

NSAID/COX-2, pred to flare
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 MARD MTX - (AI folate), he (anti/renal impairment)
 MARD MTX & interferonide contraindicated in p
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 ankylosing spondylitis.
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 pso
 netric, ankylositis (pathogenic) ankylositis, hyperkeratosis
 nd: osteitis of soft tissue ossification → ankylosis

Zac Liew & Kelly Chen

Dx Success: Navigating 3rd Year @ UNSW Medicine

2026 Edition

protein, albumin
 (un - Polynesian descent, post-menopausal first MTO
 n - renal, aspirate
 Ton - chemotherapy, pros psoriasis. ∴ all patients / rasburic
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Introduction

Welcome to third year! You've completed Phase 1, now it's time for you to build on your biomedical knowledge, apply it clinically, and get a taste of clinical workflow.

The transition to third year is challenging, as learning requires much more self-direction. This guide provides targeted advice by term and by hospital, and supplements the **How to Excel in Phase 2 event** at the beginning of the year, which provides a broader overview of the year. For more in-depth advice on the ICE MCQ and OSCE, please see the [Phase 2 ICE Guide](#).

Contributors have expressed their honest opinions and advice. This document has not been endorsed by faculty, so ensure you also refer to the Phase 2 Student Guide, Phase 2 Clinical Skills Guide and Course Guides.

Many thanks to the following contributors:

2026 Phase 2&3 Academics Subcommittee

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Do not be discouraged by the change of pace and exam expectations. As long as you engage actively in tutorials and clinical environments and sustain your study efforts, you are in an excellent position to learn and to perform.

Best wishes,
Zac Liew & Kelly Chen
Phase 2&3 Academics Directors 2026

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Helpful Resources

Tutorials

- Reach out to 5th and 6th year students - many are keen to teach!
 - Or, ask your hospital representative to reach out
- Hospital buddy system: ask to see patients or review difficult topics

ICE MCQ

- PassMedicine (Question bank, free)
- Emedici (Question bank, paid subscription. In 2026, UNSW covered this cost)
- Amboss (Reference and anki decks, paid subscription)
- Brainstorm (Neuroanatomy specimens and sections)
- Complete Anatomy

ICE OSCE

- Geeky Medics
- Tally and O'Connor's

Basics

Hospital Structure

Consultant → AT (Advanced Trainee) → Registrar → Resident (RMO) → JMO, Intern

Navigating eMR

1. Set up your access by either reaching out to hospital campus staff or calling NSW Health.
2. Common abbreviations used in eMR: [SESLHD accepted abbreviations PDF](#).
 - a. BIBA → Brought in by ambulance
 - b. SOOBIC → Seated out of bed in chair
 - c. RIB → Resting in bed
 - d. ATOR → At time of report
 - e. ASNT → Abdomen soft, non-tender
 - f. BS+/- → Bowel sounds positive or negative
 - g. NAD → No abnormalities detected
 - h. NNVD → No nausea, vomiting diarrhoea
 - i. HSDNM → Heart sounds dual, no murmurs
 - j. SOB(OE) → Shortness of breath (on exertion)
 - k. WR → Ward Rounds
 - l. CWR → Consultant ward rounds
 - m. AH → Allied Health
 - n. Ix → Investigations
 - o. PRN → As needed
3. *Documentation* or *Clinical notes* tabs are good for assignment write-up, specific letters and earlier diagnoses.
 - a. Continuous documentation is also good for assignment write-up and if searching for a specific word across multiple notes.
 - b. Recommend filtering by physician's notes only, unless your assignment grad caps require describing allied health contributions or you are looking for observations. The amount of information can be overwhelming otherwise.
4. MAR summary to see what medications your patient is on for assignments
5. Results/Flowsheet:
 - a. To change date range of results (if clicking the right arrow does not take you far enough back): right-click on the grey bar > change search criteria > date range.

AH1

General

- **Structure:** AH1 can be quite hectic due to the sheer amount of content. Each week focuses on a new system, so we advise keeping up to date.
- **Clinical:** OSCEs frequently test physical examinations from AH1 (e.g. cardio, resp), so get involved during bedside tutorials.

Key Pathologies

Cardiovascular

- Heart failure
- Ischaemic heart disease (atherosclerosis, acute coronary syndromes)
- Valvular heart disease (including infective endocarditis)
- Arrhythmia
- Hypertension
- Pulmonary embolism
- Arterial vs venous disease

Respiratory

- Obstructive: COPD, asthma, bronchiectasis
- Pleural effusions
- Pneumonia
- Acute respiratory distress syndrome
- Pulmonary embolism
- Vascular system
- Peripheral arterial disease
- Chronic venous disease
- Deep vein thrombosis

Renal

- Acute kidney injury and chronic kidney disease
- Nephrotic and nephritic syndrome
- Nephrolithiasis, diabetic nephropathy, renal cell carcinoma, BPH, polycystic kidney disease
- Pyelonephritis (+ antibiotics for UTIs)

