in Malta it's much easier: Malta's a small place!

Any comments on the teamwork you see in the cardiac service?

I think this is the same old story about the chain which is as strong as the weakest link. Unless you have teamwork and the concept of aiming for the same results together, it's pointless having first class staff if people aren't pulling on the same rope. It shows in the attitude to work and the results. Work constitutes a third of your life and if you're not happy, it causes problems.

"One thing that saddens me about the way the profession is going is that we tend to see less vocation and more business."

What influenced your decisions when it came to choosing to take up medicine as a career and eventually the speciality of

Profs. Fenech in the billboard campaign at the time of the MDH opening

cardiology?

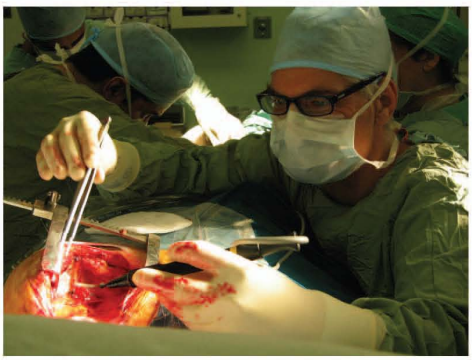
My father was a doctor; one of those doctors that they don't make any more. He was one of the pillars of the village – taking part in village life which involved much more than medicine. That's the Marcus Wellby type of GP I always wanted to be in spite of resistance from my parents. They tried to dissuade me, but I always wanted to become a doctor. I was always into mechanics as a youth, so I guess the heart was just the next thing to challenge.

Student days are meant to be the best time of your life. What's the first thing that comes to mind when one asks you to recall your student days?

You get permanent friendships: even though you don't see people for decades afterwards, when you do meet up it's like you've not lost contact. People in medicine tend to become divested of their sense in medicine tend to become divested of their sense of humour: you can't do that with people in your own year. They were excellent times – I had colleagues who had the same sense of fun – our year was the liveliest one. You guys don't sleep in as medical students; that was a great learning and social experience. They are the days when the only responsibility you had was to your family and yourself.

What do you think about the current batch of medical students? Any advice or tips for them?

One thing that saddens me about the way the profession is going is that we tend to see less vocation and more business: I get very sad when people look upon medicine as a source of making good money. Don't ever lose your humanity, your humour and your dedication. Those are the three things that keep you going when the going gets tough, and it gets tough often in medicine.



Mr. Alex Manche'

Why did you return to Malta?, what were the differences and challenges?

I returned to Malta because my mentor and teacher, Professor Frederick Fenech, encouraged me to do so. I was also getting disillusioned with the way the NHS in England was evolving.

In 1995 there was no regular cardiac surgery program in Malta and the challenge to establish one was beckoning. We had to train personnel, equip our unit and convince health care workers and Maltese patients that we could deliver. I feel we got on to a good start, with 300 cases under our belt in the first year. The main difference was less beaurocracy and more clinical freedom.

What did you start out to do originally with regards to cardiac services? Where do you see it going?

My goal was to provide a safe and comprehensive service to our local population, thereby avoiding the need for Maltese patients having to travel abroad at times of crisis. Over 13 years I have seen the service grow and become more comprehensive and as a consequence I fear that we may encounter some of the problems I left behind in the NHS.

What are the pros and cons of working here in Malta?

The pros of working in Malta centre around being able to provide a personal service to my patients. The cons are that my private life is encroached upon and it is difficult to switch off at any time.

How does being in the public eye affect you

and your work, especially when it comes to operating on personalities? What lies ahead for cardiothoracic surgeons?

I avoid being in the public eye as much as possible but one has to strike a balance when it comes to health education. The media is a powerful tool and doctors should use it to get their message across. Operating on personalities is not as difficult as operating on risky patients. The future is not rosy for cardiothoracic surgeons. We are treating an older and sicker population and a significant proportion of our straightforward work is being taken over by advances in cardiology.

What influenced your decisions when it came to choosing to take up medicine as a career and eventually the speciality your are in?

I was born into a medical family and always wanted to become a doctor. I chose my specialty the minute I walked into a cardiac operating theatre, early on in my post-graduate training. I was absolutely fascinated by the procedure and decided there and then that cardiac surgery was for me. I have no regrets

Team work: any comments? What about working together with Prof. Fenech?

Team work is absolutely essential for things to go smoothly. When teams are large it can take a lot of effort on my part to get things moving the way I would like them to. Working with my friend and colleague Professor Albert Fenech is a joy. We are like-minded and have the same goals. I consider myself very lucky.

Student days are meant to be the best time, what's the first thing that comes to mind when one asks you to recall your student days?

Rag day and our encounters with the law students. The trips we took to Gozo after our anatomy finals. Relaxing with student friends over a bottle or two or beer and trying, unsuccessfully, to seduce the opposite sex at the discotheques! And, on a more somber note, our difficulties in 1977 when we had to adjust to our new medical schools in the UK.

"I think very highly of the current batch of medical students. They are hard working, smart, and have many challenges ahead."

What do you think about the current batch of medical students? Any advice or tips for them?

I think very highly of the current batch of medical students. They are hard working, smart, and have many challenges ahead. My advice is never to be a doctor for the wrong reasons, always put the patient first and foremost, and enjoy your work. It is a most rewarding career.

Being a patient is often a difficult experience, as an anonymous medical student who experienced an eye-opening role reversal will attest. **Marquita Camilleri** discusses this case, which begs the question: does patient care go beyond plain science?

Marquita Camilleri

The Patient Orient Express

The Other Side of the Coin

"Suspected DKA- you must be admitted to hospital in less than an hour" the doctor at the Health Centre told me whilst putting the tourniquet round my arm and establishing an IV line. Before I even had time to think, the ambulance picked me up and we left for St. Luke's Hospital.

As soon as I arrived at casualty, I was wheeled into a cubicle, where the question everyone asked me was, "How long have you been a diabetic?" I always answered, "Apparently from now!" Routine tests were carried out, while I lay on the couch drinking enormous amounts of water and answering all the questions to build a history.

HGT's, ABG's, ECG, CXR, urine tests and other blood tests were all done while in casualty. Different drips were changed and I was given some insulin. After 6 to 8 hours I was taken up to a ward, to a bed in the middle of the corridor. I was not allowed to eat before other tests were done. More ABG's were done, one of them at 11.30pm. I was tired, hungry, in the middle of a cold corridor, with ice on my wrists to decrease the tenderness after 5/6 trials for ABG's! At moments I cried, alone, because it happened so fast; I knew my life would change!

The night passed- I was still tired after being woken up every 2 hours for HGT, BP and fever check. I was discharged in the afternoon with a metformin tablet prescription. Unfortunately, I was re-admitted to casualty in less than 5 hours because my glucose levels were sky-high again.

This time I barely I had the strength to move – I couldn't even get on and off the couch unassisted. I was upset at the way things had turned out – I couldn't stop crying. I was almost hyperventilating, had a splitting headache and crippling weakness.

I was also obliged by an SHO to do another CXR before being taken up to the ward again. Hours passed and some blood results did not arrive. One of the kindlier doctors taking care of my case went to the lab himself to track down the missing results only to be informed that they had been lost!

It was about one in the morning when I was again in the corridor of the ward; with an insulin pump and a still dripping IV. In the morning my doctors confirmed I was an IDD- insulin-dependent diabetic. In the following days I was taught how to check my HGT and how to self-administer insulin.

The staff in my ward was great - especially the nurses and health care team! The teamwork I saw between them was incredible. Their attitude with the patients, their smiles and winks to everyone really made my stay there better! Every now and then they would come and ask if everything was all right. It wouldn't be fair of me to say that all the doctors needed to smile more instead of frown either, because many were quite nice.

We see patients from a blinkered perspective and the patient-doctor divide is simply too big. You have to be a patient to know what being a patient feels like and believe me, it is not a nice feeling. So please, friends in the medical profession, let us not act like gods! Our mission is to improve the quality of life around us and not to make patients' miserable lives worse!

Patients' lives can be improved, if we can see the other side of the coin and act with humanity!

- By an anonymous medical student

>>

I don't know whether this case would deserve to be aired in some reality TV show. All I know is that this isn't a coloured up story to keep readers hooked and entertained. This case is for real! The happenings were many. But (funnily enough) the subliminal message is one – and it's conveniently concentrated in the last two paragraphs above...

Oh no! Please spare me!

"We have to ask ourselves whether medicine is to remain a humanitarian and respected profession or a new but depersonalized science in the service of prolonging life rather than diminishing human suffering."

