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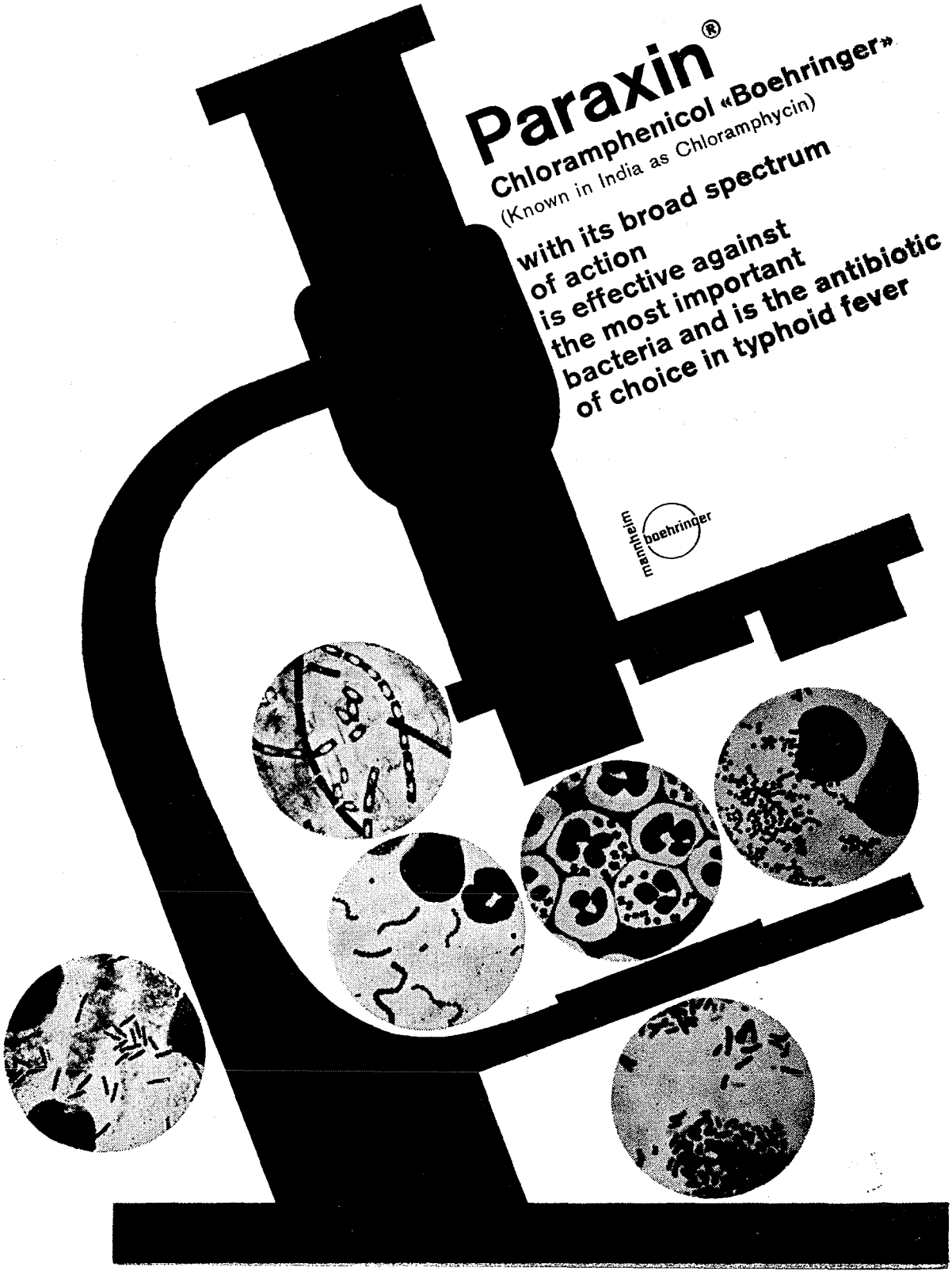
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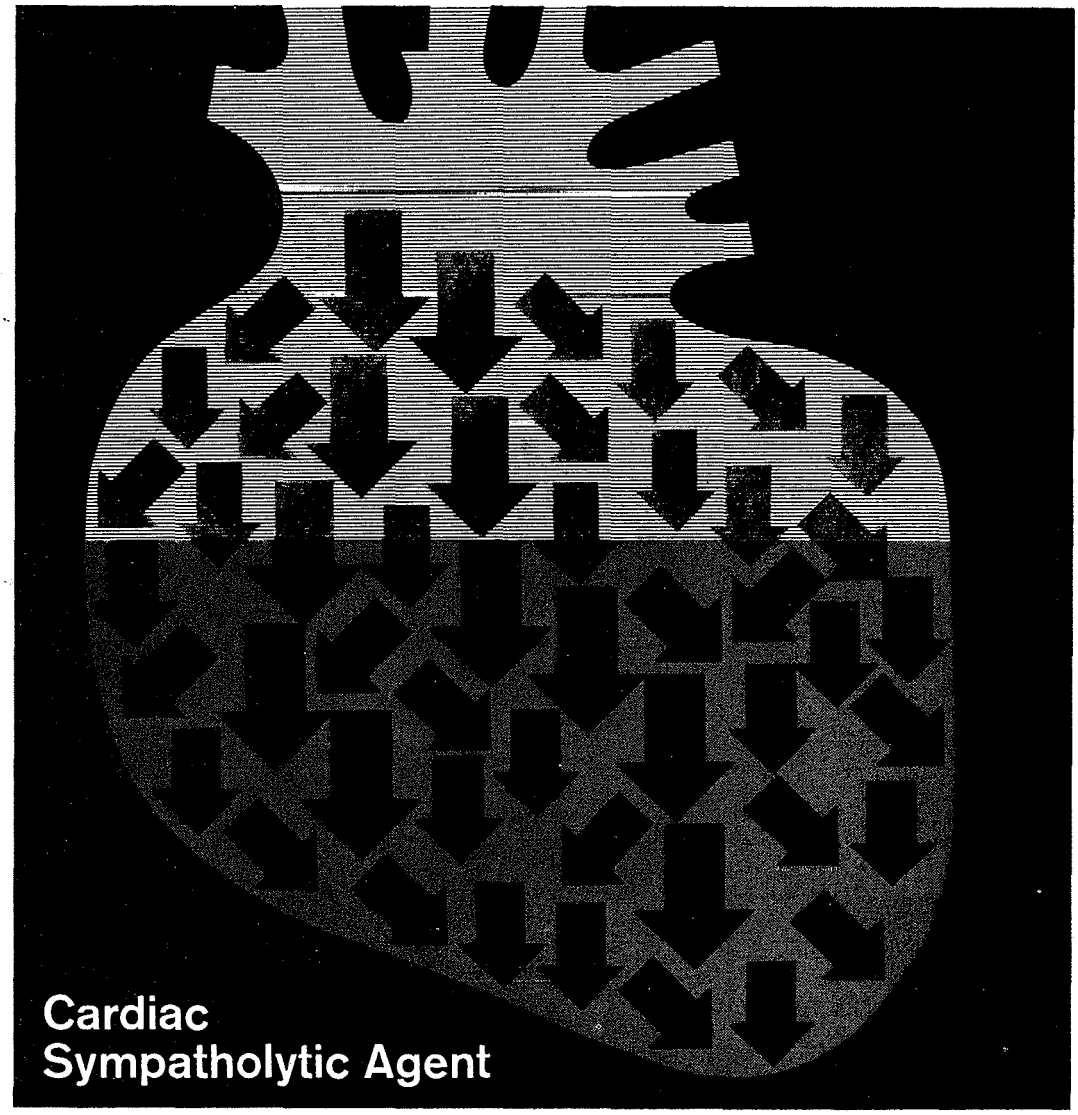

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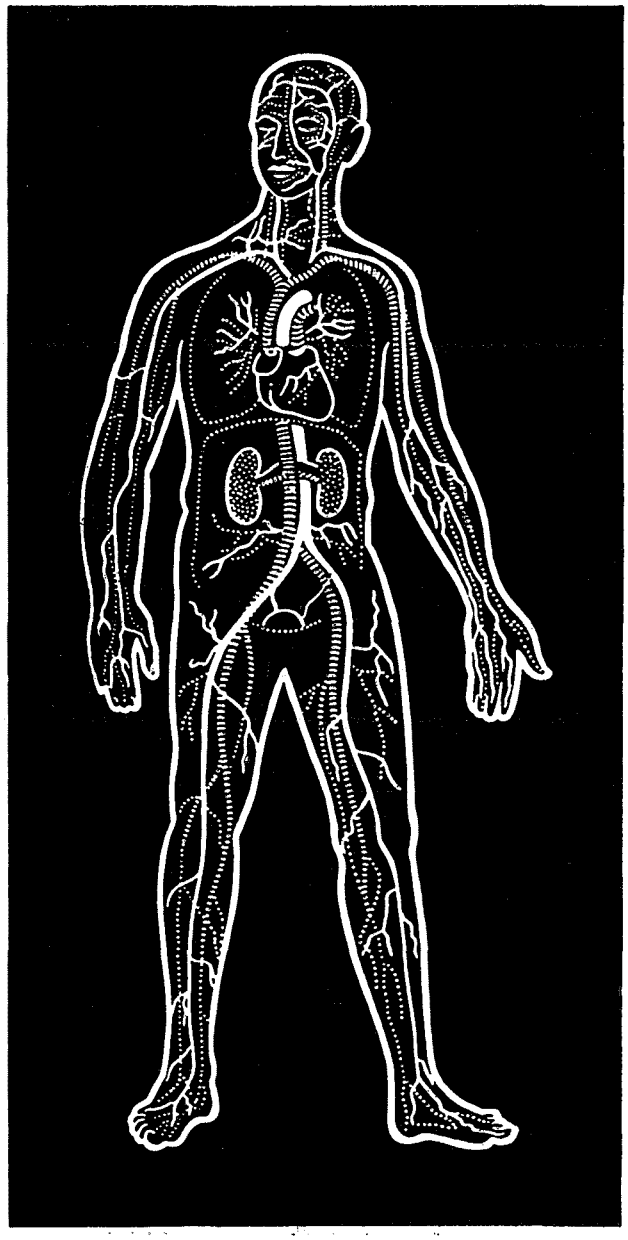

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THE CHEST-PIECE

JOURNAL OF THE MEDICAL STUDENTS' ASSOCIATION

MALTA Vol. II No. 10 APRIL 1969

CONTENTS

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EDITORIAL

At a time when students of the final course are approaching Finals, it is appropiate to protest against examinations and their influence on students, and on the whole system of education. Examinations in the Clinical subjects, as we know them, should be abolished. A start has been made in getting rid of the "minor" subjects examinations, but, why not go the whole way and include those of the "major" subjects as well? From reactionary quarters will come the excuse that the examination system protects the public. This is nonsense, the public is better protected by providing doctors-to-be with a sound medical knowledge over three years, than not by finding out how much of the lecture notes they manage to write down in three hours, on a hot and sticky morning.

Abolition of the examinations should be replaced by a series of assessments, say every three months, over the whole period of clinical study. For this assessment to be realistic, it must be made on work done in the wards, and not, as is the present tendency, on material that has been lectured on. If this system is adopted, the duration of clerkship must be extended from the current one month in each major subject, to three-monthly periods. Another radical change, must be the shift of emphasis of teaching from the lecture room to the wards. Students during the three-monthly period should be under the guidance of a full-time tutor, who would ensure that the student takes an active part in the management of patients, and writes up a selected number of cases, on which the assessment at the end of this period can be based.

Most student discontent arises from the excessive number of lectures, (these should be reduced to a maximum of five per week), and from the necessity of memorising from lecture notes or textbooks, the excessive factual demands of the written papers. They are at times critisized by members of the staff for their relative indifference to ward work, but, how can they be enthusiastic about this, if it hardly counts in the exams? Furthermore, the inadequately short period allocated to practical work in the timetable is constantly being encroached upon by lecture time. There will be no improvement in this state of affairs until the student is assured that he will be judged, in great part, if not wholly, on his performance in the wards.

Perhaps the greatest deficiency in our system is the complete disregard for the development of emotional maturity, an integral part in the successful treatment of patients, in the medical student. Several factors are responsible for this, and prominent among them is the tendency for this University to be a glorified school. However, what can one expect, when a fair proportion of administrators and academicians have a tendency to be grossly immature themselves, at times? Another factor, more amenable to reform, is the lack of time provided, or encouragement given, for students to participate in extracurricular activities, or projects involving original thought, which will help to educate them. Such work should also be used in the assessment of students at the end of their period of clinical study.

To some, examinations in their present form, are associated with standards; the tougher the examinations and the more of them there are, the higher the standards. Such misconceptions lead to vigorous opposition to a reduction in the number of examinations, and describing, rather quaintly, any further reduction as "sanguine". Let them rest assured that any measure that lowers the standards of this Medical School will be opposed by the students, and that the present suggestions are aimed at raising such standards.

The choice of cover design for this issue will be questioned by many, some may even be indignant, but as long as the journal is not left unread, it will have served its purpose. The cover is, perhaps, appropiate in the light of universal student unrest. It is a protest against those factors which are delaying the development of this Medical School to a stage where its prime purpose will be recognised as being the provision of better medical care in the community.

SURVEY OF STUDENT ATTITUDES

J. V. PSAILA

Since the first world conference on medical education, this subject has become increasingly studied by innumerable reports and surveys of student opinion. The Report of the Royal Commission on Medical Education has given the subject further impetus and is likely to result in far reaching changes. Of these a scope for more active participation by the student is among the most significant.

For students to assume a responsible and active role in Medical Education, the "Chestpiece" has considered it very important to survey the opinions of students.

This survey is an attempt to assess the more important characteristics of the average medical student, and to make an evaluation of the common teaching methods.

METHOD

Printed questionnaires were distributed to all medical students at the R.U.M.— a tota of 109. Of these 29 (81%) were returned from the intermediate course, 31 (89%) from the first year clinical, and 29 (78%) from the final year. These represent 82% of all the students in the medical courses.

Answers were then translated onto I.C.T. punch-cards, using an appropriate code. These results could then be analysed by machine and selected according to status.

CHOICE OF A CAREER

Regret chosing medicine as a career.

Few seem to regret their choice, only 13.5% ("don't know' = 2.2%). The more optimistic seem the IIIrd year (Ist year clinical) with only 3.2%. The Ist year (Intermediate course) had 10.3%, and the Vth year (Final year) 27.6%. One need hardly comment further on this.

Would have liked to do something else.

There were 5 'no answers' (5.6%). A total of 51.2% did not want to do anything else besides medicine. Again the IIIrd year seemed to be the most contented — only 26% of them specified other careers. However Ist and IIIrd year scored roughly equal, 60% and 59.3% respectively wished to do something else.

The most popular careers besides medicine were those in the Sciences (9.5%), Architecture and Engineering (6%), Economics (4.8%), Humanities (3.6%), Teaching (3.6%), and least of all Law, Drama or Music, Sport and various others (all 2.4% each).

Influence of various factors in selecting a Medical career.

Nine reasons for entering into the Medical profession were listed. Each of these was then evaluated separately by the student by alloting one of four possible grades.