GIT

- Acute abdomen (appendicitis, cholecystitis, cholangitis, peritonitis, bowel obstruction)
- Oesophageal varices, Mallory-Weiss tear
- Gastroenteritis
- Peptic ulcer disease (+ treatment, including for *H. pylori*)
- Inflammatory bowel disease
- Irritable bowel syndrome

Presenting Complaints

- Syncope
- Palpitations
- Chest pain
- Haemoptysis
- Cough
- Dyspnoea
- Oedema
- Ulcers
- Acute abdominal pain
- Gastrointestinal bleeding (frank vs occult)

Skills

- ABG and VBG interpretation
- ECG interpretation
- CXR interpretation
- CT: Be able to identify organs, neurovasculature and other anatomical features on cross-section
- Escalation of oxygen therapy

General

- **Clinical:** Clinical exposure for rheumatology is very important, as arthritis is often tested in the MCQ and OSCE.
- **Study:** Create a system for listing differential diagnoses and ensure you know *how* to differentiate between these.

Key Pathologies

Neurology

- Common nerve injury patterns, e.g. nerve palsies, causes of foot drop
- Stroke & complications
- Seizures
- Headaches, trigeminal neuralgia
- Meningitis
- Guillain-Barré syndrome (GBS)
- Multiple sclerosis (MS)
- Amyotrophic lateral sclerosis (ALS)
- Peripheral neuropathy
- Myasthenia gravis (MG)

Ophthalmology

- Glaucoma
- Conjunctivitis
- Cataract
- Retinal detachment
- Age-related macular degeneration (AMD)
- Neurological vision loss

Musculoskeletal

- Osteoarthritis (OA)
- Gout
- Calcium pyrophosphate deposition (CPPD, pseudogout)
- Osteomyelitis
- Septic arthritis
- Knee ligament injuries
- Meniscus tear
- Shoulder pathology
 - Rotator cuff tear
 - Subacromial impingement syndrome
 - Adhesive capsulitis (frozen shoulder)

Rheumatology / Autoimmune disease

- Systemic lupus erythematosus (SLE)
- Scleroderma / systemic sclerosis (SSc)
- Sjögren's syndrome
- Idiopathic inflammatory myopathies (myositis)
- Giant cell / temporal arteritis (GCA)
- Polymyalgia rheumatica (PMR)
- Rheumatoid arthritis (RA)
- Seronegative arthritis
 - Psoriatic arthritis
 - Ankylosing spondylitis
 - IBD-related / enteropathic arthritis
 - Reactive arthritis

ACR

General

- Great term to revise systems learned throughout the year.
- **Structure:** You are attached to a team. This is great because of continuity with the patients you see, and it helps you with your assignment.
- **Attendance:** Attendance at uni is strict. Missed days will result in catch-up during your holidays.
- **Placement:** Engage well with ACR ward rounds.
 - **Learning:** There have been many personal recounts of ACR's structure facilitating the best learning experiences of the year.
 - If later in the year, use the term as an opportunity to consolidate learning.
 - If early in the year, identify key areas for study that will help later in the year with internal med terms, e.g. AH1.
 - **Assignments:**
 - Use ward rounds as an opportunity to find an assignment patient — ask the friendly team if they have patients that would be good for your desired List A and List B.
 - Speak to the team about the assignment patient you've chosen — especially for patient management and how that might have changed over time, as well as the rationale for treatments if you are unsure.
- **Clinical:** Learn to assess and describe gait — a common video resource station in recent OSCEs.

Key Concepts and Pathologies

- Frailty
- Mobility
- Gait disorders, exercise, balance, declining mobility
- Parkinson's disease and Parkinson's plus syndromes
- Falls, fall prevention and osteoporosis
- Rehabilitation
- Cognitive assessment tools
- Acute confusion, delirium, dementia, BPSD, depression, and differentials
- Neuroanatomy, anatomy of back, dermatomes

Common Presentations

- Common infections: pneumonia, UTI
- Comorbidities
 - Chronic health issues: CKD, COPD, diabetes, cancers
 - Incontinence and constipation

BGD

General

- **Structure:** The first 3 weeks are focused on women's health and OBGYN, the next 3 weeks are focused on paediatrics.
 - This is a relaxed term with many low-yield lectures. Attend these lectures but spend time revising high-yield topics listed below.
- **Study:**
 - Especially in this term, organise your learning by clinical presentation or theme (see below).
 - Commit paed history taking to memory AND understand the purpose of each question in the history.
- **Attendance:** BGD lecture attendance requirements are strict. There are QR codes for every lecture.
- **Placement:** Hospital days can be quite bare during paed, so try and look for opportunities in Women's health and you will find them (highly recommended).

