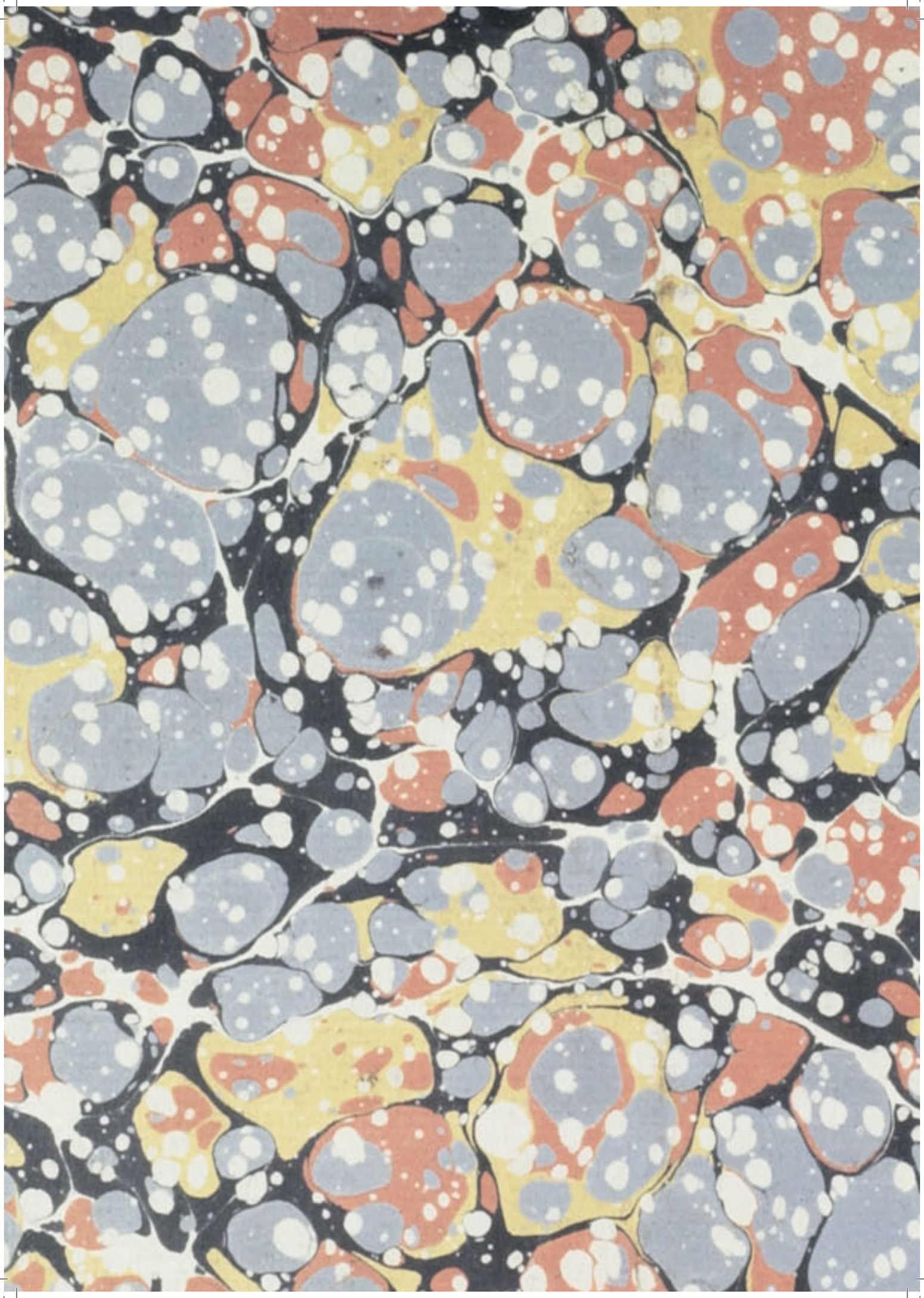
English Literature For Boys & Girls

IDIOGLOSSIA

2007



THE IDIOGLOSSIA

BEING

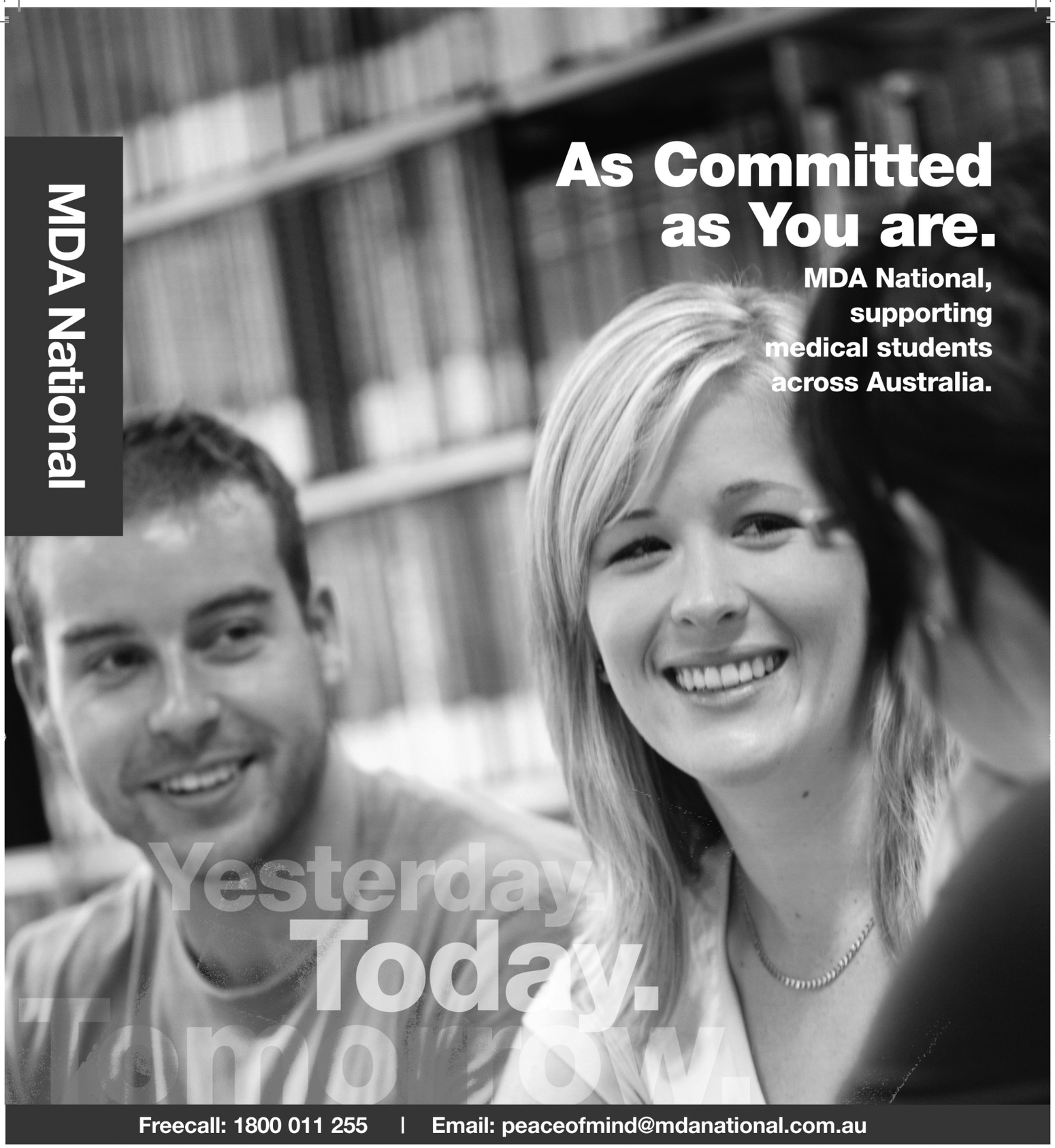
THE OFFICIAL JOURNAL
OF THE
MEDICAL SOCIETY OF
THE UNIVERSITY OF NEW SOUTH WALES

WITH

SPECIALIST CONTRIBUTORS

Errare Humanum Est

MMVII



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MDA NATIONAL

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Editorial

Never again, Idioglossia, never, ever again.

Many thanks to all of our contributors, a substantial proportion of whom chose to remain anonymous. Of course, such is the dire nature of our fiscal position that I will name and shame any and all of our authors for the right price. All donations will go to the Save Idioglossia appeal. Thanks also must go to all our sponsors.

Edited by: Andrew Colebatch
With contributions from: Jamie Alexander, Chris Hannah, Josh Hopp, Mark Horowitz, Jason Kiang, Claire Lawley, Jason Le, Nicole Lee, Srihari Mahadev, Dev Nathani, Amrita Ronnachit, Karl Ruhl, Koliarne Tong, Aditi Vedi, Pearl Wang, Kate Watson, and several others who wish to remain anonymous.