"Inclination towards Natural Sciences"

	I	III	V	ALL
No answer	10.3% (3)	6.5% (2)	—	5.6%
Main influence	21.3% (6)	34.5% (10)	17.2% (5)	25%
Secondary	50% (13)	37.9% (11)	51.7% (15)	46.4%
Slight	11.5% (3)	17.3% (5)	17.2% (5)	15.5%
None	15.4% (4)	10.3% (3)	13.8% (4)	13.1%

"To help others"

	I	III	V	ALL
No answer	3.5% (1)			1.1%
Main influence	39.9% (11)	12.9% (4)	17.2% (5)	22.7%
Secondary	28.6% (8)	45.2% (14)	62.1% (18)	45.5%
Slight	17.8% (5)	29.0% (9)	10.3% (3)	19.3%
None	14.3% (4)	12.9% (4)	10.3% (3)	12.5%

"Exercise my natural abilities to the full"

	I	III	V	ALL
No answer	13.8% (4)	9.7% (3)	3.4% (1)	9.0%
Main influence	20.0% (5)	21.4% (6)	21.4% (6)	21.0%
Secondary	20.0% (5)	14.3% (4)	28.6% (8)	21.0%
Slight	20.0% (5)	32.2% (9)	14.3% (4)	22.2%
None	40.0% (10)	32.1% (9)	35.7% (10)	35.8%

"M.D. recognised abroad"

	I	III	V	ALL
No answer	3.4% (1)	6.5% (2)	—	3.4%
Main influence	17.9% (5)	13.8% (4)	10.3% (3)	14.0%
Secondary	25.0% (7)	41.4% (12)	41.4% (12)	33.0%
Slight	32.1% (9)	24.1% (7)	13.8% (4)	23.3%
None	25.0% (7)	20.7% (6)	34.5% (10)	26.7%

"Good financial prospects"

	I	III	V	ALL
No answer	—	3.2% (1)	—	1.1%
Main influence	3.5% (1)	3.3% (1)	6.9% (2)	4.5%
Secondary	31.0% (9)	43.3% (13)	31.0% (9)	35.2%
Slight	31.0% (9)	40.0% (12)	34.5% (10)	35.2%
None	34.5% (10)	13.3% (4)	27.6% (8)	25.0%

"Good social position"

	I	III	V	ALL
No answer	3.4% (1)	3.2% (1)	—	2.2%
Main influence	14.3% (4)	16.7% (5)	—	10.3%
Secondary	21.4% (6)	46.7% (14)	34.5% (10)	34.5%
Slight	39.3% (11)	30.0% (9)	44.8% (13)	37.9%
None	25.0% (7)	6.7% (2)	20.7% (6)	17.3%

"Runs in the family"

	I	III	V	ALL
No answer	10.3% (3)	6.5% (2)	—	5.6%
Main influence	7.7% (2)	10.4% (3)	—	6.0%
Secondary	11.5% (3)	13.8% (4)	3.5% (1)	9.5%
Slight	15.4% (4)	24.1% (7)	13.9% (4)	17.9%
None	64.9% (17)	51.7% (15)	82.8% (24)	66.7%

"Urged on by others"

	I	III	V	ALL
No answer	10.3% (3)	9.7% (3)	—	6.7%
Main influence	—	—	3.5% (1)	1.2%
Secondary	—	—	—	—
Slight	7.7% (2)	28.6% (8)	24.1% (7)	20.5%
None	92.3% (24)	71.4% (20)	72.4% (21)	78.3%

"Could think of nothing else to do"

	I	III	V	ALL
No answer	6.8% (2)	6.5% (2)	3.4% (1)	5.6%
Main influence	7.4% (2)	—	10.7% (3)	5.9%
Secondary	7.4% (2)	6.9% (2)	3.6% (1)	6.0%
Slight	7.4% (2)	13.8% (4)	7.1% (2)	9.5%
None	77.8% (21)	79.3% (23)	78.6% (22)	78.6%

It seems that the strongest influences for choosing medicine were "inclination towards natural sciences" (25%), or "exercise my natural abilities to the full" (21%), and "help others" (23%). The more realistic and concrete motives for choosing medicine such as for financial reasons (35%) or for prestige (35%) were displaced to a strong secondary position.

AMBITIONS / IDEALS.

There seems a definite improvement in the fulfillment of ambition or ideals from the pre-clinical to the clinical year. Over one-third felt "frustrated" or "unaffected" when in the preclinical years, compared to only one sixth in the clinical year.

LECTURES.

Investigating the time that the medical student spent in the lecture hall, revealed that a fair proportion do not fully attend lectures. In the intermediate course 73% spend 5 - 9 hours per week, which is equivalent to the amount of lectures they have per week. In the first year clinical, who have over 15 hours of lectures per week, 43.3% said they spend from 10 - 14 hours per week attending lectures and 40.1% spend 15 - 19 hours/wk. (15.3% less than 9 hours/wk). Similarly, for the final year there are approximately 15 hours of lectures per week. Yet, 28.6% said they spend 15 - 19 hours per week attending lectures, 25% spent 10 - 14 hours weekly and 46.4% less than 9 hours/wk.

When asked to state the optimum time they wished to spend attending lectures, there was more uniformity of opinion. 50% of the final years stated 0 - 4 hours/wk as the optimum time, 42% 5 - 9 hrs/wk. In the first year clinical 25% opted for 0 - 4 hrs/wk, 32% for 5 - 9 hrs/wk, and 39% for 10 - 14 hrs/wk.

Most prominent in the final year is a definite preference for spending less time than they actually do, attending lectures.

"Lectures serve to impart the personal experience and critical judgement of the teacher"

	I	III	V	ALL
No Answers	10.3% (3)	—	—	3.4%
Great extent	15.2% (4)	48.3% (15)	27.6% (8)	31.4%
Some	23.4% (6)	32.3% (10)	41.4% (12)	32.5%
Slight	42.4% (11)	19.4% (6)	17.2% (5)	25.6%
None	19.2% (5)	—	13.8% (4)	10.5%

"Lectures provide you with a basis on which to organize your studies"

	I	III	V	ALL
No Answers	3.4% (1)	—	—	1.1%
Great extent	42.9% (12)	32.0% (10)	24.2% (7)	33.0%
Some	46.4% (13)	29.0% (9)	20.7% (6)	31.8%
Slight	7.2% (2)	19.6% (6)	31.0% (9)	19.2%
None	3.5% (1)	19.4% (6)	24.1% (7)	16.0%

"Lectures tend to discourage you from acquiring knowledge through personal effort"

	I	III	V	ALL
No Answers	6.9% (2)	—	—	2.2%
Great extent	3.8% (1)	16.1% (5)	10.3% (3)	10.3%
Some	—	12.9% (4)	4.2% (7)	12.6%
Slight	18.5% (5)	16.1% (5)	13.8% (4)	16.1%
None	77.7% (21)	54.9% (17)	51.7% (15)	60.9%

"Your attendance at lectures prejudices the Lecturer's opinion of you"

	I	III	V	ALL
No Answers	6.9% (2)	3.2% (1)	3.4% (1)	4.5%
Great extent	29.6% (8)	26.7% (8)	42.9% (12)	33.0%
Some	40.8% (11)	13.3% (4)	21.4% (6)	24.7%
Slight	7.4% (2)	33.3% (10)	21.4% (6)	21.2%
None	22.2% (6)	26.7% (8)	14.3% (4)	21.1%

"Lectures enable you to learn and understand the subject".

	I	III	V	ALL
No Answers	3.4% (1)	—	—	1.1%
Great extent	21.4% (6)	9.7% (3)	6.9% (2)	12.5%
Some	50 0% (14)	45.5% (14)	42.8% (13)	46.6%
Slight	21.4% (6)	38.7% (12)	34.5% (10)	31.8%
None	7.2% (2)	6.5% (2)	13.8% (4)	9.1%

"Lectures stimulate further interest".

	I	III	V	ALL
No Answers	3.4% (1)	—	3.4% (1)	2.2%
Great extent	21.4% (6)	16.1% (5)	3.6% (1)	13.8%
Some	35.7% (10)	38.7% (12)	21.4% (6)	32.2%
Slight	28.6% (8)	35.5% (11)	25.0% (2)	29.9%
None	14.3% (4)	9.2% (3)	50.0% (14)	24.1%

There was a mixed evaluation of lectures since 31% said that to a great extent "lectures impart personal experience and critical judgement of the more experienced teacher", while 11% disagreed completely with this statement. Similarly 33% found them to a great extent useful as a basis on which to organize their studies.

They do not in general discourage students "from acquiring knowledge through personal effort", but on the other hand are not very instrumental in stimulating further interest in the subject. Virtually all found that their "attendance at lectures prejudices the lecturers opinon of them" to some extent or other. I am sure this is of some significance.

Assessment of lectures in terms of their value;

An evaluation using four grades was made of the value of lectures in helping the students concerned to learn their subject matter.

OBSTETRICS

	III	V	ALL
No answer	—	—	0%
great value	64.5% (20)	34.5% (10)	50.0%
some	29.0% (9)	41.4% (12)	35.0%
Little	6.5% (2)	24.1% (7)	15.0%
Ins. exp.	—	—	0%

MEDICINE

	III	V	ALL
No answer	—	—	0%
great value	22.6% (7)	3.6% (1)	13.6%
some	38.7% (12)	37.9% (11)	38.1%
little/none	38.7% (12)	38.5% (17)	48.3%
ins. exp.	—	—	0%

SURGERY

	III	V	ALL
	—	—	0%
	45.2% (14)	24.1% (7)	35.0%
	38.7% (12)	24.1% (7)	31.7%
	16.1% (5)	51.8% (15)	33.3%
	—	—	0%

BACTERIOLOGY

	III	V	ALL
No answer	3.2% (1)	—	1.7%
great value	—	3.4% (1)	1.7%
some	36.7% (11)	27.6% (8)	32.2%
little	60.0% (18)	65.6% (19)	62.7%
ins. exp.	3.3% (1)	3.4% (1)	3.4%

PATHOLOGY

	III	V	ALL
	—	—	0%
	22.6% (7)	27.7% (8)	25.0%
	61.3% (19)	58.6% (17)	60.0%
	16.1% (5)	13.7% (4)	15.0%
	—	—	0%

SEMEIOTICS

	III	V	ALL
No answer	—	—	0%
Great value	9.7% (3)	10.3% (3)	10.0%
some	22.6% (7)	20.6% (6)	21.7%
little/none	61.2% (19)	62.9% (18)	61.6%
ins. exp.	6.5% (2)	6.9% (2)	6.7%

PHARMACOLOGY

	III	V	ALL
	3.2% (1)	—	1.7%
	3.3% (1)	6.9% (2)	5.1%
	23.3% (7)	24.1% (7)	23.7%
	73.4% (22)	69.0% (20)	71.2%
	—	—	0%

ANATOMY

	I	III	V	ALL
No Answer	6.9% (2)	3.2% (1)	6.9% (2)	5.6%
great value	18.5% (5)	20.0% (6)	22.3% (6)	20.2%
some	59.3% (16)	56.7% (17)	37.0% (10)	50.0%
little	18.5% (5)	23.3% (7)	37.0% (10)	26.2%
insufficient experience	3.7% (1)	—	3.7% (1)	3.6%

PHYSIOLOGY

	I	III	V	ALL
No Answer	6.8% (2)	3.2% (1)	3.4% (1)	4.5%
great value	18.5% (5)	43.3% (13)	28.5% (8)	30.6%
some	51.9% (14)	40.0% (12)	42.9% (12)	44.6%
little	25.9% (7)	16.7% (5)	25.0% (7)	22.4%
insufficient experience	3.7% (1)	—	3.6% (1)	2.4%

	OPTH. V	DERM. V	PSYCH. V	HYGIENE V	FORENSIC V
No answer	—	—	—	—	3.4% (1)
Great	3.4% (1)	3.4% (1)	31.0% (9)	3.4% (1)	10.7% (3)
some	20.8% (6)	6.9% (2)	44.9% (13)	24.1% (7)	46.5% (13)
little	65.5% (19)	79.4% (23)	17.2% (5)	58.6% (17)	32.1% (9)
Ins. Exp.	10.3% (3)	6.9% (2)	6.9% (2)	10.4% (3)	10.7% (3)

From these figures it is apparent that lectures are of limited value to the student in the "major" subjects, whereas in the lesser subjects their value is very questionable (except for psychiatry).

Duration of lectures:

It is a well known fact that lectures should not last longer than 30-45 mins. We felt it would be interesting to ask the student here what he thought was the optimum time.

	I	III	V	ALL
Less than 30 mins	3.6% (1)	12.9% (4)	13.8% (4)	10.2%
30 — 45 mins	21.4% (6)	67.7% (21)	79.3% (23)	56.8%
45 — 60 mins	50.0% (14)	9.7% (3)	6.9% (2)	21.6%
over 60 mins	3.6% (1)	6.5% (2)	—	2.3%
left to the lecturer's discretion	21.4% (6)	6.5% (2)	—	9.1%
No answer	3.4% (1)	—	—	1.1%

The clinical years who have up to 15 hrs/week of lectures definitely prefer the 30 — 45 mins lecture. On being asked how to ensure that this time-limit be observed several suggestions were put forward, none however so silent and efficient as 'the use of a trapdoor'!

PRACTICAL WORK

A detailed study of the value of the multiple aspects of the practical routine of the student was made. This was necessitated in view of the extreme importance of this facet of the curriculum.

Time Spent on Practical Work or Ward Work

	I		III		V	
No answer	48.3% (14)		* 6.5% (2)		3.4% (1)	*17.3% (5)
Less than 9 hrs/wk	26.7% (4)	12.9% (4)	*13.8% (4)		7.1% (2)	* 0.0%
10 - 14hrs/wk	20.0% (3)	32.3% (10)	*10.3% (3)		17.9% (5)	* 4.2% (1)
15 - 19 hrs/wk	20.0% (3)	29.0% (9)	*27.6% (8)		42.9% (12)	*12.5% (3)
20 - 24 hrs/wk	33.3% (5)	16.2% (5)	*20.7% (6)		21.4% (6)	*25.0% (6)
over 25 hrs/wk	0.0%	9.6% (3)	*20.7% (6)		10.7% (3)	*48.3% (14

* The figures in this column refer to the optimum time the student wishes to spend on this activity.

In general the clinical students felt they ought to spend more time than they actually do in the wards.

The pre-clinical course gave unreliable results with two-thirds of them not stating the optimum time.

Evaluation of Practical Work and Ward Work

(1) Laboratory work:

ANATOMY (Dissections)

	I	III	V	ALL
No answer	10.3% (3)	3.2% (1)	6.9% (2)	6.7%
great value	57.7% (15)	86.6% (26)	81.5% (22)	76.0%
some	30.8% (8)	10.1% (3)	11.1% (3)	17.0%
little	11.5% (3)	3.3% (1)	3.2% (1)	6.0%
ins. exp.	—	—	3.7% (1)	1.0%

PHYSIOLOGY

	I	III	V	ALL
No answer	10.3% (3)	3.2% (1)	3.4% (1)	5.6%
great value	38.5% (10)	30.0% (9)	50.0% (14)	39.2%
some	23.0% (6)	30.0% (9)	32.1% (9)	28.6%
little	30.8% (8)	40.0% (12)	14.3% (4)	28.6%
ins. exp	7.7% (2)	—	3.6% (1)	3.6%

BACTERIOLOGY

	III	V	ALL
No answer	3.2% (1)	—	1.7%
great value	63.4% (19)	37.9% (11)	50.8%
some	33.3% (10)	37.9% (11)	35.6%
little	3.3% (1)	17.3% (5)	10.2%
ins. exp.	—	6.9% (2)	3.4%

PATHOLOGY

	III	V	ALL
No answer	9.7% (3)	—	4.8%
great value	82.1% (23)	72.4% (21)	77.2%
some	14.3% (4)	20.7% (6)	17.5%
little	3.6% (1)	6.9% (3)	5.3%
ins. exp.	—	—	0%

(2) Ward work:

SURGERY

	III	V	ALL
No answer	3.2% (1)	3.4% (1)	3.2%
great value	96.7% (29)	89.3% (25)	93.1%
some	3.3% (1)	10.7% (3)	6.9%
little	—	—	—
ins. exp.	—	—	—

MEDICINE

	III	V	ALL
No answer	6.5% (2)	—	3.4%
great value	100% (29)	96.6% (28)	98.3%
some	—	3.4% (1)	1.7%
little	—	—	—

OBSTETRICS

	III	V	ALL
No answer	—	—	—
Great value	90.3% (28)	89.7% (26)	90%
some	9.7% (3)	6.9% (2)	8.3%
little	—	3.4% (1)	1.7%

SEMEIOTICS

	III	V	ALL
No answer	9.7% (3)	6.9% (2)	8.3%
great value	96.4% (2)	92.6% (21)	94.6%
some	3.6%	—	1.8%
little	—	3.7% (1)	1.8%
	—	3.7% (1)	1.8%

No other teaching method compares so favourably in being of great value to the student.

This method also showed to be of significance in learning Opthalmology and Pharmacology where roughly 30% said it was of great value. In Psychiatry, 72% found it of great value.

(3) Out patients:

A similar pattern was elicited; this teaching method being of greatest value in learning Surgery, Medicine and Obstetrics, where roughly 75% found it of great value. It was found to be of some use in Dermatology (60%: great value), Psychiatry (42%) Opthalmology (25%), and Semeiotics (60%).

(4) Attending operations:

In Anatomy roughly one third found it of little value, the rest being in favour of this method of learning. The clinical courses found this method most useful in learning Surgery (32%. great value, 49%: some value), Obstetrics (16%: great value, 46%: some value) and Pathology (13.6% great value, 36.3%: some value).

(5) Post-mortem:

In the clinical courses this teaching method was of greatest use in learning Pathology (55.2%: great value, 32.8%: some value). It also played a significant part in learning Forensic Medicine (40%: great value), Surgery (25%: great value), and to some extent Anatomy. The figures quoted are however largely unreliable because of a high percentage of "no answers".

