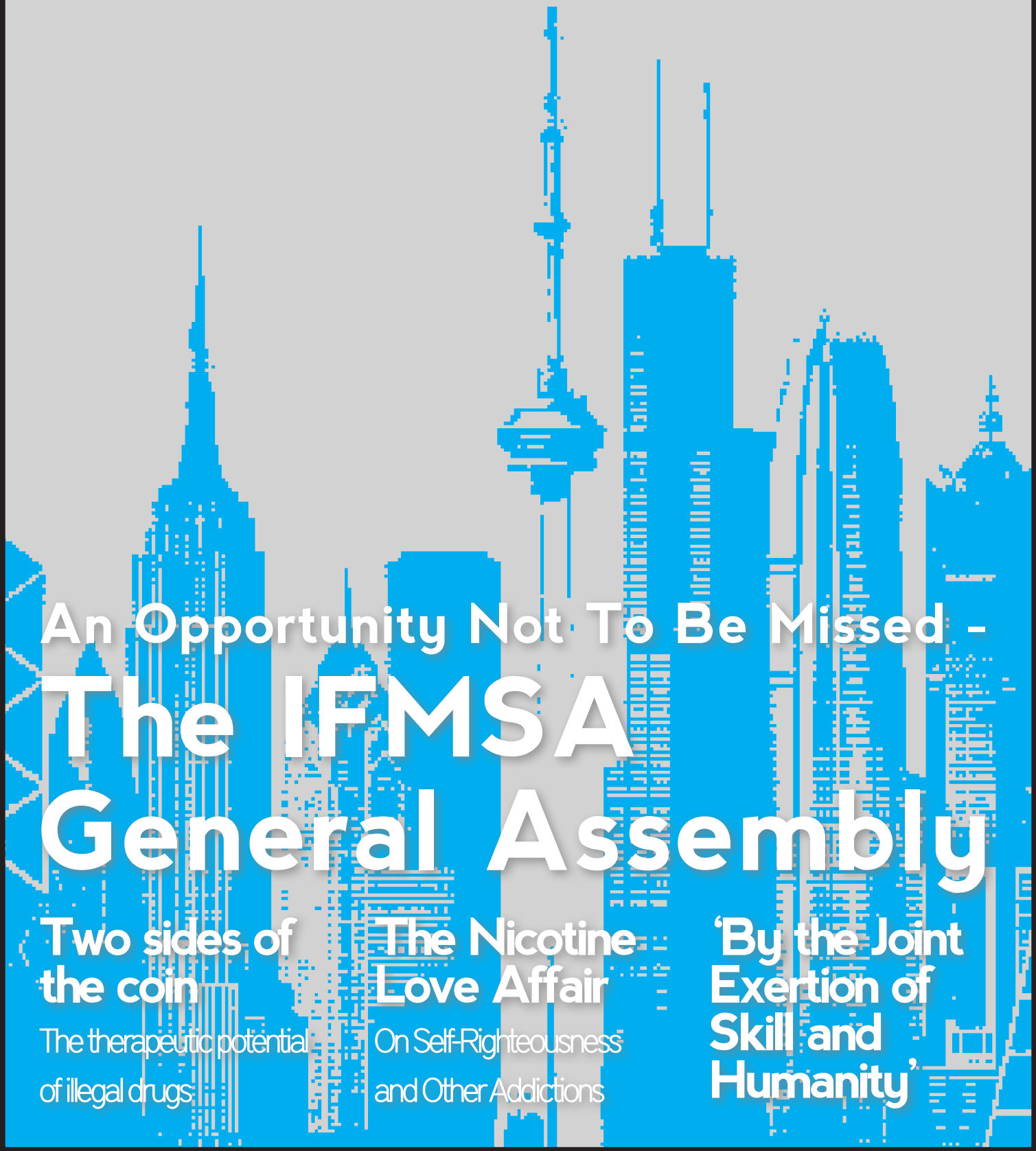
MURMUR 2013 | A Malta Medical Students' Association (MMSA) Publication

MURMUR

Yesterday | Today | Tomorrow



An Opportunity Not To Be Missed - The IFMSA General Assembly

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The therapeutic potential of illegal drugs

The Nicotine Love Affair

On Self-Righteousness and Other Addictions

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CONTENT

MURMUR 2013

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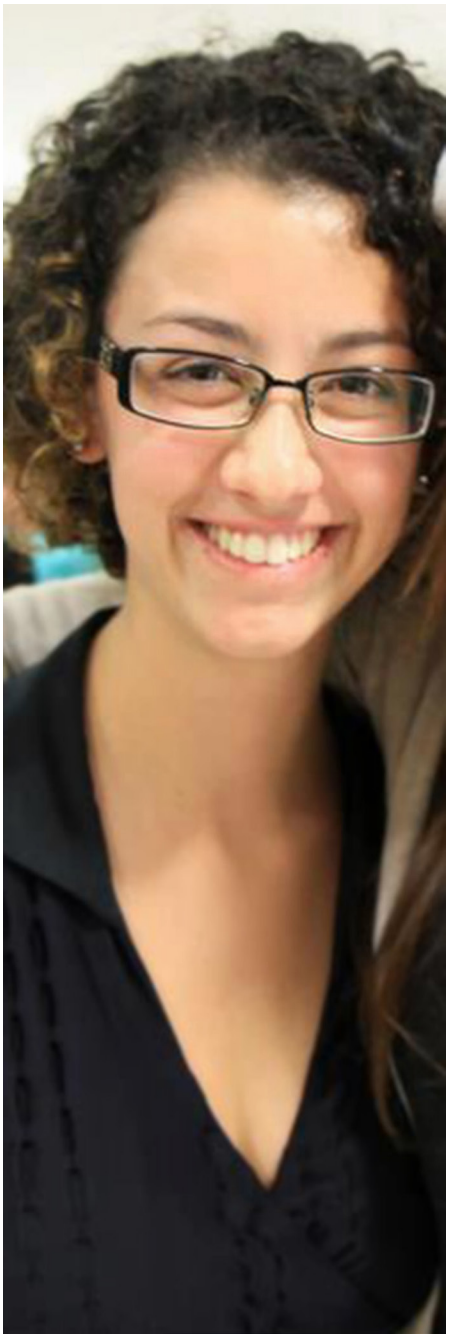


MESSAGE
FROM THE EDITOR
ARLÈNE GATT

It is with great pride that I present to you this year's edition of Murmur, with the theme chosen being CHANGE, as implied by the slogan; Yesterday, Today and Tomorrow.

Change is an intrinsic feature of society which may or may not be so easily perceivable, depending upon the situation. In recent times, there has been a drastic change in mentality, politics, technology and lifestyle and by simply looking through our own old photo albums we will realise that there have been great developments in our surroundings, not to mention in ourselves as well. This was the basis of our inspiration to take on this theme.

The focus of this publication was not solely to emphasise on how change is brought about, but also to display how we, as human beings, can be viewed from different angles. An example of such would be how we, as medical students, manage to keep up with our various hobbies and interests outside the field of medicine which aid us in being active and holistic individuals.

I would like to take this opportunity to thank the Media Team 2012-2013 for their hard work and dedication which I feel has resulted in MMSA-Media being taken to the next level. I would also like to thank the authors for their patience and contributions and the Publication Team for their creativity behind the design. Finally, I would like to thank the MMSA Executive Board 2012-2013 for their continuous support and excellent work throughout the year.

I hope that you, dear reader, enjoy this edition and possibly even learn something new.

MESSAGE
FROM THE PRESIDENT
DANIEL VELLA FONDACARO

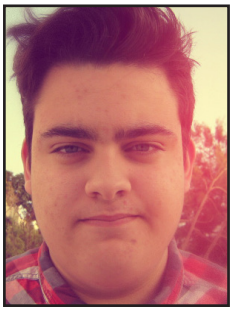
Murmur magazine has now become the most popular publication issued by the Malta Medical Students' Association (MMSA). The MMSA represents all the medical students pursuing a degree in Doctor of Medicine and Surgery at the University of Malta.

This year the association has been very busy organising numerous outreaches, campaigns, seminars and other events put together by a large team of dedicated students. Perhaps the most drastic change this year was the structural pentameric reform which was approved by the general assembly in an Extraordinary General Meeting held in December. This reform consists of a five-role administration: The Executive Board (President, Vice President for Internal Affairs, Vice-President for External Affairs, Secretary General and Treasurer) and the Team of Officials (all Standing Committee heads).

University life is not solely based on academic achievement, but it is a holistic experience that provides the student with a direction in life. The university experience should be an amalgamation of academic and proactive student life. Holistic medical students will make holistic medical doctors. This publication is a perfect example of active student life.

I would like to thank the editing team and all those who assisted in the making of this publication together with our Media and Marketing Officer, Arlène Gatt.

Please do not hesitate to contact us with your feedback, queries or suggestions.



The Frontal Lobe and Personality

David Cassar

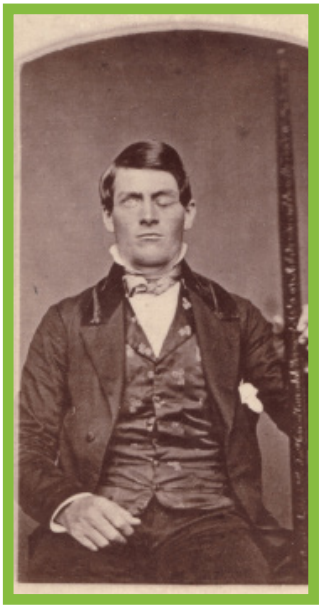
It was late afternoon and the September sun was only just visible above the emerald tree tops. The men were hard at work, constructing part of the Rutland and Burlington railroad in a peaceful area of southern Cavendish. A peace which was not to last, rudely interrupted by a gut-wrenching blast. The sound of panicked voices resonated all around, while at the centre of the commotion came desperate, anxious calls of "Gage! Gage!".

The events of that fateful day in 1848 are written down in medical folklore. Sparks given off from Phineas Gage's tamping iron as it hit the rock ignited blasting powder nearby. The force of the resulting explosion sent the iron rod through his left orbit and out of his skull. Not only did the twenty-five year-old workman survive but he also remained conscious throughout the ordeal. Amazingly, Gage spoke within a few minutes, walked with little or no assistance and sat upright in a cart for the 1.2 km ride to his lodgings in town. But things were not as rosy as they seemed. Alas, Gage would never be the same again.

