MURMUR

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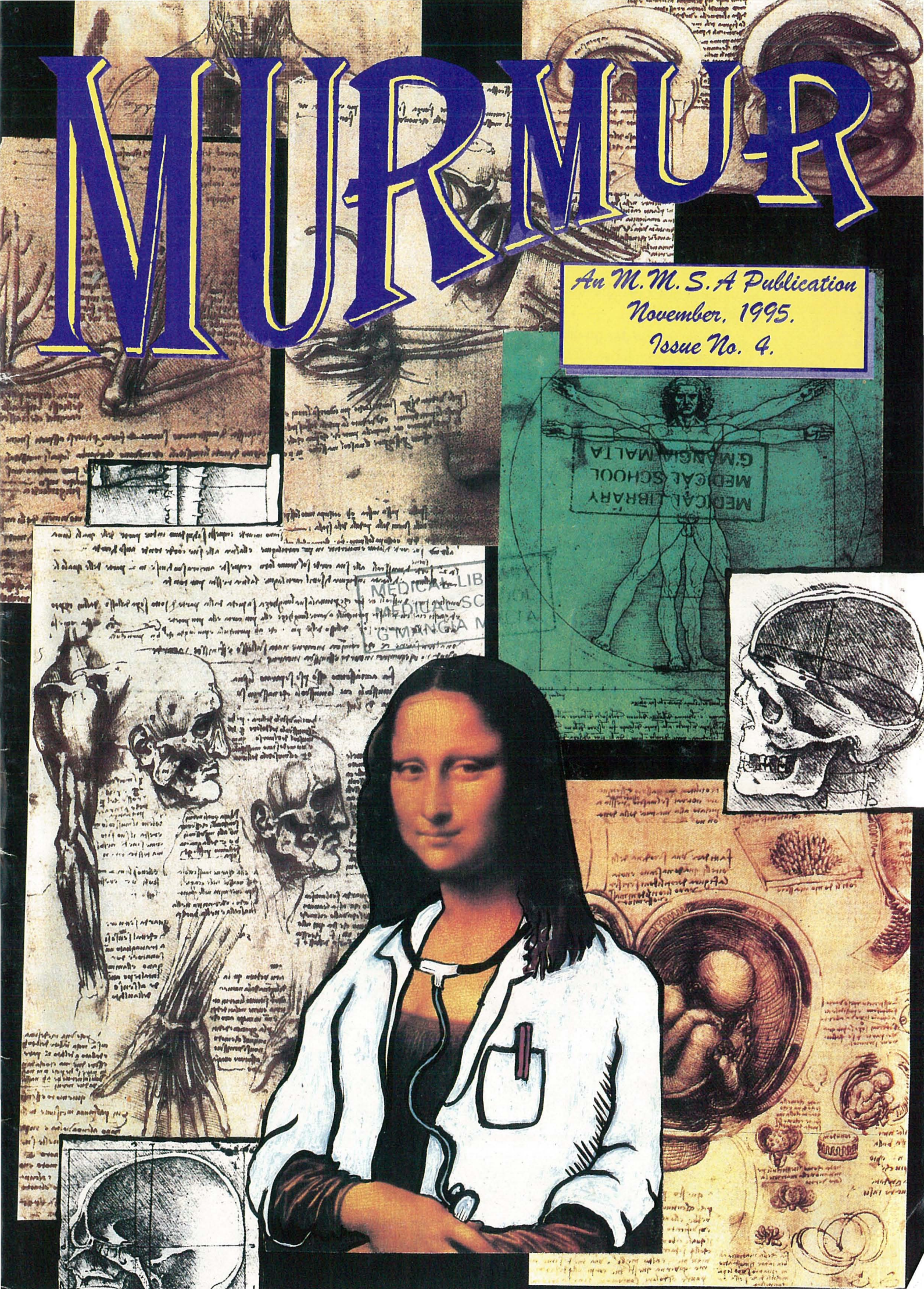

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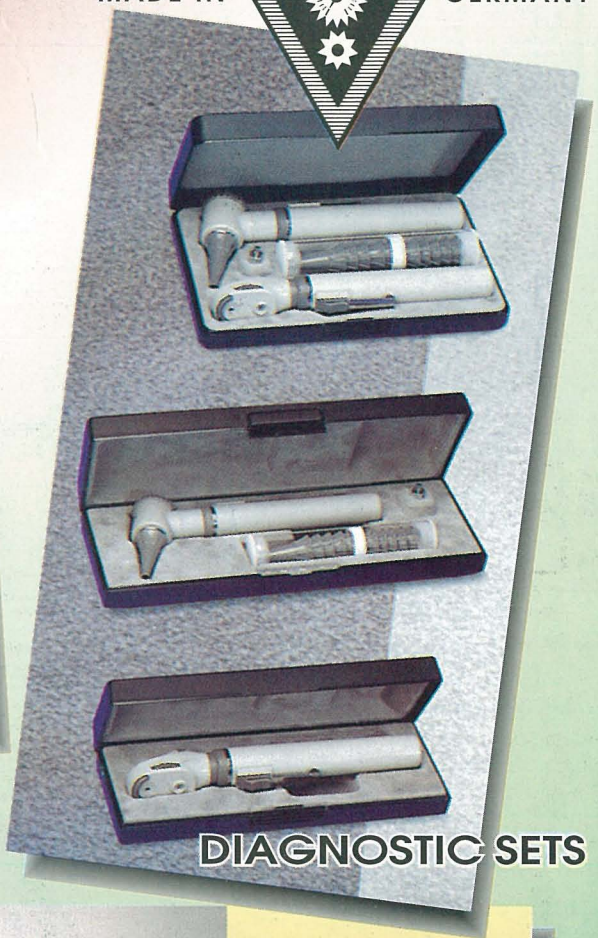

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Editorial

Murmur is celebrating its fourth issue. By now, we believe, this journal has established its roots amongst medical students, doctors and consultants at St. Luke's. No wonder, considering the urgent need of medical students to express their thoughts, ideas and beliefs, and to share their experiences with their fellow students. Murmur serves as an excellent medium for this; it is a means of communication between students, who all too often tend to be worked up with their cumbersome students' duties.

With this stance in mind, the Editorial Board set out on publicating the present issue. This proved to be no easy task. Besides the several shortcomings we had to face (which we won't bother you about), the board made the firm decision to keep up the extraordinary standard attained in the last issue, and where possible, improve on it.

We were greatly motivated by the numerous and interesting material we received; this varied from humorous articles to elaborate write-ups on art and an assortment of poems. It was impossible for us to fit each and every contribution into this issue: hence we decided to select articles having diverse themes and dealing with recent and relevant issues so as to try and suit everyone's likings whilst keeping the journal informative. We assure you that all contributions were equally and extremely appreciated.

Furthermore, may we remind you that we look forward to your comments, suggestions and criticisms. Your feedback is an invaluable contribution to the improvement of this journal. The favourable remarks received from foreign medical students' associations urge us all the more to put in our collective efffort to keep this publication alive. Hence, we encourage everyone, especially the preclinicals (whose response was not as good as we had hoped), photos or other. Remember that it is you who make this publication a reality, and you should be proud of it.

Finally, we would like to wish you all fellow students the best of luck for the forthcoming exams, and congratulate the new houseman for their success.

MEDICAL ISSUES IN ART

THE RENAISSANCE OF MEDICINE

Alex Borg (IV Year)

The 15th- and 16th-century renaissance, in medicine as in the arts and other branches of learning centred on the rediscovery of ancient Greek and Roman works in their original form. The invention of printing, around 1455, led to an explosion in the publication of these works. Interest in anatomy and classical surgery was thus revived, and given an enormous boost by the performance of human dissection, now appreciated as an absolute prerogative for anatomical knowledge. But the first man who departed completely from the inaccuracies of ancient texts (like those of Galen and Avicenna) and simply reproduced what he saw was Leonardo da Vinci (1452 - 1519). Dissecting at night and probably in secret, Leonardo produced a total of 750 anatomical drawings. A note for all those interested in history of radiology: CAT scan technology was invented in 1967 (G.N. Hounsfield), but Leonardo was the first to visualise the human body in cross-section, albeit on paper.

Leonardo da Vinci, born at Monte Albano, 50 km west Florence, has been called the "Universal Genius", without any doubt for his mastery of a wide range of scientific and artistic skills. At the age of 14 he was apprenticed to Andrea Verrocchio, one of the most respected artists in Florence. It is said that Verrocchio was so stunned by his pupil's success that he never wanted to paint again. Interestingly, Leonardo was a confirmed homosexual : he had male models and male assistants; he painted John the Baptist effeminate; he never married and never had mistresses.

But do not get carried away: in the evaluation of his achievements, the question of homosexuality is immaterial.

Probably, Leonardo had acquired his interest for the human anatomy from Verrocchio himself. The Greek sculptors were the last significant artists that had turned their attention to the study of human form, the athletic form in particular. There was one big difficulty for anatomists in Leonardo's period: there was papal anathema against the dissection of bodies. Anatomy books, however, were still available "under the counter".

Nevertheless, these texts perpetuated the inaccuracies of Galen, Avicenna and Aristotle. The impetus towards initiative in anatomy probably came from artists seeking realism in their representations. Artists in Florence at that time were lucky: they enjoyed the protection of the Princes (the Medici), and were buddies with doctors. In 1387, dissection was first permitted in the University of Florence; artists were called in to help their medical friends in the anatomy theatre, recording the dissections on canvas. Yet, dissecting material was still hard to come by.

Around 1490, Leonardo began to consider anatomy and physiology not just as ancillary to art, but as a science to be systematically studied. He was initially fascinated with comparative anatomy, as were previous masters, as can be seen in his study of human and animal legs. He departed from old techniques and used his own. Spending days and nights in slaughter houses and mortuaries, his work was a race against time, because of the putrefaction of his specimens (no artificial preservation was used at that time).

In many respects, Leonardo's methods and observations were far ahead of their time. He perfectly understood and depicted the structure and function of the musculoskeletal system. Here he used the new technique of "exploding" complicated structures while designing what he observed. After carrying out an autopsy on an old man, he gave the first clear description of arteriosclerosis, and probably even got a vague insight into the dynamic nature of the blood coagulation / fibrinolysis system:

"And this network of veins acts in man as in oranges, in which the peel becomes thicker and the pulp diminishes the more they become old. And if you say that as the blood becomes thicker it ceases to flow through the veins, this is not true, for the blood in the veins does not thicken because it continually dies and is removed."