OBGYN

PV bleeding

- Ectopic pregnancy
- Miscarriage
- Gestational trophoblastic disease
- STI / PID
- Cervical cancer (incl. screening / diagnostic pathway)
- Placenta praevia, placental abruption, vasa previa, placenta accreta
- Others: functional cyst
- Menorrhagia/dysmenorrhoea
- Endometriosis
- Fibroids/leiomyomas
- Adenomyosis
- Polyps

STIs

- Discharge: candidiasis, bacterial vaginosis, trichomoniasis, gonorrhoea, chlamydia, mycoplasma genitalium
- Ulcers: syphilis, HSV
- HIV
- Non-infectious differentials, e.g. cervical ectropion, polyps, malignancy, erosive lichen planus, genitourinary syndrome of menopause
- Conception
- Contraception

Conception and foetal syndromes

- Female infertility: PMOS, causes of recurrent miscarriage
- Male infertility: spermatogenic, transport, ejaculatory
- Sex differentiation and related syndromes
- Termination of pregnancy: suction, dilatation and curettage w/ misoprostol, mifepristone
- Management of miscarriage
- Teratogenicity and embryology
- Neural tube defects: spina bifida
- Gut tube defects: gastroschisis, omphalocele, Meckel's diverticulum
- Single-gene defects: holoprosencephaly, polydactyly
- Karyotypic defects: Down syndrome, Turner syndrome
- Foetal alcohol syndrome
- Smoking and nicotine
- Hirschsprung's disease

Antenatal care

- Antenatal symptoms and management
- Infectious diseases in pregnancy

Antenatal (** = strongly recommended, * = recommended, * = offered)

- Genetic carrier screening: CF, SMA, Fragile X syndrome*
- Extended carrier screening*
- Assisted reproductive technologies
- Dating scan (W6-12)***
- First antenatal care investigations***
- Non-invasive prenatal testing (NIPT)*
- Combined first trimester screening (cFTS) (W12)*
- Morphology scan (W19)**
- Second trimester serum screening*
- Accessory investigations
 - Iron studies
 - Chlamydia screen
 - Vitamin D
 - Thyroid function test
- Invasive diagnostic testing: amniocentesis, CVS

Labour

- Complications:
 - PV bleeding causes (see above)
 - Pre-eclampsia, eclampsia and HELLP syndrome
 - Hyperemesis gravidarum
 - Gestational diabetes mellitus
- Perinatal: stages of labour, partograms, analgesia, postpartum haemorrhage
- Postnatal: postpartum care, lactation, mental health screening

Paediatrics

- Fluid status and correction
- Coeliac disease
- Crohn's disease
- Signs of non-accidental injury
- Reading audiology reports

Neonatal

- Newborn check
- Transient tachypnoea of the newborn (TTN), Respiratory distress syndrome (RDS)
- Neonatal jaundice
- Hypoglycaemia

Respiratory

- Croup
- Bronchiolitis
- Asthma
- Cystic fibrosis

Other infectious diseases

- Sepsis in children / toxic child
- Meningitis
- Otitis media
- Immunisation

Malignancies

- Acute lymphoblastic leukaemia
- Neuroblastoma
- Nephroblastoma (Wilms tumour)
- Medulloblastoma

Development

- Milestones
- Intellectual disability

OPC

General

- OPC is a great term to unpack the impact of a chronic illness on the everyday life of patients, so make sure to explore this when speaking to patients.
- **Structure:** Three weeks of oncology, one week of palliative care.
- **Assignment:** Finding suitable patients and understanding their cases and management can be hard at first.
 - Attend ward rounds to find suitable patients and ask questions to learn about management (investigations, monitoring / observation, medications) and the rationale behind each treatment decision.
 - When speaking to patients, focus on the psychosocial and psychological impacts of their diagnosis as this is something that you won't be able to find on eMR.
- **Clinical:** OSCEs often test the thyroid exam.
- **Placement:** Clinics are a good place to ask any questions around the term and treatment of patients or if you have any questions about your case for the case presentation.
 - Patients are often on quite a few medications and may have complex management plans that can be confusing, so take your time to ask about indications for certain medications if it isn't apparent.

Key Concepts and Pathologies

- Lymphadenopathy
- Hodgkin & non-Hodgkin lymphoma
- Thyroid pathologies: malignancies, Hashimoto's thyroiditis, Graves' disease
- Urogenital pathologies: BPH, prostate adenocarcinoma, urothelial tumours, testicular tumours
- Lung cancer: adenocarcinoma, small cell, squamous cell
- Metastases: bone, brain, liver, lung
 - Know pathways for spread and why certain cancers are more likely than others to spread to specific regions/organs.
- Infectious diseases: HIV/AIDS, toxoplasmosis, EBV

For SH placements, see [SH Placement Feedback](#)

General

- **Placement**
 - Clinical experiences vary across different SH placements.
 - Use the opportunity to get hands-on experience in activities/skills you haven't yet practised to get white book skills and mini-CEXs signed off.
- **Study**
 - SH requires you to understand the general criteria of screening instead of the specific procedure of each screening.
 - ITPs, CMTs are more useful to understand and revise pathology; lectures are more useful for learning concepts about screening and public health.
- **Attendance**
 - SH class attendance is strict. Missing more than 2 teaching days (includes sick days and self-care days) → need to complete an 800-word remedial assignment.
 - Attendance at the Indigenous workshop is enforced. Be punctual.