(6) Informal group discussions with staff

Only 2% believe that informal discussions with staff are not of great value. 49% agree that they serve for "increased understanding and clarification" and "stimulation of interest in course work". 40% believe that an "extension of limits of knowledge" is achieved as well.

The majority (33%) suggested over three hours per week be devoted to such discussions. Another 23% want these to be part of lectures.

(7) Afternoon informal discussions at the bedside:

SURGERY

	III	V	ALL
No answer	6.4% (2)	3.4% (1)	5%
great value	82.8% (24)	82.1% (23)	82.5%
some	13.8% (4)	14.3% (4)	16.0%
little	—	—	0%
ins. exp.	3.4% (1)	3.6% (1)	3.5%

MEDICINE

	III	V	ALL
No Answer	3.2% (1)	3.4% (1)	3.3%
great value	10.0% (3)	82.1% (3)	82.8%
some	83.4% (25)	14.3% (4)	12.1%
little	3.3% (1)	—	1.7%
ins. exp.	3.3% (1)	3.6% (1)	3.4%

OBSTETRICS

	III	V	ALL
No answer	16.1% (5)	—	8.3%
great value	73.1% (19)	79.4% (23)	76.4%
some	23.1% (6)	13.8% (4)	18.1%
little	—	3.4% (1)	1.8%
ins. exp.	3.8 (1)	3.4% (1)	3.7%

SEMEIOTICS

	III	V	ALL
No answer	22.6% (7)	31.0% (9)	26.7%
great value	58.3% (14)	55.0% (11)	56.8%
some	12.5% (3)	30.0% (6)	20.5%
little	12.5% (3)	5.0% (1)	9.1%
ins. exp.	16.7% (4)	10.0% (2)	13.6%

This is a very popular method with the student, as is well shown from these figures

8) Tutorials:

In the pre-clinical subjects this method was of limited value: in Anatomy, Physiology and Bacteriology roughly one third found them of great value. In Semeiotics 20%, Pharmacology 27%, Pathology 43.3%, Surgery 50.8%, Medicine 50.9%, Obstetrics 48.2%, found them to be of more value.

EXAMINATION — TESTS

39% felt that examinations should be replaced with a more frequent appraisal of their performance throughout the year.

15% wanted final exams at the end of the year only, 45% said they preferred a combination of both. 32% agreed with the

present method of grading examination results by alloting marks, because they felt it is fair (9.4%) accurate (7.1%), or useful as the chief basis for appointments to other posts (2.4%), or other reasons (12.9%). When asked to state what form of grading they preferred, 20% suggested six grades, 15.3% five grades and 21.1% four grades or less.

The chief merits of examinations were "a stimulus to work" (56.3%: great extent, 25.3%: some extent), "they compel you to correlate the different facets of your subject" (25.9%: great extent, 25.9%: some extent) and "a worthwhile experience" (6.3%: great extent, 14.6%: some extent). 46.4% found that to no extent do examinations provide "an accurate index of your state of knowledge". Other effects of examinations were as follows:

"Examinations lead you to memorize and forget later"	No answer	4.5% (4)
	Great extent	31.8% (27)
	Some "	43.5% (37)
	Slight "	20.0% (17)
	None	4.7% (4)
"Examinations lead you to read and study less widely"	No answer	7.9% (7)
	Great extent	40.2% (33)
	Some	36.6% (30)
	slight	11.0% (9)
	none	12.2% (10)
"Examinations lead you to concentrate unduly on lecture notes."	No answer	5.6% (5)
	great extent	20.2% (17)
	some	23.8% (20)
	slight	26.2% (22)
	none	29.8% (5)
"Examination lead you to feel resentful of certain faculty members".	No answer	5.6% (5)
	great extent	16.7% (14)
	some	17.8% (15)
	slight	15.5% (13)
	none	50.0% (42)
"Examinations lead you to feel too nervous to think straight".	No answer	4.5% (4)
	great extent	29.4% (25)
	some	33.0% (28)
	slight	17.6% (15)
	none	20.0% (17)

Evaluation of examinations as a teaching method

Although a detailed survey of the value of examinations as a teaching method was made, it would not be worthwhile to reproduce the results because they are virtually identical for every subject.

In Anatomy, Physiology, Bacteriology, Semeiotics, Pharmacology, Pathology, Obstetrics, Surgery, and Medicine, 20 — 25% found them of great value, (except Semeiotics 12%) 20 — 27% of some value, and 35 — 50% of little value.

In general the younger the course the higher the rating in favour of examinations.

In the 'minor' subjects such as Opthalmology, Dermatology, Psychiatry, Hygiene and Forensic the rating was extremely low. Typical figures were of great value 8 — 16% of some value 20 — 28%, of little value 30 — 50%.

It is clear that apart from their use as a way of selecting students for appointments, and also that they induce 56% to work, examinations are of slight positive value and contribute little as a teaching method.

TESTS

These were evaluated separately for each subject concerned. Again in Anatomy, and Physiology, the results were identical; 30%: of great value, 26% of some value, and 35% of little value. In the other subjects the rating was lower, thus Bacteriology (21.8%, 20%, 43.7%), Semeiotics (12%, 10%, 54%), Pharmacology (9.6%, 17.3%, 52%), Pathology (16.7%, 27.8%, 44.4%), Surgery (14.6%, 23.6%, 49.1%), Medicine (15.1%, 26.4%, 45.3%), Obstetrics (18.9%, 22.6%, 45.3%).

With the exception of the preclinical subjects, these were assessed as being roughly of the same value as examinations or slightly less.

TEXTBOOKS and GENERAL READING

81 — 84% found textbooks of great value in learning Anatomy, Physiology and Pathology. In other subjects less found them to be of great value, as follows, Bacteriology 47.5%, Pharmacology 52.6%, Semeiotics 27.6%, Medicine 77.6%, Surgery 78.0%, Obstetrics 74.6%, Ophthalmology 57.7%, Dermatology 38.5%, Psychiatry 29.4%, Hygiene 32.6%, Forensic 46.6%.

Similarly for general reading; Anatomy 27.6%, Physiology 34.7%, Bacteriology 20%, Semeiotics 16.3%, Pharmacology 30.6%, Pathology 46.2%, Surgery 32.1%, Medicine 42.6%, Obstetrics 37.7%, Ophthalmology 10.8%, Dermatology 11.4%, Psychiatry 21.6%, Hygiene 18.4%, Forensic 21%, found it of great value.

AUDIO - VISUAL AIDS

As a teaching aid this method was favourably assessed, in Anatomy 53% found it of great value, Physiology 33.3%, Bacteriology 20.8%, Semeiotics 43.5% 43.5%, Pathology66%, Surgery 41.2% Medicine 32.7%, Obstetrics 43.1%, Ophthalmology 51.4%, Dermatology 43.5%, Forensic 34.8%.

TIME SPENT ON STUDY

	I		III		V	
No answer	24.1% (7)	*37.9% (11)	0%	*9.6% (3)	3.4% (1)	*17.2% (5)
less than9 hrs/wk	4.1% (1)	5.6% (1)	9.7% (3)	7.1% (2)	14.3% (4)	0%
10 - 14 hrs.	13.6% (3)	11.1% (2)	12.9% (4)	0%	17.9% (5)	29.4% (7)
15 - 19 "	9.2% (2)	0%	19.4% (6)	17.9% (5)	7.0% (2)	4.2% (1)
20 - 24 "	31.8% (7)	38.9% (7)	12.9% (4)	14.3% (4)	25.0% (7)	29.0% (7)
25 - 29 "	22.7% (5)	11.1% (2)	16.1% (5)	21.4% (6)	25.0% (7)	8.3% (2)
30 - 34 "	18.2% (4)	16.7% (3)	19.4% (6)	10.7% (2)	3.6% (1)	12.5% (3)
35 - 39 "	0%	11.0% (2)	3.2% (1)	7.1% (2)	3.6% (1)	8.3% (2)
over 40 hrs.	0%	5.6% (1)	6.4% (2)	21.5% (6)	3.6% (1)	8.3% (2)

* The figures in this column refer to the optimum time the student wishes to spend on this activity

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OTHER ASPECTS OF THE STUDENT'S ROUTINE

TRAVEL

47% devote 5 - 10 hours travelling, and another 25% spend over 10 hrs/wk. Needless to say 87% would have prefered the optimum of 0 - 4 hrs/wk on travelling although only 18% achieved this.

DAILY ROUTINE

This varied immensely from over 25 hours/wk (12%) to less than 4 hours/wk (4%). A reduction seemed desirable.

SLEEP

Over one third spend more than 55 hours per week sleeping, a surprisingly high percentage! Others, who probably sleep less blissfully, spend 50 - 54 hours/wk (26.2%), 45 - 49 hours/wk (26.2%), or less than 44 hours/wk. (8.3%). It was a great relief to find that the optimum time that they wished to dedicate to sleep was not any more than the actual time, in fact it was identical.

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RECREATION

	I		III		V	
No answer	37.9% (11)	*5.17% (15)	6.5% (2)	* 9.7% (3)	10.3% (3)	*27.6% (8)
0 - 4 hrs/wk	27.8% (5)	7.1% (1)	3.4% (1)	10.7% (3)	7.8% (2)	4.8% (1)
5 - 9 "	16.7% (3)	28.6% (4)	38.0% (11)	10.7% (3)	11.5% (3)	9.5% (2)
10 - 14 "	33.2% (6)	28.4% (4)	24.1% (7)	39.3% (11)	26.9% (7)	28.6% (6)
15 - 19 "	16.7% (3)	14.3% (2)	13.8% (4)	21.4% (6)	19.0% (5)	14.3% (3)
20 - 24 "	5.6% (1)	0%	10.5% (3)	10.7% (3)	11.5% (3)	9.5% (2)
over 25 hrs/wk	0%	21.4% (3)	10.2% (3)	7.2% (2)	23.8% (6)	33.3% (7)

* The figures in this column refer to the optimum time the student wishes to spend on recreation.

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OTHERS

Other relevant aspects of the student's routine were time spent on social or household duties (40% spend over 10hrs/wk. but not more than 15hrs.), church (70% less than 5 hrs/wk), reading (0 - 4 hrs/wk: 39%, 5 - 9 hrs/wk: 31%, 10 - 14 hrs/wk: 23%, 15 - 19hrs/wk: 7.6%), and "waste" (0 - 4 hrs/wk: 24%, 4 - 9 hrs/wk: 22%, 10 - 14 hrs/wk:28%, 15 - 19 hrs/wk: 12.5%, over 20 hrs/wk: 9.3%).

Important Traits to succeed as a Doctor

Ten triats considered to be of importance to succeed as a good doctor were ranked in order of importance.

RANK	1 — 4	5 — 8	9 — 11	N.A.
Sound medical knowledge	74.2%	16.7%	1.2%	6.7%
Kindness towards others	48.8%	42.6%	8.6%	7.9%
Sharp diagnostic acumen	67.1%	25.3%	7.3%	7.9%
Equanimity	8.9%	56.8%	33.3%	9.0%
Good intelligence	51.9%	42.0%	6.1%	9.0%
Cheerfulness	24.1%	49.5%	26.8%	6.7%
Understanding	47.6%	28.8%	3.6%	7.9%
Experience	52.0%	43.4%	3.8%	6.7%
Good at practical tasks	21.4%	31.8%	29.0%	6.7%
Ambition	17.8%	22.6%	59.6%	5.6%
Others	16.6% (15)	—	—	—

POST-GRADUATE WORK

	I	III	V	ALL
No answer	—	—	6.9% (2)	2.2%
General Practice	20.7% (6)	25.8% (8)	22.2% (6)	23.0%
Specialisation:				
Basic science	3.5% (1)	—	3.7% (1)	2.3%
Medicine	6.9% (2)	6.5% (2)	22.2% (6)	11.5%
Surgery	41.4% (12)	25.8% (8)	14.8% (4)	27.6%
Obst/Gyne.	3.5% (1)	9.7% (3)	3.7% (1)	5.7%
Paediatrics	3.5% (1)	3.2% (1)	7.4% (2)	4.6%
Psychiatry	—	—	3.7% (1)	1.2%
others	—	3.2% (1)	3.8% (1)	2.3%
undecided	6.9% (2)	19.4% (6)	3.7% (1)	10.3%
Administration	—	3.2% (1)	3.7% (1)	2.3%
Research	13.8% (4)	3.2% (1)	11.1% (3)	9.2%
Others	—	3.2% (1)	3.8% (1)	2.3%

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CONCLUSIONS

1. There are marked differences in attitude among the three courses at.

(i) The intermediate course are more idealistic in outlook placing great emphasis on altruistic motives for choosing a medical career. Comparitively they find lectures of great use — which the majority attend, but even so attach great importance to the practical side of their work. Their contribution to the questionnaire was limited in view of the fact that an identical questionnaire was issued to all the courses.

(ii) With the first year clinical (IIIrd year), it is difficult to find a majority liking for a particular answer. In general the more popular motives for choosing their career were based on personal preferences, tending to shun materialistic motives to a second influence. On the whole lectures were favourably assessed, but again there was a strong preference for practical tasks. This course spends least time on study and ward work.

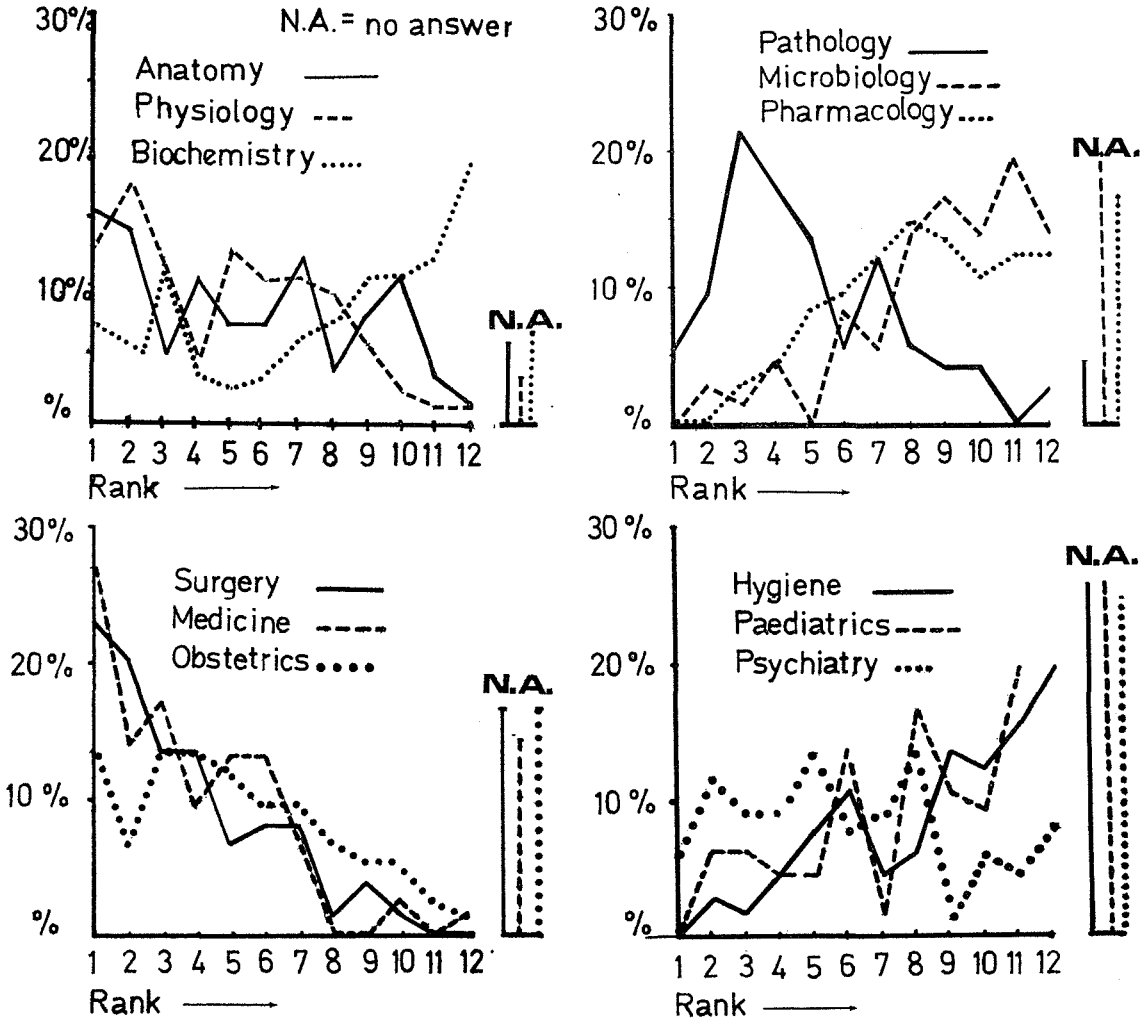
(iii) The final year (Vth) seem to be the most disillusioned with 27.6% regretting their choice of career. They give a low rating to lectures in general, and a favourable evaluation of practical work. Notwithstanding their tight routine they wish to spend more time than they actually do at practical work.