Somehow, Leonardo succeeded in dissecting a woman who had died during pregnancy (the stigma, originating from the influence of the Catholic Church, against the dissection of female cadavers was already very strong, let alone pregnant ones). For the first time in the recorded history of science he showed the correct position of a foetus in a womb. (See Fig. 1) Leonardo was even aware of the discontinuity between the foetal and maternal circulations.... a discovery which remained unknown until William Hunter's "rediscovery" in 1751. However, being strongly influenced by comparative anatomy, Leonardo drew the human foetus in a cow's uterus!

Leonardo was also aware that much of the sexual process resided in the brain, rather than in the gonads. He also dabbled in genetics: he realised that there was a "power" that was transmitted to the embryo from both mother and father. Without any concept of electricity, Leonardo mapped the human nervous system and used frogs to study nerve reflexes... long before Galvani and Pavlov's experiments. He devised a theory that nerve transmission occurred by transfer of fluids; he was further misled when he found cisterns of nerve-fluid in the brain (of course, they were the ventricles filled with CSF). (See Fig. 2) In case you're wondering if he made any more mistakes, he did think that the appendix was a sort of safety valve controlling the passage of gas in the bowel!

Borrowing from his skill as a sculptor, he made wax casts of the CNS ventricles and aorta. He recognised the unheard-of concept of a four-chambered heart. However, his ignorance of the presence of capillaries left him in the dark with regards to the

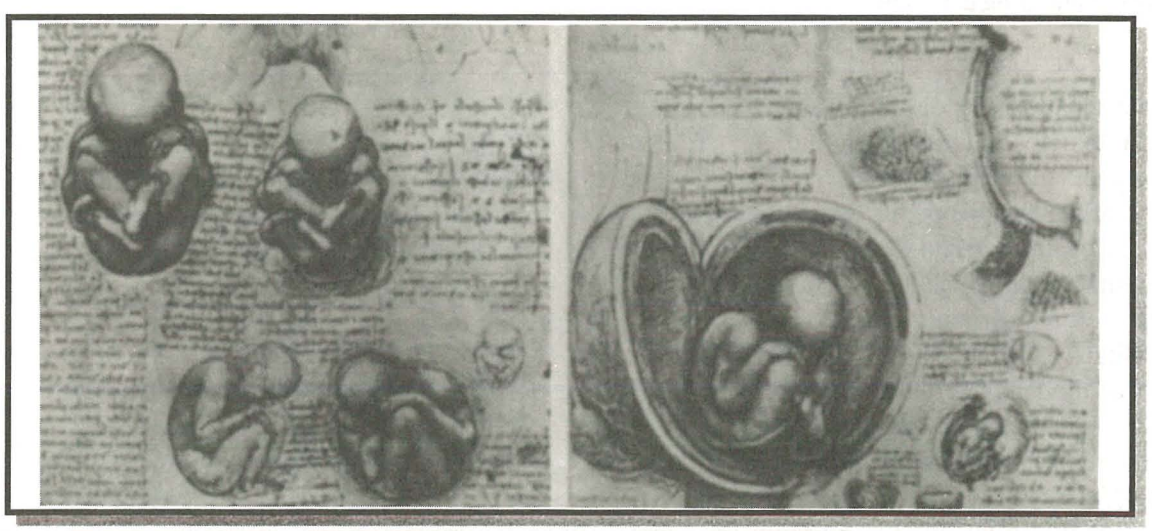

Fig. 1: The position of the foetus in the womb, drawn for the first time, c.1510-12. The picture on the right shows the cotyledons (vascular bulges of the chorionic plate in the full-term placenta, as seen from the maternal side when the decidua basalis is stripped off). Surprisingly or rather, shockingly, Leonardo has drawn the foetus in the uterus of a cow!

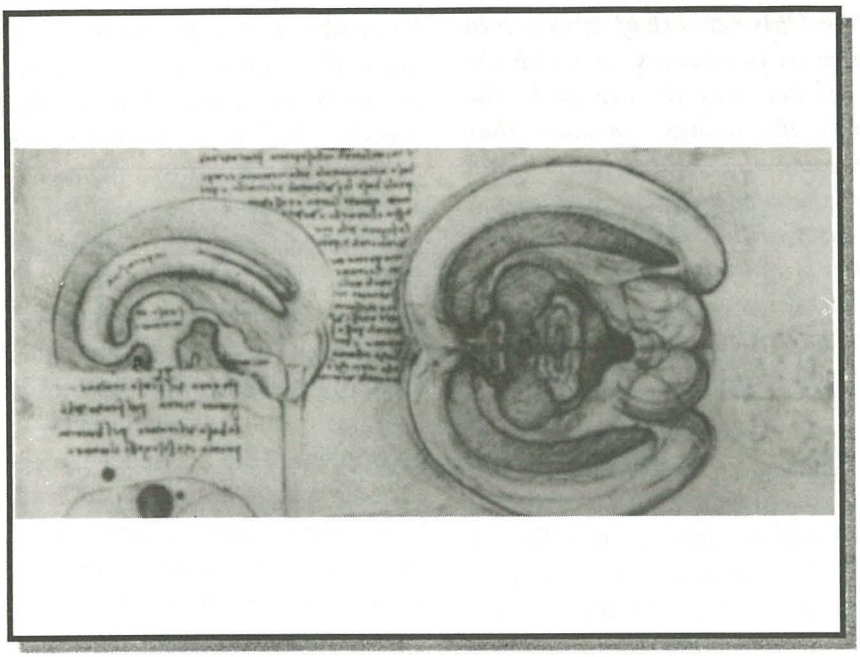

Fig. 2: Using the brain of an ox, Leonardo gives instructions for the insertion of wax to make a model of the ventricles.

transfer of blood from arteries to veins. That had to await until William Harvey demonstrated his theory about the circulation. The respiratory system was not a fruitful field of study either: Leonardo did appreciate the bellow-like action of the lungs, but he thought that the lungs are a blood-cooling system to offset the hypothetical frictional heat produced by the pumping action of the heart.

Leonardo's fascination with optics also brought him to the exploration of the eye. He defined the various parts of the eye: the pupil, the pigment layer, the iris and the vitreous humour, all of which had been known before, certainly to the Arabs. (Fig. 3) He recognised the function of the lens and other parts, and deducted that images focused at the retina were inverted from left to right and upside down, being aware of the principles of the pinhole camera. The pupillary light reflex was also known to Leonardo. He also did lots of work on comparative ophthalmology, and wrote, for example, about variations in pupillary size and shapes in different animals. In a time when the bare eye was the most important tool with which to observe the environment, Leonardo maintained that the sense of sight was the noblest of all senses.

Leonardo's anatomical work were left unfinished, like a good number of other of his ambitious works, and his research had no influence on medical thinking until William Hunter, the great eighteenth-century surgeon, found his papers, obtained from a chest at Kensington Palace in London. When William Hunter was shown the Leonardo drawings, he was flabbergasted: "I saw, and indeed with astonishment, that Leonardo had been a general and deep student. When I consider what pains he has taken upon every part of the body....I am fully persuaded that Leonardo was the best Anatomist, at that time, in the world...Leonardo was certainly the first man we know of who introduced the practice of making anatomical drawings." One could only imagine how the works of this great man could have radically changed medical ideas, which for many years after his death remained under the strong patronage of the ancient Greek and Arab fallacies.

Acknowledgements: I would like to thank Mr. E. V. Borg for providing very useful research material for this series of articles.

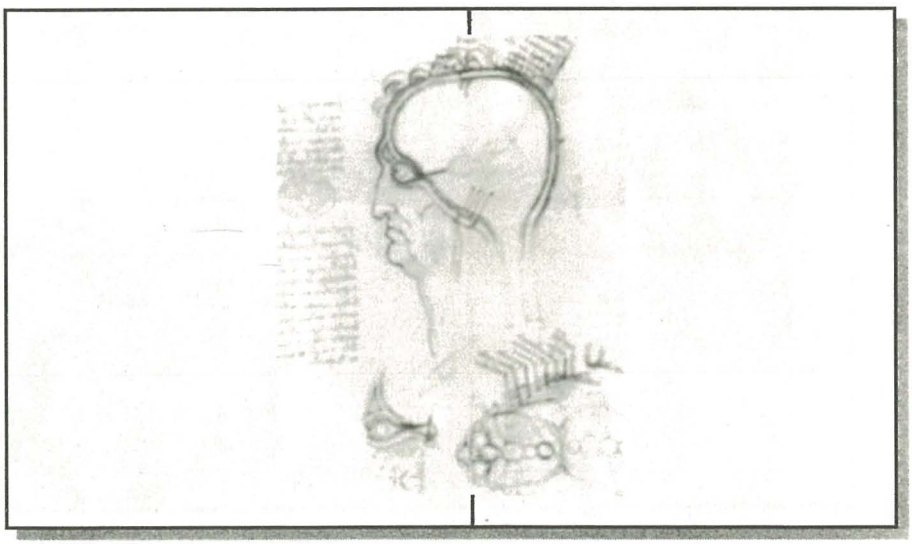

Fig. 3. Leonardo compares the head with an onion, and in slicing it through the middle, cross-sections the eye. He draws the lens as a sphere in the centre. In the plan below, he shows correctly the optic nerves crossing at the optic chiasma.