Elisabeth Kubler-Ross

"Medical training everywhere is increasingly demanding us medics... that our patients' problems go beyond the organic nature of their ailment"

Psychosocial medicine! Love it or hate it, you just cannot ignore it. Medical training everywhere is increasingly demanding us medics to appreciate that our patients' problems go beyond the organic nature of their ailment. Such facts are hammered upon the medical student quite early. Behavioural science weekends and other additional sessions teach us, even before we set our foot in hospital, the importance of maintaining a professional rapport with patients, upholding patients' dignity and respect their privacy.

Behavioural Science: Why Bother?!

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

Voltaire

Some of us simply love to hate this 'soft' and 'mushy' subject in our course because it seems to take us away from the 'real science' of medicine. And those who don't bear the same grudges might still have their own reservations regarding this module. Perhaps there's a need to analyse whether it's being taught effectively. Or maybe, the fact that all of us have experience in dealing with other people makes further study feel superfluous. As our social circles increased, we developed intuitive ways of interacting with others which may seem successful enough. We may even think that we are 'good with people'.

However, it is important to underpin good intuitive understanding with scientific knowledge from the social sciences. Nowadays, we're moving away from Sir William Osler's view on what the doctor's role is: "...to acquire facility in the art of diagnosis... to grow in clinical judgment... to appreciate the relative value of symptoms and the physical signs... to give to the patient and his friends a forecast or prognosis... [and] to conduct the treatment that the patient may be restored to health... or, failing that, be given the greatest possible measure of relief." (Osler, 1907)

This is because, as is very clearly evident even in the above case study, "the patient desires to be known as a human being, not merely to be recognized as the outer wrappings for a disease". (Lown, 1996) Hence, doctors are encouraged to treat patients more holistically. It might entail asking about the patient's emotional health or soliciting the patient's concerns and opinions through open-ended questions.

And for the cynical ones who believe that they don't have time for this mumbo jumbo... In a video-taped study of 171 office visits, doctors who

"Is it contagious, doctor?"

encouraged patients to talk about psychosocial issues such as family and job had more satisfied patients. And how much did it cost them? An average of just an extra two minutes! (Marvel et al., 1993)

But isn't that the job of the primary health care specialist?

"If I am to care for people in hospital I really must know every aspect of their treatment and to understand their suffering."

Princess Diana

Patient-centred care that embraces biopsychosocial and holistic models of healthcare is becoming increasingly evidence-based, especially when dealing with chronic illnesses such as diabetes. (Bauman et al., 2003) Medical literature insists that it should evolve to become part of the way we think, just as "evidence-based" thinking has now become now become commonplace. However, this change in medical practice demands well-developed interpersonal skills from practitioners everywhere; the reason being that patient-centred care rests on these three very important elements:

- Communication with patients
- Partnerships
- A focus beyond specific conditions, on health promotion and healthy lifestyles. (Little, 2001)

"Illness in the eyes of a professional is a disease process... But to the patient, illness is a disrupted life"

Patient-centred care is all about sharing the management of an illness between patient and doctor. But it can only be made possible when the illness is explained to patients, whilst also exploring their feelings, beliefs and expectations. (Stewart, 2001) This cognition, coupled with the patient's milieu and clinical guidelines, will influence how you'd want to treat the patient, whether you're a GP or a hospital doctor on the wards.

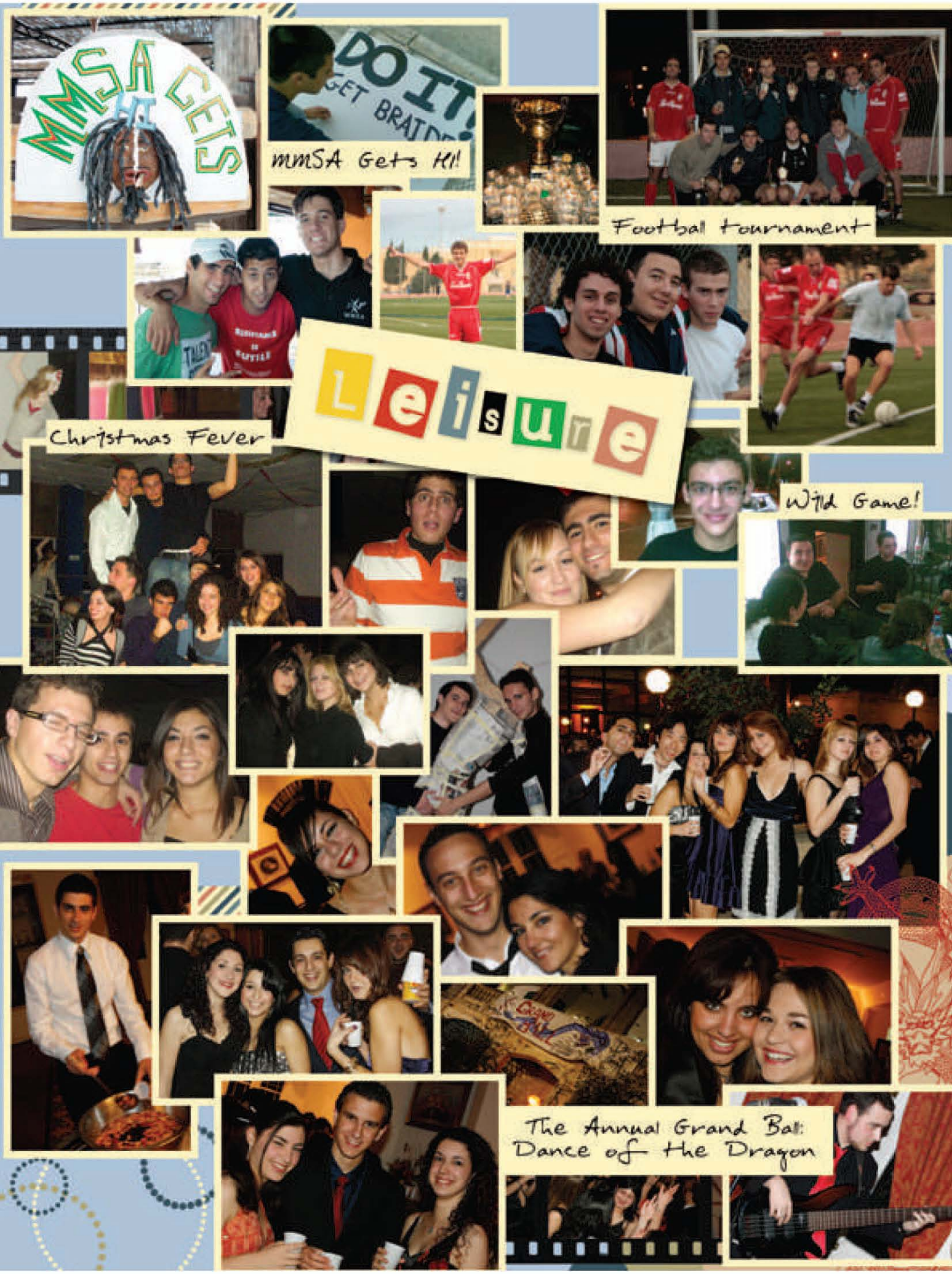
And, ultimately, this is what the patient really wants, wherever they may be seeing their doctor. Patients want good, professional healthcare that goes beyond having a one-star hotel for a hospital with MelitaMe and a first-class catering system. Patients want communicative and compassionate doctors that attend to the psychological and contextual determinants of their illness in addition to the biomedical aspects. (Farooqi, 2005) And this is to be expected. After all, illness in the eyes of the professional is a disease process that can be measured and understood through laboratory tests and clinical observations. But to the patient, illness is a disrupted life. (Seaman, 1999) Or, as extrapolated in the above story... "At moments I cried, alone, because it happened so fast; I knew my life would change!"

Patient centeredness may help put this disrupted life back in order. Many papers demonstrate that quality of life improves when making the patient feel more engaged in his/her management. (Bauman et al., 2003) And doctors are shown to be more satisfied on the job too! (Stewart, 2001)

Yet, there is a price you have to pay when embarking on the 'Patient-Orient Express'. Firstly, it certainly leaves no room for doctors to "act like gods!" Apart from the fact that solid teamwork is required for all this to be well conducted, the doctor should also accept the patient's unique knowledge as being just as important to outcome as the doctor's scientific knowledge (Rotter and Hall, 1992). A consultation should be seen as being a meeting between two experts. As this patient in this story says, "You have to be a patient to know what being a patient feels like". As much as being a patient will never be "a nice feeling", it's up to us see whether we want to make this experience better or worse than it actually is... As you extend your hand for that icebreaking handshake and say, "Hi! I'm the doctor on call, ready and at your service!"