Character Witness, or, The Irony of it all

THE Old Comedy of the Ancient Greeks is the source of many of today's theatrical delights, but chief among these must be the stock character. The Greeks were perhaps the first to employ stock characters regularly, and certainly they were the first to use them in the manner of our current appreciation. Eiron, *he* (for the Greeks were not quite as progressive as we might like to believe) who seemed to be less than he was, who at first glance was an uncouth simpleton, but whose hidden intelligence would ultimately triumph over his pompous opponents. Bomolochus, the fool; a cruder, taller old world Rove McManus plus the wit but just as irksome. And the Alazon, the opponent of Eiron, an empty braggart, full of hot air; a bombastic, wholly unlikeable pretender.

It is one of my many failings that I make assessments of people quickly. I like to do it. I would like to do it more and better than I currently do. If you ask me about someone you don't know, I would like to be able to tell you about him in a sentence. I would like to sum her up in only a few words and have you understand me perfectly. I have no wish to paint it in colours and fine detail, but rather to sketch it draftsmanlike; one stroke, two strokes, three – and for that to be enough. An expert impression with the minimum of appreciable effort. I suppose everyone does it to some degree – hence the importance of the first impression. But I do it more. And the sketch is never perfect, the people never fit the sketches, nor should they.

That is why I admire the utility of the stock character, but it is also why I am sensitive to broad shifts in the personalities of the people I meet, or rather to any questions about personality. One doesn't need to go far on campus to find the belief that medical students are something of a stock character of their own. They are, one might be told, nerdy to a greater or lesser degree. They are stresspots, boiling at the prospect of examinations. They lack hobbies, or, if they have them, they are eccentric, unusual, or slightly unsettling ones. Some of them want to cut and stitch, others would prefer to consider, to adjust and to titrate, but in the end they are much of a muchness. This might be what one is told. And yet I have never found this to be true. In fact, I have always found the medical students I have known to be more of mix than I ever thought they would be. The few ways in which they are similar have never seemed to be all that important. Some are driven and ambitious, some are surprisingly relaxed, many are scrupulously without direction. Many are passionate, some not, almost all are pleasant, a number are conservative, plenty are progressive, some radical, many are gently considered, and there are, of course, the genial oddballs. All in all, a task in description, and, I have always thought, difficult to sketch.

Those of us who started some time ago have seen vast changes in medical education take place even during the relatively short time we have been students. New schools are opening, old schools are changing the way they teach, and they way they select. Things are being done differently. And while, I suppose, I am neither particularly for nor against the many changes, though their planning and implementation do seem, time after time, to have had the flavour of the simultaneous about them, there emerges from the many changes a disturbing theme. Personality matters. Or, more accurately, certain personalities matter.

Intended or not, new selection criteria consistently favour the robust talker, the self-assured, the glib. Thoughtfulness is not an easy criterion to assess, but I doubt much effort has been made. Interviews, many of them involving the so-called "non-cognitive" (does that mean no brain required?) skills, and other means of assessing prospective entrants which amount in practice to personality tests consistently pick those who possess an easily feigned type of charm, a certain wholesomeness now familiar in medical schools and an attitude that leaves little room for self doubt. And, to be fair, it seems that UNSW has resisted this trend more than other institutions.

In those who have been through such selection processes, cynicism is not uncommon, and it is probably warranted. Many students in the younger years feel they have been through a somewhat subjective process, and who could blame them? Students in the later years are somewhat cynical also. I suspect they wonder what to make of the phalanxes of newbies, and wonder, even, what it means for them. And I think it is a question that deserves some consideration.

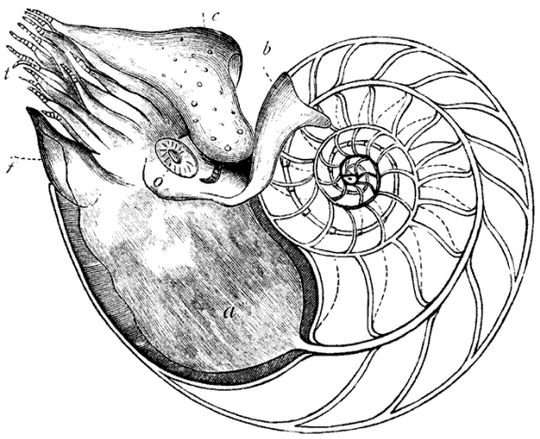
Many of those selected under old criteria perceive something of a stain to be on them. It is a stain, I think, which arises from the knowledge that they more likely than not possess attributes which do not conform to the now desired model for the potential medical graduate. It is the stain of the outmoded, a stain not entirely unwelcome to those zealous to promote the new fashions, more often referred to, curiously, as "outcomes." Among such neophytes, there is a general feeling of bullish self-congratulation, but, closely observed, there is also a touch of guilt about them, perhaps only among the more reflective, who understand that their legacy will be what they have destroyed, not what they have made. This guilt is no small part of the stain on "old system students," and it is a more deliberate component of the smear. I make this comment: the old systems may be outmoded, but that does not make them less meritorious. But if you believe without question that what is voguish in medical education is good, then I ask you to look to Problem-Based Learning, adopted unhesitatingly not long ago in American medical schools, and only now being held up to some serious criticism for some of its deficiencies.