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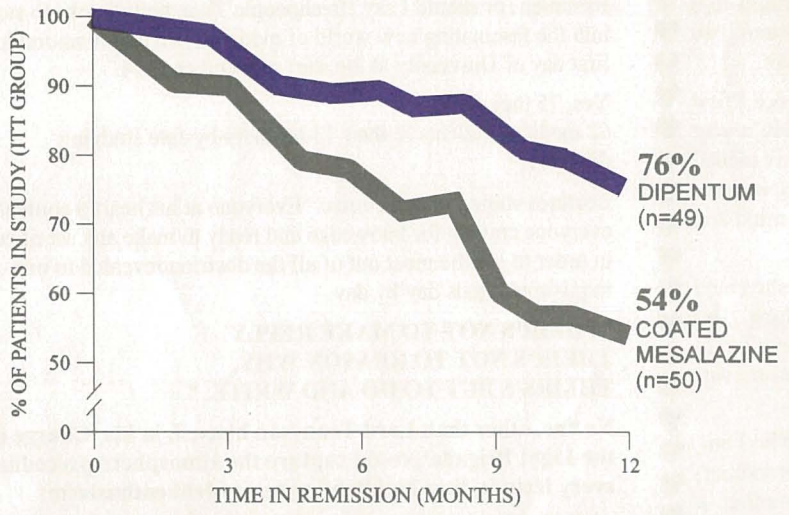

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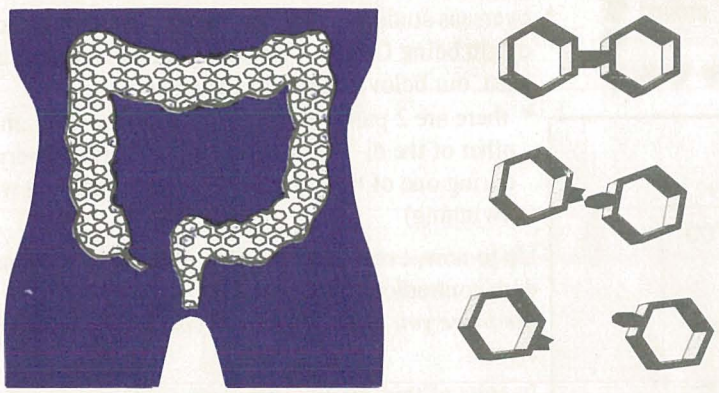

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A Syndrome Called Love

He approached her, his heart racing at 100 b.p.m., his hands cold and sweaty. Butterflies (Pieris brassicae) were dancing in his stomach, but his mind was made up.

"Good morning Maggie. Can you spare me some minutes .... in private, please?", he continued as he eyed the other three lasses sitting around her. She followed him to a relatively quiet corner, semi-concealed between two parallel rows of old, grey and cold looking lockers.

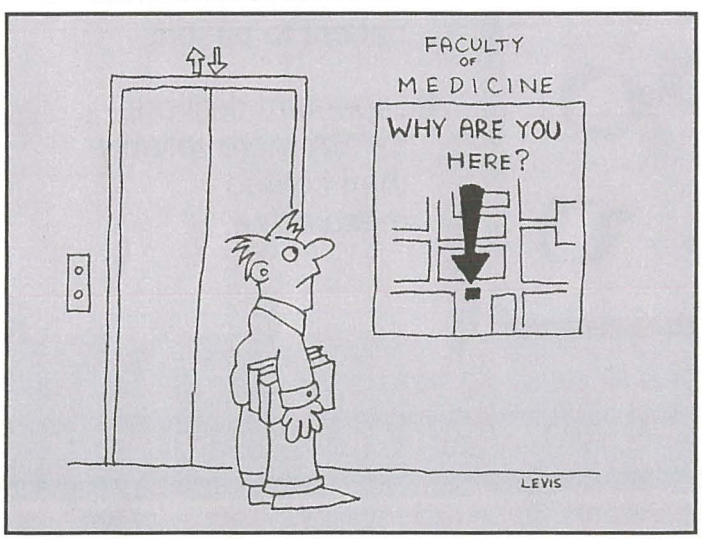
"Maggie," he started, "I have loved you ever since I first saw you doing Brodie Trendelenburg test nearly a year ago. In you, I find my physical expression and my mental fulfilment. Union with you will be *ex hypothesi*, eugenic and our children will inevitably be balanced in mind and body".

She blushed like a schoolgirl - why was it that she could not control her vasomotor nerves? - and said nothing. Her brain simply refused to transmit the appropriate efferent stimuli down the 5th, 7th, 10th and 12th cranial nerves, and in her confused silence, he continued.

"But of course, Maggie, darling you know not who I am. Let me illuminate you. My father was an astronomer, dealing with things in the large, and my mother a histologist, dealing with things in the small. I am the perfectly balanced product, in *mediis rebus*, flawless as far as I am aware, save for one tragic defect.

I suffer from congenital *erythema pernio*, popularly known as chill blains and it has been my gnawing anxiety whether this condition is hereditary. Otherwise, I would have spoken long ago, but months of research have at last brought me to a definite conclusion and I now feel justified, by induction and deduction, in asking you to become my spouse."

Maggie could not take any more; she was overcome by her emotions and gracefully dropped down to the ground under the action of gravity in a syncopal attack.



God Save The 1st Years!

Jean Agius (II Year)

"WHAT ARE THESE,
SO WITHERED AND SO WILD IN THEIR ATTIRE
THAT LOOK NOT LIKE TH'INHABITANTS O'EARTH
AND YET ARE ON 'T?" (MACBETH ACT1 SCENE 3 LINES 39 - 42)

Shakespeare could not find better words to express what was going through the lecturer's mind as he was facing a crowd of 75 freshmen (or should I say 'freshpeople'?) on tenterhooks to step into the fascinating new world of medicine, on that memorable first day of University at the start of October 1994.

Yes, 75 they were:
62 medical students & their 13 brothers-by-fate studying dentistry.

Lectures started in due course. Everyone at his heart's content, everyone craving for knowedge and ready to make any sacrifice in order to get the most out of all the doctrine revealed to our inquisitive minds day by day.

"THEIR'S NOT TO MAKE REPLY
THEIR'S NOT TO REASON WHY,
THEIRS'S BUT TO DO AND WRITE.."

No one, other than Lord Tennyson himself, in his 'Charge of the Light Brigade', could capture the atmosphere preceding every lecture, thus highlighting our ardent enthusiasm:

"O THE WILD CHARGE THEY MADE (on entering the lecture room, so as to get a front seat)
ALL THE WORLD WONDERED!
HONOUR THE CHARGE THEY MADE!
HONOUR THE MEDICAL STUDENTS
NOBLE FRESHMEN!"

To mention the several phenomena, one may pinpoint that among this year's preclinical students .....

* two-thirds XY, therefore by elementary mathematics one deduces that for every one female there are two males;
* overseas students are 9 in number, the countries of origin being Greece, Australia, Poland and, last but not least. our beloved sister island Gozo:
* there are 2 pairs of twins: one of the mono - and the other of the di- zygote (in fact they came in very handy during one of the Embrology lectures dealing with twinning)

Up to now, everything is going plainsailing. None of us dare contradict Socrates in that,
the more you know; the more you know that you don't know.

In spite of this, we are still determined to make the best of our youth. New friendships have sprouted and, on the whole, we greatly enjoy each other's company. On one occasion, a 'fenkata' night was organised and there are plans for some outings, weather- (& study-) permitting. As the saying goes, afterall:

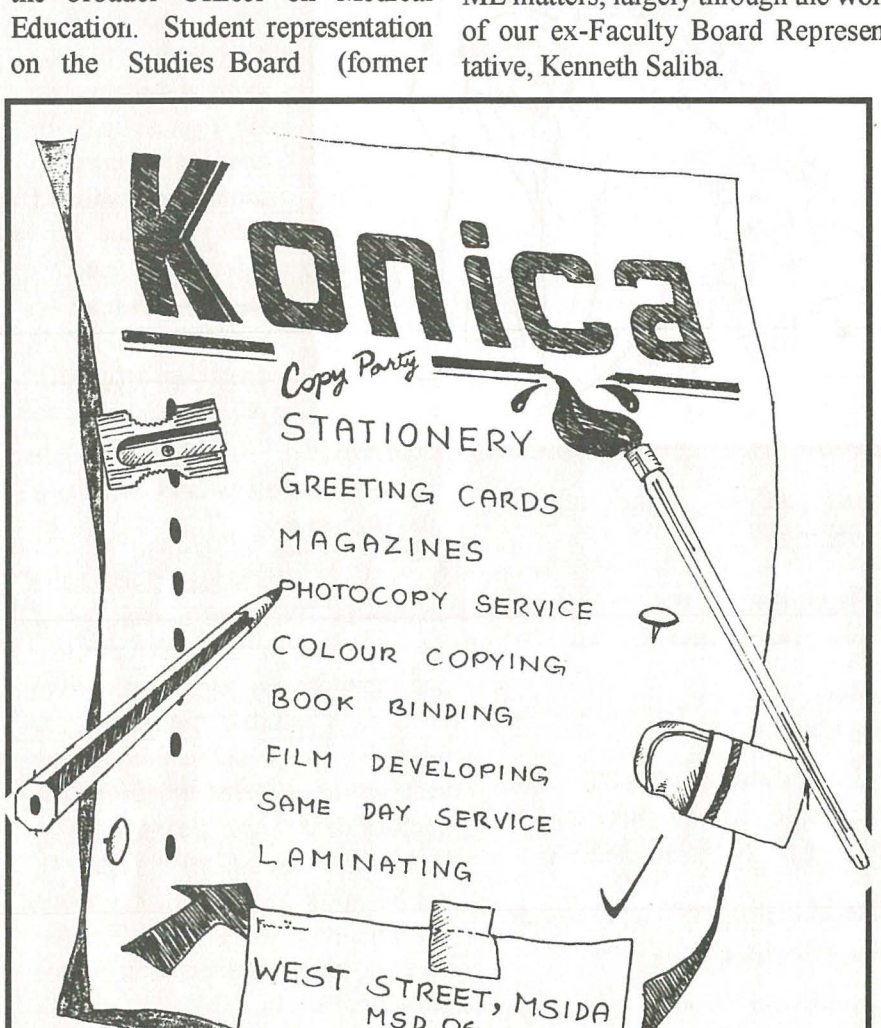
All work and no play, makes Jack a dull boy!!

M.E.

Ian Galea (IV Year)

Relax! This is not Agenda 2000 on myalgic encephalopathy but MURMUR updating its **medical education.**

M.M.S.A.'s involvement in Medical Education (ME) is gathering momentum. The post of Student Feedback Coordinator within the MMSA committee has evolved into the broader Officer on Medical Education. Student representation on the Studies Board (former Curriculum Commitee) has doubled. A sub-committee on ME has been set up. ME evaluation is set to become a regular MMSA activity. At the time of writing, plans are in the pipeline for a symposium on ME. (EDITOR'S NOTE: The symposium did take place last March). MMSA, as has always been the case, is taking an increasingly active role in practical ME matters, largely through the work of our ex-Faculty Board Representative, Kenneth Saliba.



On the international scene, last summer, MMSA's participation in the **International Federation of Medical Students' Association** (IFMSA) 43rd General Assembly in Ohrid, Macedonia, also got us involved in ME. Two members of the Maltese delegation, Marie-Klaire Farrugia and Kenneth Saliba took an active part in the **Standing Commitee on Medical Education** (SCOME) working commitee. As a result, Malta was introduced to the European Medical Curricula Access Disk (EMCAD) project, found in major European medical schools. An IFMSA position paper on student assessment, drafted jointly by Malta and Germany during the GA, was presented by the SCOME director during a meeting of the **Association for Medical Evaluation in Europe** (AMEE) in Athens.