(See page 22 for references)


Teddy Bear Hospital
SCOPH
Anti-smoking talks
WORLD DIABETES DAY
World Diabetes Day


MMSA GETS HI!
Football tournament
Leisure
Christmas Fever
Wild Game!
The Annual Grand Ball:
Dance of the Dragon

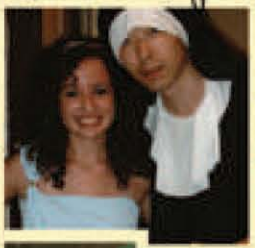
The Leisure sessions

The SCORP team >

Speed-dating with SCOPH

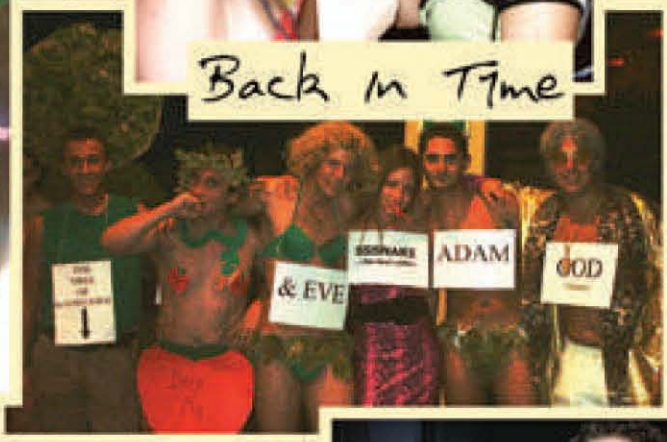
TRD

Opening ceremony



Back in Time

Life in Cartoon Motion




WORLD AIDS DAY
Piazza Cafe'
SCORA
World AIDS Day concert
SCORA sessions at TRD

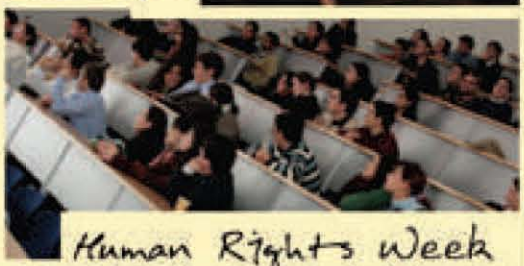
Freshers' Week

Buddies!

Freshers' Talk

SCOME

Careers Convention



Human Rights Week

Chalk the Quad!

SCORP

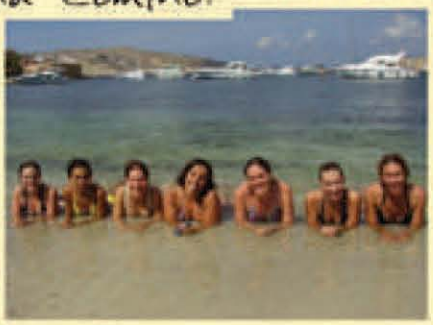
Exchanges

SCOPE/SCORE Fenkata

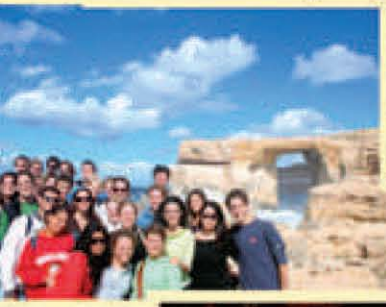
International Drinks Night

Out and about in Gozo...

...and Comino!

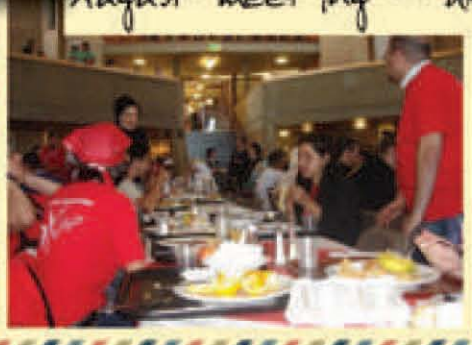


EMSA Twinning Project



IFMSA

August meeting – UK



MMSA AGM

Maritta, the Leisure Officer, takes a break by reading Sphygmo!

Mater Dei Opening

Many thanks to Daniel Azzopardi, Stefan Buttigieg, Chris Giordimaina, Paul Micallef, Darlene Muscat, and Francesca Theuma for kindly supplying the photos on these pages!!

References for "The Patient Orient Express" - page 13.

Bauman, A.E., Fardy, H.J. and Harris, P.G. (2003) Getting it right: why bother with patient-centred care? Medical Journal of Australia 179, 253–256.

Farooqi, J.H. (2005) Patient Expectation of General Practitioner Care. Middle East Journal of Family Medicine 3. http://www.mejfm.com/journal/July05/Patient-Expectations.htm

Little, P., Everitt H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K. and Payne, S. (2001) Preferences of patients for patient centred approach to consultation in primary care: observational study. British Medical Journal 322, 468-472.

Lown, B. (1996) Getting Doctors to Listen. In: The Lost Art of Healing. 1st Edition, Houghton Mifflin, New York, U.S.A, 313.

Marvel, M.K., Doherty, W.J. and Baird, M.A. (1993) Levels of physician involvement with psychosocial concerns of individual patients: a developmental model. Family Medicine 25, 337–342.

Osler W. (1907) In: Modern medicine: Its theory and practice. 1st Edition, Lea Brothers, Philadelphia, U.S.A, 34.

Rotter, D.L. and Hall J.A. (1992) The Significance of Talk In: Doctors Talking with Patients… Patients Talking with Doctors. 1st Edition, Auburn House, Westport, Connecticut, U.S.A, 12.

Seaman, B. (1999) Charting the doctor-patient relationship. The Spiral Notebook 1. http://www.spiralnotebook.org/chartingthedoctorpatientrelationship/index.html

Stewart, M. (2001) Towards a global definition of patient centred care – the patient should be the judge of patient centred care. British Medical Journal 322, 444-445.

When we enthusiastically signed up for our medical course, few of us really knew what we were going in for. **Pamela Miceli** wonders whether our expectations of our future careers are too unrealistic.

DR. COOL: Televised Division

Pamela Miceli

Forget biology. Goodbye chemistry. Admittance to medical school has just been taken up several notches. The primary qualifications for a medical student are film-star looks and disastrous interpersonal skills. Most of us can manage the latter but the majority of medical students haven't snogged the good-looks fairy (or a plastic surgeon's tools).

Ladies, how many surgeons have you noted with George Clooney's distinguished grey temples? Plenty. What about accessorized six-pack? Zilch? Zip? Nada?

Guys, how many colleagues could compete with Meredith Grey's dumb blonde good looks? Not many, huh? Or was that 'not any'?

R+R and other Myths

It seems to be an unwritten, but immutable, law of hospital life that the moment one stops for a meal or a cup of coffee, the pager is sure to ring. Not so in television land. Doctors indulge in regular gossip fests over an elegant espresso/decaf/mochachino in uninterrupted peace as patients considerately postpone having myocardial infarctions, choking or giving birth. They also find time to propose to their girlfriends in the middle of horrific disasters whilst carrying out primary surveys (Grey's Anatomy, Season 3).

"It seems to be an unwritten, but immutable, law of hospital life that the moment one stops for a meal or a cup of coffee, the pager is sure to ring."

Moreover, it is possible for those in a romantic relationship with a co-worker to de-stress with a bout of postprandial sex on a free ops table or empty closet. The 4th year classroom closet is free between 9-11am. Book a slot with a class rep at your earliest convenience to avoid disappointment.

M.R.C.T.V.

Studying is an urban myth. The ability to spout the details of obscure diseases is a gift distributed for free at the medical school door. Tape worm in your brain? ODed on cadmium-laced marijuana? Or did a rare fish swim up your penis and take up residence in your bladder when you thoughtlessly micturated in the Amazon river? No problem! Dr. House *et al* snap their fingers and trot out the correct management in a jiffy.

Textbooks have therefore become redundant. Happily alternative uses for those expensive, bulky guides to medical knowledge are currently being developed: try weightlifting with the Kumar, use the Lecture Notes series as bowling pins or turn Essential Surgery into a colourful doorstop. Oh! And the Oxford Handbooks make excellent paperweights.

Preparing for a post-grad exam, such as the M.R.C.S., has metamorphosed into a junk food orgy with optional tutoring by a qualified senior who is conveniently engaged to one of the students (Grey's Anatomy, Season 3). The boring bits, i.e. studying, have mysteriously apoptosed, atrophied or were abandoned on the editing room floor.

When the Patient is NOT your Textbook ...

Patients come complete with stories which range from fascinating to downright boring

>>

but irrespective of their (lack of) talent for storytelling must be listened to carefully as this provides 85% of clues for the diagnosis. Almost every chapter in our textbooks, irrespective of the speciality being considered, emphasises the importance of history taking. Examination of the patient provides 10% of the remainder.