2. The questionnaire was received with great enthusiasm which however did not always succeed in ensuring a logical appreciation of the questions asked. There were curious discrepancies in say, assessing the value of lectures; these were considered favourable as a basis on which to organise one's studies, and to learn and understand the subject yet did not stimulate further interest.

3. Both the response to this survey and the abundance of remarks that were added to the questionnaires reflect the keen interest that the student has for his system of education.

ACKNOWLEDGEMENTS

This immense task was of course borne by several people, notably the editor, Mr. E. Bozzino, Mr. G. Depasquale, all those who offered their advice or collected the questionnaires, and several others who wish to remain anonymous. Most important of all however, is the student without whom none of this would have been possible.



Four graphs showing the various subjects ranked in order of interest by the student.

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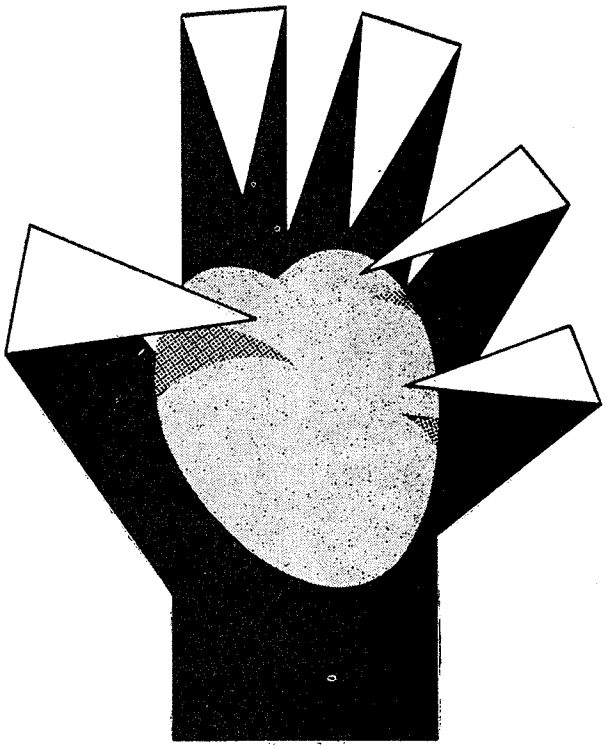

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Letters to the Editor

The Teaching of Surgery in Malta

It has been said, time and time again, that the main obstacle facing the Maltese Medical student is not the Final examinations, but the Surgery Final. This hackneyed saying, disheartening as it is to the students concerned, is, unfortunately, very true and founded on the repeatedly disastrous results published every other summer, with each final session. Results in Medicine and Obstetrics and Gynaecology are always very good, and reflect on the hard work put in by both students and teaching staff, but the Surgery results, for some obscure (?) reason, seem to indicate that i) the students are not studying Surgery; and /or ii) the teaching of Surgery at our Medical school is faulty. Let us now go into these two suppositions in a bit more detail.

The fact that most students pass their Medicine and Obstetrics and Gynaecology, but fail their Surgery, would indicate that they are neglecting this subject, for some reason known only to themselves. Straightforward as this explanation may seem, I'm afraid it is hardly tenable, since if one had to ask any Final year student which subject gets most of his attention, the answer would be — Surgery. Thus the obvious reason is the other alternative mentioned above. Is this really so?

In comparing the results of Surgery with those of the other two 'big guns', one is tempted to assume that the fault lies with the teaching, because, after all, it is the jockey that steers the racehorse home. But, is this really the case? I am sure that most of our fellow students will agree with me that our afternoon sessions, to quote one instance, are very useful indeed. What of the lectures, and the examination itself?

That we have too many lectures in this School is an undeniable fact, and it is deplorable that the only three library sessions allowed to us this year, were to be taken up by still more lectures. Moreover, it is ridiculous that lecturers should try to impart in their lectures the whole curriculum, from A to Z. What are textbooks for if a whole lecture is to be devoted to the different operations available for the treatment of Hirschprung's disease? And, anyhow, how does this concern the undergraduate studying for a general degree in Medicine and Surgery? How do lecturers expect students to flock to their lectures if, for example; one and a half months are spent on the subject of Peptic Ulcer, or five lectures are dedicated to the complications of Gall-stones?

We are, no doubt, extremely fortunate in having well-experienced lecturers, outstanding in their own fields, and we certainly appreciate their doubtless talents, but, don't they realise that, for example, the mode of performing a Splenectomy is a purely postgraduate consideration? Isn't there something of greater surgical significance to the General Practitioner than Cervico-facial Actinomycosis, or some rare orthopaedic condition? Why is it that the Surgery Final should always turn out to be a methodical search into "dusty corners"?

Surely these are the concern of the consultant surgeon, suitably equipped with his postgraduate training to probe into them. Why must postgraduate material be thrown at the undergraduate? In short, who or what is responsible for the inevitably poor results in Surgery examinations? One wonders (or does one really, after all?) whether the fault lies with the ship or with the helmsman. Captain Bligh was an excellent skipper, but this did not prevent the mutiny on the "Bounty", for the very simple reason that he did not care a hang for his sailors.

SPENCER WELLS

Letters to the Editor . . . .

MMSA Structure, 1969 and .....

The MMSA is a constituted body formed by undergraduates whose number necessarily fluctuates according to the frequency of intake by the University. There are about 110 students during a given academic year (when 3 classes are running) and 75 students during the following academic year (when only 2 classes prevail). Membership of MMSA is on a voluntary basis.

The present MMSA statute provides for the election of nine members to the MMSA Executive. These members represent the different classes in a definite ratio. However, a new statute is being drawn up and this will be presented to a General Meeting of the Association.

I believe that MMSA is unique in that its officers do not often enjoy the privilege of continuous service. This fact may put us in bad light with our immediate superiors, as well as with other representative bodies. Let us hope then, that some change will be effected in the statute whereby the terms of some offices shall be longer than one year.

I feel that the MMSA Executive should be composed of eight members with offices of President and Vice-President, General Secretary, Exchange Secretary, Treasurer, Journal Editor, Chairman QRS Management and SRC Faculty Representative.

The offices of President, General Secretary, Exchange Secretary, and Journal Editor should enjoy a term of two years. The other offices should be of a year's duration.

The Exchange Secretary, Journal Editor and Chairman QRS Management would choose their own sub-committees independently of the MMSA Executive.

I should also like to see the posts of President, Journal Editor and SRC Representative being voted for separately.

On the basis of my experience, though be it limited, I would prefer clinical students to run all the offices except those of Vice-President and Treasurer. I believe these two offices must be given to the preclinical students who may then learn MMSA's business in their own stride.

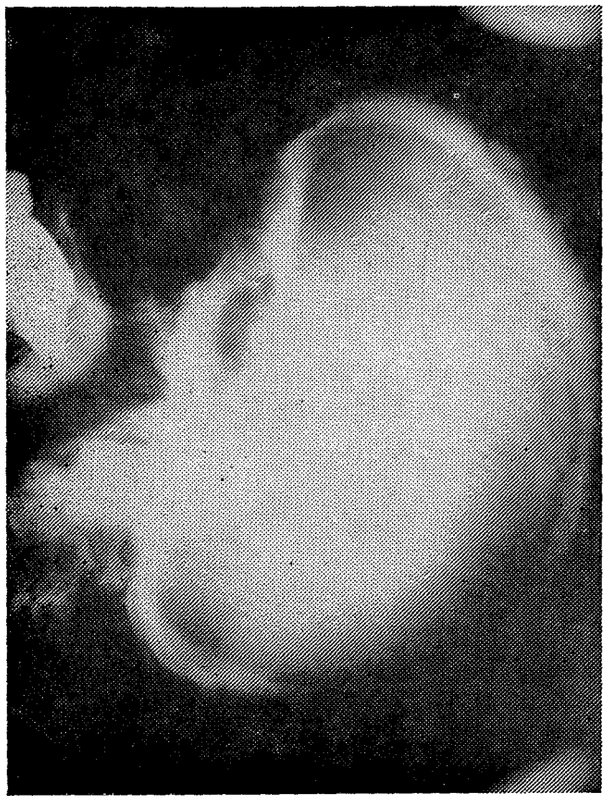
It has been traditional that the MMSA President is a member of the senior clinical class. This has often been challenged in the past. If my suggestions be adopted by the next Annual General Meeting, then, I cannot see how the problem should arise again. In such instance, the post would continually come to be occupied by a student who is about to start his 6th academic year and his term of office would end at the time that he qualifies.

The problems of the medical student must be primarily tackled by his Association, but MMSA should not be divorced from medical student representation in the SRC. This is why it is necessary that the SRC faculty representative be also ex-officio a member of the MMSA Executive. This same person should also be the Medical Education officer. When Student Representation becomes a reality, this person should be one to sit on the Faculty Board on our behalf.

Before concluding, I would like to suggest that membership of MMSA be made compulsary. I should like to point out to my colleagues that every medical student is paying, knownigly or otherwise, £1 towards the Sports Club and £1 towards the "Union". I strongly feel that we are not getting our money's worth back. MMSA should therefore ask for a share of this money, the calculation to be made at 15/- per medical student for a given academic year.

LEO SAID

X - RAY QUIZ By DEVENDRA SHARMA



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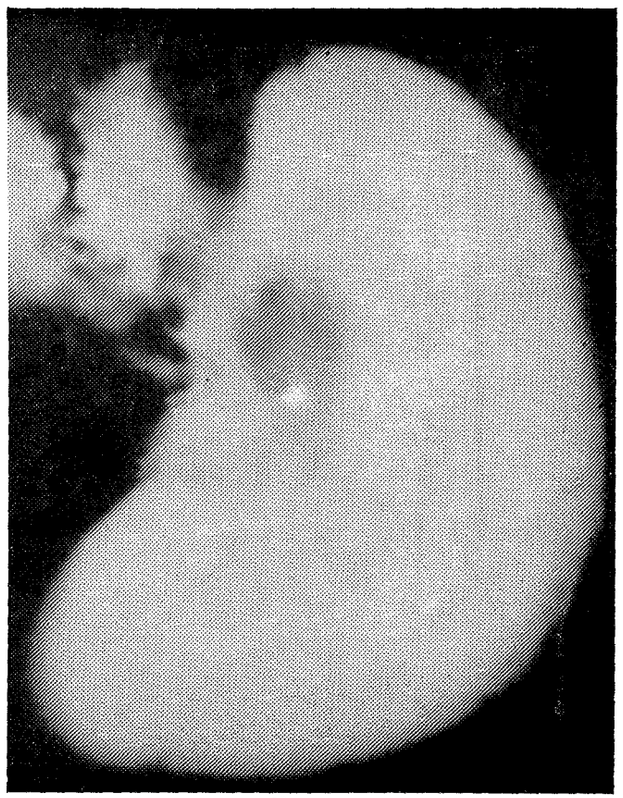

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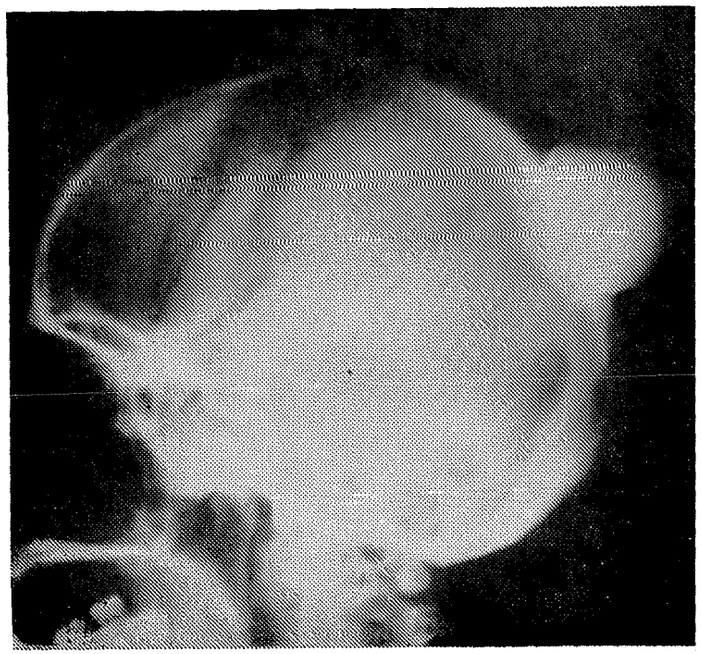


3

1. Patients had multiple bone deformities.

   a) Age 48 yrs; b) Age 81 yrs.

2. Male, aged 38 yrs, with accentuation of Pulmonary second sound. What does the X-Ray show?

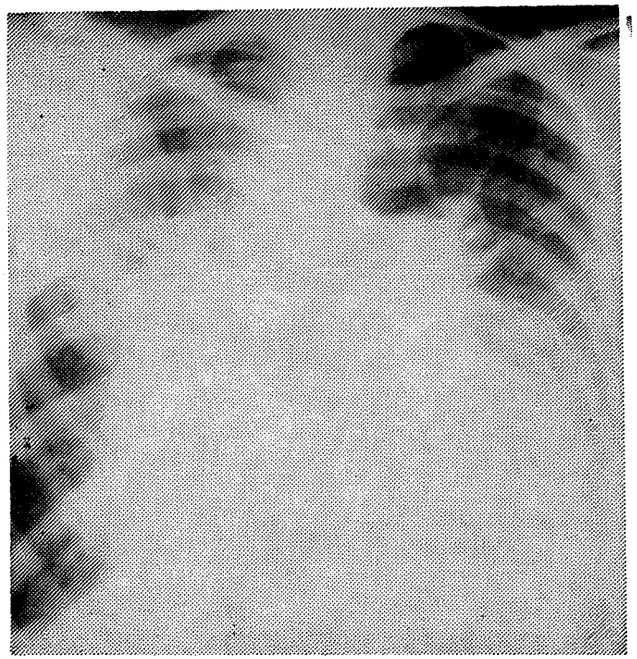
3. Patient, aged 56, complained of long standing, throbbing headache. X-Ray shows two features. What are they?