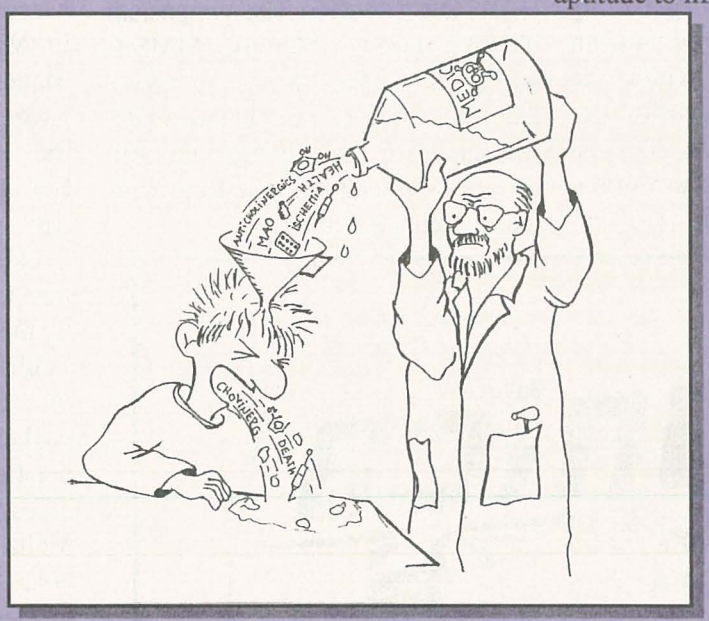
More recently MMSA participated in the **First International Workshop on the Future of Medical Education** held in Maastricht, the Netherlands. I represented MMSA in my capacity as Officer on Medical Education. During the 6-day workshop various facts of ME were discussed. Many points were relevant to the local situation and MMSA has a lot to benefit by discussing them. As a result of a Maltese proposal during the workshop, SCOME is now embarking on a so-called Medical Education Evaluation

(MEE) project. In the first stage an analysis of current MEE is to be carried out by those IFMSA countries which do already have a MEE infrastructure. Malta is set to gain at this point by learning from the experience of other countries and by securing foreign help in this field. A second stage involves encouraging other non-MEE-infrastructured countries to take up MEE.

The hottest topic in Maastricht was **Problem Based Learning (PBL),** an innovative curriculum which does away with the traditional pre-clinical teaching of basic sciences. Instead, students are presented with "problems" through which they learn the relevant anatomy, physiology, pathology, medicine, etc. Consequently the PBL curriculum is divided into blocks such as chest pain, blood loss etc. The general conclusion was an overwhelming appraisal of PBL as the eventual end-point of evaluation in regional curricula. The workshop was being held in the Faculty of Medicine and Health Sciences of the University of Limburg, which was set up in 1972 with a PBL-type curriculum. Thus I could get a first-hand feeling of PBL: it's just perfect! MMSA's exchange committee offers an exchange programme in Maastricht - it's worth the try!

The establishment of a permanent sub-committee on ME has consolidated MMSA's involvement in ME. It encompasses students from all years together with the Studies Board representatives, Faculty Board representative and the Officer on Medical Education. The following are some of its maior aims:

* A cross-roads of all the work carried out by various student representatives involved in ME where discussion and coordination can take place.
* Questionnaires and other MEE exercises: formulation, distribution, collection, analysis and report-writing.
* Organisation of an annual symposium on ME.
* Everyday practical problems in ME.
  Information centre for foreign study possibilities e.g. LEONARDO/ISEP etc.
* Monitoring of world-wide developments in ME.
* Lobbying for the introduction of new subjects e.g. ethics.
* Research in ME.
* International activity.



But why this interest in ME? Is it worth the hassle, the work, the effort?

I think that we all should be conscious of our ME. Right now, it is part and parcel of our living, more so than sports, exchange orny other MMSA activity. It is moulding our life-style and determines our daily mood. It sets our performance as students and future doctors, and stages our aptitude to life-long learning.

More than being conscious of ME, we must also have a say in our education. As a direct result of happening to be medical students, we are experts in ME, and our expertise should be respected and given due consideration.I encourage you to take an active part in moulding our own ME. We must learn to talk more on ME between ourselves and with our faculty teachers.

Deep down, we all have the same objectives. We want to make good doctors. But we have a life to live and want to enjoy our course. Five years are a hell of a time especially when they are smack in perhaps the best part of our lives. When we are doctors, consultants, deans (or, who ever knows, Nobel-prize winners), we all want to look back on our training and enjoy a copious release of endorphins rather than brace ourselves for an unpleasant stretch of tachycardia.

Note:
The Maastricht workshop attendance was partly sponsored by M.A.M.

LIVING WITH DIABETES

Natasha Muscat (Houseman)

Every day in hospital all doctors and medical students meet people suffering from chronic disease. Typical advice the patient might get is:

"....everything seems to be fine, just carry on with your medication, see you in six months time"

Undoubtedly, this phrase will sound extremely familiar to you all. From a medical point of view, this patient has a chronic condition which as yet cannot be cured. Drugs can control the illness, tide over exacerbations and possibly prevent rapid progression of the disease. A large number of so called chronic conditions exist. Here in Malta, one of the commonest conditions is Diabetes Mellitus; hereafter referred to as diabetes.

The psychological and social implications of living with a chronic condition, tend to be sidelined. In the case of diabetes, most emphasis is placed on running blood sugars within normal levels. Last summer, I had the opportunity to chat to a patient who has been living with diabetes for 65 years. Abandoning the classic formula of history taking suggested in all medical textbooks, I relaxed and listened to his story.

Diabetes has certainly blocked job opportunities and has also prevented me from getting promoted because of my reluctance to travel abroad.

"It was way back in 1929, I must have been about eight and a half years old, then, but still remember everything very clearly. I recall having felt a bit poorly for a couple of weeks and I was drinking a great deal more than usual. However my parents were alerted to the fact that something was not quite right by a very unusual incident. As a small boy, I accidentally urinated onto my shoes and my mother noticed whitish crystalline powder whilst cleaning them. It occurred to her to mention this chance finding when I was taken to the doctor after my having complained of not feeling quite right for a few weeks.

My family was told that I had diabetes and would require the "recently developed" insulin injections to maintain normal blood sugar levels. I was started on a twice daily regime to which I have adhered up to this very day. I was given glass syringes, and I still prefer to use them rather than the new-fangled modern devices. As from day one I had to learn to inject myself since my parents made it clear that I was responsible for my own health.

I started injecting myself in the right thigh and was never keen on changing site since with passage of time, injection always became less and less painful. The result is a big and unsightly lump of fat on my thigh which doctors refer to as lipohypertrophy. Well I have injected about 50,000 injections into my thigh so there has to be some consequence!

The biggest blow to me as a child was that I could not eat sweets as all children love to do. Otherwise I coped with school, played sports and carried out all my daily activities. In those days, it was fashionable to advocate a very rigid diet known as the "nine lines diet". I was equipped with scales to weigh precise amounts of food and I have done this for over sixty years. Today's diabeticians have a different approach when prescribing diet but old habits die hard and I am still very strict with myself.

When I became a young man and started thinking of getting married and building a family, I was afraid that my diabetes would make this

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somewhat impossible to achieve. I was always extremely reluctant to reveal the existence of my condition to my peers and colleagues. However, when I started courting my wife, I decided to let her know immediately. I have had a happy marriage, two children and several grandchildren.

'I do not know what living without diabetes is like!"

Although my family life was not shackled by diabetes, the same cannot be said for my working life. Diabetes has certainly blocked job opportunities and has also prevented me from getting promoted because of my reluctance to travel abroad.

The most frightening episode as a result of my diabetes occurred in 1933. I had cut my hand and my GP stopped my insulin. I was later rushed into hospital with an episode of severe diabetic ketoacidosis. The same thing happened again when my insulin was stopped prior to an operation, although this time it was less severe. I do wish all doctors know more about the dangers of stopping insulin and the fear that a person with diabetes feels if DKA occurs.

On the other hand, the general public should be made aware that diabetics can easily get "hypo", and all it takes is a bit of sugar as a remedy. I always try to carry sugar lumps in my pocket but not everybody can remember to do this all the time.

Over the past few years, I have started to suffer from certain complications as a result of my diabetes. I have been operated for cataracts and had laser therapy in my eye. I have lost sensation in my fingers and also suffer from impotence. I suppose at my age even a non-diabetic could have such problems!

I have spent a life time worrying about the complications from diabetes; about leaving a widow and orphaned children, about not being able to cope. Today I realise how futile worry is and I do my best to encourage younger diabetics to look forward to a brighter future. All diabetic patients await the day when a cure for the disease will be found. As it is, a diabetic has no choice other than to accept diabetes as a way of life.

Your question, young lady, was:
"What is it like to have lived with diabetes for 65 years?"

My answer is:
"I do not know what living without diabetes is like!"

It was definitely one of the most rewarding hours in an outpatient session. I would really like to use this opportunity to suggest that all students carry out this exercise with a patient suffering from a chronic condition.

Take The Plunge(r)

Gordon J. Ellul (Houseman)

What is cylindrical, has a formed tip and is made to go in and out?

Why a syringe of course! How many of us have approached defenceless patients with the avidity of a mosquito and remained unflinched as the patient desecrated all that is Holy?

Last summer I was sunbathing instead of attending monotonous ward rounds when I pondered in the most philosophical manner (i.e. cold beer in hand) on God's gift to dad's toolbox.

It all started in first year when I nicked my first 10 ml syringe from the Outpatients' Department (shock horror !). It was a great help with refilling my ink pen without filling the cracks in my desk. After that came a slumber where it lay forgotten in the recesses of my drawer.

The deep sleep ended the next year when I entered for the first time the A&E department (and was kicked out the first time!). My eyes fell on a 60ml syringe in its virginal state, glistening invitingly beneath the wrapper as a top model wearing the flimsiest of negligees. That day the syringe lost its sterility (or should I say virginity?). I had discovered a new way of topping up the car battery precisely and without making a mess.

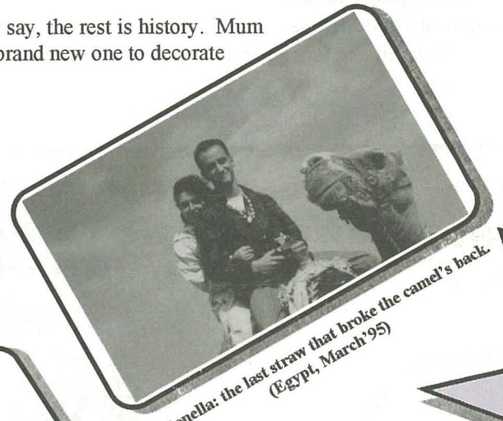
From then on I was hooked. The syringe took the place of honour on the altar (which the rest of the family insist on calling the toolbox!).