Yet, Dr House, the patient pariah, prefers to avoid prodding, poking or merely talking to a patient. In fact, he practically never sees a patient unless forced to at the point of a gun or a lawsuit. His abrasive manner is possibly amusing in the original but in the Italian translation he comes across as an insufferable boor.

Social niceties aside, the most disturbing thing about him is his disregard for ethics. How about the time he took a suprapubic urine sample in order to test for AIP when the patient had repeatedly refused consent? Or when he blackmailed a colleague to operate on a terminally ill-patient with liver cancer and after the surgeon complied, snitched to the wife anyway? Primum non nocere flew out of the window and was run over by a ten-ton truck: like when he ordered the reversal of sedation of a patient with third degree burns although colleagues reminded him that it would be torture for the patient.

"Our generation has been characterized as 'paper doctors' because of our abuse of the magical pink investigation forms."

Investigations are given pride of place by scriptwriters with little understanding of the mantra: history, examination, investigation. The heroics seen on screen are alien to anyone with the slightest hospital experience: in episode 24, a circa 10 year old terminal cancer patient had a hypothermic MI induced so as to locate an embolus in her brain resulting from an (unrelated) second cardiac tumour. The phrase "House orders a battery of tests" is repeated ad nauseum in the episode recaps on the official website. Our generation has been characterized as "paper doctors" because of our abuse of the magical pink investigation forms. Perhaps Dr House should win another award: an Oscar for Paper Medicine.

Through the Looking Glass

Terrorism of juniors is as traditional as the white coat and stethoscope. Look at the way J.D. (Scrubs) is treated. His superior, Dr Cox takes excessive pleasure in deriding J.D. and justifies himself by claiming that this is the hospital equivalent of bodybuilding for a role in 300. Sounds familiar? Granted that J.D. is a particularly blond goldfish, however, the majority of MD students, while not always Nobel candidates, have at least normal IQ levels.

So why is there an over-abundant crop of bright eyed hopefuls every year? And why would most of us still go for this course (even if it drives us to the brink of despair) if given a second chance? Are we all secret masochists with a fetish for obese books and matching patients? If you can't answer this question, you've probably not paid enough attention in Behavioural Sciences.

Andrew Busuttil

Paul Cacciottolo

Home and Away

No-one is a medical student forever. It may seem like an obvious aphorism, but it is one which has been ignored by cohorts of medical students for a long time. Nowadays, however, all you hear in the breaks between ward-rounds and lectures is talk about job applications, the pros and cons of working in Malta or elsewhere, and other such chatter. Medical students, it seems, are finally waking up to realise that in a couple of years they're going to be part of a workforce.

For quite a while, the natural history of the average Maltese medic was to graduate from medical school straight into a 2-year stint as a local houseman. All students were guaranteed a post according to their ranking in exams, and by and large, everyone was catered for. The concept of post-graduate training was shady at best, as people sat for foreign exams on the strength of their clinical exposure on the job, and applied for posts higher up on the career ladder. The system wasn't perfect, but it seemed to work.

Cut to 2004, and we see Malta's entry into the European Union opening borders for workers, up to and including doctors. EU regulations mean that a degree obtained in any one of the 27 member states has some equivalency in the other 26, and fresh graduates find it much easier to apply for and get jobs abroad. Added to that, warrants granted by any other EU state are valid for practice in Malta, meaning that failure to complete the 'obligatory' 2-year housemanship no longer bars you from private practice locally.

Aside from the legal technicalities, Maltese graduates are becoming increasingly aware of the job situation in other countries, and can easily compare them with the package offered locally. Working conditions, post-graduate training and a social life all come into play. Traditionally, Maltese doctors have migrated to the UK (though far from exclusively), and this trend has increased exponentially over the past few years, simply because students and doctors are comparing like with like, and for the emigrants, abroad is better.

This year, Murmur has set out to look into the prospects of working in Malta compared with abroad, specifically the UK. Both offer a package with its pros and cons, but it is not within the scope of this article to say which of the two is the better offer. Students and doctors are still going to have to weigh up each situation, and make a decision based on where they would like their life to lead them. The take home lesson is that in order to make that decision, they need to be well-informed.

Read on...

Andrew Busuttil

The UK

The UK has long been the traditional emigration site for Maltese doctors, and at first glance, the opportunity to gain experience working in a foreign country seems an ideal one, but when one weighs everything, is It really worth it? Let us try and find out.

The first step is taking a look at the application process, as this is no walk in the park, and many applicants can go wrong here. Eligibility is the first phase of the application process, and this consists of submitting proof that you are a final year medical student or a graduated doctor. Time frames are strict and no concessions are made.

Next comes the actual application form, where one has to sit down and put some serious thought into filling out an online application form. The questions asked in the application change from year to year, but what is required from the applicant is to use experiences from his/her medical training to answer the questions. The style and type of English used is also taken into consideration. A score is awarded according to the answers and other criteria. 45% of this score is derived from the applicants' examination marks, with the full 45% being awarded to the students who are in the top 25% of their year. This decreases in groups of 25%.

Maltese students are at an advantage over other Europeans for a number of reasons, namely the fact that we are proficient in English and that our course is based on and verified by the British system. The behavioural sciences module, I'm told, is also sought after.

After the overall mark is awarded for the application, the next step is to choose the region or deanery where you wish to spend the next two years of your life. This also requires some planning as one must take into account accommodation, rotations available, and travel to and fro.

The final step, on receiving acceptance, is choosing the rotations within the deanery that one has been accepted into. A list of 150 rotations must be placed in order of preference and this is where the application form score comes into play, as one needs a very competitive score to be accepted into more sought-after rotations!

Once that is settled some deaneries require an interview and the usual pre-employment checks. The catch is that this has to be done while preparing for fifth year finals, whilst if planning on staying in Malta, none of this is needed.

The foundation program is not a stand-alone, it is merely the stepping stone to further post graduate training, which means that prospective applicants should consider long term plans.

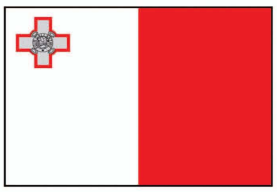
On the other hand, the post graduate training in the UK is a serious matter. Curriculum and syllabi have been devised for each course and these detailed documents go to show the level of effort being put into training. This helps too, as a quality assurance tool, as each trainee knows what is expected of him/her.

Working in the UK has its specific challenges. The first, and most obvious is that it is far away from home – and by the looks of things it will become the (when they open) in Malta will only be available to those who have completed the two-year house jobs. This means that in order to return to our shores, one must better have a certificate of completion of training (CCT) from the country overseas in order to have a decent practice.

In the UK, following the foundation program is more than just a house job. The foundation doctors are constantly assessed by their peers and their seniors. A log book of procedures, observed by the senior registrar needs to be completed, as well as exams at the end of the program. The mentality behind this is to prepare the young trainees for the specialist training posts, and with these assessments to help the young doctors to take a good look at themselves, and decide which line they are to follow.

Next come the trainee posts. These are hard sought after, and one doesn't simply inherit one following the foundation program. There is yet another round of application filling, interviews and crossed fingers, at each stage (ST1, 2, 3, and 4). The fact that a doctor has completed the foundation program seriously helps his chances of getting a training post. This is in stark contrast to those of us who choose to do our house jobs in Malta, where working comes as a well earned break from the books, and it's only after 18 months that the studying begins for membership examinations.

The transition from fifth year medical student to doctor is a dramatic one as it is, but the fact that this will also involve a move to a different country, and working in a different hospital would not help make things easier. Talk about being placed in the deep end!



Paul Cacciottolo:
Malta

For quite a while, pursuing a housemanship in Malta has been the natural choice for most Maltese graduates. Students by and large took it for granted that once they'd passed their exams, they had a job to go to a couple of weeks later. There was a natural chain of progression, whereby during the housemanship doctors would work to build up their CV, progress to SHO level, and then they'd 'see from there'. Does this mentality still hold today?

With foundation courses in the UK being far more available to local graduates than before, staying in Malta has become something of a conscious, active decision. It takes into account a variety of factors, including job satisfaction, career-progression opportunities and plenty more. As with most things, even the housemanship is vulnerable to 'the grass is greener on the other side' mentality. While it is true that a local housemanship has its pros too.

When starting off as a junior doctor in Malta, you're starting off in a place which is home territory. After 3 clinical years patrolling the wards as a medical student, the working environs, the staff and the local practices should all be familiar to you. Doctors at your level are people who you've studied and partied with for the past 5 years; the element of camaraderie is already there, and doesn't need building up from scratch. Malta is also where you've grown up, and family and friends are likely to still be around and within close reach. Living here is definitely an excellent choice. Working is a bit of a tougher one.