We all know about the baby and the bathwater. I am the first to admit there may have been problems with the old system of entry, but there are certainly some strong defences. For those too young to remember, it was your

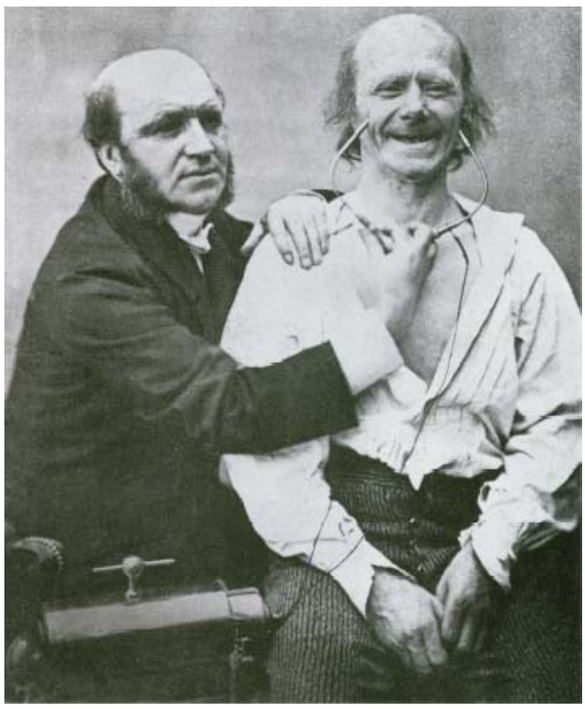
UAI, plain and simple. It was, after all, impartial and objective, as any test is, even those whose structure is as complex as the NSW HSC. It might also be claimed that, because the system relied on work completed consistently over a year-long period (the Higher School Certificate), it was an excellent reflection of both a student's capacity and consistent perseverance.

Furthermore, it took the chicanery out of the admissions process. We are all too familiar with the platitude that marks do not necessarily make good doctors, but I am curious as to whether interviews, structured or unstructured, produce doctors who are any better. It is logical, I suppose, that a process which is dependent on one's verbal skills should produce more voluble doctors. It may, indeed, produce doctors who are more personable, less eccentric and more accustomed to conversation, and, the cynical among you may say, less attractive to litigants. I am yet to be convinced that these qualities necessarily mean better doctors. In an evidence-driven medical age, it should be noted that there is little if any evidence for selecting for these qualities at the beginning of medical school.

It may be true to say that interviewers enjoy the company of the new medical entrant in those short twenty minutes they spend with them prior to their selection. I cannot believe, however, that this is any way at all to come to an understanding of a person. So long as personality tests are the standard for entry selection, hokey charm and practiced altruism will trump candidates of substance every time. It should occur to those responsible for this system that interviews and structured personality tests are not a panacea for discovering the real person, but rather, they are a formula for determining a result. They are a system, just like the UAI. Except that, unlike the UAI, which required two years of hard work and shrewd choices of subject, this new system requires two weekends at a coaching college, a few choice phrases and a rust on smile.



It is a system that can be worked by those who understand its nuances with cynical ease. Are these the kind of doctors we want? The fact that two current 4th year medical students at UNSW started a business teaching candidates how to play the UNSW system, and had some serious success, should have come as a rude shock to the Medical Faculty. It should have prompted searching questions about the system of entry, not to mention questions of how these two were selected in the first place. But instead, the head is buried deeply in the sand. The political orthodoxy dictates all.



Substance is out. Instead we have "reflectiveness" which means the ability to describe your bad qualities without prejudice to yourself. We have "genuine" which means deeply dishonest. And we have "life experience" which means a period of four to seven years spent trying to get into various medical schools. I wonder how many candidates for interview at UNSW come with a prepared tale of how they have overcome adversity? I expect there are more than a few.

Personality selection is offensive, if nothing else. It demeans people's capacities. It elevates the fraudulent at the expense of the honest. And it selects those with more political savvy than substance or ability. Moreover, it demeans those who employ it. It makes them the arbiters of a system which invites manipulation and then rewards it.