The next inspiration came whilst watching a pleural tap being done in M7. That evening I found myself home armed with a three way tap and a suction catheter. I threaded the tube down the radiator outlet of the car and flushed it repeatedly until all the muck came out. Whilst my neighbour spied on me from her strategically placed ***gallerija*** I felt ecstatic.

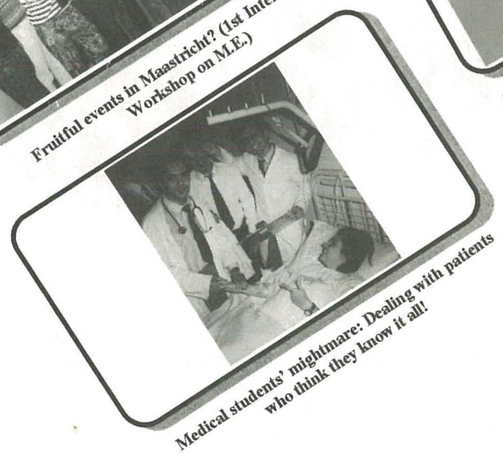
As they say, the rest is history. Mum used a brand new one to decorate the *'figolli'* and to fill stuffed olives....the plumber used it to undo the mess he made in the bathroom....I used it to fill the gaps in the marble skirting with *'Polyfilla'* ..... an unnamed medical student uses it to pump his ball with (I must specify it is a beach volleyball !). My latest improvisation was to unblock the windscreen washer tubes inspissated after injudicious use of *'Stergene'* as an additive to water!

But the greatest surprise was reserved for me at my car electrician's shop.Whilst rummaging in his toolbox I spotted it there, unmistakeable, even though it was dirty and the graduations were faded. I cringed at the irreverence it was subjected to. But at the same time I was pleased that the cult of the syringe was wider than I thought.

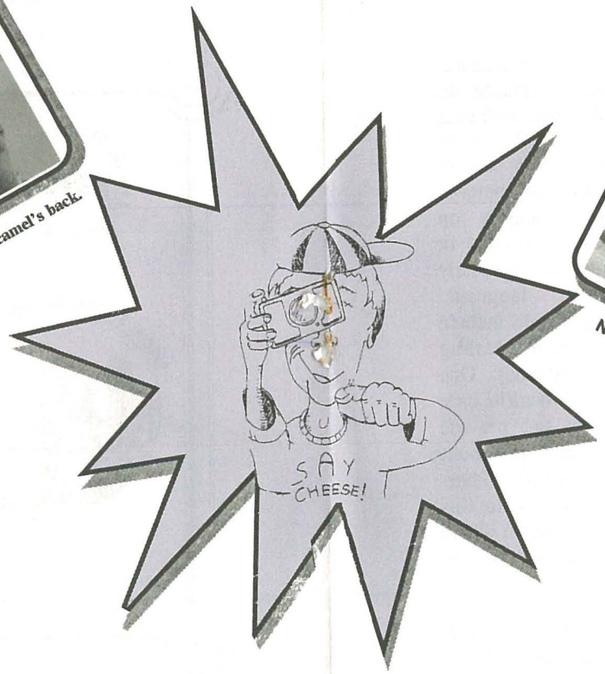
Fruitful events in Maastricht? (1st International Workshop on M.E.)



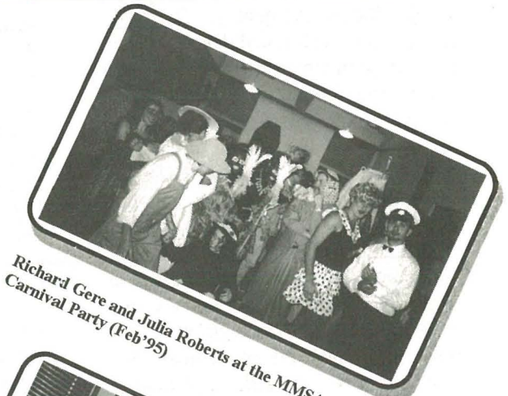
Antonella: the last straw that broke the camel's back. (Egypt, March'95)



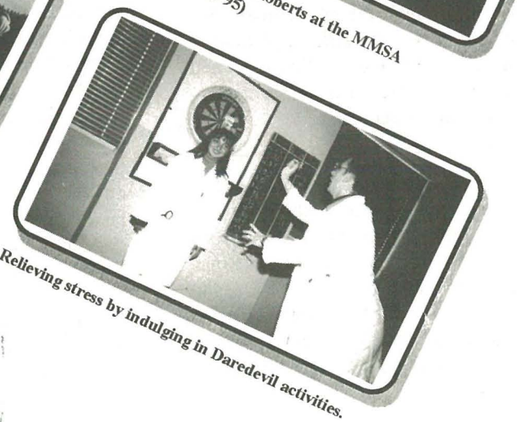
Medical students' nightmare: Dealing with patients who think they know it all!



Nitkesshu ..... fiċ-Ċekoslovakia! (Feb'95)



Richard Gere and Julia Roberts at the MMSA Carnival Party (Feb'95)

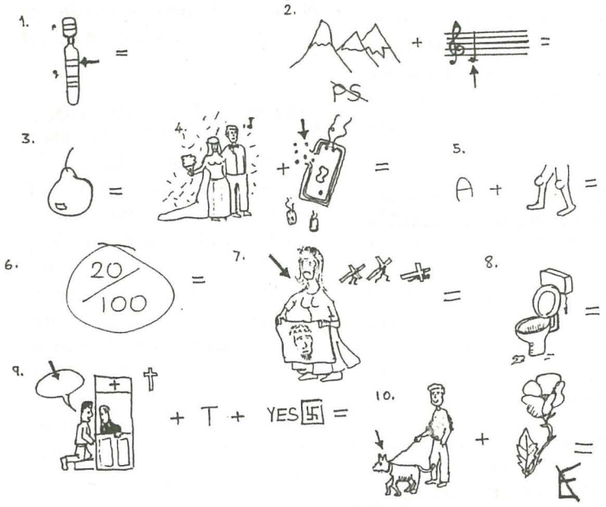


Relieving stress by indulging in Daredevil activities.

Ir-Rokna Taz-Zija Tona

By (= Antonella) + + + A

Jekk tħabblu daqsxejn moħħkhom, tindunaw li dawn it-tpinġijiet jirrapreżentaw l-ismijiet ta' xi studenti tal-mediċina . Ara taqtgħux liema huma.....



Solutions: 1. Jean 2. Aldo 3. Pierre 4. Mary-Lyse
5. Alex 6. Mark 7. Veronique 8. John
9. Cynthia 10. Petros

'Stick to dairy products, vegetables, fruit, but at all costs avoid MEAT!'

'I'm so absent-minded I was going to write the prescription with the thermometer. . . . Say! Where IS my fountain pen?'

Public Health Issues In Europe
The Rational Use of Medicines

Marie Klaire Farrugia (II Year)

To my mind, Rationality and Medicinals first met in our med icine chest . With a grandmother like mine who takes pride in being the veteran herbal specialist of our household, I already feel redundant before even becoming the first doctor of the family! Anything I humbly advise will be subject to fulminant criticism (if not about the price, it will be some trivial side effect). When it comes to the rational use of medicines, whether it is on such a small scale as my family or on a much larger scale as is the European scene, there should be a standard set of guidelines with which the various members have to abide.

The first directives governing the placing of a medicinal on the market were issued by the European Community in 1965. The directives were based on three criteria, namely, safety, efficacy and quality. The work in the public health field thus started by the European Union was later resumed within the council of Europe, when seven states signed a **Partial Agreement in the Social and Public Health Field.** These states (Belgium, France, Germany, Italy, Luxembourg, the Netherlands and the U.K.) are linked by the aim of "pursuing common action in the social and public health fields and working towards harmonisation of their legislation also where medicinals are concerned". Six other states (Austria, Denmark, Finland, Ireland, Spain and Switzerland) are also active participants in this agreement.

The latest project undertaken by the representatives of all these countries was the draughting of a **Resolution on the Rational Use of Medicines** issued in Strasbourg last October. Since Malta is heading for European integration, it might be interesting to consider the measures discussed, as these are bound to be adopted not only by the countries currently involved in the agreement, but also by most other European states. The seven points which will form the basis of a harmonised legislation on the rational use of medicines are the following:

1 ***Establishment of priorities for availability of medicines at public expense*** - To optimise the use of resources in health care, priority for availability of medicines at public expense should be on the basis of clinical need, therapeutic value and efficacy in comparison with other medicines.

2. ***Rational prescription of medicines***- To facilitate the prescribing of effective low-cost medicines, a coherent policy for the distribution of information on medicines should be implemented. Information should be addressed to the medical and pharmaceutical professionals and be in accord with the most up-to-date scientific evidence, notably as contained in information bulletins - such as those on the rational use of drugs issued by the World Health Organisation - or as provided by impartial drug-information centres and independent drug-information bulletins.

The organisation of multidisciplinary drug and therapeutics comittees should be encouraged. They should have a consultative role enabling them on the one hand to resolve problems involved in the prescription, selection, administration and supply of medicines, and, on the other hand, to devise a medicines policy applicable to all prescribers in a hospital or care unit. These drug and therapeutic committees should evaluate the quality of utilisation on a regular basis. Moreover, and this is an important point, consideration should be given to the setting up of such multidisciplinary groups in a community setting at a local level.

3. ***Training of pharmacists*** - Pharmacists and pharmacy students should have the appropriate initial training and further training opportunities which enable them to fully contribute to patient care. These should include not only the broad principles of public health, clinical pharmacy and applied pharmacology, pathology therapeutics and pharmacy administration, but also encompass relevant aspects of communication sciences and sociology.

4. ***Development of clinical pharmacy*** - A pivotal role is to be played by the clinical pharmacist in the rational use of medicines both in hospitals and in the community setting.

5. ***Establishing medicines education and information programmes for the public*** - Information given by the mass media on the correct use of medicines and any other material or activity for education on medicines should be framed in objective, neutral and easily comprehensible language. School education should include preventive programmes dealing with the use of medicines. One of the duties of health care professionals is to provide appropriate information about medicines to the public. Pharmacists play a key role in this respect due to the ease in which they may be consulted by the public.