In the months that followed the accident, Gage returned to his parents' home in New Hampshire to recuperate. When his physician, Dr. Harlow, saw Gage again the following year, he noted that while Gage had lost vision in his eye and was left with obvious scars from the accident, he was in good physical health and appeared recovered. However, in a report that dates back to twenty years after the incident, Harlow wrote of a disturbing change he observed in his patient:

"The equilibrium or balance, so to speak, between his intellectual faculties and animal propensities, seems to have been destroyed. He is fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom), manifesting but little deference for his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate, yet capricious and vacillating, devising many plans of future operations, which are no sooner arranged than they are abandoned in turn for others appearing more feasible. A child in his intellectual capacity and manifestations, he has the animal passions of a strong man. Previous to his injury, although untrained in the schools, he possessed a well-balanced mind, and was looked upon by those who knew him as a shrewd, smart businessman, very energetic and persistent in executing all his plans of operation. "

(Massachusetts Medical Society 2: 339-340)



What had happened to the diligent and polite young man that his friends and family had known? In fact

Dr. Harlow confirmed that those closest to him agreed that he was "no longer Gage".

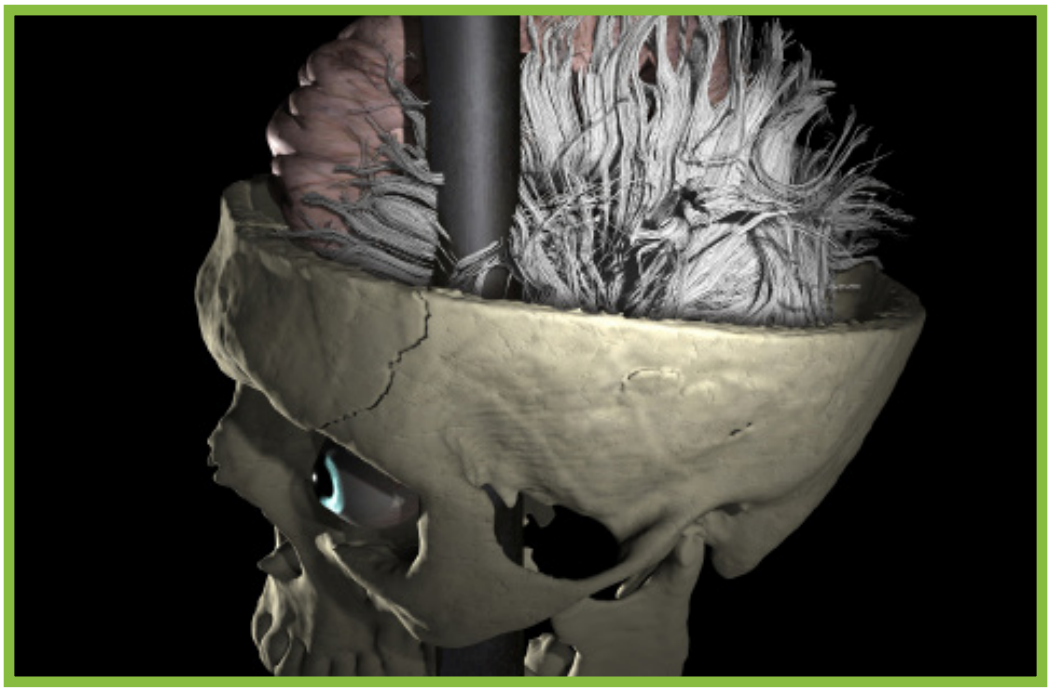
Indeed he an 'altered' Gage. He was Gage with a damaged frontal lobe. Such an injury has serious ramifications, particularly if both hemispheres are involved, mainly due to the reason that the frontal cortex is the centre of control for many a function, more than any other neocortical

region. The frontal lobe's importance is mirrored in its size, being the largest of the brain's lobes due to its many cytoarchitectonic areas. By cytoarchitectonic areas we mean to say that it is an area rich in neuronal cell bodies; this is associated with higher functions. The frontal cortex integrates complex information from sensory and motor cortices as well as from the parietal and temporal association cortices. When all these are computed, the frontal lobe helps us to appreciate ourselves in relation to the world and allows our behaviour to be planned and our actions to be executed as best befits the situation. So it is no wonder that damage to this area, which compromises the normal ability to match ongoing behaviour to present or future demands, is interpreted as a change in character or personality.

Significant brain injury is often fatal, but Harlow called Gage "the man for the case. His physique, will and capacity for endurance could scarcely be excelled". So is this merely an exceptional case of incredible psychological endurance, an unrivalled will to overcome serious injury? Whatever the case, the brain tissue destroyed must have been substantial, particularly when considering not only the initial trauma but a subsequent bacterial infection that rubbed salt in the already grievous wound.

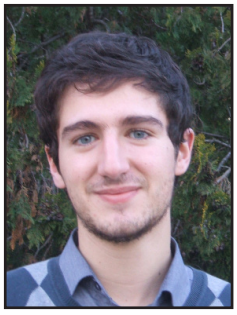
Though debate as to whether the tamping iron impaled both frontal lobes, or primarily the left, began with the earliest papers by physicians who had examined Gage. It was only in 2012 that a definite conclusion was reached. The study conducted by Van Horn *et al.* was based on CT scans of Gage's actual skull and confirmed Harlow's initial conclusion (based on probing Gage's wounds with his finger) that the right hemisphere remained intact and harm was limited exclusively to the left hemisphere.

Unfortunately, Phineas Gage's predicament is not an isolated case. There are various other cases of frontal lobe damage accompanied by subsequent personality changes. Victims of lightning strikes and brain tumours and survivors of failed suicide attempts make up the majority of a number of known sufferers of such a condition. Such people may not recognise they have a problem or they actually deny it. They may become embarrassed when they cannot carry on a conversation, work at their previous job, or do the same activities that they used to handle. As a result, many self-isolate, withdrawing from public interaction, friends, family and other activities. Relatives and co-workers, who see the same external person, often do not understand why their spouse, their sibling or best friend is acting so differently.



According to René Descartes, personality is rooted in the mind. In his opinion, the mind has a cognitive faculty of understanding which is oriented towards knowledge, a voluntary faculty of will which is oriented towards free choice and an affective dimension oriented towards feelings or emotions. It seems the Frenchman couldn't have been more right.

'By the Joint Exertion of Skill and Humanity'



Leonard Farrugia

*A year following its inception and formal recognition, the University of Malta's Humanities, Medicine & Sciences programme (HUMS) is well into its prime. The transition from St. Luke's to Mater Dei Hospital has brought the medical faculty closer to University grounds, but HUMS promises to make this new proximity be more than merely a geographical one. An interview with HUMS coordinator **Prof. Joseph Cacciottolo** enlightens us on what it's all about.*

The French philosopher Voltaire famously said that "The art of medicine consists in amusing the patient while nature cures the disease", but once, in a more charitable mood, he described doctors as "men who are occupied in the restoration of health to other men, by the joint exertion of skill and humanity", going on to say that "they even partake of divinity, since to preserve and renew is almost as noble as to create."

This harmony between skill and humanity is partly what HUMS is about. This university programme proposes to explore and encourage interfaces between the humanities, medicine and other sciences aiming to facilitate and disseminate cross-disciplinary research. In practice, this ideological endeavour translates into the setting-up of seminars and conferences where research ideas are presented, as well as the possibility of sponsorship of students' postgraduate studies.

Interfaces between medicine, other sciences and the humanities are legion, ranging from the "pharmacolocal immortality in science fiction" to "the feminisation of the Maltese medical profession". The ubiquity of health and illness as themes in art, literature and music makes such sources a mine well worth digging into, providing meanings ("truths", if you will) that facts alone cannot provide. An intimate knowledge of the pathophysiology of liver cirrhosis will teach you next to nothing about the life of an alcoholic and there's only so much you can learn about the experience of depression from memorising the Beck Depression

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

Anatomía del corazón (1890), Enrique Simonet

Inventory.

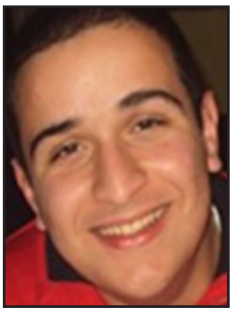
For those less art-inclined, HUMS also offers interfaces between medicine and other sciences, including the social sciences (e.g. sociology, anthropology). The newly-emerging Earth sciences discipline is extremely amenable to interdisciplinary discourse about man's relation to the environment and aspects of environmental health. The History of Medicine is a recognised evolving discipline in and of itself, with academics still engaged in heated debate about the details of Florence Nightingale's life and the first documented case of syphilis. Nor has medicine eluded the keening gaze of philosophers, with seminal works like Foucalt's The Birth of the Clinic tracing the development of the medical profession. The very definitions of "health", "illness" and "disease" remain fundamentally subject to philosophical debate.

Sadly, while offering various opportunities for research at a postgraduate level, interdisciplinary dialogue between faculties at an undergraduate level remains largely stunted, mostly owing to the stringent requirements and sheer weight of the medical curriculum. Unlike most other courses, the medical curriculum is too packed to allow students to take up elective study units, with the narrowness of education that this entails. Even sadder is the fact that, given the choice, most students would still much prefer not having "more to study" (ma tarax, aktar x'nistudja!) and they are hardly to blame when one considers how taxing medical education often is.

Against this backdrop, it is largely up to the medical student not to relinquish the richness of interests and lust for life that one had before enlisting with this army of boring drones that is the medical profession. Find a passion and hold on to it. Be it music or modelling, fishing or bird-watching, passion is the medical profession's last link to humanity. With the exertion of skill alone and no humanity to practice with, you may yet make a brilliant doctor, but never much of a human being.

For more information about HUMS, visit :
http://www.um.edu.mt/programme/hums

Medical Technology
Tech that Saves Lives



Leonard Callus

Deep Brain Stimulation
Cure for Parkinson's Disease

The first scientist to formally describe the disease was the British physician James Parkinson who, in 1817, wrote a famous essay on "The Shaking Palsy". In his work, he described the daily lives and symptoms of six patients affected by problems such as constant shaking, rigidity and slowness of movement. He noted the progressive disease course with increasing immobility and dependence, disturbances of sleep, speech and bodily functions, but sparing of the senses and intellect. Later in the 19th century, the disease was formally named after Dr. Parkinson by the French neurologist Charcot. Interestingly, the characteristics of the disorder had been described as early as in the second century AD by the Greek physician Galen.

The Indians were the first to find a way to control this disease. As far back as 5000 B.C. they used a tropical legume called Mucuna Pruriens, which they called Atmagupta. The seeds of Mucuna Pruriens are a natural source of therapeutic quantities of L-dopa. Mucuna pruriens is the oldest known method of treating the symptoms of Parkinson's Disease and is still being used today.