Key Concepts and Pathologies

- Skin infection
 - Pyoderma, folliculitis, carbuncles, boils, cellulitis
 - Antibiotic prophylaxis
 - Impetigo, scabies, tinea corporis
 - Dermatitis: atopic, irritant contact, allergic contact
 - History taking for skin lesions, description and investigation of lesions
- Skin cancer
 - Basal cell carcinoma – most common and least dangerous
 - Squamous cell carcinoma
 - Melanoma
 - Melanocytic naevi
 - Sun safety strategies
 - Common mimics
- Interstitial lung disease (environmental lung disease)
- Screening
 - Diabetes and hypertension screening and management depending on risk group
 - New Australian CVD risk calculator
 - AUSDRISK diabetic risk assessment
 - RACGP red book screening guidelines
 - CRC screening
 - Cervical screening
 - Breast screening
 - Prostate screening
 - Lung cancer and paraneoplastic syndromes

Group Project Advice

Remember to give your teammates feedback on eMed, so you have material for Portfolio! If you forget, you will have to address this in your portfolio, so it is best to avoid this in the first place by taking a few minutes to give each member some feedback.

AH1 audit

- Pass / fail, but still receive feedback.
- Emphasise the importance of the intervention you are auditing.
- Observe consecutive interactions.
- Speak with healthcare workers on the ward to gauge the general attitude towards the intervention and reasons for non-compliance, e.g. completing the form is overkill, intervention not enforced.
- Consider talking to the ward NUM for accurate information on how this intervention came to be, how well it is performed, barriers to its uptake, etc.

SH teamwork presentation

- Rehearse together and time, overtime groups get marked down.
- Read the requirements/marketing criteria, as there are a lot of parts to this and anything can easily be missed (happened to me → P-).

BGD case presentations

- Both students can do List A, or both do List B, or one each.
- Find a patient early before the crowd comes. Patients from bed-sides are usually good as this means they are willing to talk (and you get a cheeky sneak peek).
- Some tutors will request that no two students can present on the same pathology / ward — plan ahead and ask nurses / doctors.

Individual Assignment Advice

- It is good practice to follow up with your patient, but if you only get to talk to the patient once, make use of eMR.
 - Psychosocial history is where your own history will be superior to records (since you have more time than most doctors to speak about this with patients), except for social worker notes.
 - If you miss out on viewing pre-op and post-op care for your AH1/2 surgical assignment, eMR should have you covered, but it is best practice to be present.
- Use the patient-finding process as an opportunity to practise identifying clinical signs / findings.
- Either AH1 or AH2 will be an oral presentation.
 - Structure will be in the student guide, including how many slides for each section and what you should include (different hospital and different markers may / may not care, but try to stick to the suggested structure).
 - Typically take less time to write up compared to written assignments, but do not leave for last minute and make sure you know your case well enough to answer vivas and follow-up questions on what you have presented (especially on details you did not have time to present).
 - Include a reflection as you would in a written assignment.

AH1	AH2
- Many opt for medical in AH1 as orthopaedic surgery in AH2 is easier than most AH1 surgeries. Simple surgeries are what you want; complexity is NOT rewarded. Gather a solid psychosocial history since you have more time than most doctors to speak about this. - When considering DDx, think holistically. For example, if a patient presents with dyspnoea, consider differentials for other symptoms they presented with too, and do not limit differentials to respiratory pathology. List A - Microbiology (GI, endocarditis) - Pharmacology (anticoagulants, antiarrhythmics, beta-blockers) - Physiology, biochemistry and manifestations (troponins, chest pain, dyspnoea) List B - SC impact - SC screening (cardiovascular risk)	Surgical - Choose a straightforward orthopaedics case (e.g. joint replacement) or day surgeries, which most ophthalmology cases fall under. - If choosing anatomy for List A, include diagrams and imaging findings. - For written, structure as follows: Case summary (PC, planning, benefits / risks of surgery, pre-op Ix) → List A → List B → peri-operative care (pre, intra, transfer, post, DC planning) → reflection. Medical - Can do neurology. List A - Anatomy (ortho surgery) List B - Teamwork (surgical team, nursing staff)
BGD	SH
SH case presentation - Pass / fail, but still receive feedback. - Focus on the sociocultural factors that influence their health. Focusing on clinical presentation and signs alone can result in a fail. SH reflective - Pass / fail, does not appear in Portfolio. SH group project - Only graded assessment for the term. - Try to find a project theme early on that fits the criteria — there is a check-in with your facilitator later to ensure it fits, but best to settle on a topic and initiative early in case you have to change at the last minute.	BGD reflective - Update the learning log as you go — hard to recall to cram (multiple of us can attest). - May require references (students have lost marks— a formal complaint was made and it appears the issue with the wrong marking criteria being provided to markers has been rectified; no harm confirming with term convenor though). BGD presentation - OBGYN was marked to a higher standard, know your content thoroughly as you will likely be asked questions. - Paeds assignment was very chill and presented online. List A - Physiology (normal pregnancy changes) - Pathology (pre-eclampsia) - Microbiology (RSV, GI, respiratory, skin infection) List B - Screening - SC factors