6. ***Refinement of the range of medicines on the market*** - This

should be an institutionalised reassessment carried out systematically and coherently by the registration authorities on the whole range of medicines with a view to withdrawing those medicines which are obsolete.

7 ***Wastage of medicines*** - The benefit/cost ratio should be evaluated at each stage: manufacture, prescription and supply. Package sizes should be better adapted to dosage and length of treatment; expectations of medicines prescribed should be more realistic and prescription rationalised.The patient should be advised throughout the period of treatment, with the aim of improving compliance, of enabling persons to better manage their own medicine cabinet and of ensuring the safe collection or disposal of unused medicines (i.e. no pet dogs on expensive ACE-inhibitors, please).

Other activities carried out by the Council of Europe in the health field include the *Pharmacopoeia* (aimed to prevent the faulty or fraudulent manufacture of medicinal products via legally enforceable standards for some 800 medicinal substances), the running of a network of national *Blood-Transfusion Centres* including a European bank of frozen blood of rare groups based in Amsterdam, the *Pompidou Group* (combating drug abuse and illicit drug trafficking) and *the Antidoping Convention,* which includes a reference list of banned substances in order to harmonise European anti-doping regulations.

L-IMDINA

Tħallux ir-riħ itajjar, bla mogħdrija
ġmiel trab is-swar mudlama
fejn, bil-għożża
ż-żmien, kemm kemm imgħaġġel
mess, u naqqax
bil-ħila l-ġebla sbejħa,
safranija.

Halluni, imbagħad, inmissu jiena wkoll,
it-trab - ħa jinfed ġild illum,
bil-għerf tal-bieraħ.
Ha nisma' għajjat il-poplu
jbati, jifraħ, jidħak, jibki,
imbagħad jipprova jinsa.....

Bil-mod il-faraġ taffa l-għelt, bil-mod,
inkesa s-sur bid-demm, u x-xita, l-bard
bil-mod, ħekk, qajla qajla
naddfu dmugħ il-mewt, it-tbajja.

U rrid niġġerra ħafja
f'djuq is-sqaq, nissemma għall-pass
imgħaġġel, umli, dgħajjef
t'omm beżgħana - erħilha
tiġri lejn id-dar, il-għorfa ċkejkna.
Qalbha tiżżeffen mal-karba ta' wliedha
u wiċċha ma jidhirx. L-għonnella msewsa
mhix sewda daqs dik ruħha mtaqqla.
U ma kull nifs li tieħu
t-tama tonqos - U hi tissemma
w jien nissemma magħha.....

Nieqes illum pass żewġha, sod u kburi.
U smajna, minflok, is-scherzo ta' l-għadu
il-karba tad-dgħajjef
ir-rondo tal-mewt tal-vjolini
jwerżqu it-tema makabra, midinba
tal-kilba għall-unuri.

U issa xejn ħlief toroq imħaffra
bil-passi li għadni ma smajtx.
U dellijiet mifxula, u fanal
- ħadid imsaddad miżbugħ iswed -
u riħa ta' kesħa u xita u dlam
ta' katakombi u ċimiterji.
U tieqa ċkejkna mżejjna b'sardinella
- tbissima niedja wara l-ilfieq -
U qanpiena ddoqq, u l-kant divin
ta' vuċijiet msaħħra, mistura,
msakkra
bejn erba' ħitan
mitlufa,
moħbija taħt dell l-għonnella
llum biss xhieda
ta' safa
dejjiema.

U issa skiet, skiet biss, u jiena -
Ħafja, minsija, għajjiena.

Sonia Stafrace
(III Sena)

Żerniq

Lejl kiesaħ.
Lejl għeri.
Lejl bla qamar u bla stilel.
Lejl tal-biża'.
Lejl ħalliel.
Lejl oħxon li fgali ħsusi.

Vażun bil-fjuri,
maħżuż tant tajjeb fuq karta.
Karta ta' ftit ċentežmi, tpinġija mprezzabbli.

U sebaħ....

U l-gaġġa nfetħet
u l-ħsus ġrew mal-vini kollha ta' ġismi.
Il-lejl nkiser;
u ma deherx aktar.
Dawl ħlejju idda fuqi
Ferħ kbir daħal f'qalbi.

Kif kellek il-wiċċ, ja lejl,
li ċċaħħadni minn dan kollu?

Neville Calleja
(II Sena)

THE ETHICAL ANGLE

David Grech

Imagine for a moment that you are in your final viva. The consultant looks you straight in the eye and asks. "How would you treat heart failure?". Most students would give quite an acceptable answer. But if instead the examiner asks you, "What would you say to a man who begs you not to tell his wife she has breast cancer?", how would you reply?

There is a tendency to regard ethics as an intellectual pursuit detached from the rigour of the scientific method and the practicalities of patient care. Yet it is clear that ethics is an integral aspect of all clinical encounters. Most students seem to assume that ethical problems should be treated by using common sense. This is, infortunately, easier said than done. Try, for instance, applying your 'common sense' to the following situations, some of which may ring a bell...

Case 1: Mr P, a known drug abuser, presents with a history of generalized weakness and fever. He has a moderately loud heart murmur and conjunctival petechiae on examination. Suspecting subacute bacterial endocarditis, you strongly advise admission for intravenous antibiotics and possibly surgery. He turns down admission, asking instead for a prescription, claiming "some pills will put me right".

Case 2: Miss W is a 17-year old, victim of a car accident. She is conscious and alert when she tells you that she is Jehovah's witness and refuses to consent to a life-saving blood transfusion. Is her refusal valid? What moral justification do you have for overriding a patient's wishes?

Case 3: You are on your general practice attachment when you find that your GP, who is a heavy smoker himself, refuses to give his patients advice on their smoking habits, on the grounds that it would be hypocritical. What do you think?

Case 4: Mr V, a 62-year old previously fit Maltese gentleman, presents with a two-month history of increasing dyspnoea. A chest X-ray reveals extensive bilateral pulmonary infiltrates consistent with malignancy. His wife and son appeal to you not to tell him he has cancer, starting "If he knew he had cancer he would certainly die of worry".

Case 5: You are clerking a young male patient on the surgical ward due for a hernia operation when he tells you, in confidence, that he is HIV positive. The patient's file shows no mention of this. Should you respect the patient's confidentiality? Or should you respect the surgeons who are to operate?

Case 6: A hospital worker has told a patient that she intends keeping all information confidential. The patient agrees to counselling and during one of the sessions reveals his intention to physically assault one of the neurology nurses on being discharged. What should the social worker do?

The objective of these cases is to make you think, and also perhaps to expose the general inadequacy of our preparation on the subject. If you discuss ethical questions simply using common sense and your own values, you run the risk of a meaningless conversation. Your values are the product of your social, religious and educational upbringing. Words like 'good', 'honourable' or 'unethical' carry different meanings when spoken by different individuals.

How can one adapt a logical, detached approach when faced with these issues? One widely accepted method is to think of four basic principles of medical ethics (see box below), and then to apply these in relation to the doctor, the patient and his carers.

FOUR PRINCIPLES OF MEDICAL ETHICS

* Respect for autonomy - the need to respect the right of another person to make a decision for himself.
* Beneficence - the obligation to do good.
* Non-malificence - the obligation to avoid doing harm.
* Justice.

There is no room to go into each of these in detail. I would, however, like to raise a few points with regards to patient autonomy and the case outlined above.

A paternalistic approach in medicine, that is, treating/admitting/going against the patient's

ifications. Sometimes, if doctors have a patient's long-term best interests in mind, they may be right to go over the patient's wishes or need for information. A person admitted to A&E with chest pain may be confused, in pain and worried. It is not the time to expound why treatment is necessary and what possible complications are. The patient will be in a better position to understand later.

A second argument is that patients are likely to be uninformed and too biased to make the best desicions. In practice, however, a doctor is less qualified than the patient to judge what course of action will bring the least unhappiness. It is awkward to ask the parents of a severly handicapped child if they want their child to live or not, but it is downright cruel not to give them the choice to be involved in the decision.

A third case, which bring in Pictures 5 and 6 above, is when respect for an individual's autonomy conflicts with respect for the autonomy of others. Another point, often assumed but barely thought about, is if the patient has too little autonomy for the principle to apply, for example, a person with a long history of depression who has attempted/wants to attempt suicide can be compulsorily admitted to a psychiatric unit under a section of the Mental Health Act.

Lastly, good communication skills are essential, and are also the attributes which most of us are sadly lacking. Good communication facilitates the collection of all the relevant information from the patients and assists in the resolution of conflicts and differences in opinion between all parties involved. Conveying a willingness to listen, sensitivity, compassion and an empathic (not sympathetic) regard for the patient increases the chances of patient satisfaction and an adequate resolution of the problem

There are no right answers to any question of medical ethics. Its value lies in giving you the tools, the concepts, with which you can analyze what you believe to be right and adjust your perspective when you have found good reasons for doing so.

* **Introduction to ethics Nos. 1, 2, 3. Claxton et al Student BMJ Vol 2 Nov: Dec 1994, Feb 1995.**

* **Clinical ethics and clinical decision making. Kerridge et al. Student BMJ Vol 3 Mar 1995**

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Letters to the Editor

What's in a murmur?

Dear Editor,

I would like to launch an appeal to all experienced physicians to have mercy on us students who have just entered the tenebrous realm of auscultation. We are under relentless pressure to acquire the skill of correctly diagnosing those insidious sounds known as murmurs. Textbooks tend to describe murmurs with such vivid and onomatopoetic expressions as:

1. The "seagull-cry" of aortic stenosis which, in other instances, is said to produce a saw-like murmur.
2. The "rumble-of-rocks-in-a-mountain-river-in-a-flood" sound of mitral stenosis.
3. The "fabric-tearing" quality of ventricular septal defect.
4. Then there is the more down-to-earth sound of soft aortic regurgitation described as resembling a breath sound.

The picture is further complicated by descriptions of mewing cats and "bluebottles-trapped-in-the-hand" sounds for thrills. not to mention the clicks and snaps and crunches and knocks! At this rate, we'll get phrases such as "like the grunt of a pig with rustling leaves in the background".....heaven bless me if I have mastered the "lub-dup"!