As an early treatment of Parkinson's, levodopa is still used to cure Parkinson's disease and dopamine related dystonia (involuntary muscle movement) by increasing the levels of dopamine. However, long-term treatment using dopamine was causing a lot of side-effects with minor causes including hair loss, nausea, insomnia, disorientation and hypotension. More serious side-effects of long term treatment using levodopa are sudden freezing of movement, end-of-dose deterioration of function and other involuntary movement at peak doses of levodopa.

Limitations of dopaminergic therapy led to the rebirth of new surgical techniques directed at basal ganglia thought to be responsible for Parkinson's. The first to be used was pallidotomy, a technique in which a small electrical probe was heated and used to burn some of the basal ganglia cells. However this technique also has some serious complications such as stroke caused by bleeding in the brain and problems with thought and memory (cognitive impairment) in some people. A surgical technique that does not damage the brain had to be invented and this led to the invention of the Deep Brain Stimulation.

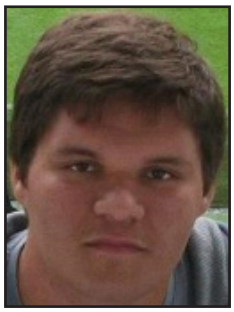
Deep Brain Stimulation is a surgical treatment where a device called a neurostimulator delivers tiny electrical signals to the areas of the brain that control movement – mainly the basal ganglia, in particular areas known as the globus pallidus and the subthalmic nucleus. The deep brain stimulation system consists of three components: the implanted pulse generator (IPG), the lead and the extension. The IPG is placed subcutaneously i.e. under the skin of the patient below the clavicle or in some cases in the abdomen. The wire is passed behind the ear, down to the neck and then to the IPG.

Since such technique avoids the use of drugs, which require increase in dosages and no damage is done to the brain it is considered to be a safe and effective intervention despite its possible side effects like hallucinations and depression.

Neurosurgeons first used Deep Brain Stimulation in the United States in 1997 at Mayo Clinic in Florida and on 30 July 2011, the first successful DBS surgery was performed in Malta by Dr. L. Zrinzo, Visiting Consultant Neurosurgeon at Mater Dei. By then, this new technology started to become popular in Malta and by the end of 2012, 15 patients have been cured thanks to Deep Brain Stimulation.

50-year-old Anthony Borg, who underwent the operation last year, described his experience as "a magical miracle, restoring me back to life".

PET-CT Scan
A Scanning Hybrid



Gianluca Fava

Positron Emission Tomography - Computed Tomography is a hybrid imaging technique that combines two imaging modalities into one scan. This enables for biochemical and metabolic activity within the body, obtained through PET scan, to be correlated and interpreted with anatomic data, obtained through the X-ray CT scan, into a single co-registered image. This added anatomical precision to functional imaging has a synergic effect on the information obtained and has thus facilitated the process for PET-CT scanning to rapidly make its way into and revolutionise many fields of medical diagnosis.

This technology has very important applications in oncology where it plays a crucial role in the imaging of neoplasms and metastases. It is useful in the staging and restaging of cancer before, during and after treatment. It is also useful in surgery and radiotherapy planning and in conducting follow-ups of various neoplastic pathologies. Other fields where PET-CT scanning has important applications include neurology, cardiology, pulmonology and angiology.

PET-CT scans can detect changes in functional molecular biology and biochemistry before any changes in structure and anatomy take place. This has important medical implications since it allows for the early detection of onset of disease. Thus, this type of imaging may yield more precise information than exploratory surgery with the added benefit that it is practically non-invasive, save for intravenous injections which may be given to introduce radiotracers into the body for nuclear imaging. Contrast medium may also be introduced in some cases.

From the patient's view, this type of imaging also has the benefit of undergoing two medical examinations in one sitting rather than separately. Additionally, since both scans are performed at one go without the patient having to change position, there is less room for error and a greater level of accurate detail is obtained. Another important consideration concerning the patient is that allergic reactions to radiotracers are rare and usually mild, however the patient should still report them to the nuclear medicine physician.

One of the biggest disadvantages of this imaging technique is that PET-CT scanners are not readily available in most hospitals due to the fact that they are incredibly expensive. In fact, in Malta, such scanners have only been recently introduced, with the first PET-CT scanner on the islands being made available by Saint James Hospital. The procedure itself is also quite time-consuming. The patient has to fast for a minimum of 6 hours before the scan, while at least another hour must be allocated for the radiotracer to circulate around the body and accumulate in the tissues.

In Malta, another limitation experienced by this imaging technique is that the radiotracer has to be produced in a cyclotron in specialised centres abroad and has to be shipped in on the same day of the scan. This is because the radioactive substance decays quickly and is effective only for a short period of time. Furthermore, false positive test results may be obtained if chemical balances within the body are abnormal, specifically in diabetic patients or in patients who have not fasted. This is because of altered blood sugar and blood insulin levels respectively. One would do well to keep this in mind considering the high incidence of diabetes in Malta.

The Nicotine Love Affair:

On Self-Righteousness & Other Addictions

Alex Curmi

Emerging from the hospital into the fading sunlight it seemed, unbelievably, that the working day had finally come to an end. The car park at 5.34pm had a special serenity unmatched by a church, a white sandy beach or Mount Kilimanjaro. Indeed, it was the ideal time for reflection, nestled just after intense labour and just before flaccid recreation. Opening the car door releases the day's accumulation of stuffy comforting heat. Slumping down onto the seat, opening the front windows and turning on the radio are accomplished in one swift manoeuvre. For now though, the engine is left off. Before driving, before getting into the traffic, before diving back down into daily proceedings: a gasp of air.

A cigarette.

In the often pragmatic and practical world of healthcare it is not too uncommon to come across a doctor (that supposedly pillar of health) who partakes in a habit which, in modern society, has become the symbol of anti-health and self-destruction. It is perhaps this paradox which can help us understand the nature of the addictive process and, once better understood, it can naturally be more effectively dealt with.

Things have changed since the days when one could open a newspaper to find adverts featuring doctors endorsing their favourite brand. Nowadays doctors and cigarettes find themselves on opposite sides of a health war, with smokers caught precariously in between. And what of the physicians who remain bound by nicotine's charm?

" ... merely asking a patient to stop smoking is akin to treating a disease symptomatically, without treating addressing the underlying issue"

A simplistic viewpoint may cite the doctor's habit as an act of persistent stupidity. Alternatively, one who anchors oneself in morality may lump the smoking doctor with any number of horrific yet inexplicable phenomena, another earthly manifestation of Satan's work. I believe however, that this paradox may provide more answers than raise questions.

Firstly, it tells us that stupidity is not a pre-requisite of addiction. But this is nothing new. Secondly and perhaps more importantly, it confirms that one can have a thorough and intimate knowledge of the damage that cigarettes cause without dampening the urge to light up. This correlates well with what is known about nicotine's effect on the brain. Since it hijacks the reward pathways related to sex, water, food and the like, cigarettes hit us on a level more primal than a lecture on lung cancer ever could.

This is what life-long non-smokers fail to understand and I believe it is why smoking cessation advice given by doctors is often so crude and misguided. At times like these, perhaps we must turn to unconventional sources for additional insight.

In Jim Jarmusch's 2003 film, "Coffee & Cigarettes", we are presented with eleven vignettes centred around the act of drinking coffee and smoking cigarettes. Among other things, the film crystallises the ability of the smoker to rationalise his or her smoking. In one particular scene, starring Iggy Pop and Tom Waits, the duo justify their smoking three times:

1. They could have just one, because they quit.

2. They could have just one, because cigarettes and coffee are a great combination.

3. They could have just one because they are the coffee and cigarettes generation.

The viewer is invited to laugh

Shot in black and white and featuring a variety of guest appearances (including Bill Murray, the White Stripes, Roberto Benigni, Steve Buscemi, Steve Coogan etc.) Coffee & Cigarettes has since become a cult classic.

at their inability to kick their habit, yet Jarmusch is only crystallising the process of rationalisation which occurs in all of our minds, both in relation to smoking and otherwise.

Other highlights of the film include Wu-Tang rapper RZA informing Bill Murray that nicotine interferes with the central nervous system and the "vasculatorial" system and warning him of the depression inducing effects of caffeine. Interestingly, both Tom Waits and RZA claim to be medically inclined in their respective roles, living in the place where music and medicine overlap and generally casting a cloud of absurdity over their scenes.

What one learns from observing smokers is that the underlying reasons for their addictions are far more complex than they might first appear and while the physical component is obvious, the psychological element may be more subtle and indeed more binding to the vice.

Therefore, I believe when dealing with smoking cessation at a patient level it is important to attempt to understand the reasons behind the behaviour, that is to say the perceived benefits of cigarettes in order to truly tackle the problem. For example, if simply asked during the history-taking, a patient might readily confess: "Smoking makes me feel less anxious", already providing valuable insight and a starting point for the discussion of quitting.

Too often patients are instructed to quit somewhat condescendingly, leaving them feeling alienated and their problem fundamentally untreated. Moreover, one could say that merely asking a patient to will themselves to stop smoking is akin to treating a disease symptomatically, without addressing the underlying issue.

Instead, I believe a more human approach is warranted, keeping in mind that (be it smoking, drinking, sex, gambling, Facebook, smart phones or self-righteousness) perhaps we all have addictions of our own.

Sexual Health and Migration

Keith Pace

As the world becomes more of a global village and migration continues to increase, so do concerns regarding the health of migrants and their access to healthcare services both in their country of origin and where they are now living. Concerns regarding the epidemiology of disease and the way in which migration has affected prevalence have also been brought to light over the last few years. Language barriers, cultural differences, marginalisation and stigmatisation all make it very difficult to reach migrant populations and ethnic communities through health and social services across Europe. Sexual Health education and outreach is no exception. This poses a risk to Europe as migrant populations are at high risk for infection and being subject to discrimination.