Fittingly, the adopted logo for the new medical course and, correspondingly, its selection process, is a nautilus shell. It goes round and round in circles of ever-decreasing diameter, never getting anywhere, until, at last, dizzy from the journey, it ends up more or less where it started, in the centre of big spiral, feeling confused. To do some justice to those charged with administration of these new entry systems, I'm sure many of them share my concerns. I don't doubt that for some of them, this is not what they wanted when all this began. The fashions in medical education come and go, and I suppose this one will eventually spiral back the other way when good sense demands it. In the meantime, some of us are left contemplating the Alazon.

- *A departing sixth year student*

Interview with the Dean

DID you know that you might be able to start specialist streaming during your medical degree? Or that in future, UNSW may offer a combined medical degree with Music? What does our Dean really think about full-fee paying places? What about Bonded Medical Places? Koliarne Tong caught up with Professor Smith, Dean of the Faculty of Medicine, to talk about our medical degree and the future of medical education.

What was your first impression of the new medical program?

I guess the first thing I thought was good grief, this is a six-year undergraduate medical program, we will be one of the few universities in Australia with a full six-year program. However, I'm now a very strong supporter of the program here. I believe we have a very strong program, it's a unique program, and it's flexible. People who do medicine with us can be assured they get a very robust and rigorous training in medicine and can look forward to a very strong future in any branch of medicine.

What are the strengths of the program?

The strengths of the program are that it is undergraduate so that we will attract the best of the school-leavers: people who know they want to do medicine and have the academic capacity and the personal attributes to do medicine. I believe this six-year program will train the medical leaders of the future. We have the capacity here to do things you can't do in a four-year graduate program or even a five-year undergraduate program. We can build a strong research thread through the program [and] we have very strong groundings in science. That can't be achieved in shorter programs. It gives people opportunities to do joint degrees, and we're even now thinking of doing a program with music and other things.

The other very strong feature of our program is our rural program. We have the strongest rural program certainly in NSW and probably one of the strongest in the country. We can offer rural training without reduction in quality of training; the students who go to the rural centres graduate in the top percentiles of the class so there is no disadvantage in going and spending time in a rural campus.

Are there any new developments in our medical program?

The other capacity that this program has, and we're well down the track of doing this, is developing specialist streaming within the medical program. We already have an agreement with two of the Colleges – the College of Pathologists and the College of Radiologists – to identify students during their third year, who feel they might want to specialise in these areas. We can offer them electives and an ILP that will be oriented towards one of these specialties. The students will still graduate with a full MBBS and will have full medical registration, but by streaming them, there will be advanced standing to some degree offered by these specialist colleges. It will also enable them to engage with the specialty fairly early on in their career. The Royal Colleges at the moment are talking of offering up to one year advanced standing in their programs, so it could clip up to a year off training time. We are in consultation with a number of the other colleges but we want to get these two up and running first.

PROFILE

Professor Peter J. Smith

Qualifications
BSc University of QLD
MBBS University of QLD
MD University of QLD
FRACP
FRCPA
Fellow, Aust. Insitiute of Company Directors

RAAF Service
RAAF service 1968-2001, retiring with rank of Wing Commander and the Reserve Forces Declaration

Current appointments (summary)
Dean, Faculty of Medicine, UNSW
Founding partner and Director, MedSys Assurance
Board Directorships -
St. Vincent's and Mater Health, Sydney
Garvan Institute of Medical Research
Prince of Wales MRI
The Sax Institute
New South Innovations
Committee Chair - The Australian Vietnam Veterans Mortality and Cancer Incidence Study

Past appointments (summary)
Dean, Faculty of Medicine and Health Sciences, University of Auckland
Professor/Director, Hamatology and Oncology, Royal Children's Hospital and University of Melbourne
Board Directorships -
Royal Children's Hospital Foundation
Murdoch Institute for Birth Defects
Murdoch Children's Research Institute
Uniservices Auckland Ltd.
Advisor to NZ Government Health Select Committee on exposure of NZ Vietnam Veterans to Agent Orange

Clinical and research training posts
Resident, Royal Brisbane and Royal Children's Hospitals, Brisbane
Fellow in Haematology and Oncology, Royal Children's Hospital, Melbourne
Leon Journey Fellow in Biomedical Research, St Jude Children's Research Hospital

Family
Professor Smith has three daughters, including one following in his footsteps by studying Paediatrics at the Royal Children's in Brisbane

We hope to be able to call for expressions of interest later this year.

Do you foresee any other changes in our medical program?

I think the issues facing us are the issues of just rolling out the program. We're learning about the scenarios, whether we need to have exactly the number of scenario groups that we're having now, what's a balance between scenarios and expert tutorials that we should have. There are going to be issues rolling out in the clinical area as to how the program will be managed there. But we want to get feedback from students and from staff teaching the program so we can modify it as we run along. I expect that there will be modifications necessary. It is critical we get that feedback. We're not just going to say 'tough,' we're going to say, 'OK, well how can we make it work?'