OPC	ACR
• It can be easy to go too complex. A simple, new diagnosis is fine, as is a patient in pall care whose management is now fairly straightforward. • Finding patients who are willing to talk might be hard. Attending ward rounds can be helpful. • Find a patient early as patient turnover is slow. ◦ If all the patients in the haem and onc wards are taken, you can try looking at other wards (i.e. gastro / resp) for colorectal or lung cancer patients. • For Liverpool in particular, get a very detailed history. Inquire also about risk factors, e.g. for breast cancer, ask menstrual history, breastfeeding, smoking, family history. • Have a clear checklist of questions you definitely want to get answered before you speak to the patient (especially psychosocial questions). List A • Diagnostic tests (imaging → biopsy → staging) • Pharmacology (chemotherapy + supportive medication) List B • SC factors • SC impact	• Use ward rounds to find an assignment patient. • Speak to the AT/reg about the patient.. • Expect that you will have to visit the patient several times to conduct various tests, e.g. MMSE, RUDAS. Do not get offended if the patient says no on a particular day despite providing consent for you to talk about them in your assignment. Patients may be delirious or exhausted, so don't disturb them when they are not in the mood to talk to you. You can always come back at another time! • Patient assessment and management section: Analyse causes of the patient's frailty (comorbidities, repeated hospitalisations, nutrition, mobility) and how these relate to each other. It may be a multifactorial gait disorder! List A • Pathology (osteoporosis) • Microbiology (aspiration pneumonia) List B • Ethics and legal should be addressed here unless completed prior (recommend reserving this list for ACR as almost every patient will have something to discuss). ◦ Advanced care planning and limits of care ◦ Voluntary and assisted dying ◦ Substitute decision-making and power of attorney ◦ Aged care facilities and respite care ◦ Use of hospital resources

Placement Advice

Clinical experience is how you learn. It is a valuable experience that you do not get from studying alone and will improve your knowledge, clinical judgement and communication skills. Seize the opportunities that you can!

What to do when you are on the wards (e.g. waiting to speak to a doctor or patient)

- Anki, PassMedicine, eMedici, AMBOSS, Geeky Medics for clinical exams
 - If you are afraid that doing this on your phone will appear unprofessional, use an iPad or similar device if you have one.
- Study notes you have taken from earlier in the term to refresh pertinent content

What to do between clinical activities

- Practice history-taking / OSCEs with peers.
- Talk to nursing staff to recommend patients for you to practise history taking and examination.
- Reach out to doctors or all staff members to observe procedures (CT, endoscopy, pathology lab).

How to participate in ward rounds

- Sometimes you are timetabled depending on the term, e.g. OPC, AH1 (gastro week)
- Consultants giving you tutorials may also invite you to join.
- If you demonstrate enthusiasm, you are likely to be better received.
- Offer to document / scribe for the team if you feel able to do so. This is more likely to be appreciated if the team is small.

Advice by Term and Clinical Campus

For SH placements, see [SH Placement Feedback \(Responses\)](#)

Sydney Children's Hospital (for all paediatrics placements)

- Send in WWCC and SDH forms ASAP, or you miss out on some placements.
- Timetable will not be packed — there are few outpatient clinics and ward rounds that students can attend.
- Everyone is placed at Sydney Children's Hospital for paediatrics
 - Many students and few patients—find your assignment case early!
 - Try not to overcrowd the same ward cause you may be reprimanded and banned (it has happened).

Campus	POW	STV
General	Clinical skills completion: • Venepuncture: Try to find a phlebotomist to supervise you; ask the nurses what times they come around to draw bloods. Acute aged care and community health have been good. ED not recommended • SC: Easily done at aged care with insulin patients. • IM: Ask regs if you can vaccinate a patient. If it is flu season, can ask at the staff-vaccination clinic.	Use hospital time for deliberate targeted practice. Speaking to doctors will give you the most relevant information much more quickly than going through notes. Progress notes are kept in the brown cupboards you will see around while patients are admitted. Notes on admissions discharged up to 02/06/2026 are on paper, which you had to request from the medical records department. Some records can be found on Mediweb and Webdelacy. Request the file by emailing the medical records department at least 2 days before you require it. Attach the request form, which you can get from the clinical school staff. After 02/06/2026, they are transitioning to a scanned medical record system.
Attendance	Signed attendance is needed for the majority of sessions. Attendance is recommended, and absences are only excused if sick or self-caring.	Attendance is mandatory for scheduled tutorials with a paper roll. Try to go to ward rounds at least once during each rotation, as it can be quite useful to see how each specialty functions.
AH1	Content-heavy and many tutorials planned, less time to explore ward rounds and observe surgeries. Weekly case presentations. Resp and cardio / CCU are big wards with many patients. Cardio / CCU patients are often complex / surgical, but JMOs here are very willing to help out. Don't take it personally if surgeons are mean when they correct you — their job requires them to be precise. Really put yourself out there and join bedside tutorials.	STV has a specialised heart and lung transplant ward, so you may be able to look at some cool cases (but they may be far too complex for assignments). Weekly case presentations where students are expected to find cases (comprehensive) and present them. It is recommended that you do your medical case in this term, and leave surgical for AH2, as it tends to be easier to find surgical cases in ortho/neuro.