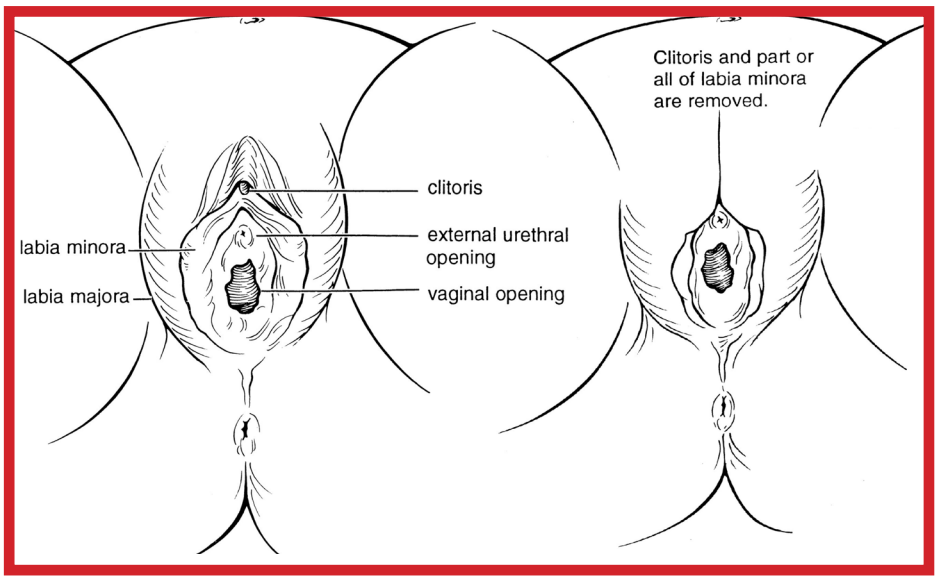
Research strongly indicates that migrants and people from ethnic minorities are vulnerable to HIV infection and this may be due to poor access to HIV services, health care in general and sexual education. With this in mind, one must emphasise the importance of reaching out to such communities. It has been shown that of the 26,712 new cases of HIV in the European Economic area in 2006, 53% were transmitted through heterosexual contact and 65% of these were reported outside the country of origin. Interestingly border regions are the most vulnerable to harnessing conditions that augment HIV transmission and lack of sufficient care. This is probably due to the higher levels of prostitution and uneven access to healthcare in these regions.

Various efforts are being made with respect to this problem. In Germany NGOs organise sexual education for migrant women in mosques. Women who have received such training will then be able to pass on the information to others in their community. By creating these 'agents of change' knowledge becomes disseminated in an inexpensive, cost-effective and powerful way. In Sofia, Bulgaria there is also a similar programme aimed to involve minority communities in their own sexual education programmes, this is run by the HESED centre. The centre also gives particular attention to MSM individuals involved in sex services. These men are very stigmatised and also highly mobile.

Malta's position in the heart of the Mediterranean, between the continents of Africa and Europe, also leads to a large annual influx of migrants seeking refuge from hardships in their homeland. Approximately 15,000 asylum seekers have landed by boat on our small island nation between 2002 and 2012. These migrants, typically from sub-Saharan Africa, arrive in Malta after treacherous boat journeys across the Mediterranean, in unseaworthy boats, without enough food, water or fuel. This has subjected Maltese doctors to dealing with health-related problems which we are not used to and with issues such as Female Genital Mutilation.

Female Genital Mutilation (sometimes referred to as female circumcision) is a cultural practice in which parts of the external genitalia are excised in young girls, although it may also be done in infancy or in adolescence. This practice is both traumatic and highly dangerous, with repercussions spanning throughout their lifetime with pain,

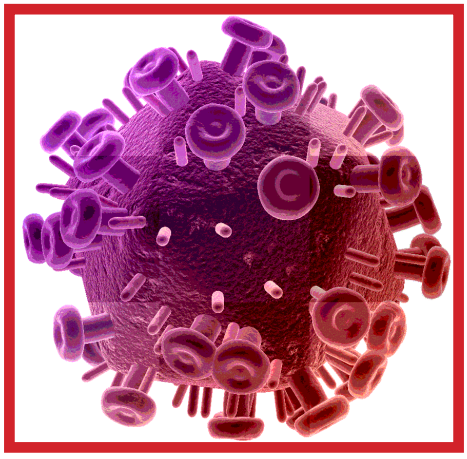
problems urinating, severe bleeding, cysts, infections, complicated childbirths and even death. There are absolutely no health benefits to the procedure. It is mainly done due to the belief that it will aid proper sexual behaviour. The basic rationale is that this will reduce woman's libido and help her resist premarital sex and other 'illicit' sexual acts. Local structures of power and authority, such as community leaders, religious leaders, circumcisers and even some medical personnel can contribute to upholding this practice. Approximately 140 million girls worldwide are living with the consequences of female genital mutilation.



Efforts are being made to stop the practice; the UN adopted a resolution for the elimination of female genital mutilation in 2012. In the same year WHO adopted its "Global strategy to stop health care providers from performing female genital mutilation" in collaboration with other key UN agencies and international organisations. The main areas of focus include strengthening the health sector response through training and policy, building evidence and statistics regarding causes and consequences and increasing advocacy through publications and other advocacy tools. These are areas that we should be well aware of, considering how migration is affecting Malta in this regard.

Other sexual health needs should also be addressed amongst asylum seekers and there is much to tackle in this regard. In the UK, for instance, surveillance programmes of sexually transmitted diseases (except HIV) do not routinely collect data on country of origin. Healthcare service providers should not perceive the presence of asylum seekers as creating new problems, rather the approach should be focused on highlighting gaps in existing healthcare provision and taking on a proactive role towards providing the best service possible.

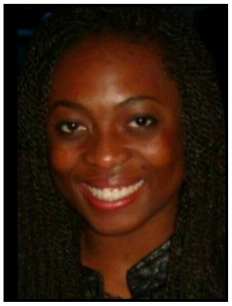
Sexual Migration is a term coined to refer to the international relocation that is motivated, directly or indirectly, by the sexuality of those who migrate. This concept moves away from the usual economic drives to relocate and puts emphasis on the idea of sexuality as a motivation for migration. There may be a desire to continue a romantic relationship with a foreign national or perhaps the hopes of exploring sexual desires or gender identity transformation. Sexual migration may also be necessary to avoid persecution, or to search for more hospitable environments – perhaps especially in light of LGBT issues. Malta received a zero rating in the ILGA report on LGBT rights released on 17 May 2012 – international day against homophobia. This was the worst result amongst all the EU member states. This result emphasised the need for action and might have been one of the catalysts to hearing more about LGBT issues in local media over the past months.



As healthcare shifts from a local system to one which is geared more towards global health, we must consider many issues that such changes bring about. Breaking boundaries, building bridges and removing borders are all buzz words in today's world and in essence they are all very positive concepts. However, advocating for such change needs to be well calculated to balance the healthcare needs of each and every individual.

Who Are You?

Your Hobbies have the Answer!



Olive Ochuba

I have a proposition for you.

Activities you choose to engage in outside your primary occupation, in order to relax, are particularly indicative of your personality type and your success as a medical student.

On first consideration, it may not seem too far-fetched. Quite plausible, in fact, and you wouldn't have to search for long before coming across theories and studies that support it. Most hobbies possess the peculiar quality of stimulating yet relaxing the mind.

Personality plays a significant role in determining the type of hobby a person chooses. An introverted and reserved personality is very unlikely to choose a hobby which demands a high level of social interaction. Introverts obtain their energy from within, as opposed to extroverts who do so from interacting with others. The difference between introverts and extroverts and other personality distinctions such as thinking versus feeling, sensing versus intuitive and judging versus perceiving, all characterised by Carl Jung, a Swiss psychotherapist and psychiatrist whose work has been the basis for many personality assessment models and tests.

The medical profession has long occupied an esteemed position in society and physicians have largely enjoyed this prestigious label. Traditionally, and to a lesser yet significant extent today, the doctor was revered as an omniscient being, who knew all there was to know about others, but very little was known about himself. This mystery surrounding the psyche of the doctor coupled with the rising interest in personality studies sparked an entire movement seeking to place the doctor on the examination table. They sought to learn how to identify the salient qualities of a successful doctor early, during and even before medical school. The successful medical student prototype has been described as conscientious, intelligent, meticulous, driven, idealistic, highly competitive and a perfectionist. Such personalities naturally lend themselves to hobbies such as arts and crafts, playing a musical instrument, reading and exercising, as they demand high levels of concentration and attention paid to detail together with an idealist perception of the end-product.

It may be useful to appreciate the psychological conception of 'the medical student' using Gordon Allport's Trait Theory, which characterises traits into four levels – cardinal, central, secondary and common traits. Cardinal traits are broad, overarching qualities that dominate and characterise a person's life or stage in life. The cardinal traits become so defining, that the person is known almost exclusively for those traits, e.g. Freudian or Christ-like. Central traits are those that others use to describe us, e.g. humorous or intelligent whereas, secondary traits are those that appear circumstantially: they are usually general and reflective of one's culture, e.g. the welcoming and friendly culture of Mediterranean societies. Considering 'the medical student' as a somewhat cardinal trait can allow for the large variation we see in the

medical student population.

Although considered under the umbrella of the medical student, many traits divide us. Psychologists refer to these as the Big Five personality variables or, more formally, as the Five-Factor Model (FFM). The Big Five are extraversion, agreeableness, conscientiousness, emotional stability and openness to experience. Studies comparing medical students to students of other disciplines have found that medical students score highest on extraversion and agreeableness, in general. Those with particularly high success during the clinical years scored high on conscientiousness (i.e.' self-achievement' and 'self-discipline'). A high rate of failure during the preclinical years were noted in students scoring low on conscientiousness and high on both 'gregariousness' and 'excitement-seeking', both sub-characteristics of extraversion. However, those scoring high on extraversion, performed with much success during the clinical years.

Drawing linear parallels to predict the type of hobby a successful medical student may engage in, however, may not be accurate in the slightest. This topic has become more significant as medical student education, particularly the selection of, have come under the microscope in recent years. Many proposals have been made to include personality tests as part of the medical student selection process, but many have warned of its limitations in the prediction of success and suggested that they may better serve as a useful tool for medical student guidance and counselling. Another proposal along the same lines suggested the use of a list of hobbies given by the applicant as a rough indicator of personality and therefore success.

A quick survey conducted in the first year MD class here at the University of Malta showed that by far the most popular hobby selected from a list of various hobbies (with an option to include those not listed) was 'watching movies/theatre'. This may come as a surprise to those unfamiliar with the rigours and stresses of being a medical student. The medical student personality classifies the student as academically capable, highly competitive and a stickler for detail and predicts that such a personality will engage in activities that demand such qualities. However, the condition of the medical student is a result of the complex interplay of the perfectionist and competitive personality within themselves, between their peers, and between their educators. There is a high level of expectation from all parties, leading to high levels of stress and criticism of both the self and others. It is therefore highly likely that a medical student might engage in a somewhat 'passive' hobby to relieve stress. Nonetheless, the theories do hold some weight. The rest of the hobbies selected did follow the theory as the second most popular hobby selected was engaging in a 'physical sporting activity' followed by 'reading/writing', then 'exercise', 'playing PC games' and 'playing a musical instrument'.