What are your views on domestic full-fee paying medical places?

I realize that there are different views on this. There are various ways you

can get into medicine. You can get a fully HECS funded, Commonwealth-supported place, you can have a bonded place, you can have a rural entry place, you can have an Indigenous place, you can be an International full-fee paying student. I guess one could then argue from a logical point of view, provided someone is qualified to come into Medicine, why shouldn't you take a domestic fee paying student into the program, provided the program can handle that person? It's almost going back to when I was studying Medicine – when I enrolled in Medicine, you paid fees. In fact, the UAI cut-off for our domestic fee-paying students is not the lowest cut-off of all those groups. For domestic fee-payers, I think their UAI in the last round was higher than for example, some of the students of rural origin.

There is international evidence that bonded schemes fail to achieve sustainable workforce increases, with up to 38% buying their way out. What are your views on the Bonded Medical Places Scheme?

We have the scheme whether we like it or not, that's not negotiable. I'm not totally opposed to it, but I do think the better way to get people into rural areas is by encouraging them to go there, to actually provide incentives for people to go rural areas to work there. Because as you've observed, if you send someone to a place that they didn't want to go, then they'll simply buy their way out of the bond, and there is no penalty for doing that at the moment. Queensland operated a bonded system in the 60s and 70s and a significant number of people paid their way out of those as well.

Some frightening statistics have been quoted on increasing medical student numbers. How do you think increasing numbers will affect UNSW medical students?

Well within our own program we're very conscious of our capacity to handle students both on the campus here and in the clinical domains. We're very conscious that when you increase numbers, you can sort of add incrementally to a class, but then you hit a ceiling and to take even five more students, you actually need a major jump-up in your infrastructure. So we're aware that we're basically hitting our ceiling or very close to the ceiling at the moment.

In terms of other universities that will be sort of moving into our space, we're in negotiations with them around how clinical placements will be managed. To date, these issues have been worked out in collaboration. I'm not concerned about clinical teaching spaces for our students. We know exactly the number of students will be coming through and we've mapped out where they can be placed.

We're working on a model where one university will for want of a better term 'auspice' a hospital. So UWS will 'auspice' Campbelltown. If [UNSW medical] students go down there, they will be our students but they will sort of operate under a UWS umbrella. Within the hospitals, the programs will be aligned. It'll be impossible if we have Notre Dame, UWS and UNSW say on the one site, three very different programs – that isn't going to work.

Do you think that medical students have a right to an internship place i.e. a right to employment?

I think it would be difficult to argue that medical graduates have a right of employment. However, I think, both government and universities have to be responsible for not training people who are not needed in the first place. If we are training many, many more doctors than are needed then we are falling down on our responsibility. Now at the moment, we're still facing a huge shortfall so I don't think we're training too many doctors.

Do you know if there will be enough internship places for all graduates?

There are issues around finding intern places for everybody. We are in negotiations and discussions with [the NSW] Department of Health regularly around ensuring there will be places for interns. We're being told at State level that there will be [internship] places for our graduates. The only class that there are issues around are full-fee paying International students, whether they will be given places before or after overseas-trained doctors who are accredited by AMC [Australian Medical Council].

Another possible solution to help ease the medical workforce shortage is to diversify, for example through the introduction of Physicians Assistants. What are your views on the diversification of the medical workforce?

The NSW government has not been pushing this very hard; Queensland has. I think there is a good case for Physicians Assistants, that these are sort of qualified, virtually paramedical people that will work under the direction of a doctor. I think in a lot of domains they can work well, for example in the military you have paramedical people who do a lot of the jobs of a doctor under direction from a doctor. But the NSW government has not embraced this as of the moment.

We, this university, this Faculty did look at whether we would set up a Physicians Assistants training program. But we've decided not to at the moment, it's sort of been put on the back burner for a while. This would divert us from training doctors. I don't intend on reviewing the decision in the near future.

You get what you pay for Australia

EVALUATION of candidates for places in Australian undergraduate degree programs, until recently, took into account only one parameter: the UAI (previously TER). One number, the culmination of twelve years of schooling, eighteen years of life, is still the sole tool used in most cases to match young people to their future professions. Given the significance of this process to Australian innovation and society, it is curious how little scrutiny and discussion has been aimed at the manner in which this task should be carried out. The universities shroud their admissions policies in secrecy, inviting and accepting little debate about procedures. Although they are aware that the system is problem-ridden, universities are reluctant to fix it. Tertiary admission based on a single parameter does not serve the interests of the nation, nor the candidate; the entire process is designed for the convenience of universities. Institutions are able to quickly and cheaply secure candidates to fill their places, in a monopolistic fashion, with minimal investment in the admissions procedures. And even as the UAI system slowly unravels, exposing its shortcomings, change occurs only very slowly, as the culture is ingrained in Australia that admissions are unimportant and should come cheap. The universities are loath to fork out the (significant) investment needed to improve and overhaul the system.