Mind you, appreciating the nature of the murmur is not sufficient; you have to place it in the proper phase of the cardiac cycle, something which is terribly difficult with a tachycardic patient and with the consultant inspecting every move. So, please, doctors and prof.'s, allow me to make you conscious of our dilemma by letting out a loud HELP! Or, rather, S $_{1}$ .....HE**LP**P**P**P..S $_{2}$ **!** Either invest in a phonocardiograph, or please spend more of your precious time helping us attune our Organs of Corti. I hope this appeal does not fall on deaf ears!

Yours sincerely,A.B.

"Surgery in the 20th Century"

Dear Editor,

Kindly allow me to reffer to Dr N. Azzopardi's letter (Murmur October 94 No.3) relating to my contribution, 'Surgery in the 20th Century', published in Murmur May 94 No. 2.

Quoting from the article:

(1) "...Chloroform, rather than ether, was initially the anaesthetic of choice, in spite of threatening fatal cardiac arrest. This gave way to nitrous oxide by 1910...."

This essentially means that:

(a) Chloroform was much more popular than ether **at the turn of the century,**

(b) nitrous oxide (combined with ether) had for the most part displaced the use of chloroform by the first decade **of this century.**

Chloroform was favoured as it was easier to administer, although it could stop the heart and result in the patient's departure to the other world.

(2) "...A student, nurse, or porter wielding rag and bottle frequently rendered the patient unconcious."

Perusal of source texts shows that at the turn of the century anaesthesia was slow to progress - few physicians made a career of the subject. Nevertheless, this detracts nothing from the merit of an anaesthetist in operation procedure today. Nor does it imply that Dr Spencer Wells did not administer ether in Malta!

The article is therefore consistent with history; the critique overlooks the 20th century frame of reference.

Yours truly, Claude Magri (MD IV)

REMBRANDT'S "Dr. TULP"

Dear Editor,

I refer to the article "History of Medicine....by pictures" by Alex Borg (III Year) No.3, October, 1994 dealing with Rembrandt's Anatomy Lessons. It would seem that there are more anatomical inaccuracies in the painting "The Anatomy Lesson of Dt. Tulp" (featured on your front cover) than pointed out in your article.

It seems surprising how Dr. Tulp, a distinguished anatomist, failed to notice Rembrandt's anatomical error of attaching the Flexor Digitorum Superficialis to the lateral epicondyle (and it is highly unlikely that the corpse might have had an anomalous muscle attachment). The painting was criticised from the anatomical viewpoint by Fromentin, and Hendriks made a copy of the painting in which he improved the representation of the muscles of the right upper arm and legs, that of the serratus anterior, and accentuated the seperation between the lower ribs and abdomen. It would also seem that the right arm appears too short, the lower part of the legs too long and the feet too large, and this relative disproportion of the limbs cannot be explained by the position of the dead body lying sloping in an oblique direction.

These anatomical errors are the more surprising when it is known that in the 17th century there were a large number of paintings depicting dissections which Rembrandt might have known and which could have influenced the masterpiece; I have listed ten such paintings in my article "Anatomy and the Art of Rembrandt" (Scientia 34(4): 149-157, 1971.)

Yours truly Professor J.L. Pace.

A Letter of appreciation

Dear Editor,

Many thanks for the copy of the M.M.S.A.'s journal "Murmur". I found it very interesting and wish to congratulate you in bringing out a medical students' journal which I believe represents a very good quality.

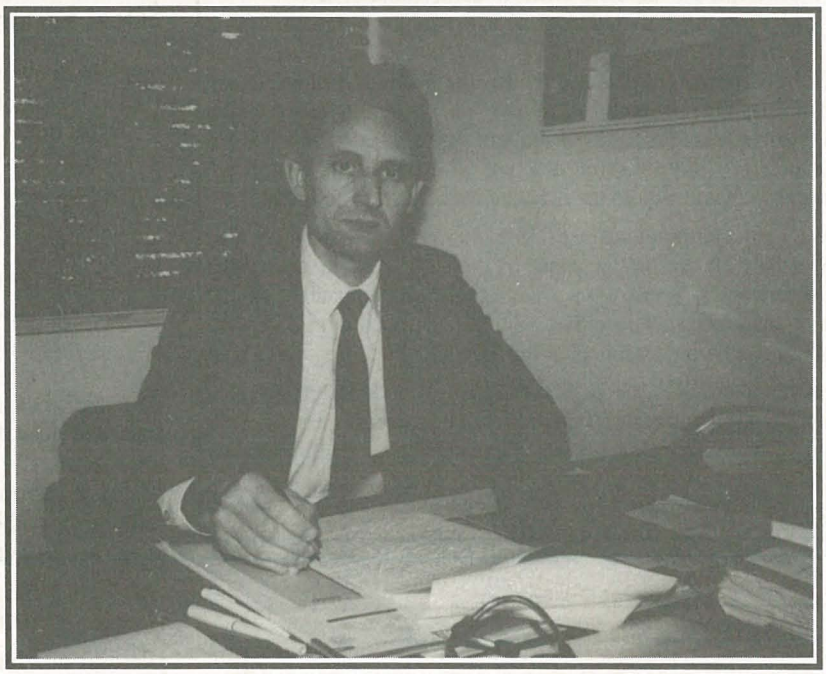
I am particularly interested in the medical historical articles that will appear in this journal and therefore wonder whether you would be so kind as to let me have a copy of future journals containing these articles.

Yours sincerely, Douglas N. Golding MA, MD, FRCP. Consultant Rheumatologist.
West Essex Rheumatology unit (Princess Alexandra Hospital)

THE INTERVIEW

The two men who reside in the offices on the first floor of Medical School are often the subject of a medical student conversation. They are also encountered in tutorials with some degree of trepidation. Andrew Scott and Natasha Muscat set off to find out more about these enigmatic personalities.

DR. MARTIN EBEJER



Q. ***Could you outline your medical career?***

I completed my medical studies at the University of Malta. However, I had to sit for my final examinations in London because of the 1977 political problem. After qualifying, I remained in Britain and after my housejobs, I proceeded to train in general medicine. In 1987, I was appointed consultant physician in general and respiratory medicine with the Ministry of Health, Sultanate of Oman. In 1991, I came to Malta as full time lecturer in Medicine at the University of Malta.

Q. ***Were you involved in any extra-curricular activities during your student years?***

I was active in student affairs. When at Medical School I was elected Secretary of MMSA. I was keen on sport, hockey, judo and athletics being my favourite. However, it became quite difficult to keep up these activities when I moved to the medical school in G'Mangia. No matter how close to University Campus it may be, you still feel there is a barrier.

Q. ***What do you expect out of a medical student?***

The ideal medical student in my eyes is someone who has a deep fascination for medicine and who can empathise with patients; someone who is inquisitive and hardworking but also lives life fully; a person who enjoys activities outside the sphere of medicine and hospital such as sport, music, drama etc. I believe that Medicine is one of those professions where it is essential to remain in touch with the real world outside. It is so easy to become engrossed and isolated in hospital life.

I believe that Medicine is one of those professions where it is essential to remain in touch with the real world outside. It is so easy to become engrossed and isolated in hospital life.

A medical student should also have some leadership qualities for, as a member of society or as a co-ordinator of a health care team, he or she will most certainly find such qualities an asset. From the academic point of view, a medical student should have the ability to organise priorities and solve

problems as well as develop the ability to retain a large number of facts.

Last but not least, good communication skills are a very important requisite. Listening to patients and giving instructions or offering explanations in everyday language may not be all that easy especially when one is thinking in terms of medical jargon. Indeed, most patient's complaints arise from failure of communication usually on the part of the doctor.

Indeed, most patient's complaints arise from failure of communication usually on the part of the doctor.

Q. ***What differences do you see between students in Malta and those abroad?***

Students here are highly intelligent and motivated. However, despite being more studious, they are probably less clever. What I mean is they are less worldly, less assertive, and less independent. Perhaps, this reflects their early education, life on a small island and overwhelming family pressures.

Students in Malta are also less involved in extra-curricular activities and less conscious of the world around them and science outside medicine.

I also feel that a number of students here are rather spoilt. Apart from the general prevailing attitude that one studies to get through exams more than to actually learn, some seem to develop quite the wrong attitude towards work and money. Here, I am not condemning the stipend system, but perhaps financial assistance should be given in some other way that wouldn't pose such a threat to the values of work and earning one's living.

Q. ***What would you like to change in undergraduate medical education?***

I believe the course needs to be better structured. There is often repetition in some areas while others are left out completely. This happens especially in

tutorials or clinical assignments. With a little more planning and co-operation from tutors, more could be delivered in the short time available.

I would also like to remove students' sense of intimidation (sometimes justified) by their superiors and replace it by a sense of belonging to the medical profession. There should be a better doctor-student relationship and respect. I would also like to instill the idea that medicine is a science not an art. Often doctors hide behind the convenient cliche: "medicine is an art and a science" when they cannot offer a logical explanation for their actions. Art only comes into the picture when communicating the science to the patient.

Finally, I would also like to slow down the rate of change to the medical curriculum. It is important not to lose perspective. The basic course structure which for many years has produced so many good doctors must surely have some value.

Q. ***What are your views on problem-based learning i.e. an instructional method of medical education characterized by the use of patient problems as a context for students to learn problem-solving skills and acquire knowledge about the basic and clinical sciences?***

This is something I have experienced abroad and it is certainly very effective. It does not apply equally well to all specialities. I have found it most suitable for the clinical part of the course. We have to remember that most students are capable of finding facts on their own. Clinical tutors should concentrate on teaching clinical skills and acting as chairman in seminar based teaching. However, a system based solely on problem-based learning requires a great deal of organisational effort and commitment from the tutor's side.

It is important to stress the fact that St Luke's is a teaching hospital and doctors employed there should have a contractual obligation to teach.

I have an intense dislike to bureaucracy, lack of punctuality and bad manners. I value honesty and friendships.

Q. ***What new opportunities exist for graduates in Malta?***

A growth area in Maltese medical practice is undoubtedly family medicine. This must become a speciality in its own right requiring highly skilled and fully trained doctors. Many patients complain of a lack of continuity of care. GP's should no longer be perceived as the "clerk" who diverts patients to this or that specialist.

Another growth area is Public Health Medicine. This has great impact on the health of a nation and very good mature doctors are required who have been trained in clinical medicine and acquired years of experience.