4. Female, aged 42. What is seen on the X-Ray?

5. Patient had a history of menorrhagia. What is seen on the hysterogram?

6. Plain X-Ray abdomen of a patient aged 56. What is seen?

(Answers on page 48)



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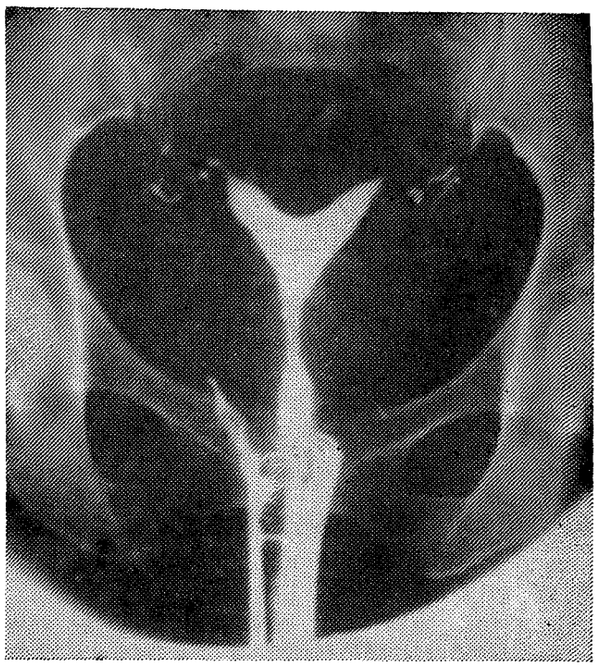

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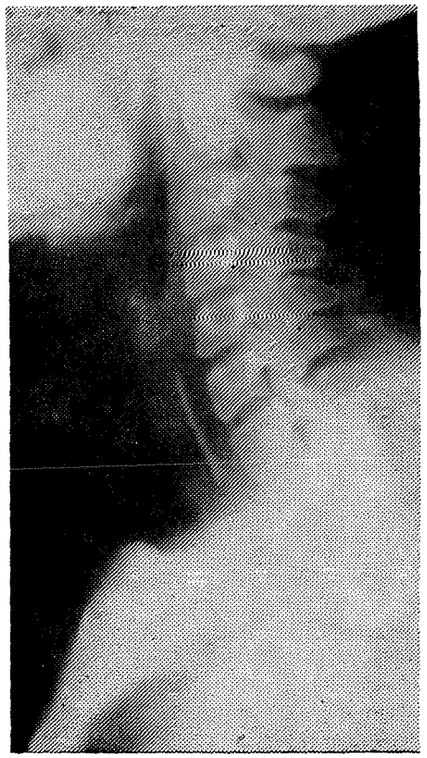

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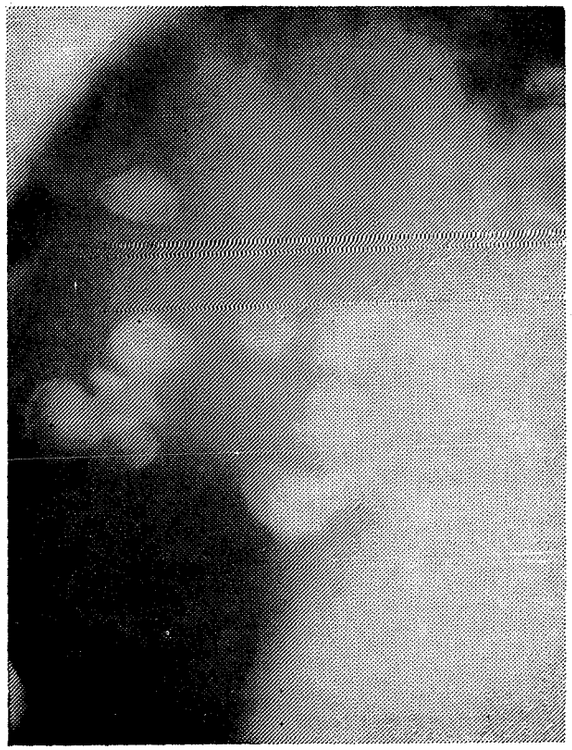

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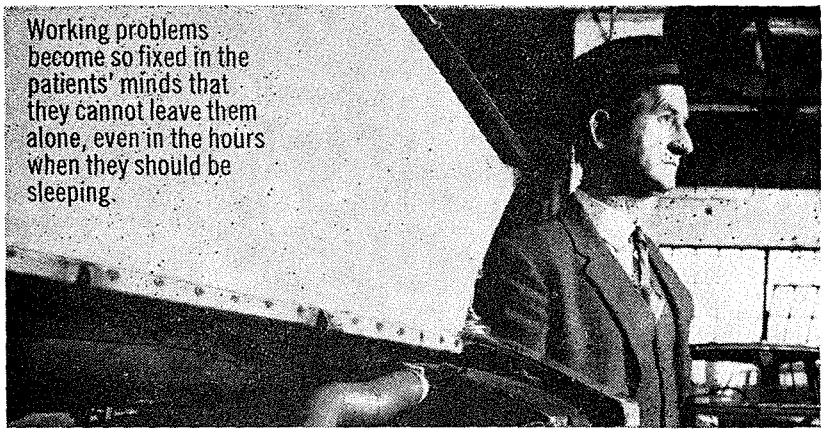
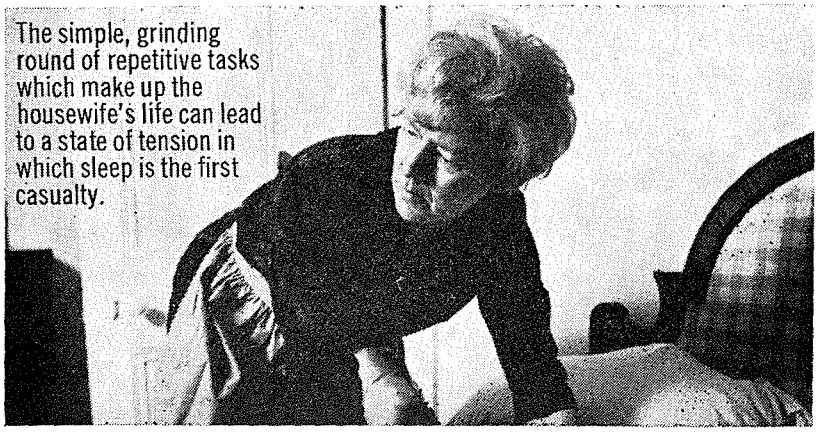


HOWEVER THE PROBLEM OF INSOMNIA STARTS, IT ENDS CERTAINLY AND SAFELY WITH MOGADON*



Sleep and a truly remarkable margin of safety.
The lethal dose of Mogadon in humans is unknown. Up to 70 tablets have been taken without harm. In the mouse the LD_{50} is the equivalent of 360 tablets per kg body weight.

* Registered trade mark for preparations containing nitrazepam.

ROCHE

Agents: Cherubino, 64 Old Mint Street, Valletta

J219

CLASS '69

by I. C. POPEYE

After several and seven years
Of looking on with countless fears....
After the prescribed hours at coffee or tea,
Where brooding over just why did we
Choose Hippocratic roles
As our lifelong goals...
Oh..... mercy on our wretched souls!!

To closely examine this class '69
One finds a gradation from rockstone to slime
The outstanding, the dull, and the nondescript
Some the pulse of life; some just-not-with-it.
Some for mutual discomfort go two by two....
The middle road stragglers are more than just few,
While so called INDIVIDUALS seem to have much ado.

NOW, in my favourite seat of the solemn library
I.C. those who are keen on bookish rivalry.
-----Athletic, tall, head bowed in quiet meditation
In manner so intent as for pre-levitation.
His feet incessantly measure the tiles
As he scans through a book, now pauses and smiles,
as if to say, — "Azzo's fine" ..... pseudo-Socrates, class '69.

Round face, springy gait and eyes a dazzling grey
His verbose, voluminous chatter, continues each day.
Head distinguished by a shock of premature white mop
Indeed..... our quasi — Mrs Malaprop!
Young Bianchi a sceptic all round —
Head bowed as he scrutinises the ground.
"To prevent is to cure."
This he will assure
Is the teaching that's really profound!
Short and stubby
Face pink and chubby..... a self-asserted lad.
Hands in his pocket
Nose up like a rocket..... imitating is his fad
But carry-on Caru-an..... to have you we are glad.

The editor I can tell,
Has many ideas to sell.
He awakens the students
To rebellion and prudence
Though his efforts be not received well,
He's one of the workers
Amongst many shirkers
Let's relieve him from this wicked spell!

This venerable and veritable "BWANA"
Hails from down East Africana.
We'll confer an M.D.
Then send him by sea.....
Home to doctor the "MAU-MAU".
His fellow tea-brooder
A moody intruder..... with writing precise to the dot.
Who carries a large weight
And at times in good faith..... has weilded EXCALIBUR of Camelot!

Two form a Cupid's affair,
One reserved, one fashionable
Their affection remarkable
Indeed... 'tis a charming pair.
Then there are those who with life are frustrated,
plus fears that their future's ill-fated —
A purging drug
Kills their psychotic bug
And relieves those mentally constipated.

There are three who answer to "Galea"
One femininely fair,
Her twin eccentric and queer
The third aspiringly bourgeois.... inter alia.
Another three at Mount Carmel enrolled,
For reasons I've never been told.
One Mifsud's collateral,
One cool and quite practical....
The third sniffs like the snuffers of old!

One short with moustache neglected;
His president portentously directed.
Both cunning and sly
With politics they try
To have Jekyll and Hyde resurrected!
Too busy is this "Busubody" by far.....
Who divulges his news to Cassar,
They stand in the corners
These gossiping horners
Alas..... let's brand them with tar!!

I'm scared when I.C. "Castro's" beard;
Or when I hear Cilia and Carabott compared.
I find Vella amusing,
Pisani confusing
And Raymondo for folly prepared.
But to see Rene and Schranz....
Do a quick-step dance.
Or to hear the latter
In "colourful" chatter —
Makes Marie's heart go pitapata!

George, quite a negotiating chap....
Contrived to remove Schembri's night cap.
Frederick assisted
While the poor lad resisted,
But alas, 'twas the end of his nap!
With an inevitable question to ask,
Bonnici finds it a pleasurable task.
Though Scibby is a hesitant fellow,
Once he starts to get going he's mellow!
And sober Delicata
I think that he oughta' ..... be given a can of spray;
For the infectious laughter,
From the West Indian quarter
Who goes smiling through each day.

This Museum piece from the past,
has found the Messiah at last.
'Tis his heart's desire....
To form a choir
And sing for his daily repast!
I've left for the end
Our true-to-form friend.
That he's inevitably late,
Needs no debate..... and an artist too at that!
That he sleeps through the lecture,
Needs no conjecture..... I think it is due to his fat.

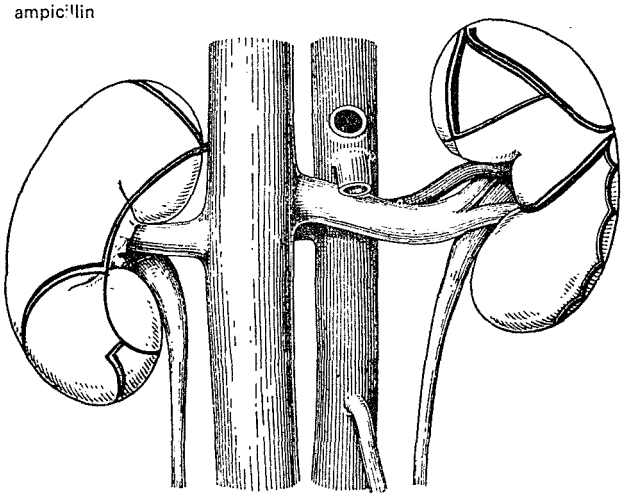
Soon comes the day,
When we all choose our way.
"Primum non nocere" shall beset thy mind,
Though with the stresses of life you shall find....
That you harm without knowing
To admit you're wrong,
And alter your song
Indicates, my friends, your wisdom's agrowing!

AMEN.

Bactericidal antibiotic for urinary tract infections

PENBRITIN

ampicillin trade mark



treats the acute; prevents the chronic

The majority of drugs available for the antibacterial therapy of urinary infections are bacteriostatic. They suppress bacterial growth but do not kill the organisms. In some cases the natural body defences are themselves capable of clearing the stunned bacteria, but in many others, even after prolonged therapy, sufficient viable bacteria remain to cause a focus for continual re-infection.

By using an antibiotic such as Penbritin that kills organisms at therapeutic dosage levels, the risk of recurrence leading to chronic infection may be reduced.

Penbritin combines bactericidal action with high urine concentration and tissue diffusion and is therefore particularly indicated in the treatment of kidney and urinary tract infections, especially those due to:

- Escherichia coli
- Proteus mirabilis
- Proteus vulgaris
- Streptococcus faecalis

Dosage:
Urinary Tract Infections—oral 500mg., 8 hourly.
In serious infections double the dose or administer Penbritin injectable intramuscularly 500mg., 4-6 hourly.
Availability:
Capsules, Injection, Paediatric syrup, Paediatric tablets.

Penbritin is a product of British research at
Beecham Research Laboratories, Brentford, England
Distributors: Joseph Cassar, 207-208 Old Bakery Street, Valletta

Students Abroad — Summer '68

Clerking in Surgery at Cardiff

To enjoy a clerkship in Cardiff, one's attitude to the weather has to be philosophical.... you see, it's a matter of crawling out of bed, to the soporific tunes of rain spattering against the window; then tramping around the wards with the anticipation of a glorious sunshine at lunch, then rolling into bed in the waning hours of the day; indifferent to the bellowing and biting winds. The word 'indifferent' here is significant, as it indicates that you have imbibed the true spirits of the nation. Indeed, it is the students' hobby to have their regular pints each day and, I daresay, the pastime of every man in the street. At least three pints of beer per night provides the pulse of the nation, (whether this be of the "collapsing" or "water-hammer" type I leave it to your clinical acumen) and indeed, when a patient turns up at casualty, first thing in the morning, with an "acute abdomen" preceded by general malaise, the first consideration in your clinical diagnosis must be "Syndrome of less than three pints on yesternight".

To be forewarned is to be forearmed, and the students' council provides adequate prophylactic treatment by sequestering ample quarters for "Liquor-therapy" in the basement of one of the boarding houses.

Life in Summer is relatively calm, and there is plenty of quietude for concentrated study. A modern and well equipped library is close at hand, and you are free to choose whom you shall serve.... whether Bacchus or Hippocrates.... but the wisest of us do both, with more or less of one or the other.

The daily routine on the wards can be quite exacting, a case is discussed from 9 to 10 a.m., and thereafter the whole ward is yours, and one is expected to know everything about each patient. In the afternoons, there were operations, where attentive observation did serve to drive a few principles home.

Very stimulating were the lunch-hour meetings, where interesting cases were discussed along with the aid of a very modern Radiological Department. Comes Friday morning when the "big guns" meet at a combined Surgical and Medical ward around, it was not enough to be erudite in the fields of Medicine and Surgery, as with every bullet of fact there followed in its wake a sharp and stinging witticism..... indeed, 'twas stimulating. Also available are clerkships in Anaesthesia, Urology, Neurology, anything..... you name it, it's there.

One should never fail to avail oneself of the opportunity of getting out into the open countryside of South Wales, where lush greenery of the alternating hills and valleys is the best prescription for "sore eyes". Nor should one miss the extensive sandy beaches in Mumbles. Contrast the life in Cardiff with that in Swansea, then hop on a bus to nearby Bristol. Every day can be packed with activity for the adventurous individual. St. Fagans and other historical sights must be visited, and available are cheap tourist rates to Oxford, Stratford etc., etc..... indeed, it was a wonderful summer.

ERROL MORRISON

Medical Clerkship in Wales

When an opportunity arose to spend a month's medical clerkship in Cardiff, I took it immediately for two very different — but, I suppose, perfectly legitimate — reasons. The first is that I had never visited the United Kingdom before; the second is that I had heard and read a lot about The Welsh National School of Medicine, and that a period

spent working in this school is considered quite a feather in any medical undergraduate's cap. Thus psychologically armed, I left the humid heat of a Maltese August for a wet, cold and instructive stay in Cardiff, Glamorgan, South Wales, or — to be more specific — at the Cardiff Royal Infirmary.

The Cardiff Royal Infirmary, or C.R.I., is a very old and tumbledown building which dates from 1839 and behind its red brick walls some very sound and sensible medicine is taught. I was attached to the main medical ward, the "William Diamond", under the supreme command of Professor Harold Scarborough. The latter gentleman was very helpful to my colleague and I, and told us that we were at liberty to do what we wanted and ask anything reasonable. This was hardly necessary, however, since his two S.H.O.'s laid on a very useful scheme of ward-rounds and tutorials for us. There is plenty to see at this hospital, if only for the fantastic "artificial kidney" which is the pride and joy of the place. Maltese students need not feel any complexes if they propose going to the C.R.I., since it was our impression that— although streets ahead of us in practical procedures, — the Welsh lads are pretty much like us when it comes to book-work and theory.

Extracurricular life in Cardiff is pleasant but tame, as compared to London or Rome, say, but there is a lot to see in South Wales, and the intending visitor would be well-advised to arm himself with a guide-book and sally forth on his own. Then, of course, Professor Scarborough is a perfect host; when we were there, for example, he showed us most of the sights, took us to the new hospital on The Heath and even stood us a stupendous dinner in Penarth — all the time keeping us informed about this that and the other, be it opera, medicine, literature or Welsh customs.

The accomodation we were provided with left absolutely nothing to be desired, but the food was typically British (very insipid, that is!) The local students are very easy to get on with, very boisterous, very friendly, very alcoholic and altogether very Welsh. The nurses . . . . . highly decorative!

To summarise — I strongly advise anybody to seriously consider clerking for a month or two in Cardiff this summer. There is a wealth of clinical material always to be seen, the teaching is of a very high standard and the accommodation excellent. Professor Scarborough is an old friend of our Medical School, and I am sure that he will always be happy to see a couple of our lads in Cardiff — working hard, of course. A clerkship is primarily a period of intense clinical work, and it would be a waste of time to go all the way to Wales and just wander around the wards.

I should like to take this opportunity to thank Professor Harold Scarborough for all the interest he showed in us during our stay in Cardiff, as well as for his boundless generosity and hospitality. My thanks are also due to Professor George Xuereb, who suggested my going to Wales in the first place.