The package offered to junior doctors is becoming increasingly important in a market where it is not just the doctor who is fighting for the best job, but also the institutions fighting for the best doctors. Locally, the job situation for housemen is in dire straits. An increase in graduate and post-graduate medic emigration is leaving the remaining doctors with an increased workload. Medical firms (sometimes hosting over 25 patients) are being manned by a solitary houseman who has to deal with the paper- and bloodwork all on his own. Lack of staff thus puts a strain on the administration, which then expects remaining staff to take up the slack. Night duties have become more frequent, with the average houseman spending some 30 hours on site with each duty. This is leaving housemen over-worked, tired and demoralised, contributing to their decision to leave the country even before they've finished their two years as housemen. It's quite the vicious circle.

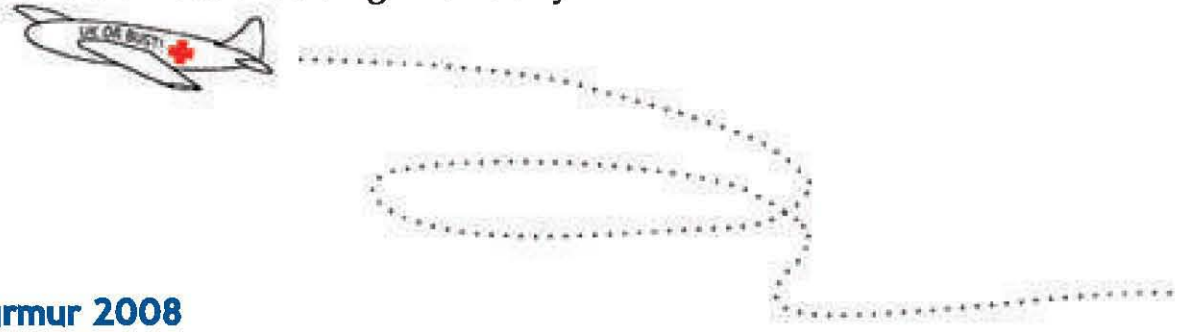
First year houseman Dr. David Falzon cites the major issues as being working conditions and training opportunities. "Lack of staff is rectifiable by ensuring people stay here - by increasing incentives and projecting a better image of the working conditions," he expounds. Along with most doctors, he's most concerned that the current training is insufficient to keep career-hopefuls here for very long. At the moment, the training system is very haphazard, with only a small number of departments having certifiable training up and running. "At some point in time it is beneficial to go abroad for your training and to expand your horizons, get new experience and learn new methods of practicing medicine and surgery. It is easier to get in abroad at a junior level than it is at a senior level." Dr. Falzon will be pursuing Foundation Programme in the UK at the end of his first year of housemanship.

Not all is doom and gloom, however. As of last **>>**

year, the Medical Association of Malta (MAM) secured an agreement with the government to increase pay for doctors in the National Health Service across the board. Part of the collective agreement was to institute better structured post-graduate training. The concept MAM is pushing for is to ensure that every single houseman gets into training. This contrasts with the UK, where competition ratios for Specialty Training (ST) is all anyone talks about.

Murmur approached MAM president Dr. Martin Balzan for some comment on the issue. Dr. Balzan is quite fervent on the matter: "Housemen leaving the country are playing Russian Roulette: there's an average chance they're going to be stuck in a bottle-neck, waiting for the ST post of their choice to open up. According to the MAM-government agreement, we're guaranteeing that every houseman gets an SHO post." When asked whether these posts will be accompanied by adequate training, he's quick to point out that training already occurs: "Exposure and training is already being recognized. Most Royal Colleges already accredit training in Malta, and EU experts have given positive reports to the local system. The introduction of a formal structure is at an advanced stage and Dr. Joe Cassar (the parliamentary secretary for Health) is putting all his weight behind the development of training programmes." Trainers and trainees are being financially sustained, and slots are reserved in their work schedule to ensure training occurs. However, specialty training in Malta will also include an allotment for study leave, with trainees being encouraged to spend a period of one to two years abroad as part of their training programme. "A career in Malta does not mean you're locked in on our shores," Dr. Balzan stresses.

Both the houseman and the consultant interviewed for this article seem to agree on this point: deciding whether to stay or go is a personal decision. The Department of Health needs to review the current training and employment systems at a faster pace if it wants to influence this decision in favour of doctors staying here. Only then will more doctors remain, the workload decrease and the brain-drain reverse.



Last year, *Murmur* featured the new hospital just before its completion. Now that we are finally based in Mater Dei, can we safely say that the move was for the best? **Malcolm Marquette** checks out the atmosphere in the new hospital just months after the relocation.

Malcolm Marquette

Vox Pop: Mater Dei

The aim of this VoxPop is to explore the feelings of different members of the medical staff about the new Mater Dei Hospital. The participants ranged from medical students, to healthcare providers (mostly nursing and midwifery staff) and doctors. The participants were chosen from every hospital setting offered by MDH; that is, those working at outpatients and those on the wards. The questions asked were aimed to determine if their expectations were met or not regarding the new hospital. Where negative answers were given, the participants were encouraged to give appropriate explanations, and also suggestions to improve the situation.

Such data is presented below tackling the questions asked one by one. An increased emphasis on negative answers is given where it is thought that there is a general consensus on the issue. The same is true for the positive answers, but one has to note that the proportion of one relative to the other is solely circumstantial and reflects the data collected.

Do you think a change in hospital was needed?

Most of the participants agreed that a change was indeed needed, and the reasons being that St. Luke's was becoming unmanageable with regards to maintenance, and also because of the general dirty environment one met in the hospital premises. They also argued that this structural change was needed, because the St. Luke's architecture has become old and that it was aesthetically not up to standard. Most of the staff interviewed said that the sight of the old hospital, including its surroundings used to depress them, and they argued that this was mainly due to the tall buildings which did not allow much sun light on the premises, and also, because of the dark exterior walls of the building resulting from the high level of pollution in the area.

On the other hand, a minority of participants argued that the change was useless, and that it would have been better to fully refurbish and modernise St. Luke's Hospital. Some medical students also felt that there needs to be a change in the way the hospital is run, apart from a structural one. The reason for this being that the new hospital will inevitably regress to the point of the old one, if it is still going to be managed in much the same way. They alluded to the lack of maintenance observed so far, and also to the delays seen in day care and outpatients causing some crowds and inevitable vandalism.

What do you think about the environment in the new hospital? Do you find it more appealing or less appealing?

All the participants taking part in this VoxPop agreed that they liked the new hospital environment, including the surrounding area. This was most evident when the question was asked to medical students, and the main reason being, the close proximity to university campus. As medical students we are not as isolated as we were at St. Luke's hospital.

Staff members said that they liked the hospital premises and feel more comfortable going to work. This is also true for the doctors who participated in this VoxPop. A general agreement was thus expressed, that they find the new environment more appealing.

How has this change in environment affected you?

Medical students were the ones which felt the most positively affected and motivated, because of the hospital's proximity to university campus, and also because the building is not as depressing as the

one of St. Luke's Hospital. Most healthcare workers participating, who liked this new environment, said that this change has not affected them in any way, whilst others mentioned the same reasons as medical students regarding the new hospital building. Most doctors did not feel that this new environment affected them in any way. With regards to the new working environment, how has this influenced your life on the job?

Medical students feel that they were influenced positively with the new working environment. Amongst their comments, they mentioned the new modern lecture rooms, seminar rooms, and also the wards themselves. Most said that they feel more comfortable during lectures, and also tutorials on the wards. In fact, with regards to tutorials on the wards, they said that there is more place for them to organise such sessions and that the environment of such places is much more comfortable than the one experienced at the old hospital.

Mixed feelings were expressed by healthcare professionals working in different hospital settings. Those persons working in outpatients feel that the new working environment created at MDH has influenced them in a negative way, and this is because life has become much more chaotic on the job. They mentioned that there was an apparent decrease in space, and an increase in workload.

Those working on the wards said that they liked the new working environment, but this has not profoundly influenced their lives on the job. Participants from both settings expressed positive comments regarding the increased privacy at work provided by these changes.

"Doctors said that the new work environment influenced them quite positively, in that, they feel much more motivated."

Doctors said that the new work environment influenced them quite positively, in that they feel much more motivated.

With regards to basic facilities, how do you think these have changed?

Medical students expressed positive feelings with regards to basic facilities such as toilets. They said that there are more toilets throughout the hospital and that, most importantly, these are kept clean. They also mentioned the staff cafeteria, which they said they liked a lot and is optimal for recreation. Such feelings were also expressed by most of the participants.

Most participants complained about the food being served at the cafeteria during breaks and throughout the day. They said that there is not enough variety, and complained about the quality of the food as well. One particular doctor complained that himself and some of his colleagues ended up with gastroenteritis after having some dish consisting supposedly of chicken.