STG	TSH	SWS
Use the library on Level 1 (above the common room) — quiet and many computers with eMR access.	A less busy hospital due to scale. This means: • Very nice doctors all round! Willing to teach and help you with assignments and fill out miniCEX's. • More opportunities to get hands on, e.g. practising venepuncture / cannulation. • Very very good for gaining clinical experience.	Many of the doctors and allied health are super willing to teach. You get as much as you put in for your hospital placements. Most are very open to students attending clinics, wards and procedures if you just ask.
I attended most activities, but there were a number of students in my sequence who skipped a lot of classes. While I don't think there were many repercussions, admin and doctors definitely did show disappointment and I think they may become stricter on attendance.	Particularly among older students, TSH has a reputation for being lax on attendance, however we found in 2025 that admin were able to identify students who often skipped classes, as the hospital groups here are small. You will be spoken to about this.	Attendance is recommended to gain as much as you can. QR codes are posted all at once, but they enforce a paper roll that tutors sign off. OPC is particularly strict. Be sure to attend everything in OPC as you do not want to fail the course because of attendance.
There are weekly case presentations where two students are required to find a patient presenting with the focus sign/symptom for that week. The cardio ward has patients with relevant findings for assignments and OSCE practice, but try to visit a range of wards.	Resp WR is worth attending. Offer to help with documentation. Gastro is good, you can see cirrhosis and interesting and uncommon GI disorders. Gastro bosses are largely very approachable. Patients in CCU have shorter admissions than Yarrabee; consider this when choosing an assignment patient. For presentations, Dr Bell emphasises including the patient's vitals and likes an interesting fact at the end of the presentation.	The cohort will be split in half between Bankstown and Liverpool according to last name (second half at Liverpool, as of 2025). Cardiology consultants have high expectations, so pre-read and know differentials and causes for common presentations when they quiz you. Expected to present a weekly case to a consultant or AT.

Campus	POW	STV
AH2	Neuro WR is very useful. You will get quizzed. Stay to watch a stroke call. Clinics are optional, but good opportunities to learn from consultants. Neuro grand rounds can be hit-or-miss (interactive w/ live patient interaction or purely didactic). Rheumatology has only one registrar. Ask JMO / AT's number because they will run across the hospital during rounds (7:30 am or 4 pm). After rounds, you can usually leave. Outpatient clinics are every Wednesday afternoon. Ask the team when grand rounds are. Ortho ward rounds are low-yield. However, ask surgeons if there are upcoming procedures that you could observe. Surgeons can be found through tutorials, lecturers, or asking the JMOs / regs. Ask for patient consent in the peri-op suite. Prepare MSK anatomy. Grand rounds are not mandatory.	Neuro and ortho WR can be quite busy, and doctors do not have many opportunities to teach during this time. However, attend as much as you can to get exposure. Two mandatory tutorials are planned each week with the same doctor. These can be quite useful. Find patient cases throughout the week by exploring the ward to prepare for these. Note down the entire history, examination, and investigations. You can just clarify these by looking at their notes and on Mediweb. There were meant to be livestreamed eye tutorials from POW every Wednesday morning from 8 am to 10 am, but this did not happen. You are recommended to do your surgical case in this term.
ACR	As of TP3 2026, paper roll for the following: • Ward rounds • Education meetings • Clinical tutorials • Case presentations • MOCA/RUDAS/MMSE Consultants will quiz you, but are happy to teach if you don't know the answer. You will be asked to participate (simple chest exam, MOCA, 4AT, venepuncture, scribing during WR). Ask for a patient list. Learn common geriatric syndromes. Learn antipsychotics, antihypertensives, antithrombotics, and diabetes management.	You are allocated to a team on the ward. The geriatricians are all lovely and keen to teach. WR can be high-yield as teams have a lot more time to answer questions and go through the patient history in detail. Students are also invited to neuroradiology and geriatric radiology meetings. These present important and high-yield findings that you can look into independently. There is one compulsory tutorial each week with a doctor. Prepare full patient cases to present at tutorials.