Psychological theories on personality are helpful in characterising others but it must be recognised that the medical student body, although considered to share overarching qualities, is a diverse mix of personality traits. This should be carefully considered when moves to select medical students who fit an explicit specification are made; there are many strengths in producing a generation of doctors who are non-homogenous in order to cater for a non-homogenous population. It is after all the ultimate purpose to produce effective doctors, is it not?

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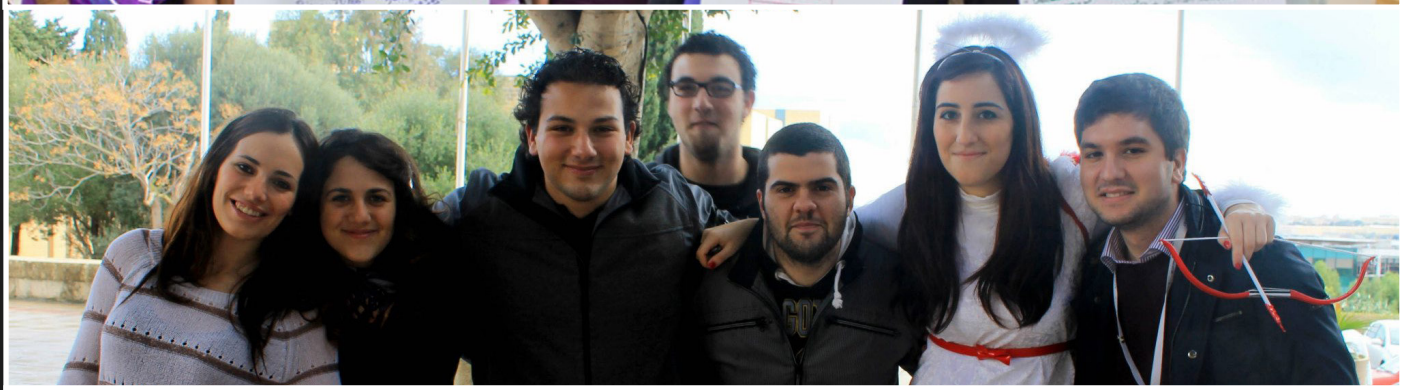

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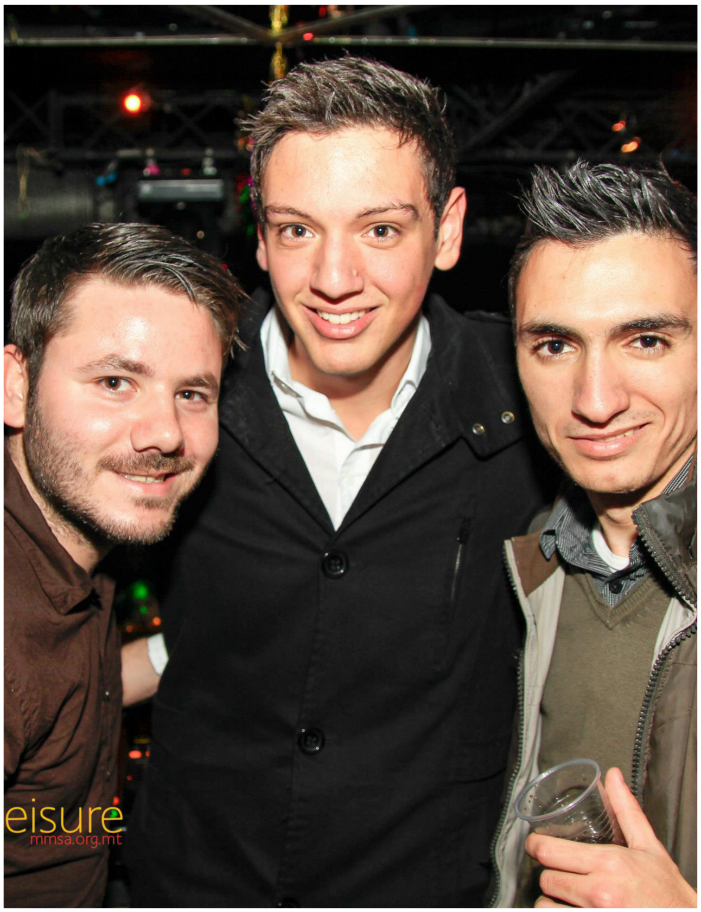
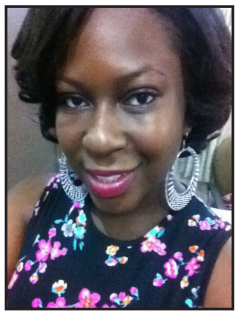


EXCHANGES

NPET

First Proper Paycheck at 27?

Studying medicine with a previous degree



Moyo Naomi Awobajo

The decision to pursue a medical degree as a graduate is a significant life choice that many face. Medicine is a difficult course that requires a career choice from the onset and has been proposed to not only require academic brilliance, but also a substantial level of maturity.

The medical school system in the United States of America is already established as a graduate program requiring a pre-med degree for entry. Graduate Entry Programmes came into existence in the UK in 2000, encouraging students who have gained a first degree to study medicine. The major reason for this was to create an opportunity for career change for suitable candidates.

Graduate entry medicine is a highly competitive course and many students find that they can increase their chances of getting into medical school by applying for the undergraduate 5-year medical courses instead. According to the NHS careers website, "It is estimated that graduates, mostly with science degrees, make up 10-15% of recent intakes to the five and six-year MB courses in Britain. "This is the reason for which I find myself in the University of Malta Medical School.

My Story

I am a life-sciences graduate with a BSc in Medical Genetics from the University of Leicester and an MSc in Human Molecular Genetics from Imperial College London, UK. I have always had the desire to study medicine but

"By some peoples' standards, a degree before medicine can be deemed as a waste of time."

was unsuccessful in my applications for undergraduate entry in the UK. Many ask why I still went onto studying genetics at a master's level even though I was interested in a career in medicine. At the time I started my postgraduate course, I was unsure about whether

I should still pursue medicine and had developed a passion for genetics from my undergraduate studies. During the course of my master's programme, I was exposed to the close relationship between genetics and medicine and by working with a number of Medical Geneticists, MDs with genetic backgrounds, my interest in medicine was rekindled. Now, with a couple of degrees in my pocket, I am pursing the career path I wanted to years ago with a more direct focus of what branch of medicine I want to specialise in.

The good, the bad , and the medicine

The bigger picture of studying medicine as a graduate has a few pros and cons. As a 23-year old graduate, I have reason to believe that I stand apart from my 18-year old undergraduate colleagues, not by means of better academic standing but via increased life experiences. I am a more focused student now than I was during my undergraduate course and I have already had previous experience of student life away from home so I am more prepared this time around. Academic-wise, my previous degrees have given me some advantage in certain aspects but not to the extent that I expected. My degree has helped provide me with a substantial foundation in cell biology, biochemistry, pharmacology and most of all genetics. However, these subjects have only acted as a foundation for me, as everything I have learnt so far in this course has been new information to add to my body of knowledge.

By some peoples' standards, a degree before medicine can be deemed as a waste of time and money spent on funding it. My response to that however, is that no time spent acquiring knowledge is wasted and no knowledge obtained is unimportant.

On the other side of the coin, coming back to university to study another course especially one as tasking and lengthy as medicine poses a number of challenges for most. I personally found it quite difficult re-adjusting to student life again. This was not only due to the social need to make new friends but also due to the financial ramifications of being a student again while my peers are in full time jobs earning a living. It is especially difficult for me being an international student due to the added burden of adjusting to an unfamiliar environment, a new language in a new country and being away from family and friends whilst trying to maintain relationships with them over long distance. Inevitably, I also worry about my future and think about how old I will be by the time I'm done with my training in my chosen field of medicine and how that may affect my plans of starting a family.

Despite all this, I have no regrets about my career path which involved obtaining a degree before studying medicine. I believe that entering medicine with a few more years of life experience has developed my ability to relate better to people, which I think will be a very useful skill when I finally become a doctor. I hope this means I will have increased my ability to empathise with patients. I also know myself better in terms of my own strengths and weaknesses, a skill I believe is important in the medical profession.

The Intercalated Degree

The option of studying medicine as a graduate is not one that is available to all due to a number of reasons; one of them being the financial costs that studying an extra degree poses. As a solution, many UK universities provide another option that is not only cheaper but also less time consuming because it does not involve taking out 3 to 4 years to study a degree.

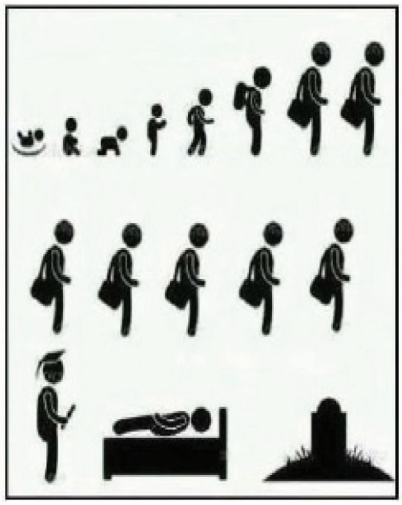
The intercalated degree is an opportunity tor medical students to obtain a further qualification. This degree is usually a year in length and provides the successful student with a qualification of a BSc, BMedSci, BA or

"The intercalated year is mostly done by taking a year out in between years 2&3 or 3&4 of the medical degree."

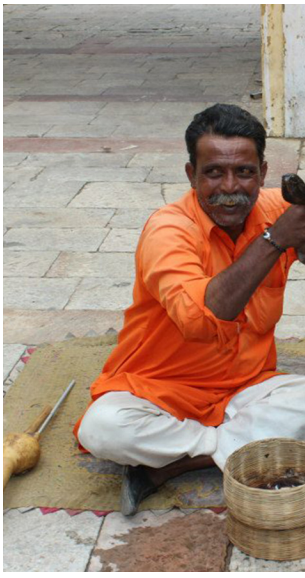
MMedSec in a medically related subject. The intercalated year is mostly done by taking a year out in between years 2&3 or 3&4 of the medical degree, thus making the total duration of studying to become an MD 6 years instead of 5. Students value the intercalated degree because they get to study an area of science they particularly enjoyed in one of their study-units. It is also an opportunity to demonstrate commitment to a particular speciality of interest, experience a different university environment for a year and make new friends. However, it is said to be a very competitive programme, and some students find it quite difficult to adjust, feeling like they are thrown in at the deep end, as the intercalated degree is designed to mimic the final year of a particular degree. Notwithstanding this, overall, students I know who have partaken in an intercalated degree have spoken highly of it and have suggested it should be an option available to all medical students.