They also complained about the prices being charged, and the discrepancy in prices between the staff cafeteria and the visitors' coffee shop. They argued that it is not always possible to buy from the one reserved for the staff since they are too far apart.

With regards to working/studying facilities, how do you think these have changed the way you work? Did these help in improving your life on the job?

Medical students commented mainly about the lecture rooms; most of the students said that this was a positive change especially with regards to the acoustics of the rooms. Some said that the seats were a bit small and thus quite uncomfortable and this made long lectures difficult to follow. Overall all students said these new facilities have improved their lives.

With regards to the library, students argued that this was much smaller than that of St. Luke's. Moreover, it has to be shared with Institute of Healthcare (IHC) students, which made the space even more limited.

Medical students complained about the lack of lockers. They argued that this issue was making life much more difficult for them as we have to carry around our heavy bags all day. This made life much more difficult especially during ward rounds. One has to point out that recently MMSA has been granted permission to transfer some SLH lockers to MDH on condition that we paint them first so this is a problem which should resolve itself.

Another issue concerning medical students regards the lack of authorization for access into the

computerised PACS system for review of various patient imaging data, and other medical results. Such information is of the utmost importance in our curriculum and thus we have become much limited in our studies on the, unless there is someone kind enough to log on for us, and this is not always possible. This issue is also being taken care of by MMSA, and in fact, our student organization has managed to get the MDH authorities to give students access to computerised data. This process should be finalized soon, and hopefully we will all have our password.

Doctors said that they were quite happy with the new working facilities and that these managed to improve their lives on the job. They commented that such facilities helped them increase their efficiency at work. They complained only on one thing, and this being, that space at the bedside was limited and this interfered a little in their work. The rest of the participants were quite happy with regards to the change in work facilities and claimed that these have made their lives in the job much easier.

Are there any things in the new hospital which could be improved? What do you think these are?

All participants mentioned the food at the cafeteria, and said that this had to be improved. They also said the prices are to be reviewed. They also said that the area of the staff cafeteria should be kept cleaner. Participants also felt that there should be more lift maintenance, since most of these are constantly out of order.

Medical students commented on the problem regarding the library, PACS system and the lockers, and feel that these should be dealt with as early as possible.

All agree that that there should be an improvement in the way the hospital is run, particularly regarding the delays and waiting lists and the lack of bed space in the hospital.

Overall, do you think that this change has improved your life? If not, why?

A general positive answer was given to this question. They also added that much of their expectations were met. Only a few of the participants said that they felt there was no improvement, and that they felt that this is because there has not been a big change in their lives.

Mr. John Camilleri Brennan

Mr. John Camilleri-Brennan MD(Malta), MD(Dundee), FRCS(Glas), FRCS(GenSurg), a Maltese consultant surgeon practising in the Stirling Royal Infirmary in Scotland, gives advice on how to handle perhaps the toughest exams of the course.

Talk Your Way Into Success From A Viva

'When he who hears does not know what he who speaks means, and he who speaks does not himself know what he means, then chaos reigns.'
- Voltaire

Oral communication is an essential part of the daily life of every doctor. Thus, oral exams are important in order to assess not only the amount of factual knowledge, but also the ability to express it in a clear and comprehensible manner.

In this article I will give you some tips, most of which are based on my experience both as a candidate as well as an examiner, on how to conduct yourselves during an oral exam and how to prepare for it.

Effective preparation

As with all professional exams, sound preparation is vital. Nobody, however brilliant, ever passed medical examinations without hard work. Preparation is an ongoing process, and certainly must not be left to the eve of the exam.

Acquiring knowledge

Most of the medical information may be divided into three categories:

1. What is essential and necessary (basic knowledge)
2. What is inessential but may possibly be useful
3. What is merely ornamental (trivia).

I am sure that you are guided by your lecturers as to what should be included in each of the above categories. You must therefore try to obtain complete mastery of the essential information first before you even attempt to learn much within the second or third group.

Practice your technique

Many students, however well-read, are unable to answer questions appropriately because of poor technique. You may practice your viva technique by doing the following:

1. Attend teaching ward rounds and allow yourself to be grilled in front of your colleagues.

2. Arrange sessions for viva and clinical examination practice with one of your tutors or with an experienced doctor.

"Medical students, however well-read, are unable to answer questions appropriately because of poor technique"

3. Form 'quiz groups' of about 3 or 4 from amongst your colleagues and practice the art of answering questions.

4. Get a senior colleague to write out suitable examination questions. Practice answering these questions whist recording your voice on a tape or digital recorder. Then, playback your recording and note any deficiencies, such as silences, waffling, actual lack of knowledge, etc.. Your task will then be to correct those faults.

The Examination

- Be early. Reach the examination place half an hour before the exam starts.

- Be well presented. The oral exam is not a fashion show or a wedding, but you should

nonetheless be well groomed and neatly and professionally dressed.

• Greet the examiners in a polite and professional manner.

• The art of any oral exam is to convey an attitude of confidence and self-assurance, without appearing to be smug or arrogant. Stay calm, be pleasant and don't panic. Examiners are used to nervous candidates and will make allowances, but the less flustered you are, the more justice you do to yourself. An occasional smile is always a great help, but on the other hand do not go to the other extreme and display a continuous grin.

•Listen carefully to the questions. Look directly at the examiner all the time.

• No silences. Silences never gain marks. The candidate must realise that the examiner is waiting for him to talk and he should do so instantly. Some candidates are so afraid of giving a wrong answer that they hesitate unduly before speaking. Such silences display lack of confidence. Your task in the exam is therefore to keep talking whenever allowed to do so. You must try to prevent the examiner from falling asleep.

• Don't answer simply 'yes' or 'no' to questions; on the other hand do not give a prepared speech. Do not rush your answers but answer carefully and methodically. All your words and phrases should be as simple and as non-controversial as possible. Use precise, intelligible and logical language, avoid technical jargon and never use abbreviations.

• If you don't understand the question, ask the examiner politely to repeat or rephrase the question. If you still don't understand the question or don't know the answer, then it is better to admit your ignorance rather than remain dumb or to try and bluff. Hopefully the examiner moves on to another topic.

• Speak clearly and do not waffle. Clear speech is often a sign of self-confidence. Make sure that the examiners are able to hear you distinctly. Avoid mumbling, talking with a hand across the mouth or with fingers inside that cavity, or the use of 'ums' or 'ers'. Many examiners are annoyed if they have to ask a candidate to speak up or repeat something.

"Examiners are used to nervous candidates and will make allowances, but the less flustered you are, the more justice you do to yourself"

• Be prepared to justify your answers. If the examiners challenge your interpretation but you feel that your answer is a good one, present your answer firmly but courteously. However, if the examiners have identified a genuine weakness, concede the point gracefully and admit your mistake without a hint of any excuse. Even if you feel the examiners are unreasonably critical do not become argumentative or allow the discussion to become heated. Anger shows a serious lack of control. Keep your cool.

At the end of the exam always leave graciously, however unhappy the experience may have been. This helps to leave a good impression and may be vital in marginal circumstances.

Best of Luck!!

Happy Birthday MURMUR!

Claire Vella

This year, Murmur blows out the candles on its fifteenth birthday cake. After 15 issues of our annual magazine, what has Murmur become, and how much of the original idea behind the magazine remains?

In reality, the forerunner to Murmur was a student publication in 1988 called *Apoplexy Now!* – a tongue-in-cheek newsletter spoofing the academic staff and the realities of medical student life. Typewritten in Maltese and featuring hand-drawn artwork and editorials from the Student Organization for Reform of Medical Instruction (SORMI), Apoplexy was a huge success but sadly fizzled out when the class responsible for its publication graduated in 1989.

It was in October 1992, that the need for a steady publication resulted in the creation of MMSA's official annual magazine. The first issue of Murmur was handed out to eager medical students and the academic staff, but it contained no 'sormitorjals' or professor parodies. A slim volume merely 16 pages thick, the pages were black and white and printed in English on stiff, matte paper. In the first editorial, Adrian Vella wrote:

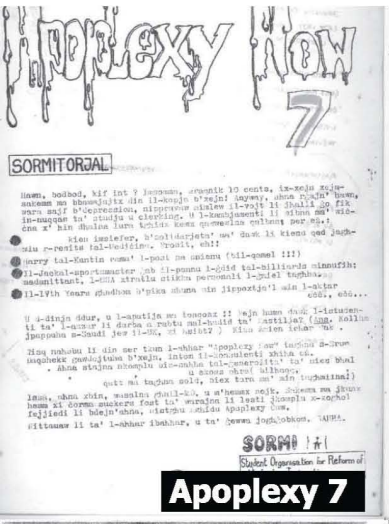
"Murmur does not intend to evolve into a cheap copy of the Malta Medical Journal or any other academic journal for that matter. It is our intention that this magazine will concern itself with the social and practical realities of being a Maltese medical student as well as (sometimes) providing insight into subjects which have relevance to the medical curriculum."