STG	TSH	SWS
Spend some time on the neuro ward — lots of interesting presentations to practise applying your knowledge. Not many of us attended the clinics since they were optional, but they could be useful. If you are doing surgical in AH2, find surgical cases early as there can be a shortage. Go to the ortho ward (3A), ask the regs at the doctors' office for scheduled surgeries in the coming days.	Ortho WR not worth attending (just assessing pain, neurovasculature, ROM). After your surgery, talking to an ortho reg will give you very concise and useful information (especially if you require this for assignment / presentation). They may also invite you to the fortnightly suturing workshop. Neuro WR is good, especially seeing stroke patients. Try to get on at least one stroke call, i.e. follow from patient arrival through to intervention completion. If you enjoy a particular neurologist's tutorials, ask to attend their clinic. Attend ophthalmology clinic especially if you are ophthalmic. The doctors will let you use the slit lamp. You may be tasked with bringing in patients from the waiting room and measuring their acuity and pressure on your own!	Engage in as many clinics as you can as they all have great value. In particular, the rheumatology clinics at Liverpool are very good opportunities — you will be allocated to attend them and make sure you do! Bankstown has fewer opportunities, unfortunately. Ortho WR are not worth attending. There are some ophthalmology tutorials, but their place in the course material is questionable.
Workload / expectations can be quite relaxed, though it likely depends on your team. Finding assignment patients is easier during this term. Get experience performing MOCA and MMSE.	You will get quizzed on ward rounds; revise after each round so you know the answer for next time. As one doctor said, "If you don't know the answer the first time, that's fine. If you don't know the answer the second time, that is not okay." If a teaching session is scheduled at the same time as the assigned WR, choose whichever you think will be more beneficial. The teaching session can be more worthwhile as the round can be continued later or repeated at a later date. One exception is the speech pathology tutorial, which is less worthwhile if your WR is really good.	ACR is amazing at Liverpool and Bankstown. Join the ward rounds, as you will gain the most out of active engagement. The team will often quiz you. This is a great way to see what you know and don't know.

Campus	POW	STV
OPC	Clinics will have more stable patients than the haem / onc ward. Ask the doctor if you can sit and observe. Outpatients having radio / chemotherapy will also visit regularly. Records may be kept on MOSAIQ (separate to eMR). Melvin Chin is a wonderful person and a strict marker. Listen to his preferences and use the case tutor sessions to test how the progression of your narrative lands. He really emphasised the way the story flowed and wanted us to make sure each new piece of information is well contextualised.	OPC takes place at Kinghorn Cancer Centre. For clinic, make sure to check with reception whether the doctor has patients during your allocated times, or you may be left waiting for no reason. Kinghorn chemotherapy infusion centre can be a potential place to find an assignment patient; the hospital oncology ward is very small (so not enough patients for the whole group) and patients are much more complex. Choosing a patient under the doctor you follow in clinic is also a good idea.
BGD	RHW Patients can be quite limited, so faculty get upset when students do not show up. • Birthing unit: Be proactive. Ask the midwives how you can help even if it's just getting extra towels. • Bring some work to do in case patients do not consent to you attending their consultation/procedure. • Ask if you can practice skills, e.g. fundal height. • Some tutors have private clinics and offer students to come and see their work (e.g. Dr Lynn Townsend's Ultrasound Care clinic @ Bondi — can show you antenatal screening, pre-conception counselling, invasive diagnostic testing, US interpretation).	

STG	TSH	SWS
Oncology staff are very friendly — don't be afraid to go up to the doctors and ask for help, whether it's joining WR or finding an assignment patient. Haematology team may be a bit colder, and adult haematological cancers don't seem to be emphasised in the ICE exam.	See STG. STG admin occasionally forgets to include TSH students in hospital lecture tutorials — check with STG peers beforehand or you can strategically email for slides afterwards. For an OPC assignment patient, you can choose an outpatient undergoing chemotherapy. These patients may have a simpler PMHx, however the information is split between eMR and another system (Aria) that you can only access on-site. Bangawarra nurses are approachable and will be able to guide you.	This term is tighter on attendance, with sign-in sheets for nearly all tutorials. Kelly Mok is quite strict at assignment marking. She expects a lot, so it is important that you clarify expectations with her (what does she think about your case, etc.). Some of the nicest doctors I've ever met, especially in palliative care. The doctors are happy to answer your questions, even if not directly related to haem / onc. Some specialised haem / onc medications won't be listed on the usual MAR summary in eMR. Look through the MOSAIQ Letters tab. (MOSAIQ is Haem / Onc's specialised eMR). If you want the specific dose and administration, ask one of the doctors for their MOSAIQ login.
STG Highly recommend attending scheduled antenatal clinic — you'll end up being able to recite the antenatal screen for OSCEs. Volunteer to measure fundal height, palpate, and use the Doppler for the foetal heartbeat, as you won't get another opportunity this year. Scheduled birthing unit: Make sure you bring some work to do as there is a lot of waiting. You may not see a vaginal birth. If the doctors mention an upcoming C-section, ask if you can follow them to the OT and observe.		Liverpool Self-directed, quite chill. Dani organises the timetable, and it is very flexible. You get allocated to a location in the morning and in the afternoon. It is encouraged to try to go to a good variety of clinics. Some may be quite repetitive, so it would be a better use of your time to go elsewhere or study. Bankstown Very intense. You are allocated to several classes per day and days are quite full-on.