Perhaps this would serve as a source of encouragement to the Heads within the Faculty of Medicine & Surgery at the University of Malta to consider liaising with other departments in the university and other universities in Europe to make an intercalated degree an option available to Maltese medical students. This would not only provide the opportunity to gain an extra qualification, but also the experience of studying abroad which can only boost CVs when the time for the 'oh so' important Foundation programme interviews and the applications for specialisation arrive.

Random person



Doctor

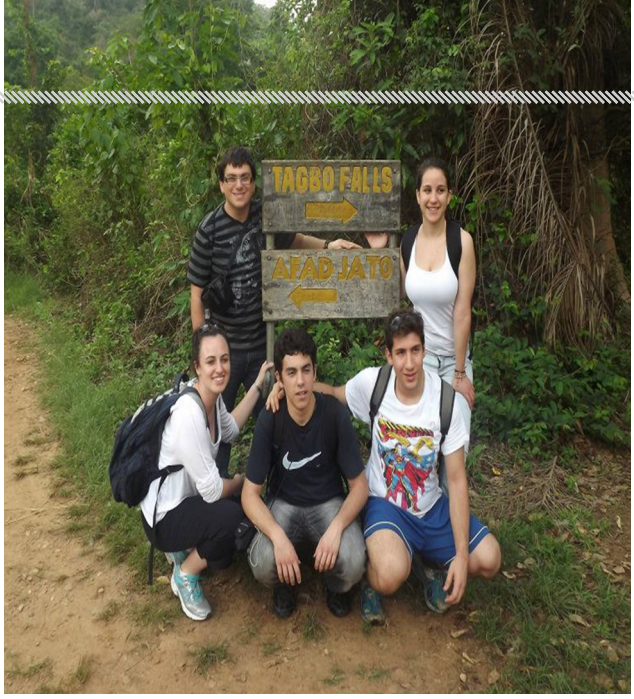


An Opportunity Not To Be Missed – The IFMSA General Assembly

Robert Cachia

Getting into medical school was a big step in my life and a major milestone in the path to becoming a doctor. However, I always knew that I did not want to spend the next five years of my life studying day and night and therefore I kept an open eye for any opportunities that came my way. I strongly believe that different experiences outside the classroom do contribute a lot to my holistic education and therefore I do everything in my power to go as far as possible to gain experience which is impossible to gain from books and lectures. My most cherished experiences as a medical student were surely the three General Assemblies (GA) of the International Federation of Medical Students' Associations (IFMSA) that I have attended till now.

The IFMSA holds two GA's every year, the March Meeting (MM) and the August Meeting (AM), held in the respective months. The GA's serve as a platform for members of IFMSA



"Don't wait for extraordinary opportunities. Seize common occasions and make them great"

to meet and discuss projects organised all over the world, statute and bylaws, elections of Executive Board's (EB) and Team of Officials' (TO) members such as the standing committee directors, sign exchange contracts, organise workshops and trainings and create policy papers amongst other things. The GA is the highest entity of the IFMSA and therefore serves as an opportunity for important decision-making.

My first experience of a GA was in August 2011 when the AM was held in Copenhagen, Denmark. This was the 60th anniversary of the IFMSA and therefore a very special occasion for all IFMSA members. It was a new and overwhelming experience and seeing so many future doctors gathered in one place was quite astonishing. It was very heart-warming to see more than a thousand medical students from over a hundred countries working together to achieve better universal healthcare. The theme chosen for this meeting was "Building Bridges", which fit in very well for my very first GA. The amount of friends and contacts I made during those ten days of hard work and fun was incredible. Friends from all over the globe including countries such as Mexico, Saudi Arabia, the Netherlands, Argentina, New Zealand, Chile, Switzerland, China amongst others, with whom I am still in contact today.

This GA also helped me a lot since this was my first international experience before taking up the role of National Officer on Medical Education (NOME) for the Malta Medical Students' Association (MMSA) for the year 2011 – 2012. Discussing different projects and curricula of different countries did not only give me a lot of knowledge as to how things work beyond the shores of our small island, but it was also very motivating and insightful. Apart from other medical students, I also had the opportunity to meet a number of persons who have greatly contributed to healthcare and the medical profession on an international level. These included Prof. Hans Rosling who is a Professor of International Health, very well known for his work in public health and his TED talks, Prof. Erik Holst who was the 1st President of the IFMSA

back in 1951, Sir Michael Marmot who is an expert on the topic of Social Determinants of Health, and Prof. Stefan Lindgren who is the President of the World Federation for Medical Education (WFME).

My next GA experience was the following March when it was held in Accra, Ghana. Knowing that I would be visiting the African continent for the first time, I truly believed this would be a once in a lifetime experience. Not only would I be living in a totally different cultural world but once again meet some of the people I had met in Copenhagen a few months prior. The theme chosen for this GA was "Youth and the Social Determinants of Health" which focused on delivering a message about the importance of medical students and young doctors within the healthcare setting. After all we are the future of the medical profession and what we do know will be what changes the future of national, international and global health.

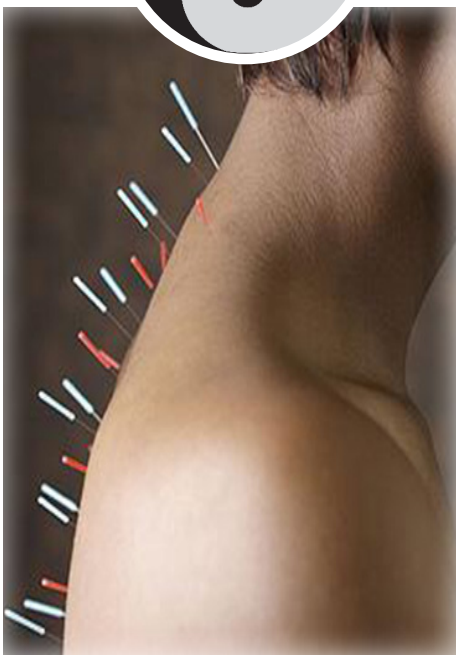
Living for two weeks in a country with a large number of inequalities was a very humbling experience. So many medical students gathered in a country where the need for equitable healthcare is enormous, surely affected the lives of those who had never experienced poverty and inequity before. Personally, it was a life-changing experience which made me fall in love with Africa and I would surely love to go back in the future and maybe contribute to a better healthcare in the developing countries of this resourceful continent which has not yet reached its full potential.

My latest GA experience was in August 2012 when it was held in Mumbai, India. This time, the chosen theme was "Universal Health Care – The Time is Now!", also a very appropriate theme with the current Indian government aiming to reach Universal Health Coverage by the year 2022. Once again I was excited to fly out of the European continent for the second time that year to visit "Incredible India", the land of the Taj Mahal. The Indian experience was another cultural shock for me and many of my colleagues. One of the experiences I will never forget was my visit to the slums of Mumbai which was very moving. Seeing so many people living under a metal roof, but yet so content with life, was just astonishing. Of course we also got to do some fun things such as riding an elephant, going on a safari, visiting Hindu temples and learning about such a huge country which is home to over a billion people.

All my three GA's were invaluable experiences and I learnt a lot of life lessons by attending these meetings. Meeting different people, having fun, discussing daily life across the globe, attending the "National Food & Drinking Party" (NFDP), collecting badges and souvenirs of different countries and National Member Organisations (NMO's), getting innovative ideas, feeding off other's motivation and making lifelong friends from all over the globe are all things that made a difference in my life. My advice to all those looking for such opportunities would be to attend an IFMSA GA as it is the ultimate experience a medical student can have. I would myself love to attend my fourth and possibly fifth GA before I find myself working as a doctor!

EAST meets WEST

Rheinallt Morgan



This article offers a comparison of Western allopathic medicine and Eastern systems including Traditional Chinese Medicine (TCM), acupuncture and osteopathy.

Traditional Chinese Medicine has been around for centuries; its beliefs stem from illness being the result of an interruption of meridians or channels that convey 'qi' (a life giving energy or force that is present all around us) throughout the body. Certain martial arts develop 'qi' (or 'ki' in Japanese)) such as to render a devastating effect; to temporarily disable an opponent or to condition the body to break objects (tamashiwari) such as a stack of roof tiles or concrete blocks.

TCM incorporates the use of herbs, some of which have achieved notoriety; since endangered species have been killed in order to use parts of their body as ingredients in TCM products, e.g. tiger bones. Acupuncture and moxibustion (heating a specific acupuncture point by burning herbs, to stimulate the flow of 'qi' through the body) are also examples of TCM.

Acupuncture can be used to successfully treat a wrist ganglion that presses on a nerve (a ganglion is a collection of cell bodies outside the central nervous system) by using a bifurcated solid needle, instead of the Western approach which is by doing a surgical excision.

Academic papers suggest that acupuncture stimulates the inhibitory nervous system. "Osteopathy is a system of diagnosis and treatment that lays emphasis on the structural and functional integrity of the body".

The General Medical Council of the United Kingdom only recognises allopathic medical degrees as a basis for medical practice; this is in stark contrast with the USA where a number of DO (Doctor of Osteopathy) schools operate. Their degree courses have lower admission requirements than the traditional MD (Medical Doctor) degree but are recognised at par with the MD for postgraduate training jobs.

Osteopathy is considered by the British Medical Association as having a complementary role in healthcare.

Two sides of the coin

Kurt Apap

Malcolm Falzon

The therapeutic potential of illegal drugs

The frequent mention of illegal drug finds and overdoses in the media serve as a reminder that despite constant battles against illegal drugs, they continue to exist and thrive in our society. Laws and regulation addressing drug offenses do not seem to be an effective deterrent because the drug abuse still remains a rampant problem in today's society. From a young age, we are educated about the health risks that illicit drugs pose. But whilst many are aware that recreational drugs are dangerous, few are aware that these same drugs have been researched for years and some have been found to have surprising therapeutic applications. Ironically, some of the recreational drugs used today were discovered whilst carrying out research to develop new medical treatment.

LSD

Since its inception, around 60 years ago in a Swiss lab, the psychedelic drug LSD, also referred to as California sunshine, Electric Kool-Aid and countless other colourful nicknames, has been taken by thousands upon thousands of people. The primary effect of this drug is an overall sense of happiness and euphoria hence its association with the hippy movement. Prior to its use as a recreational drug, LSD was used as a cure for some forms of mental illness. Different approaches were utilised, some clinicians gave patients low doses over several sessions in order to encourage them to focus on their subconscious and to reflect on childhood experiences. Others gave patients high doses, with the aim of triggerring a positive spiritual awakening to help them find meaning in their lives. LSD was also given by psychiatrists to alcoholics and criminals in the hope that they could be reformed. Many psychiatrists reported good results, but large scale studies were lacking. The last studies on the therapeutic potential of LSD took place in the 80's where it was believed that LSD can be used to give relief to terminally ill patients by reducing pain and by helping them feel more connected to their family members. In recent years, there has been renewed interest in the potential therapeutic use of LSD but we shall have to wait to see what the future holds.