The use of the UAI alone to determine who is accepted and rejected from tertiary admissions is a poor system for differentiation of candidates. It fails in its most fundamental role – that is to match young people to professions appropriate for their talents and interests. More disturbing is its tendency to influence society's perception of the 'value' of professions based on the irrelevant metric of candidate demand. In addition, it does not fairly represent the abilities of candidates, and leaves them with little or no flexibility to choose between courses and institutions. The prevailing system short-changes the candidate and the nation for the thrift and convenience of universities.

Success in the Higher School Certificate examinations funnels bright students into courses whose places are in high demand, even if the courses themselves do not suit the talents or preferences of the student. UAI cut-offs are set in response to demand for seats: perceived post-graduation income, prestige and security drive demand for courses, setting the highest UAIs for professions such as law, medicine, and finance. Courses that garner little demand – often in areas where Australia is in need of graduates – are allocated low entry cut-offs. High UAI achievers choose courses with high UAIs at least in part because they can; they are reluctant to squander a hard-earned mark on a course with a low cut-off. Consider the following example: a talented student who is thinking about a career in teaching graduates with a UAI of 99. Despite his interest, the low cut-off for the Bachelor of Education degree makes him feel as though he could do "better". He chooses a combined law degree so as to "spend" his UAI wisely. Thus his talent and passion is diverted from its calling, simply because of the flawed nature of allocation procedure. The example reflects the realities of the UAI system: although set up to rank candidates, it cannot avoid in the process ranking degrees and professions, prejudicing public perceptions. Professions are hierarchicalised and defined by their well-publicised UAI cut-offs. A vicious circle develops, as the perception feeds back into demand. Disciplines in need of talent and numbers cannot generate demand, thus have low cut-offs, which reduce public perceptions of the value of the discipline and drive away talent, further exacerbating the problem. Pick any number of areas in which Australia is struggling – education, nursing, science, the arts – and you can bet the UAI system is hindering rather than helping.

The UAI functions as a device to match supply and demand for places in our tertiary education marketplace. It is designed in exactly the same way as a price. If supply for a university place is low and demand is high, the price (or UAI cut-off) increases, reducing demand by ensuring some individuals can no longer afford the place. The problems with this way of choosing candidates are apparent immediately. If a course cut-off functions as the price, then a candidate's UAI functions as the money. Imagine choosing how to spend a sum of money that you have worked twelve years to earn. Now imagine that you had to spend it in one go, with the purchase of one item. The marketplace will almost certainly prejudice your choice. You are likely to buy the most expensive item that you can afford, rather than the item you want or need; after all, the money is useless once you have made your decision. Clearly the UAI system is inappropriate here: it sets up incentives that undermine the real goals of the selection process. Australia needs to recognise that the challenge of selecting candidates for tertiary places is not met merely by matching the supply and demand for seats, as though education were any other commodity. Choosing to train the right people for the right positions in society is a vital responsibility that universities must take seriously. Until that time when they overhaul selection procedures towards a more enlightened approach, they are simply shirking their responsibilities.

The assessment of a candidate's suitability for a position is necessarily a subjective, multifactorial task, not effectively carried out using objective, single-parameter procedures. Universities need to employ a subjective, holistic approach to evaluation of the candidate. The current UAI system is inflexible and unrepresentative of students' diverse realms of talent. No account is taken of the large range of backgrounds from which students emerge. As young adults frequently intersperse the study of multiple degrees with work, research, travel, and volunteer work, only careful, case-by-case examination of each candidate's achievements can result in a fair outcome. Australian universities must bite the bullet and set up admissions com-

mittees charged with the task of weighing up candidates' grades, entrance exam results, personal essays, letters of reference, interviews, research/employment experience, as well as extracurricular activities to arrive at a global sense of how suitable someone is for a position. The best tertiary institutions elsewhere in the world invest a great deal of resources in this process, with the understanding that the selection of quality candidates assures the future success of the university and the nation. We in Australia have so far largely neglected this crucial aspect of higher education, preferring to bury our heads in the sand while we under-invest.