ANTON J. BISAZZA

Pathology at the Istituto Di Anatomia Ed Istologia Patologica

It is with some nostalgia that we recall to mind the days we spent in Rome last summer when we were clerking in Pathology at the Istituto di Anatomia ed Istologia Patologica of the Università di Roma, and with good reason too, for those were some of the happiest days in our academic life.

We arrived in Rome on the 29th July, and the morning of the Ist August saw us at the Istituto. After a preliminary introduction with the Director, Prof. L. Ajello, we were shown around the place. The Istituto

forms part of the Policlinico which, as its name implies, is a collection of clinics, each speciality being represented by a small hospital. The dissecting rooms are not comprised in the main building but are situated a couple of hundred yards from the Istituto.

Each one of us was then assigned to a Pathologist, and our lot fell with Dr. A. Spivach who could also speak English quite fluently. Hence there was no language barrier. We were also supplied with a pair of rubber gloves and we were urged to take an active part in the dissection and examination of specimens. Post-mortems started at 8 a.m. and by 11.30 most of the work was over. The pathologists spend the afternoon examining sections so that when we were interested in a particular case all we had to do was to stay at the Istituto till 2 p.m. when the study of the sections would start.

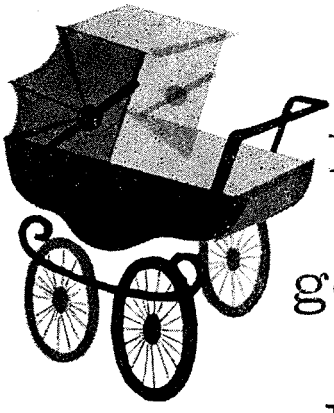
We saw many autopsies and although about seventy were recorded, we saw several others. Amongst the interesting cases we recall hepatoma, nephroblastoma, neuroblastoma, astrocytoma of the cerebellum, several carcinoma head of pancreas, tuberculous meningitis in a child, bronchiectatic abscess complicated by frontal lobe abscess, a case of air embolism.

The Istituto is also equipped with a superb Museum containing specimens of practically every pathological entity. We were given free access to the Museum and we availed ourselves of this opportunity.

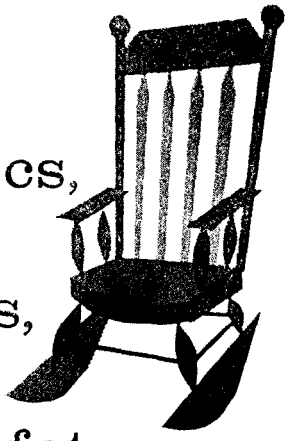
Finally we would like to thank Prof. G.P. Xuereb and the Italian Embassy who made this instructive period of clerking in Rome possible for us, as well as Prof. L. Ajello and his staff for their constant help and encouragement.

CARMEL MALLIA

RONALD MIFSUD



from pediatrics, to geriatrics, when speed and safety are desired



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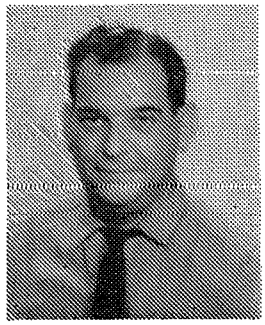
5233

Twenty years ago . . . .

October 1948 marked "an important step forward in the work of the Malta Branch of the British Medical Students Association". With these words the first "Chest-piece" appeared, complete with editorial board (Editor: C. Xuereb; Ass. Editor: F. Vella, Business: A. Gerada, and L.A. Camilleri), a message from the Vice-Chancellor (Prof. J. Manche), and of course an address from the Minister of Health (Dr. T. Schembri-Adami).

What struck me, however, was the warm idealism one senses in the journal; sprinkled among the Medical articles were lines from Descartes, Voltaire, Emerson, a



DR. C.J. XUEREB

generous part of Sir William Osler's Valedictory address "Aequanimitas", and also the Hippocratic Oath. Rather than be cynical about this excess of poetry, I thought that it perhaps indicated that our predecessors were more erudite than us in this respect.

It was unfortunate that I was unable to trace the man responsible for suggesting the name 'Chest-piece'. The first editor, (now Dr. C. Xuereb) told me that various other names were put forward such as 'The Stethoscope' or 'The End-piece'. He felt the need for setting up a student journal when he saw that students should be given the means for publishing original clinical material. As usual, people were difficult to entice into writing up articles, but the first issue came out with five articles on Medical topics including one by two students. The journal was an instant success. Advertisements were easy to obtain including one advertising "viril nets" (for men) and "fertilinets" (for women)!

Dr. C. Xuereb graduated in 1949, after five years on the council of the Medical Students Association. He left for Nigeria, for 10 years, and then to London for postgraduate work. He is now married, has four children and lives at Kappara.

He is no doubt, one of the few graduates who as a student did much for the betterment of the Medical School. I feel that what he aimed at in creating this journal is well summed up in the quotation by Emerson he printed at the end of his first editorial:

"The secret of Education lies in respecting the student."

J.V. PSAILA

SPORTS

CRICKET

The R.U.M. Cricket team is composed almost entirely of students from the Medical School. Every Saturday afternoon, regardless of the elements, we troupe off to Ghajn Tuffieha in whatever transport we can find (sometimes seven chaps crammed into a mini — not counting the couple in the boot!) to practice our cricket. Soon we hope to start practising at the Marsa Club, availing ourselves of the proper cricket pitch there and of the services of a prominent R.A.F. cricketer as coach.

The difficulties we face are many, mainly the unwillingness of the R.U.S.C. to provide us with decent transport and the various other 'Saturday afternoon engagements' of our members. In spite of these difficulties however, we hope to build up a good team in due course and start challenging any local opposition available: we are not really expecting to win any major honours, but in cricket as in all other forms of sport, the fun is to play the game like a gentleman and play it well.

I would like to conclude by thanking Mr. Dave Sharma (l-Indjan) and Mr. Ben Anazodo (l-Ibo tal-Biafra), for their constant help, advice and encouragement.

CHARLES A. GAUCI
(Capt.)

● ● ●

ROWING

Rowing is an old sport, but it is only recently that the university student is showing such enthusiasm locally. This response is mainly due to the decision of the Inter-Faculty Board to hold an inter-faculty competition this coming Easter. But it is still unbelievable that the faculties are putting down seven teams. Viz. Arts (1), Architecture(1), Laws (2), Medicine (2), and Science (1).

It is only in 1966 that the first inter-faculty boat race was held here. This was won by the science crew who beat the medical team by three quarters of a length.

It is obvious that the second interfaculty competition will be hotly disputed, but I am sure that the toughest race will be that between the two medical teams. My (A) team started training two winters ago, but due to changes in the crew and lack of competitions it was established only recently. The (B) team has some experienced oarsmen and this fact has helped to make it just as tough even though formed only this winter. I hope one of us will win the cup for Medicine.

The two teams row like this:
(A) team (IIIrd year) Charles Swain (position 1), Tony Leone Ganado (2), Joe Psaila (3), Anton Bencini (4), John Aquilina (5), and Bernard Anastasi (coxswain).

(B) team (Ist year): Dennis Soler, Mark Vella Bardon, Christopher Vella Bonnici, Peter Sant Cassia, John Sammut Tagliaferro, John Symes, and Alfred Caruana Galizia (coxswain).

Every oarsman is doing his best not to let his team down, and on that day of reckoning he will surely recall those lines from Virgil:

"Ranged in a row, their arms stretched to [the oars
All tense the starting signal they await.
Together at the trumpet's thrilling blast,
Their bent arms churn the water into [foam;"

BERNARD ANASTASI
(Capt.)

FOOTBALL

Hear ye, hear ye, to whom it may concern, last year's "Gray's Bone Crushers", (new version name "Griff's Disciples") are on the rampage again. So Beware . . . . . ! ! !

The team's nucleus is based on last year's one, and in spite of the fact that some players have given up, the new elements introduced still make us a force to be reckoned with. This year's probable line up is as follows: Alfred Magri Demajo, Joe Carabott Damato, Leo Said, Tony DeBono, Mark Vella Bardon, Valhmor Zammit, Raymond Zammit, Saviour Xerri, Anto ne Schranz, John Sammut Tagliaferro, Joe Azzopardi. Reserves: Anton Bencini, Klaus Vella Bardon, Patrick Farrugia, John Aquilina, Tony Leone Ganado.

The initiative and stamina are still there, though the team as such have not played together for some time. However, most of the players make part of various teams so that a certain amount of individual training is still being carried out. The team still bases its' play on a sound defence, and efficient mid-field and a powerful goal getting forwardline. The 4-3-3 system is usually adopted with the half backs coming down to help in defence when the need arises.

Last year's team indulged in studying their pocket Anatomy books during lemon time but this procedure has been dropped. It is now the custom for the players to grab their shot-guns and anti-aircraft guns (Bc ! that's life) and shoot down any unfortunate quails or eagles which happen to be in range. This passtime helps us indirectly to keep our minds on our studies.

I am supremely confident that we will achieve our goal this time.

VALHMOR ZAMMIT
(Capt.)

ACUTE BARBITURATE POISONING

ANTHONY A. BUSUTTIL, M.D.

Demonstrator, Department of Pathology.

One of the landmarks of twentieth century medicine and therapeutics was undoubtedly the synthesis of the first barbituric acid derivative with hypnotic properties. Barbitone, the di-ethyl ester of barbituric acid (malonyl urea) was first synthetized by Professor E. Fischer and Professor J. Mering in 1902. After a series of controlled tests on animals and humans, a year later, barbitone was exhibited on the market as Veronal, and was advertised widely as the panacea for all forms of insomnia and anxiety. Barely four years later, in 1906, the first fatality due to acute barbiturate poisoning following an overdosage of barbitone, was recorded.

AN EMERGENCY MEDICAL SYNDROME

During the last fifteen years the role of acute barbiturate poisoning in foreign centres as an emergency medical syndrome has come to the lime light and specialized, full-time, 'intensive care units' are equipped to deal with these emergencies as they arise.

A few representative figures will help to illustrate the state of affairs. In the United States of America, barbiturates account for 20% of cases of acute poisoning admitted to general hospitals — a figure in the region of 20,000 cases per annum. Despite a mortality rate of only 8%, in 1962 barbiturates took the toll of about 1,500 deaths. Besides this, barbiturate over-dosage accounts for 6% of all suicides, and 18% of all accidental deaths. In 1965 alone, 4,500 kilograms of barbiturates were sold in the United Kingdom and about 400 barbiturate deaths were reported. In the Scandinavian countries statistics provide fabulous figures: In Canada, A Richman and R. Orlaw have recently reported that deaths due to barbiturates have quadrupled from 63 in 1950, to 252 in 1963. Mortality was higher in females than in males and was highest in females aged 45-64.

In Malta there have been 57 admissions for Acute Barbiturate poisoning over the last 5 years; of these 22 were male and 35 were females. 14 of the total number of patients were expatriates on holiday, or permanent residence in Malta. The age distribution of these cases is shown in the accompanying table.

Age	Male	Female	Total
Below 20	3	3	6
20-29	7	12	19
30-39	4	8	12
40-49	4	6	10
50-59	2	1	3
60-69	1	4	5
70-79	1	1	2
Total	22	25	57

CLASSIFICATION

Over fifty barbiturate derivatives have been retailed for clinical use. The following are the ones found with any frequency in cases of acute intoxication. Of the 'persistent' barbiturates i.e. barbiturates with a prolonged period of action Barbitone (Veronal), Barbitone Sodium (Medinal), and phenobarbitone (Luminal) are the commonest encountered. Of the medium-acting barbiturates, Butobarbitone (Soneryl), Amylobarbitone (Amatal), Pentobarbitone (Nembutal), Seco- or Quinal- barbitone (Seconal), and Aprobarbitone (Alurate) are the more commonly encountered. Barbiturate combinations are also common, such as Tuinal (Quinalbarb. Sod. & Amylobarb. Sod.) and Cabrital (Pentobarb. Sod. & Cabromal.). The ingestion of five to ten times the full hypnotic dose may give rise to quite heavy intoxication.

WHY?

The ingestion of large amounts of these drugs takes place either accidentally or with a suicidal intent. The accidental type of poisoning has been met with uncommonly in children who manage to have their fill of the capsules from the domestic medicine

chest. Another form described by American authors as 'involuntary suicide' or 'automatism' has been described in regular partakers of these drugs who due to alcoholic intoxication or confusion from the ingestion of barbiturates themselves, manage to gulp down a second or perhaps a third helping of the drug in an attempt to doze off. The availability of barbiturates and the facility with which they may be procured has augmented, to a tremendous degree, the use of these drugs for suicidal purposes. This is particularly true in societies in which cultural level is high, competition keen, and instability rules. Such ingestions are often the acts of depressed patients or individuals with a psychopathic or hysterical personality who miscalculate the toxic dosage or who take them impulsively when inebriated. At times it is also a suicidal gesture performed in order to blackmail relatives or other associates. Thus it is not uncommon to have to deal with other drugs ingested by the patient in cases of acute barbiturate poisoning. Tranquillizers and antidepressants alcohol, aspirin, nonoamine oxidase inhibitors and psycho-therapeutic drugs may find their way into the patient's stomach together with the barbiturates taken, complicating the clinical picture. Coal-gas poisoning may also be associated in suicidal cases.

RATIONALE OF TREATMENT

The prognosis of acute barbiturate poisoning has improved in the last decade owing to the greater efficiency and urgency with which the treatment is instituted. Clinically active treatment may be channeled along three ways namely:—

a) the reduction of further absorption of the barbiturate,

b) the abatement of the dangerous systemic effects of the barbiturate

c) the enhancement of the rate at which the poison is removed from the body.

GASTRIC WASH-OUT

If the ingestion of the drug has been recent, gastric lavage may have its place both as a therapeutic as well as a diagnostic procedure. J.T. Wright of the London Hospital has proved by micro-chemical and chromatographic techniques that gastric washouts are of little value if more than two hours from the ingestion of the drug have elapsed.

According to Benseley and Joron the best method in which a gastric lavage may be performed in these cases is by pumping into the stomach via a Ryle's tube, dilute potassium permanganate until the aspirate starts turning pink. The remaining permanganate solution is then removed from the stomach, the mucosa is rinsed with water, and a tablet of sodium sulphate is left inside the stomach; otherwise 50 ml. of 50% magnesium sulphate are left inside the stomach.

Some scepticism is shown by the Scandinavian school of anaesthesia on the usefulness of gastric lavage. They postulate that the drugs often used in self-poisoning are the sodium salts of the respective barbituric acid derivatives, and, as such, are water soluble. So that if more water is introduced into the stomach a solution of the residual amounts of the undissolved barbiturates is made and some of it finds its way into the duodenum, thus further enhancing absorption. With gastric lavage there is also the increased risk of aspiration pneumonia: gastric juice and perhaps other infected secretions may find their way into the bronchi and pulmonary tissues. An attack of laryngospasm may also complicate the procedure, helping to aggravate the degree of anoxia in the unconscious patient. Peripheral vascular collapse is also known to have occurred during stomach wash-outs. In the series of 80 cases discussed by Fergusson & Grace all of which had undergone gastric lavage, five aspirated fluid during wash-out, 2 of whom developed apnoea and needed a tracheostomy; 2 others went into shock and vasopressors had to be used for resuscitation.

The conservative school of anaesthesia contends that gastric lavage always manages to rid the patient's stomach of a certain quantity of barbiturates. Sheelman and Shaw have shown that ingestion of large doses causes pylorospasm and thus a gastric wash-out is still very useful as most of the drug has been dammed back. Laryngospasm may be safe-guarded against by preliminary endotracheal intubation. Gastric la-

vage is still also of importance in cases when the stomach is ballooned with fluids or food.

If after a moderate overdose a patient is still fully conscious, R. Tattersall advocates the household remedy of induction of vomiting by digital stimulation of the fauces. However, in such cases the patient is also to be hospitalized for adequate observation and assessment.

CLINICAL PICTURE

Death is not instantaneous in acute barbiturate poisoning even though huge doses of the drugs may have been ingested. The absorption rate from the gastro-intestinal tract is not sufficiently rapid to provide massive doses to the brain and to the rest of the C.N.S. as to cause immediate obitus. However, a lowering of the level of consciousness is always present, usually associated with depression of respiration, possibly also with some degree of circulatory failure and cerebral damage.

The clinical picture is that of a patient who appears deeply asleep. The pupils react sluggishly to light, the deep tendon reflexes are diminished and plantar responses may be extensor. An erythematous papular rash may be associated. Respiratory failure develops in a couple of hours or after a longer period, depending on the type of barbiturate ingested.