" ... as the use of these drugs has been fluctuating, one wonders what the future holds in store for their use, possibly even dicriminalisation and use in medical setting."

Ecstasy

According to the World Drug Report 2010, published by the United Nations Office on Drugs and Crime, ecstasy use among Maltese 15-16 year olds is increasing significantly. In 2003 about 1% of this demographic used ecstacy while in 2007 the number had increased to circa 4%. The club drug ecstasy, also known as MDMA in the scientific world was discovered at the turn of the 20th century by the giant chemical company Merck whilst it was conducting research to develop a drug to counter blood clotting.

MDMA proved to be unsuitable for this purpose and it was only around 70 years later that there was renewed interest in MDMA. Psychotherapists of the time started to use the drug on patients who were having trouble opening up and expressing their problems. In the meantime recreational use was also on the rise and soon became the drug of choice for many people. Governments were quick to catch on and MDMA was made illegal in most Western countries. Once the drug became illegal, it was no longer used for therapeutic purposes. In recent years, the use of MDMA as treatment was revisted. It was discovered that MDMA can be used to eliminate dyskinesia, a frequent side effect of Levadopa treatment in patients with Parkinson's disease. However, due to the effect of MDMA on mood, current studies rather than focusing on widespread use of MDMA (which is unikely) are trying to determine how MDMA controls dyskinesia in order to develop similar drugs. Other research teams are revaluating the use of MDMA in psychotherapy, for example to treat anxiety disorders and Post Traumatic Stress Disorder.

Cocaine

Cocaine (also known as crack or the 'caviar of street drugs' due to its high price) besides being an extremely addictive and dangerous narcotic also has potential therapeutic use. Nowadays, cocaine markets are quite stabilised in the developed world with coca cultivation decreasing by about 28% in the past ten years. Cocaine actually can serve as a local anesthetic due to its numbing action. Nowadays, its use as an anaesthethic has diminished since it has been replaced by safer drugs. Cocaine can also be used as topical treatment for those who suffer from severe cluster headaches.The use of cocaine in the medical field has been limited since its benefits are outweighed by its risks. On the other hand, this does not apply for the coca plant, from where cocaine is derived. Some physicians claim that the coca plant can be used to treat motion sickness, laryngitis, constipation and obesity.

Heroin

Heroin is one of the most common illegal drugs on our islands, particularly amongst older drug abusers. Heroin is produced from the acetylation of the sister drug morphine which is extracted from natural opium sources such as poppy flowers. Opium poppy flowers were grown and harvested as early as the 3400 BC in Mesopotamia. The name 'Heroin' was coined by the pharmaceutical company Bayer in the late 1800s because it was supposed to 'heroically' treat pain without the addictive potential of morphine. Heroin hence is associated with pain relief, particularly severe chronic pain associated with cancer and labour. It has been shown that heroin used in terminally ill cancer patients is safer and more effective than other drugs that are already administered such as synthetic opiate oxycodone. However, although heroin is more potent since it achieves mood elevation effects and peak pain soothing much quicker, both pain control and mood elevation are at a prolonged timeframe with morphine. In 1901, the New York Medical Journal stated that "Heroin will take the place of morphine without its disagreeable qualities". Nevertheless, up till today, there is a total ban on the drug which does not allow hospitals and health centres to administer heroin, even when morphine administration is futile.

Amphetamines

According to the UN drug report, about 1% of the Maltese population was abusing of amphetamines in 2009. Even though they are available strictly as prescription medication, they are still abused of. Amphetamine drugs come from the class of phenethylamines and are psychostimulants, hence they aid in decreasing fatigue and increasing one's ability to focus. They are therefore used in the medical

field in treatment of narcolepsy – a neurological disorder affecting the sleep centres in the brain, often leading to excessive daytime drowsiness. Amphetamines are also the most common drug prescribed to children with ADHD (attention deficit hyperactivity disorder) since they release dopamine and norepinephrine allowing longer focus periods and aiding the child to calm down during tantrums. Furthermore, according to the State University of New York, amphetamines can be used in the treatment of depression and obesity. Perhaps the most unexpected therapeutic effect of amphetamines was suggested in 2007 by the Karolinska Institute of Sweden, stating that amphetamines have a possible positive effect on motor recovery in stroke patients.

Marijuana

Use of marijuana as relaxing agent, The use of marijuana as a relaxing agent dates back to ancient times. There is reference to marijuana in Chinese medical reference traditionally considered to date from 2737 B.C. Its use spread from China to India and then to North Africa and reached Europe as early as A.D. 500. Today, cannabis (also known as pot or weed) use is stabilising at a European level, but Malta has registered an increase throughout the past years. Cannabis is usually the first illicit drug one opts for after cigarettes and is thus very common among teenagers. Perhaps the most common use of this drug in a medical setting is in the management of cancer pain, phantom limb pain and post-operative pain. In cancer patients, apart from acting as an analgesic, it was found that marijuana might have an anti-emetic effect and can thus relieve chemotherapy nausea and vomiting. Besides this, cannabis has a bronchodilator effect on the

smaller airways of the lungs and can thus be used in treatment of bronchial asthma. Furthermore, studies have shown that cannabis users had a decreased intraocular pressure i.e fluid pressure within the eyeball, implying that marijuana could have a potential therapeutic effect in patients suffering from glaucoma, where the intraocular pressure is very high.

It may be quite paradoxical, since marijuana usually causes muscle spasticity, but it was observed that this drug could help alleviate ataxia and muscle weakness. This opened a window to the treatment of patients with multiple sclerosis, where there is decreased myelination and therefore frequent muscle spasms together with other neurological symptoms. Patients with cerebral palsy and spinal cord injuries can also benefit from this therapeutic effect. Finally, cannabis can be an appetite stimulant and therefore would be ideally used in palliative care of patients with anorexia resulting from opiods, antiviral drugs, terminal cancer and even AIDS-related illnesses. However, further research is required in order to establish adequate doses and administration routes, minimising the chance of adverse drug reactions.

In view of all the potential therapeutic effects of all these drugs, it is imperative not to put aside the fact that they are illicit because they do have evident adverse effects most of which outweigh the positive effects. However, just as the use of these drugs has been fluctuating, one wonders what the future holds in store for their use, possibly even their decriminalisation and use in the medical setting. It is proved that a regulated drug market would be better than the present situation where substances are sold illegally since it would be easier to check the strength and the purity of the drugs, the way they are administered and who is buying them. On the other hand, if from a public health point of view, decriminalisation is to make life better, one must make sure that there is no increase in the overall use and no abuse of the drug whatsoever and that is not something which is easily controllable. Consequently, it is the well-informed society that has to weigh all the pros and cons and encourage or oppose major changes in the field of drug legalisation.

THE OTHER SIDE...

In our walk towards becoming doctors, we always view the doctor-patient relationship from the doctor's point of view. But how does it feel to be able to relate to both situations at the same time?

Abigail Mula

As medical students we all enter medical school with a mindset, which is to become the best doctors we can be. But then again what is a good doctor? What defines good? According to Plato a good person would be someone who performs his function well and in the case of doctors that would mean curing patients. As medical students we eagerly look forward to our clinical years, during which we feel closer to fulfilling our, so to say, function. Establishing a good doctor-patient relationship is therefore crucial. Being on the other side of this relationship was definitely an eye-opening experience. Being a patient while looking at things from a medical perspective turned out to be quite interesting.

Medicine has been an interest of mine ever since I was about ten years old. When I was close to sitting for my O-levels I found out I was suffering from severe idiopathic scoliosis, for which I needed spinal fusion surgery. I underwent the surgery during my first year at sixth form. Although I was not a medical student at the time, I can

still say I looked at the experience from a scientific point of view. In spite of the fact I obviously wasn't ecstatic when I learnt the news, I did not let myself get depressed over it either. My philosophy was that at least this was a problem for which there was a solution. I reasoned out that the best thing I could do was make the best out of it and hence use it as a learning experience.

Prior to the surgery there was an informative session which was held at the Central Auditorium which I eagerly looked forward to, not only because it would allow me to learn more about my condition but also because I would also possibly learn more about the surgery. Although I had asked a multitude of questions to my orthopaedic surgeon and watched several videos on You-Tube, I was still eager to absorb as much information as possible.

About a week prior to the surgery, I went in for the pre-op where I did all the required standard tests; CBC, ECG, lung function tests, scoliograms and chest X-ray. I still remember my frustration due to the fact that I was unable to interpret my ECG together with most other tests. Something embarassing I remember is the fact I absolutely could not get the lung function test right, apparently something which is common amongst patients. The machine kept saying poor effort. To say the truth I was quite alarmed because the lung volumes and lung capacities which resulted were quite different from the textbook values I had learnt. Probably if this would have happened to me this year I would have stayed thinking about all the lung diseases I could be suffering from. If there is something I learnt from this is to look at results in an objective manner without thinking about the worst case scenario straight away.

"It was then that I actually fell in love with medicine, because although I had always expressed my interest in it, actually experiencing its results was a feeling I shall never forget."

As I was waiting to be allocated a hospital bed, a day before surgery, I met other patients who had to undergo spinal fusion surgery. As one might expect the topic of conversation was the surgery. A girl next to me started crying and as other people tried to console her, I tried to do the same, or so I thought. I told her: "Why are you worried, it's not like you will be the one holding the scalpel!", something I thought would be thought of as a joke. However it did not have the effect I was hoping for, because every person in the room turned to look at me with a blank expression. That was an awkward moment I will definitely remember. The night before the surgery I was quite excited, I could not sleep and neither could my room-mate. As my room-mate was watching Katy Perry's music video of "Fireworks" I decided to google some videos showing spinal fusion surgery for the last time. I was extremely happy when I managed to find a video showing the anterior approach (the approach which was used in my case as the curve was mostly prominent in the Lumbar region), as previously all the videos I had found showed the posterior approach.

"Being on the other side of this relationship was definitely an eye-opening experience. Being a patient while looking at things from a medical perspective turned out to be quite interesting."