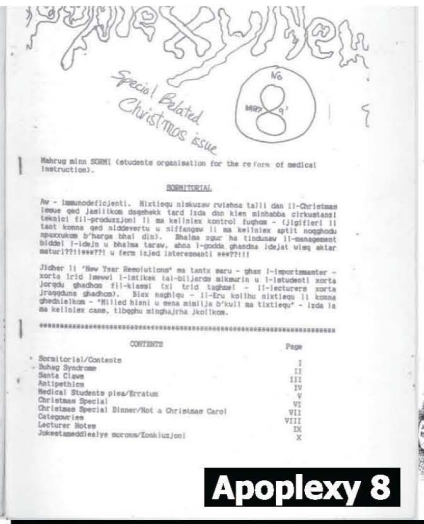
In keeping with this statement, the first issue of Murmur contained an extended report of MMSA's activities, an article on doping, three pages for Freshers, and an interview with the then Dean, Prof. Frederick Fenech. It was Sphygmo and Freshers' Booklet rolled into one volume, with the consultants' interview which has been a staple of every Murmur ever since.

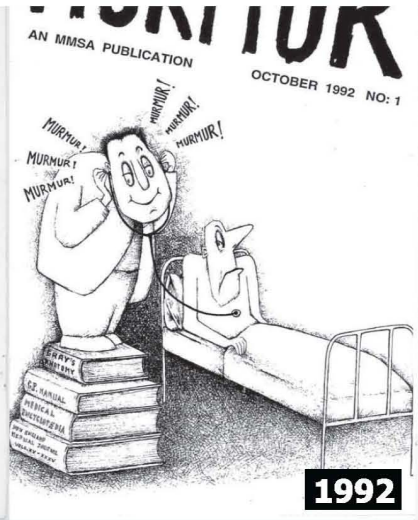
Over the years, Murmur evolved into a thirty-plus page magazine printed on glossy, coloured paper. It was only natural that its aims as a publication would change. In fact, with the introduction of Sphygmo in 2005, and Freshers' Booklet, together with the pushing back of its publication date to late in the scholastic year, Murmur is not just a newsletter anymore. Rather, it has become a sounding board for student opinions and a collection of humorous and medically relevant articles. Its run has increased – Murmur is now distributed to doctors as well as medical students, which has lent it a more serious edge.

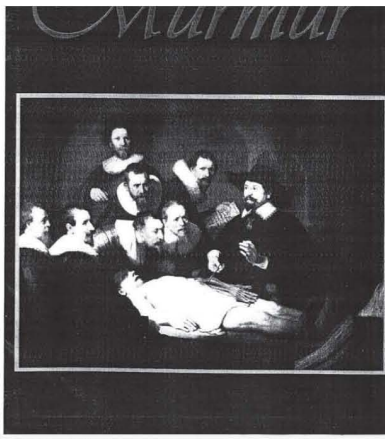
However, the essence of what Adrian Vella wrote in October 1992 remains in the pages of this magazine. First and foremost, Murmur remains a student publication which gives voice to student issues. It has gained respect in IFMSA for its witty and intelligent content and for its changing design. The first cover of this magazine depicted a medical student listening to the murmurs of a patient's heart, and that is what Murmur still strives to be today – a finger on the vitality of the students' pulse.

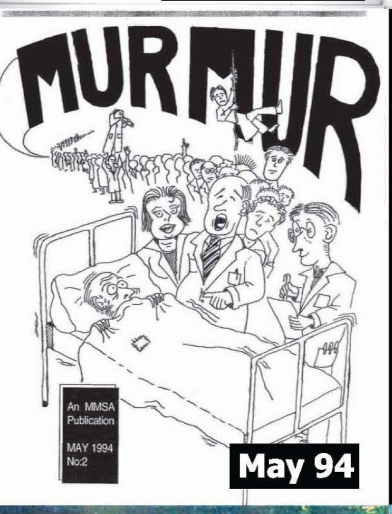
Hopefully this will not change and Murmur will continue to grow and improve as a publication. Next year, though, is another cause for celebration, as Murmur can pop the cap on its first (legal) bottle of beer on its sweet sixteen!





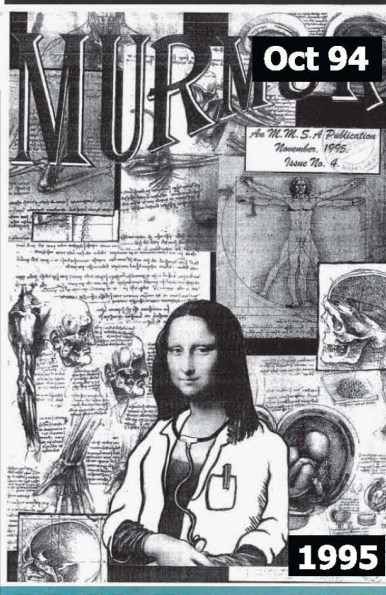


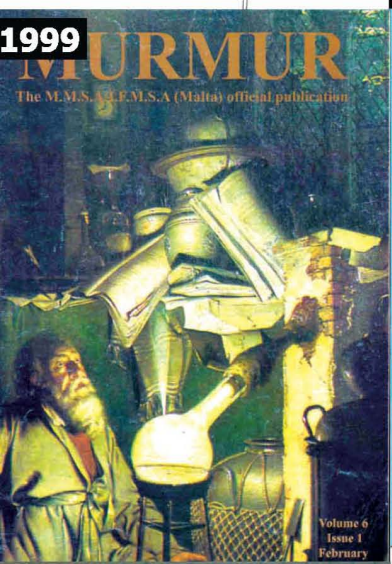


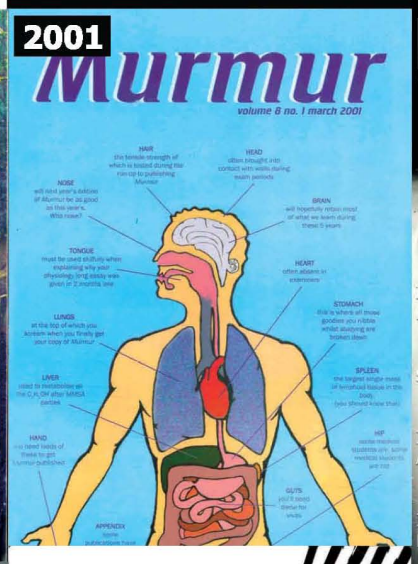


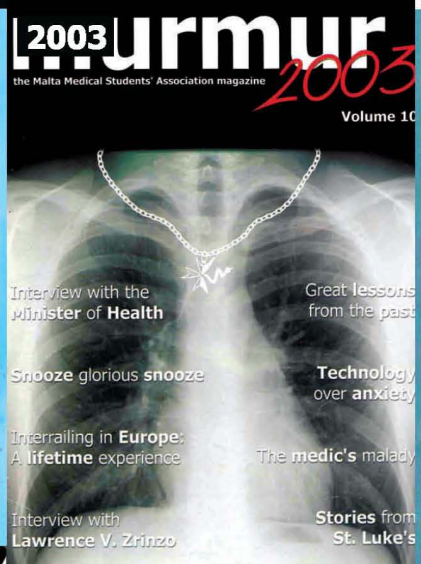
Murmur: A celebration

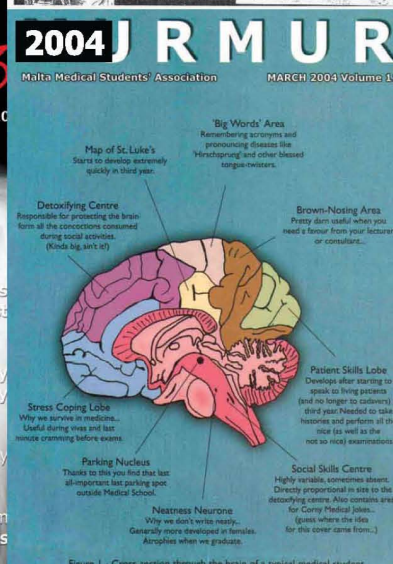
The 2008 Murmur team dusted off the MMSA archives and presents a collection of past **Murmur** covers. Thanks also to Mr. John Camilleri-Brennan for graciously providing us with two covers of **Apoplexy Now!**