MAINTENANCE OF RESPIRATION

On admission to hospital the patency of the airway is the first to be assessed. It is preferable to introduce a laryngoscope and thus to find out whether the laryngeal and the pharyngeal reflexes are present. If absent, a cuffed endotracheal tube is best inserted and any secretions present in the upper respiratory tract are aspirated. Respirations are to be maintained manually until an anaesthetist is available, at which time a positive-pressure respirator using an increased oxygen content is connected to the patient. The trachea and bronchi are to be aspirated frequently to maintain a clear airway. Hospitals with efficient, well-trained nursing staff prefer a tracheostomy and a cuffed tracheostomy tube, and constant attention to the airway. To facilitate drainage from the respiratory tract the patient's bed is placed on shock blocks and the patient is turned frequently in bed.

Notwithstanding this the incidence of pulmonary atelectasis often followed by a fulminating broncho-pneumonia is still high. Thus prophylactic parenteral broad-spectrum antibiotics are to be given routinely, especially in centres where gastric lavage is performed.

THE USE OF ANALEPTICS

On the treatment of respiratory depression a great polemic exists between two schools of thought. The Scandinavian school championed by Nilsson calls for expectant treatment. The creed of the conservative school led by Koppanyi and Fagekas is the use of central analeptics as adjuvants to respiration.

Nilsson describes the clinical syndrome of acute barbiturate poisoning as, "an anaesthesia which is drawn out to last for days instead of lasting like a common so-called surgical anaesthesia for, at most, a few hours. Thus the rationale of this form of treatment is in accordance with anaesthesiological principles. Faithful supporters of this form of therapy rely solely on a carefully planned, supportive, medical regime without the use of medullary stimulants. This expectant routine of treatment is accredited with low mortality rates ranging from 1.6% — 4%. This method entails two disadvantages. One cannot foresee when the patient will regain consciousness and when complications will set in. Secondly the patient provides a serious problem in a crowded, overtaxed general hospital and calls for the setting into operation of full-time 'intensive care units'.

Dobos et al in 141 cases followed over a period of seven years found no significant advantage of the use of analeptics over supportive therapy. Such complications of their use as cardiac arrythmias, convulsions, and vomiting with subsequent fatal or intractable aspiration pneumonia, may even make things much worse.

The protagonists of the analeptic school insist on the fact that acute barbiturate intoxication is a definite indication for the use of central analeptics especially in severe

cases of intoxications and in cases due to poisoning by long-acting barbiturates. The search for the antidote to barbiturates has as yet been futile. Scores of drugs have been attributed with this property and the medical literature abounds with the clinical trials of these drugs in series of cases of acute intoxication. The mortality rates claimed by the various investigators range from 1.8% — 3.7%.

TYPES OF ANALEPTICS USED

Various analeptics have been used in the resuscitation of patients who have taken overdoses of barbiturates. Caffeine and Sodium benzoate, Leptazol and Nikethamide were some of the first drugs to be used. In long-acting barbiturate poisoning Pentylene tetrazol (Metrazol), Picrotoxin and Bemegride (Megimide) have been described as life-saving by F. Haler. In the cases of the medium-acting barbiturate poisoning Amphetamine Sulphate (Benzedrine) and Dexamphetamine Sulphate (Dexedrine) have been used. Balagot, Tsuji and Sadore from Chicago claimed that Bemegride is a direct antagonist to the barbiturates; no such effective antidotal effect has been demonstrated empirically. Ferguson and Grace tried to attribute the same property to Benzedrine in a series of 80 cases. In 1955 two new barbiturate antagonists were described: NP 13 i.e. Beta-Beta. Methyl. Ethyl. glutarimide which has a chemical structure definitely similar to the barbiturate ring system and D.A.P.T. i.e. 2:4 diamino 5. phenylthiazole hydrochloride or hydrobromide, itself a weak barbiturate antagonist, also a synergist of N P 13 and an excellent respiratory stimulant. In 1961 the American Silipo and his colleagues published the results of their clinical trials with Ethamivan i.e. Vanillic diethyl amide, discovered in Germany by Kratzl and Korasincha. R.J. Hoagland advocated the use of methyl phenidate (Ritalin).

The criterion in the use of these drugs lies with the side-effects that they are liable to produce. Bemegride is often regarded as the analeptic of choice on this account. 50mgm. of the drug dissolved in 10 ml. of N. Saline are injected every 5 minutes until the patient has regained consciousness. Overdosage is indicated by retching, vomiting, muscular twitchings and at times even convulsions. These usually resolve if no further injections are administered but paradoxically thiopentone sodium (Pentothal) intravenously may become indicated. It is often combined with Nikethamide (Coramine, Nicamid); 2 to 8 ml. of a 25% aqueous solutions are injected i.v. This drug acts reflexly through the carotid chemoreceptors and directly on the medullary centres. Picrotoxin has also been used but is less favoured nowadays due to the convulsions that it may easily give rise to. It is given in doses of 6 mg. i. m. or 3 mgm. i. v. every fifteen minutes until the corneal reflex returns. Leptazol, also fallen into disuse, is now being revived by the American anaesthetists. 5 ml. of 10% Leptazol are given i.v. every 20 to 30 minutes. Amiphenazole hydrochloride (Daptazol) is another drug often used in combination with Bemegride; it possesses a direct stimulant effect on the C. N. S. with special reference to the respiratory centre. Before each Bemegride injection 1 ml. of a 1.5% aqueous solution is given intravenously. Amphetamine sulphate in these cases is given at the rate of 20 mgm. half hourly i.v. until the patient wakes up. Sheelman, Shaw et al. describe the use of a 0.5% (5 mgm./ml) of N P 13 and 1.5% (15 mgm./ml.) of D. A. P. T. in physiological saline. Convulsions may easily be brought about during this form of treatment. Ethamivan is given in doses of 400-500 mgm. i.v. start followed by continuous i.v. infusions containing 1.0 G. in 250 ml. of 5% dextrose in water. Side effects include generalized pruritus, muscular twitching, sneezing, excitation and restlessness. Probably the least dangerous and the least effective analeptic was the combination of caffeine and sodium benzoate; the time hallowed remedy of a strong coffee retention enema is well known.

The factor that is of great importance in the prevention of respiratory failure and cerebral anoxaemia, with consequent permanent damage to the brain, is oxygen. It is to be administered in all cases save those with only slight impairment of consciousness. If an endotracheal tube had been passed into the patient's larynx, oxygen is preferably administered through it. In all cases, meticulous care of the air-way by regular suction of secretions has to be instituted.

In 1951 Robie described the use of electrical stimulation through the head as a means of producing respiratory stimulation in barbiturate poisoning cases. He made use of a non-convulsive current and believed that this treatment significantly reduced the duration of coma. Blackly and Brookhart in '55 could not substantiate these findings in controlled experiments on dogs.

DEPRESSION OF VITAL CENTRES

Respiratory depression may be accompanied by depression of the near-by vasomotor and cardiac centres in the medulla with consequent peripheral vascular collapse and hypotension. Hershey and Zweifach even postulated a direct peripheral depressant effect on the myocardium and on the peripheral vascular system. In the treatment of this complication of barbiturate intoxication such first-aid measures as keeping the patient warm and raising the foot-end of the bed are not very effective on their own. The use of analeptics for respiratory depression may have some central effect on the vaso-motor centre. Such conditions are, however, best treated as cases of oligaemic shock with transfusion: glucose-saline, dextran and other 'plasma expanders', plasma, and even blood (R.C. Balgot, H. Tsuji, M.S. Sadore) have been used by different physicians. The role of vasopressors is, however, still debatable; some postulate a rebound phenomenon by which there is greater fall in blood pressure after the action of the vasopressor has withered away. Bensley and Joron have used noradrenaline acid tartrate (Levarterenol) in 5% glucose-saline, plasma or dexran. Ferguson used i.v. infusions of Neosynephrine and norepinephrine (Levarterenol) in glucose-saline. Methylamphtamine hydrochloride (Methedrine) has also been used.

An integral part of the treatment of such patients is a continuous and careful look-out for any changes in the state of the patient. These may be the index of deterioration of the cerebral damage. Scrupulous and regular recordings of temperature, pulse and respiratory rate, and Blood pressure are taken at least two-hourly. (According to de Bobo and Prescott this is to be done half-hourly.) Reflexes and a careful testing of the sensorium are to be recorded at regular intervals as well as an estimation of the level of consciousness by the state of the pupils and by the response of the patient to stimulation.

FORCED DIURESIS

As barbiturates are weak organic acids, the urine by glomerular filtration and by secretion from the proximal convoluted tubules. In the non-ionised form they are diffusible and lipoid soluble, and this permits back-diffusion from the renal tubular fluid into the peritubular blood, especially if the urine is scanty and acid (Weiner, Washington and Rindge).

The rate at which barbiturate is eliminated from the body is therefore enhanced by polyuria and alkalinity of the urine. This theory was first worked out by Koppanyi in 1933. As early as 1945 De Bodo and Prescott had postulated an antidiuretic action of barbiturates. It was followed up by the work of Ohlsson in 1949 who proved this theory of 'blood lavage' by using mercurial diuretics and isotonic saline infusions. Giotti and Maynert have even shown that barbiturates are actually absorbed from the tubules, most probably through the proximal and to some extent from the distal tubules by a process of passive diffusion. Osmotic diuretics, as urea, have been found to interfere with this absorption perhaps due to an electrolyte inbalance which in turn blocks the passive barbiturate diffusion. Myschitsky and Lassen of Denmark, were the first to prove the effect of alkalinization and polyuria clinically by a controlled test on a series of 57 patients. They used two solutions: a 50% solution of urea in physiological saline and an electrolyte solution containing Sodium lactate, Sodium and Potassium Chloride and glucose. The latter solution was designed to alkalinize the urine and to prevent electrolyte depletion from the osmotic diuresis that would be produced by the urea solution. An i.v. infusion of 30 ml. of urea solution and 300 ml. of the electrolyte cocktail were given every hour for four hours. At the end af this period, the rate of the infusion was changed to the amount of urine that was being passed by the patient. A failure of a diuresis is indicative of acute tubular necrosis in which case haemodialysis is to be started immediately if the patient's

life is to be saved. In the series quoted only 3 of the patients died. The average duration of coma was definitely reduced by a third, and the complications of treatment were slight. There was no incidence of fluid retention but a few cases of electrolyte rected under biochemical and electrocardiogram controls.

Other diuretics were tried. Cirksena and others tried solutions of mannitol with less spectacular results. In '61 the Americans R.C. Balgot, H. Tsuji and M.S. Sadore introduced a new osmotic diuretic, the tris-buffer THAM, trishydroxylmethylaminomethane. A diuresis of 11 litres in the first 24 hours was produced during therapy and this lasted for 42 hours.

Other clinical trials were those of Laus in 1954 and of Waddell and Butler in 1957. These also have shown that the alkalosis that is induced by alkalinization of the urine helps to lighten the depth of the barbiturate narcosis, especially in phenobarbitone poisonings.

Haemodialysis by the 'artificial kidney has made it possible to save the life of a patient suffering from phenobarbitone or barbitone poisoning and patients having impaired renal function. This method is also most useful in the treatment of very severe cases of poisoning in those with normal renal function, as shown by Jorgensen and Wieth. The amount of barbiturate that can be recovered by haemodialysis in 7 hours is about that which can be obtained in 4½ days by diuresis. Not all barbiturates react to dialysis in the same way and this, according to Henry and Jackson, is due to the variability in the binding of the barbiturate molecule to tissue and plasma protein.

CONSTANT NURSING AND OBSERVATION

Part and parcel of the medical treatment of cases of acute barbiturate poisoning is the meticulous application of constant, painstaking, nursing care. Meticulous care of the patients' skin by constant turning in bed to prevent pressure sores, catheterisation of the bladder under aseptic conditions to prevent retention of urine with the possibility of infection and urolithiasis, and regular enemata to prevent distension of the patient's rectum are essential. The patient's nutrition is kept up by i.v. drips of glucose at first and later, when the pharyngeal reflexes have returned, by tube feeding. Vitamin injections may also be necessary in neglected persons.

BULLOUS DERMATITIS — A COMPLICATION

A recent accession to the syndrome of acute barbiturate intoxication is the description of the formation of bullae on the skin of such patients by G.W. Beveridge and A.A.H. Lawson. Definite dermal bullous lesions were noted in 19 (6.5%) out of 290 patients within 24 hours of the ingestion of the overdose. The lesions that apeared over pressure areas resembled a superficial burn and healed spontaneously without scarring unless secondary infection superceded.

THE NEED FOR THE PSYCHIATRIST

In cases of deliberate 'self-poisoning' by overdosage of barbiturates, the management following resuscitation is best achieved by psychiatric methods. Thus the *prima causa* of the patient's act is the factor that is to be carefully pondered into and discussed with him. The root of the trouble if possible is set right and hence is the importance of proper social welfare. Tranquillizers and other psychotherapeutic measures may have to be set into action on a long term policy to supplement the patient's mental attitude. As Neil Kessel, the Scottish psychiatrist, puts it 'the doctor is not to be impressed by the dozen tablets that the patient has taken but by the threescore that he can be prevented from swallowing'.

PREVENTION

The treatment and the prognosis of acute barbiturate intoxication have been greatly improved but as usual in medicine the preventive aspect is to be taken seriously too. Two alternatives remain to combat the rise in the incidence of barbiturate intoxication: either to stop using barbiturates or to safeguard their use. Various measures have been taken in different countries to control excessive prescription and use of barbiturates but these measures on their own have proved inadequate. Barbiturates

may be made less dangerous by combination with emetics and stimulants. Such preparations have been marketed, but they have not gone a long way in practice. Following the work on Bemegride in 1954, its combination with barbiturates was tried. Trautner at al. (1957), and Gersban and Shaw (1957) were able to show that 10-20% of Bemegride with barbiturates in capsule form reduced or even prevented the development of coma when doses up to 2-6G. of barbiturates were taken. Further proofs were the reports of Shunn in 1960 in which 50 'Phenaglate' capuseles (Quinalbarb. 50 mg., Phenobarb. 25 mg. and Bemegride 7.5 mg.) were taken with no resultant coma or respiratory depression and that of Hefferman (1959) who described two cases of ingestion of 24 capsules of 'Mylemide' (Amylobarb 100 mg. Bemegride 10 mg.). This method has its limits too. B. W. Meynin and K.J. Roberts have reported a fatality following the taking of 100 capsules of 'Phenaglate'.

Acute barbiturate poisoning has come to stay as a specialized, emergency, medical syndrome. Treament of the more severe cases may require the co-operation of the experienced clinician, the anaesthetist to advise on the maintanance of an adequate airway and of assisted respiration, the biochemist and the chemical pathologist, and an expert nursing staff.

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BOOK REVIEWS

LECTURE NOTES ON PATHOLOGY
Thomson and Cotton. Second edition.
Published by Blackwell Scientific Publications.
Price 63/-

This is the second edition of a book that has become very popular with students. The liberal use of lists, headings and subheadings makes the subject easy to understand, and the summaries at the beginning of each chapter should be valuable in last minute revisions before an exam. Most sections can be used for a first reading (not bly those on kidney), others will be most useful only after having read the larger text books.

The two new chapters on Genetics are excellent but I found those on Acid — Base Balance and Exfoliative Cytology disappointing. Additions have been made throughout and the number of diagrams have been increased. I particularly liked the ones of the Endocrine Glands, menstrual cycle, and circulation of CSF. The sections on Immunology and some parts of Heamatology have been rearranged and expanded with good results.

This book simplifies the whole subject of Pathology, yet contains more than enough information for the undergraduate. It is not a book to be discarded after the exam, as reference to it can help in preparing any other Clinical subject.

J.M.B.

LECTURE NOTES ON GASTROENTEROLOGY
by Tonkin and Parrish
First published 1968 by Blackwell Scientific Publications
Price 22s 6d.

This latest addition to the series of "Lecture Notes", follows the usual pattern of classifications, heading and subheadings. Once more, I found the lists at the beginning of each chapter extremely useful. The smallness of the print and the faintness of a few pages is slightly irritating, but this is adequately compensated by the completeness with which topics are dealt with. The small size of the book should not arouse any fears that anything is missing, for familiarity with its contents will satisfy the most exacting examiner in Medicine and go most of the way in satisfying the one in surgery. The simplicity with which the material is presented, should also make this book very valuable for newcomers to the wards.

I found chapters on general topics, such as Acute GIT bleeding, Malabsorption syndrome, Anaemia, Diarrhoea, and Diet to be particulary excellent.

J.M.B.