ICE MCQ

60 marks: 54 questions + 6 x anatomy and histopathology identification (each 4 or 5 features).

- Heavy on clinical reasoning! Experience from being on the wards can be very helpful — cannot emphasise this enough as it worked very well for us!
- **REVISE AS YOU GO, START STUDYING EARLY** and be consistent. The whole year is so high-yield that if you're not constantly revising, it's easy to forget what you learnt in previous terms
 - Many Anki decks on Prisma. Some software / note-taking apps (e.g. Notion Education accounts) can also turn your pages / notes / slides into flashcards using AI.
- **High-yield content** (since a 60-mark MCQ exam can't cover everything from the year)
 - ITPs! CMTs less so, and they can get quite complicated, but also term-dependent (AH1 can be quite complex, but AH2 and BGD can be useful).
 - Microbiology pracs — guaranteed marks! Almost all the questions in the exam are replicas of those in the pracs, with changes to wording.
 - Pharmacology, pathology and anatomy lectures
 - If you are very secure in anatomy from first and second year, you don't need to devote as much time in third year, but still practise spot tests — BlueLink and the Moodle links to Logan's anatomy are very good.
 - The exam can test (and has tested) anatomy from Phase 1 that was not taught again in third year.
- Note-taking
 - Some lectures are more suited to typing notes from scratch.
 - Some ITPs are more suited to annotating slides.
 - Make summaries of what you have learnt by theme. This will also help you make the most of placement.

For more in-depth advice on the ICE MCQ and OSCE, please see the **ICE Guide**: [Phase 2 ICE Guide](#)

ICE OSCE

What to prepare for and how to study

Your histories and exams now have a goal — to establish provisional and differential diagnoses.

- You will be expected to detect abnormal findings on examination.
- For each exam, be aware that you may be asked:
 - What each sign suggests
 - Pathophysiology of signs
 - Relevant anatomy
- Structure your suggested investigations by bed-sides (vitals / A-G, samples) → bloods → imaging → special tests. Below are two approaches you could take to studying this:
 - Memorising all the tests according to the above categories and deciding on a case-by-case basis which are necessary.
 - Memorising a set of tests per system; however, differentials can sometimes be across multiple systems.
- Counselling stations:
 - Spam SimConverse / AI tools or peer-practice to practise
 - ***Gentle reminder that SimConverse transcripts are screened by faculty***
 - Motivational interviewing
 - Be familiar with resources / organisations you can refer patients to
 - General: Black Dog Institute, LifeLine, Aboriginal Controlled Community Organisations (ACCOs) and Aboriginal Health Workers
 - BGD: Where to get STI testing / contraception, mental health support for women
 - AH2/AH1: QuitLine, diet apps / resources, GP CCMPs, IPTAAS forms, Alcoholics Anonymous
 - ACR: GOS, HIH, MyAgedCare services (SHP and CHSP)

How to practise

- Find someone to go up on the wards together to practise. Practise under timed conditions — students do run out of time in the final exam, and consequently cannot be graded on summary and interpretation (separate categories in marking criteria).

MiniCEXs

- Take every opportunity to get them done so they are out of sight, out of mind. Bed-sides are great opportunities. You can't do too many, so keep practising.
- It is not an assessment, rather an indicator of progress throughout the year (thus forms good evidence for effective communication in Portfolio if you need it).
- Some JMOs (especially UNSW graduates) will be very generous with grades or even ask you what grades you want... questionable ethics, but you can use this to show progression/improvement throughout the year.

Group Study Strategies

Studying in groups can be an effective way to consolidate your understanding and also help each other out. Ideally, members are in the same hospital and sequence, but this is not the only way! It is far more important to have a group of friends you know that you can study well with. Having friends in different sequences can be beneficial as you can cover a variety of topics early on and be more prepared for upcoming terms.

Some general advice:

- Plan ahead — think about how you want to organise study sessions. Some ideas include:
 - Creating and discussing cases (much like your CMTs)
 - Teaching specific diseases / conditions
 - OSCE practice — history / examination / counselling
 - Creating interesting MCQs that mimic ICE and work through them together
- It makes it easier if everyone can meet at the same time every week.
- In the second half of the year, and especially towards the end, consider combining MCQ and OSCE preparation, e.g. two people do OSCEs and two people teach in each session.
- During OSCE prep, write some vivas to simulate real OSCEs and revise MCQ knowledge.

*We hope this helps you make the most of third year,
best of luck with your exam preparation!*