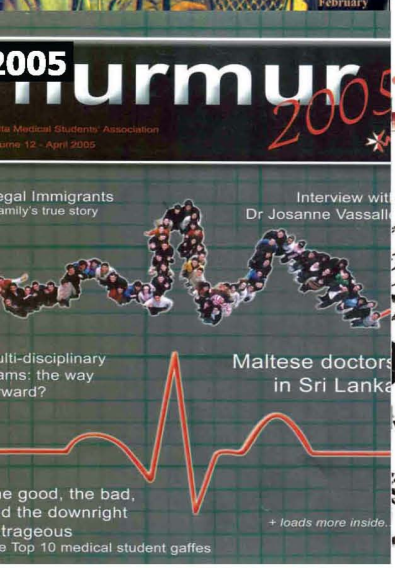


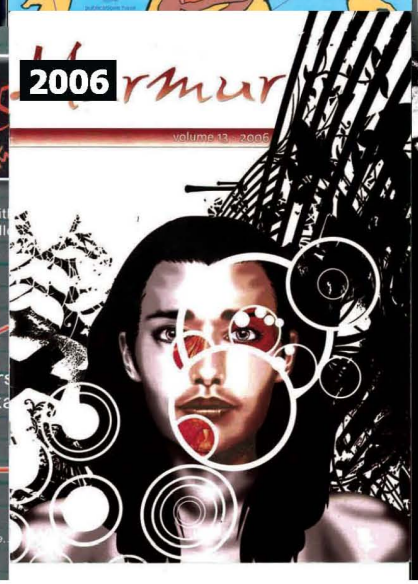












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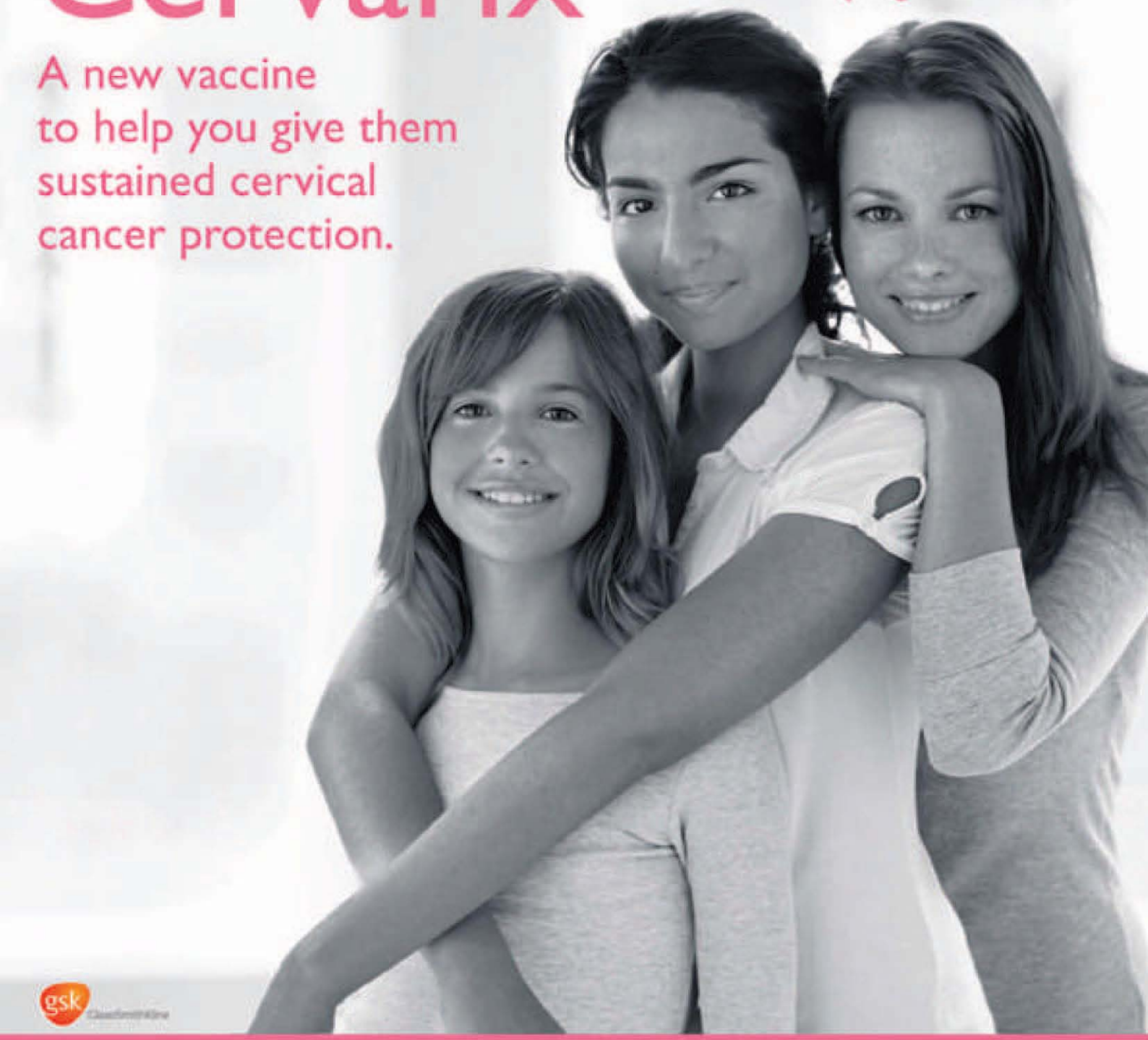

New *Cervarix*® has proven efficacy that's sustained for up to 5.5 years to date.[1]

1. Gall SA, Teixeira J, Wheeler C *et al.* Substantial impact on precancerous lesions and HPV infections through 5.5 years in women vaccinated with the HPV-16/18 VLP AS04 candidate vaccine. Presented at the 2007 meeting of the American Association for Cancer Research, Los Angeles, CA, April 14-18, 2007. Abstract 4900.

CERVARIX ABRIDGED PRESCRIBING INFORMATION: Please refer to the full Summary of Product Characteristics before prescribing. Detailed information on this medicinal product is available on the website of the European Medicines Agency (EMEA) (http://www.emea.europa.eu).
TRADE NAME: CERVARIX. ACTIVE INGREDIENT: 1 dose (0.5 ml) contains: Human Papillomavirus type 16 L1 protein 20 micrograms, Human Papillomavirus type 18 L1 protein 20 micrograms, cervicomonad, adjuvanted, adsorbed). PHARMACEUTICAL FORM: Suspension for injection in prefilled syringe. THERAPEUTIC INDICATIONS: CERVARIX is indicated for the prevention of high-grade cervical intraepithelial neoplasia (CIN) grades 2 and 3 and cervical cancer caused by oncogenic Human Papillomavirus (HPV) types 16 and 18. POSOLOGY AND METHOD OF ADMINISTRATION: The recommended vaccination schedule is 0, 1, 6 months. Not recommended for use in girls below 10 years of age. Cervarix is for intramuscular injection in the deltoid region. CONTRAINDICATIONS: Hypersensitivity to the active substances or to any of the excipients; acute severe febrile illness. PRECAUTIONS: Anaphylactic reactions. Caution in individuals with thrombocytopenia or any coagulation disorder. Cervarix protects against disease caused by HPV types 16 and 18. Other oncogenic HPV types can also cause cervical cancer and therefore routine cervical screening remains critically important and should follow local recommendations. Not indicated for treatment of cervical cancer, cervical intraepithelial neoplasia (CIN) or any other established HPV-related lesions. Cervarix does not prevent HPV-related lesions in women who are infected with HPV-16 or HPV-18 at the time of vaccination. DRUG INTERACTIONS: Data have not been generated on the concomitant administration of Cervarix and other vaccines. There is no evidence that the use of hormonal contraceptives has an impact on the efficacy of Cervarix. In patients receiving immunosuppressive treatment, an adequate response may not be elicited. PREGNANCY AND LACTATION: Vaccination should be postponed until after completion of pregnancy. Cervarix should only be used during breast-feeding when the possible advantages outweigh the possible risks. ADVERSE EVENTS: Common and very common: headache, gastrointestinal symptoms including nausea, vomiting, diarrhoea and abdominal pain; chills/pyrexia, rash, urticaria, myalgia and arthralgia; injection site reactions including pain, redness, swelling, fatigue, fever (≥37°C). Uncommon: dizziness, upper respiratory tract infection, other injection site reactions such as induration, local paraesthesia. PRESENTATION: Pack of 1 pre-filled syringe with a plunger stopper containing 0.5mL of suspension + 1 needle (color to fit) NPC for information on dispensed). LEGAL CATEGORY: POM. M.A. HOLDER: GlaxoSmithKline Biologicals S.A. Belgium. M.A. NUMBER: EU/1/07/410/001. For further information and full prescribing information contact GlaxoSmithKline (Malta) Ltd. Tel: 21 238 131. Date of preparation: September 2007.

Cervarix®
Human Papillomavirus Vaccine Types 16 and 18 (Recombinant, adjuvanted, adsorbed)