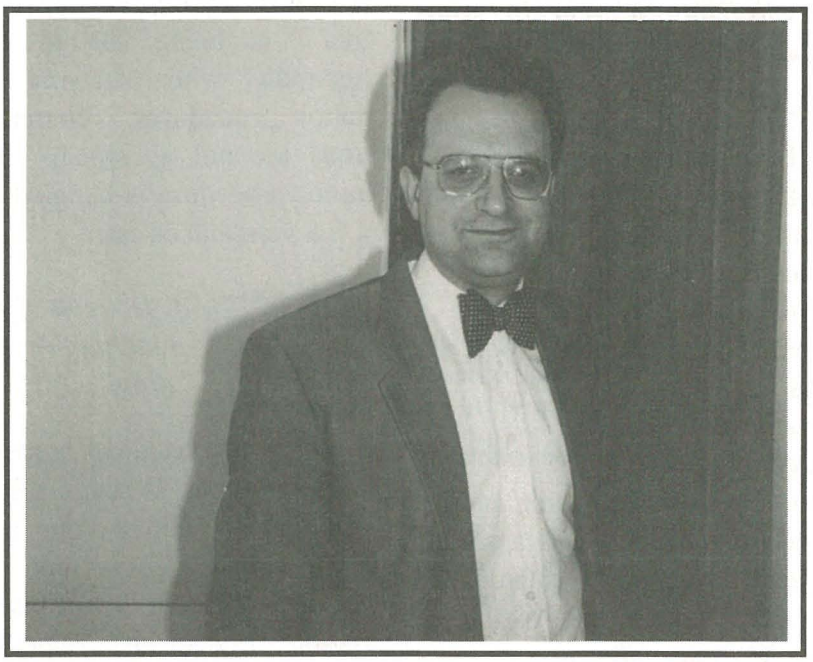
Q. ***How would you describe yourself?***

I am generally of a quiet disposition, with a tendency to be fussy and meticulous and occasionally short tempered. I have an intense dislike to bureaucracy, lack of punctuality and bad manners. I value honesty and friendships. Always aiming to get things right might be a disadvantage as one could fall into the trap of doing little for fear of doing wrong.

Q. ***Do you have any regrets for choosing Medicine?***

Absolutely not. Although, if I had to start all over again, I might choose a different speciality or plan my career differently. Having said that, however, circumstances often dictate which way one goes. Back in England, two respiratory physicians went out of their way to teach me on a personal basis. I learnt bronchoscopy and had extensive training in chest radiology when still a senior house officer. It was difficult for me not to develop some enthusiasm for respiratory medicine.

MR. ALEX ATTARD



We entered the smoke filled room and found Mr. Attard seated behind his desk looking relaxed, finishing off the end of a cigar.....

Q. ***Could you briefly outline your medical career?***

Having completed my secondary education at the Lyceum in Hamrun, I started Medicine at the University of Malta in 1976. I finished my undergraduate studies at Leeds University in 1982. I carried out surgical training in Leeds, Leicester and Birmingham. I obtained my FRCS in 1988. Between 1990 and 1992, I undertook research in antibody targeting in colorectal cancer for my Masters in Surgery.

A person (medical student) should be confident, enquiring, open to criticism, ready to evaluate his performance, capable of admitting failure and obviously enough technically able manually.

Q. ***Which qualities should a medical student aspiring to become a competent surgeon possess?***

The list is a long one. A person should be confident, enquiring, open to criticism, ready to evaluate his performance, capable of admitting failure and obviously enough technically able manually. In surgery, one must be prepared to work for long hours and also to stay on after hours. In a way, a determined and slightly selfish attitude sometimes required . This can place a great strain on one's relationship or marriage. An understanding partner is a necessity since it is sometimes impossible for surgeons to carry out domestic and other duties. Today my wife had to attend parents' day alone .....

The academic aspect to surgery is always taking on increasing importance. Traditionally in Malta after FRCS you can call yourself a surgeon. Abroad a surgeon has to be academically oriented and has to carry out activities such as reasearch and publishing of papers to progress in the career.

Other essential qualities include being able to work in a team and being capable of communicating well with patients and their relatives. Historically surgeons have been notoriously bad communicators, today this is changing.

Returning to your question, at an undergraduate level, it is difficult to tell who will make a good surgeon. Certainly a good mark in surgery is not all that is required!

Q. ***Were there any surgeons in your family?***

No, not even any doctors. I had no medical connections whatsoever. I was also the first and only person in my family to go to University.

Q. ***Do you recall the most rewarding moment in your career?***

Yes, I do. I was still a house officer during my medical assignment. A 42 year old patient came in with some medical condition, probably it was some chest pain. As an aspiring surgeon, I decided to carry out a rectal examination and lo and behold there was a rectal mass. This purely incidental finding turned out to be a Duke's stage A tumour.

Although I may appear to be relaxed, inside I am always tense whilst operating. I think it is imperative to give 100% attention to every patient.

Q. ***I am sure that surgery is full of tense moments. Do you think you can remember a time when you were frightened?***

Well, yes I suppose one of the worst moments was when I was dissecting close to the hepatic veins and the Inferior Vena Cava; all of a sudden I heard the gushing of air rushing in. It was an air embolus. My boss stuck his finger in the hole and yelled "Just get on with it!"

Although I may appear to be relaxed, inside I am always tense whilst operating. I think it is imperative to give 100% attention to every patient. Sometimes it is tempting to treat minor operations in a lighter fashion. I think this should not be done. As a start, for the patient it is not a minor operation but it is the most important operation that is being carried out. Secondly, when carrying out minor procedures, complications are not accepted. If a minor procedure is bungled up, it is a veritable disaster!

Q. ***Do you find teaching rewarding?***

Medical students are important. Whilst teaching you can crystallize your own ideas and sometimes you can see something from a different angle, or even be reminded about things that could have possibly slipped your mind. I like being with students and besides it keeps me on my toes!

Q. ***Your bow-ties and your pipe give you the air of a distinct gentleman. Actually, I notice you happen to be wearing a tie today, but are there any reasons for your habitual wearing of bow-ties?***

Surgery is full of frustrating moments. Surgeons spend at least one third of their time waiting for things to happen rather than operating.

As a doctor in Malta it is necessary that you present yourself in a certain manner. Maltese patients have similar attitudes as British patients and expect to find a well-groomed doctor. On the continent surgeons are more relaxed in their style of dress.

Why a bow-tie? For a start it is more practical than a tie in that it does not come in the way. However there are other reasons.....

I never wear pre-tied bow-ties. I tie each one of them myself. It was a challenge for me to learn to tie them. Whether I wear a bow-tie or a tie depends on my mood, but do not ask what type of mood, since I will not answer! I must add, my wife does not like bow-ties.

You want to know why I smoke a pipe? Surgery is full of frustrating moments. Surgeons spend at least one third of their time waiting for things to happen rather than operating. My pipe helps me to ignore everything around me and to relax. I caught the habit whilst working in a liver unit in Birmingham. Everyone around me used to smoke a pipe. I started and found it was rewarding, relaxing and it is also healthier than smoking cigarettes.

Q. ***Do you have any particular projects or ambitions for the future?***

I would like to set up a dedicated transplant team. I am also currently involved in raising awareness about organ donation and I would like to get people to think about the problem.

Another project which I hope to establish with Mr Dennis Gatt is the setting up of a better Vascular Assessment Unit.

Right

graphic occasions

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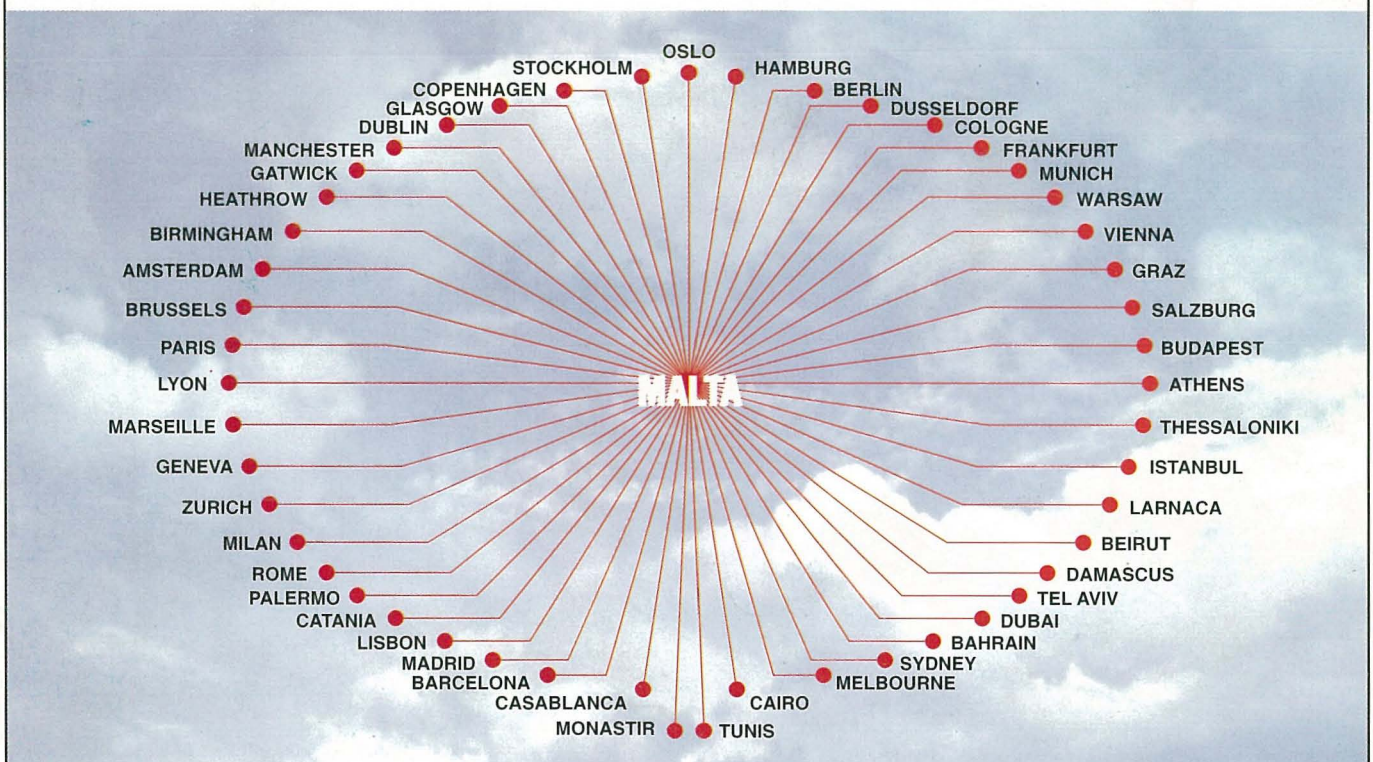




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