November 19th: Surgery Day was upon me. That was the day I first set foot, or rather was pushed into, an operating theatre. One of my greatest fears, apart from the risk of spinal cord damage, was suffering from anaesthesia awareness, i.e. remaining awake all throughout the surgery without being able to move. As is typical of me, I had to say something to embarass myself, even exactly before the surgery. As the anaesthetist explained the procedure, all I kept thinking about was the aforementioned fear. He told me that after the administration of the anaesthetic I would be out in less than 10 seconds. However as soon as the

anaesthetic was administered, or so I thought, I realised that it was having none of the effects the anaesthetist had previously explained to me. As I expressed my alarm to him, he smiled and told me that he had not actually administered the anaesthetic at the time and hence had no need to alarm myself. I can now safely say I am not one of those 1 in 150 patients who suffer from anaesthesia awareness.

As soon as I woke up, still in the theatre, the nurses ensured that my nerve function was intact. Although I remember this clearly, everything afterwards was a haze and I remember how I couldn't regain consciousness for more than a few minutes throughout the rest of the day. The pain I experienced was excruciating and it was then that my love-hate relationship with morphine flourished. Unfortunately I experienced a multitude of withdrawal symptoms associated with the drug. I remember that I tried playing my own doctor and determine how long it took for it to leave my system by seeing what withdrawal symptoms I was suffering from. However the pain was not the only negative aspect I faced the first few weeks after surgery. Being completely dependent on others was perhaps even worse. I remember about two days after the surgery, I had started regretting my decision, however as soon as the nurse showed me the post-operative scoliogram I was so happy it was as if all the pain went away just for that moment. It was then that I actually fell in love with medicine, because although I had always expressed my interest in it, actually experiencing its results was a feeling I shall never forget. As time went by I went back to my normal life, which at the time mainly involved studying. This experience definitely provided me with the motivation I needed to continue pushing forward, doing whatever I could to get into the medical course and continue looking at things from an optimistic perspective, from a medical perspective.

However that was not it. 21st November last year was yet another memorable day. As I went for my final check-up, I told the consultant surgeon and another orthopoedic surgeon I was in my first year in medical school. The check-up quickly turned into a tutorial, with the consultant asking me which subjects I had covered, together with a multitude of questions regarding such subjects. I remember I got out of hospital feeling more motivated than ever.

I now look forward to actually witnessing a spinal fusion surgery, being next to the operating table and not on it!

How many organs can you name in Maltese?

"Bonġu dott, dalgħodu qomt b'uġigħ fiċ-ċinturin ta' dari. Naħseb dan l-aħħar kont qiegħed nistrappazza xi ftit iż-żejjed fuq ix-xogħol!"

Robert Cachia

Living in a bilingual country is a great honour and offers us wonderful opportunities. The Maltese language gives us a sense of identity and pride and distinguishes us from any other country. On the other hand, the English language serves to connect us with the rest of the world and enables us to build bridges and connections with those unable to speak our mother tongue. It is also the main language used in the writing of educational materials and resources. These facts make both languages invaluable to our personal and social development while providing the Maltese nation with solid grounds for communication.

It was when I started my clinical years that I realised how important the Maltese language still is within the Maltese health care scenario. Encountering patients who feel more comfortable communicating in their mother tongue is quite a common occurrence in the clinic, especially with most elderly patients having spent most of their lives interacting in Maltese. On the other hand, the younger generations tend to be using English more frequently especially since our education is based on resources, which more often than not, are only available in this language. This is therefore, slowly but concretely, creating a communication gap between Maltese generations. This phenomenon is being experienced especially by clinical students when communicating with elderly patients who still tend to use traditional Maltese words to describe medical terms such as organs, diseases and feelings, which would only be familiar to us in English.

With such an issue in mind, under the SCOME umbrella, I felt the need to tackle this matter and came up with the idea of creating a medical language translator which contains a valuable repertoire of medical terms translated from Maltese to English and vice-versa. Being the MMSA Medical Education Officer at the time, I felt highly motivated and also duty-bound to tackle such issues which may hinder the medical education of Maltese and international students reading for degrees which lead to a career in the Maltese healthcare sector.

The Medical Language Translator - Traduttur tal-Lingwaġġ Mediku , is an initiative which aims to provide an aide to all healthcare professionals and students when communicating with their patients. Apart from allowing the patient to feel understood, it enables an appropriate medical history to be elicited from the patient. Since a good history is the most essential tool to drawing up diagnoses, we are aiming to ultimately enhance the quality of care we provide to our patients.

The main difficulty with this project was to start off and select the words to be included in the translator. This required intense

research from two main sources, one being written materials such as English and Medical dictionaries, and more importantly, the students and patients themselves.
The next challenge was to select the appropriate translated words which fit in adequately within this publication, especially when considering that the amount of scientific words in Maltese is quite limited when compared to those found in the English language. Keeping the aims of this publication in mind, it was also decided not to limit the translation to one word so as to make the publication a more complete reference. Highly scientific words were translated both into the scientific version, when available, and also into a colloquial saying which the patients usually understand and use to communicate. Such an example would be the word "anaemia" which is translated into the scientific version " anemija" and the more colloquial version "demm baxx".

Even with words which are mostly used in English, we still opted to include a Maltese translation. An example would be the word "thyroid", which although used by a lot of Maltese, is still translated to the less popular "tirojde" for completeness' sake. This will not only make the translator more comprehensive, but will also help us reach another of our aims i.e. to provide a reference for anyone writing a scientific article in Maltese.

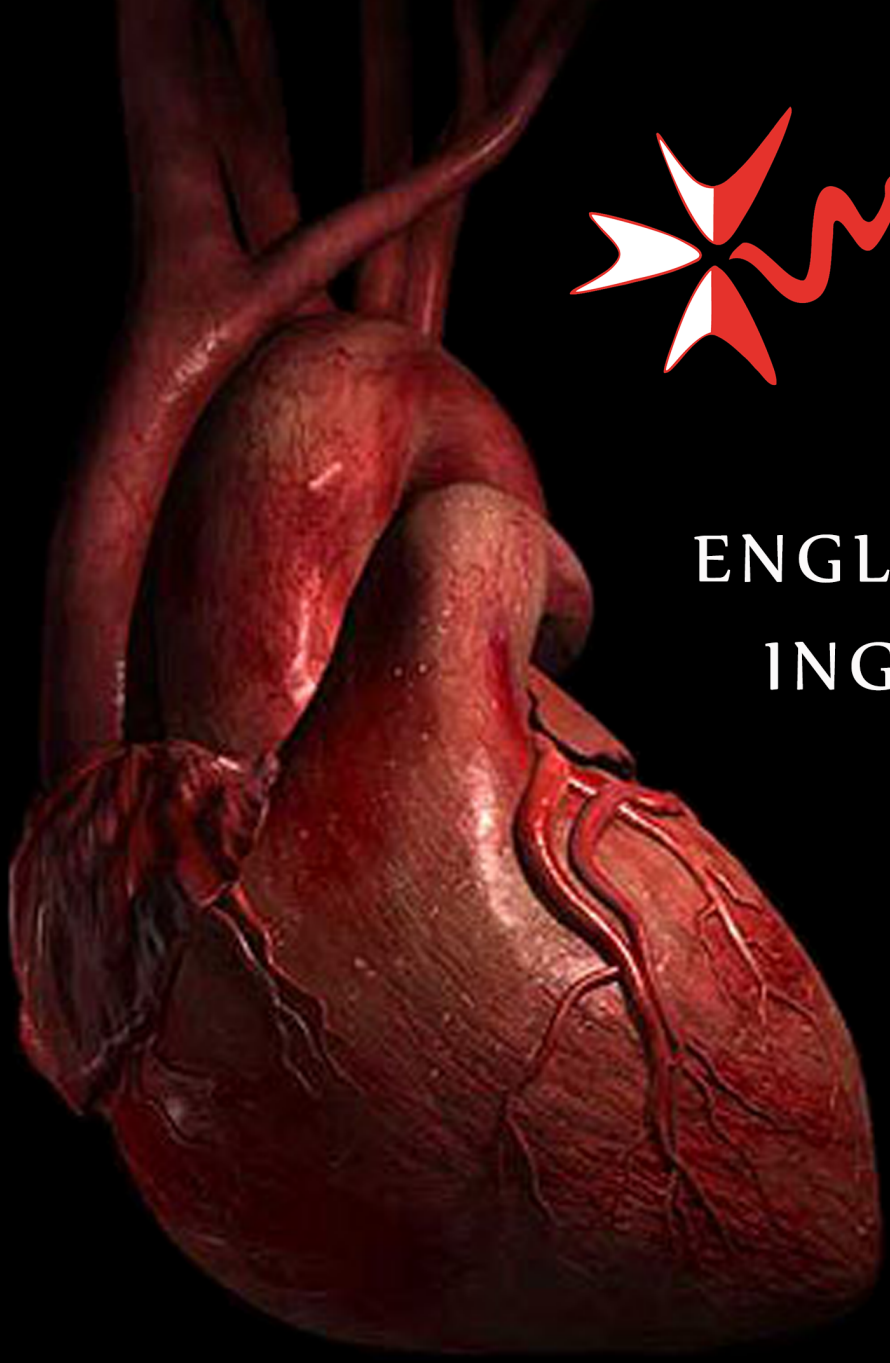
Apart from being a great tool for Maltese students who lack knowledge of traditional Maltese words such as milsa, frixa, suffejra, qabla and mendil, this publication is an instrumental partner to international students and professionals, who are contributing to the care of our patients in Malta. The number of foreigners coming to Malta to pursue their dreams within the healthcare field is on the increase year after year, and getting a hang of the Maltese language is essential for effective communication especially with patients. Thus, we aim to provide a translator which does not only help them communicate, but is easy to carry around and friendly to use.

To give this publication more value, I have been assisted by members of the Department of Maltese of the University of Malta who proofread and reviewed my work several times. Therefore I can confidently say that the quality of work in this publication is of a very professional standard. Together with all the members of our association, I would like to personally thank Prof. Manwel Mifsud, Dr. Michael Spagnol and Mr. Josef Trapani who were kind enough to offer their expert help so as to assist us with the correct use of the Maltese language.

This publication is out now. Our aim is to make the translator available to and usable by anyone, however it is especially aimed towards those involved within the healthcare sector, both professionals and students and also those who have a special interest in the Maltese language. Therefore, we hope, not only to contribute to medical education, but also to the quality of care the patients we encounter day after day receive, while promoting the Maltese language within the healthcare sector.

For more information send us an email on medicaltranslator@mmsa.org.mt !

"My belief is that communication is the best way to create strong relationships." — Jada Pinkett



MMSA

Malta Medical Students' Association

L-Għaqda tal-Istudenti tal-Mediċina ta' Malta

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MEDICAL LANGUAGE TRANSLATOR

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