LECTURE NOTES ON FORENSIC MEDICINE
by D.J. Gee
First published 1968 by Blackwell Scientific Publications.
Price 25/-

Unfortunately for the students, this is an excellent book, well worth 25/-. Unfortunately, because as long as students are expected to sit examinations in their present form, then they will require such a book to help them 'cram' their knowledge.

This unpretentious book, a 'must' for those of us who can't make an early lecture, is divided into three main sections on Medicolegal aspects of General Practice, Forensic Medicine and Toxicology, each section being subdivided into twelve chapters. It may be read safely without fear of your neighbour on the bus (or setee) suffering cardiac arrest from glimpses of lurid photographs which decorate our set textbook. For the students who confess they dare not read a Forensic Medicine book at night for fear of waking up with nightmarish visions of mangled corpses, this surely is a boon.

For those addicted to clogging their brains in a last-minute surge of activity prior to examinations: remember that this book is aimed at those intending to practise in Britain and the variants of Maltese law could well be marked in the margin where appropiate.

B.M.C.

LECTURE NOTES ON DISEASES OF THE EAR, NOSE AND THROAT.
E.H. Miles Foxen. 2nd Edition.
Blackwell Scientific Publication 1968.
25 shillings.

The essentials of the subject are very clearly set out in a number of short chapters, each complete in itself. A large number

of line drawings admirably illustrate the text and the book more than fulfils the Publisher's aim of providing for the student both an introductory guide and an aid to revision.

The text is crisp and will almost certainly maintain the reader's attention and interest from the beginning to the end of each chapter.

The Causes of many of the conditions discussed are conveniently grouped under functional and anatomical subheadings. A measure of the student's grasp of the subject may be gained on attempting the selection of questions from past examination papers which form the final chapter of the book.

G.B.

LECTURE NOTES IN PHARMACOLOGY.
by Burn, 9th Edition, 1968
Blackwell Scientific Publications
Price 15s.

This book is written with the needs of the medical undergraduate well in mind. One is sure that like other works in the 'Lecture Notes' series it is a positive contribution to medical education. The size is refreshingly small-150 pp. I cannot help but agree with what prof. Burn says in the preface that "A short book of this kind may help to raise the general level of the student's knowledge of Pharmacology." It will serve the student who approaches with an enquiring mind as a foundation on which to expand one's knowledge from the more detailed texts. It will also be found useful as a quick general revision of the subject. Biological data is presented in an easily accessible well classified form. There is a good essay on the pharmacology of the antibiotics. The chapters on the pharmacology of the brain and psychopharmacology may help to put into order what are generally confusing accounts of the subject. One looks forward to their being somewhat expanded in future editions. Unfortunately the account of the Diuretics should be considered unsatisfactory by anybody's standards. In general one laments the fact that the text is weakest where it comes to practical applications in Therapeutics. For those of us who have the capacity to work on their own this book should find a place in the library and be kept handy. One would suggest that a limp cover edition be made available at a cheaper price which at 15/- is on the higher side for the average medical student in Malta.

A.F.

LECTURE NOTES ON BACTERIOLOGY
R.R. Gillies,
Blackwell Scientific Publications 1968
price = 20s.

The description of each genera is extremely well laid out and clear to follow. I am not of the opinion that Bacteriology is to be studied so lightly and would not be contented with the information in this book. Nevertheless it is a beautifully written and a worthwhile book to go through. I feel it will be a strong favourite in years to come when Microbiology will be taught in the preclinicals.

Although using this book, one will have but a limited aquaintence with Bacteriology, it will be free from any confusing or misunderstood facts.

J.V.P.

LECTURE NOTES ON THE USE OF THE MICROSCOPE
R. Barer,
Price = 9s.6d.
Blackwell Scientific Publications 1953
Third Ed. 1958

Reading through 'Lecture notes on the use of the Microscope' was both fascinating and instructive. It is indeed a book from which the experienced microscopist may benefit and it is a must for the beginner.

M.T.

ANSWERS TO X-RAY QUIZ

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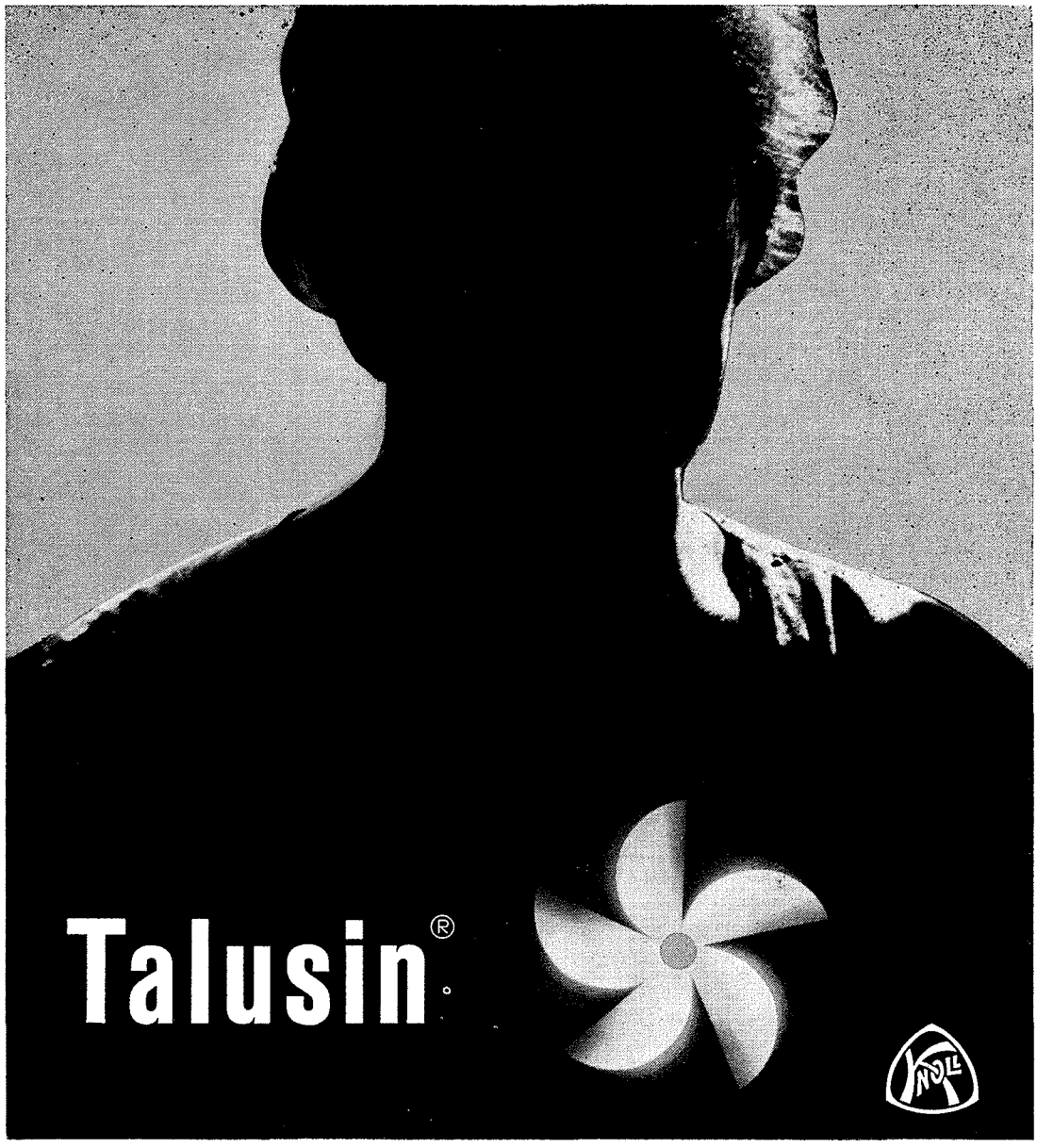
3 i) Rounded calcification; ii) Widening of the suture lines due to increased intracranial pressure.
4. Foreign Body in the oesophagus.
5. Bicornuate Uterus.
6. Stag horn Calculi in kidney.



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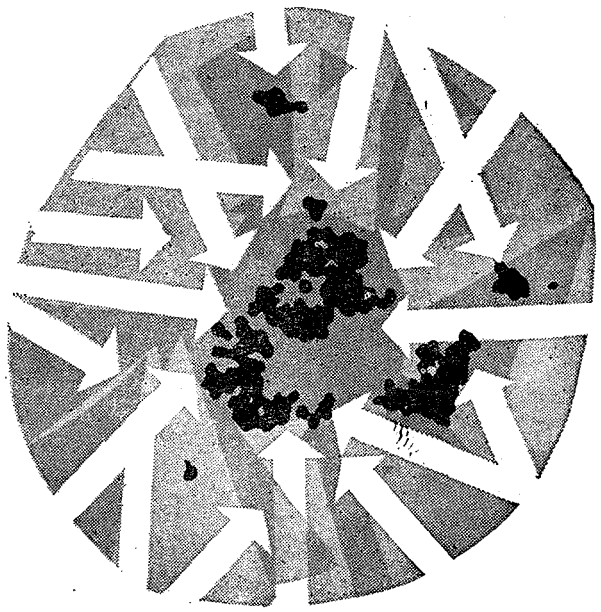

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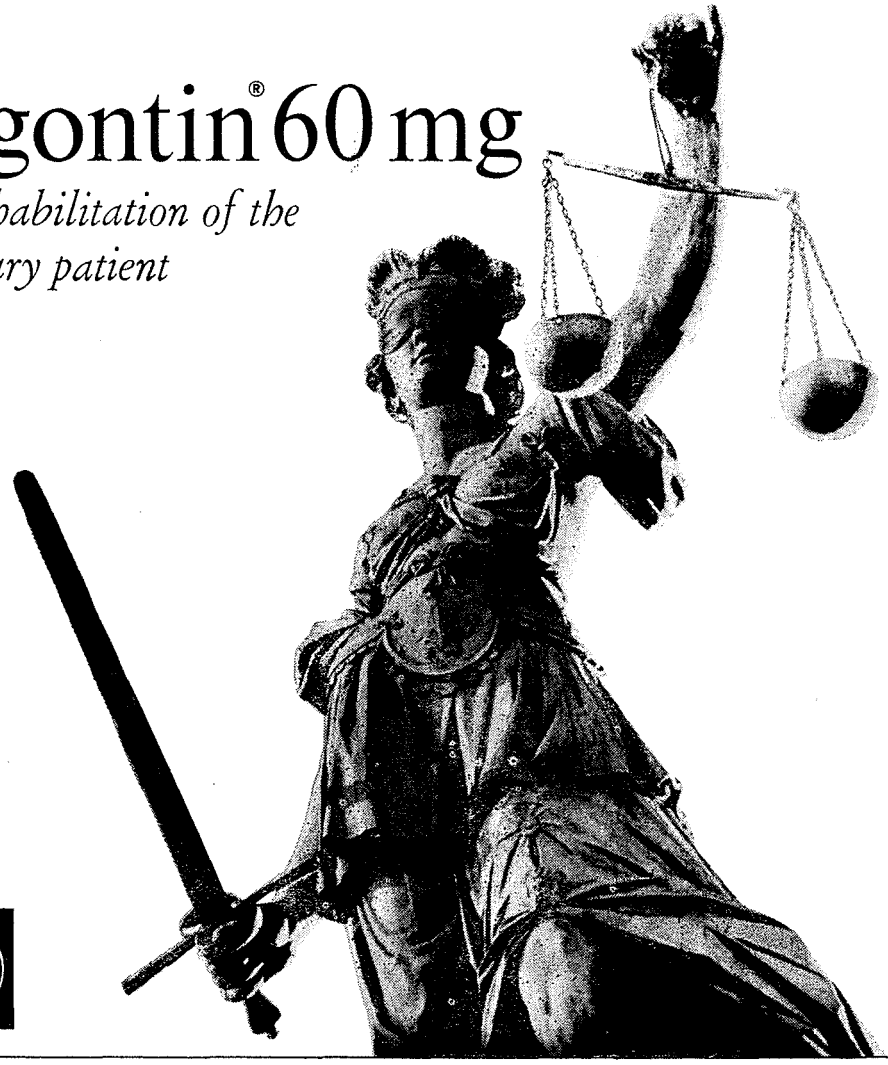

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Segontin »S«: 30 dragees

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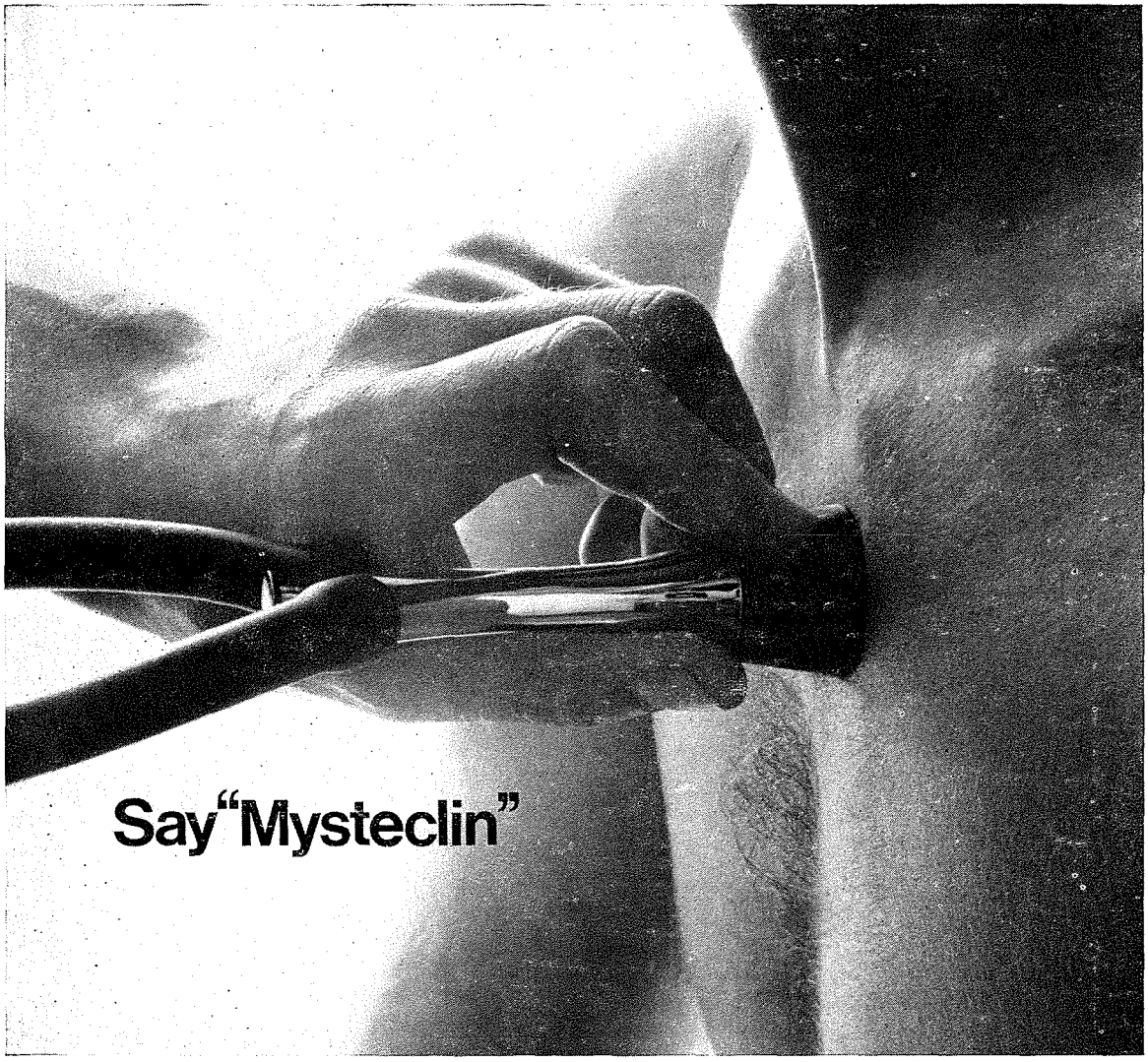

...when tetracycline is indicated

because, in Mysteclin-V, the combination of the antifungal antibiotic, Mycostatin (Squibb nystatin), with tetracycline can protect the patient against monilial super-infection* which often occurs after only a few days treatment with tetracycline alone. When tetracycline is indicated you can ensure greater patient comfort by prescribing Mysteclin-V Capsules.

Also available:

Mysteclin-V Improved Syrup: tetracycline plus amphotericin B.

**which can cause intestinal discomfort, diarrhoea, pruritus ani and vulvae and thrush.*

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Mysteclin Squibb

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