Australia's resource-starved public universities will, no doubt, find it hard to justify and execute the large investment needed to salvage our candidate selection procedures. However, the fact that many institutions have already started to consider other parameters of achievement in addition to the UAI shows that universities recognise the imperative to change. Medical faculties have long since rejected the use of UAI alone, and a diverse range of faculties are now demanding candidates present evidence of achievement in other areas, including individual subject results, interviews, personal statements, and portfolios of previous work. Although this move represents a step in the right direction, Australian universities still have a long way to achieve reform. And the pace of change will be slow – most of all because no university is keen to spend the big bucks on what they now get for (virtually) free.

- Srihari Mahadev
Med 1 (USYD)

Transcript of a speech from St. Elsewhere's

Chairperson, sorry, chair… thing, members of the board

St. Elsewhere's hospital goes from strength to strength. In the two years since we undertook extensive renovations and radical restructuring, our clinical capacity has increased, patient turnover has improved and patient and staff satisfaction levels are at an all time high. How have we achieved this? (especially after having been voted "best simulation of purgatory in a clinical environment" three years in a row) Through increased funding? Ha. No. Through improved management techniques? Lord no. Let me take this opportunity to inform you all that I am blind drunk by 11 am each morning. In fact I'm still inebriated right now. The enforcement of asymmetrical haircuts? No, no, thrice nay, but that is one of my more inspired directives. A representative from each taxonomic Kingdom on the board? Again no, but I felt mycotic representation could be ameliorated somewhat. (Did I mention that I also consume vast quantities of laudanum? Quite the experience. Far better than honeydew, or that milk of paradise stuff…) No - what's with all the questions anyway? No. The answer my friends [looks at fungus - a particularly fine example of a basidiomycete] is hypnosis. We sit deep within a hypnotic field, generated by the great, enigmatic and very subcontracted Mysterio (and Janice). St.Elsewhere's hospital is completely constructed out of the collective belief that it does and must, in fact, exist. It is crucial and of the utmost import therefore that we all continue to believe that it exists in time and space, and that I am somehow competent to run it. Now now, I beseech you all, do not expend too much thought on this central paradox that constitutes the very foundations of this place, lest we infest it with rational thought [the paramecium ceases the twirling of its flagella in anticipation]. Needless to say, our plans for a medical school are being fast-tracked and we are seen as a vanguard for the future of the hospital system…

STRESSFUL, UNEASY FEELING

You walk up to the bedside and introduce yourself. Jacket, bag and stethoscope dangle precariously, trading positions in a telltale dance. You put the bag down and try to maintain composure, to keep up the masquerade. But the second you open your mouth, you give it all away. The patient looks at you apprehensively, quizzically. Draped in a paper-thin gown, poked and prodded, humiliated, the man lying in the hospital bed is not terribly motivated by altruism. He is backed up into a corner, scared, and thinking of only one thing: What can this person do for me?

There lies the dilemma for today's first-year medical student, thrown headlong into clinical situations: we are utterly, appallingly ignorant. We can offer absolutely nothing of value to a sick person. And they know it. Yet we are expected to approach patients experiencing amongst the most stressful and terrifying circumstances of their lives, and ask them to do us a favour. "May I please be the fifth medical student today to ask you questions about your urination difficulties?" Sure thing. "Do you mind if get you to heave your frail octogenarian torso up from the bed so I can practice tapping on a back?" Umm, ok. "Can you please take big, deep breaths (even though it hurts) so I can get used to hearing breath sounds through my stethoscope?" No way, José.

Medical education has always grappled with this issue: educating inexperienced medical trainees requires exposing them to patients in real clinical situations. To do so necessitates exposing the patients themselves to inexperienced medical trainees. This trade-off weighs the health of the next generation of patients who will seek treatment from future doctors against the health of the patient who is having their lumbar puncture performed by a first-timer. Even if the young doctor has seen the procedure a hundred times, there must always be a first time he performs it on a real patient. Ethicists have argued that a principle of "do no harm" applies – that is, as long as the patient's health is not (seriously) compromised, then there is nothing wrong with teaching from the bedside. This safeguard has traditionally been implemented by supervision – trainees only earn their independence through demonstration of competence.

The problematic aspect with this principle is that, in reality, when a patient comes into hospital seeking treatment for their illness, a greater ethical burden than simply "do no harm" falls upon the health profession. Patients in hospitals have an expectation that they will be helped and cared for whenever they interact with individuals in the system. Reflecting this reality, almost all medical training occurs in a context in which the patient is being treated and helped: for example, when a trainee assists in a surgery, or makes a preliminary diagnosis that is reviewed by the consultant, the student participates and aids in the care of the patient in some way. Unique to the first-year medical student is a complete lack of skills and knowledge that entirely precludes their participation in the care of the patient. There is simply no way to integrate clinical training of first-years into patient treatment because we have nothing to offer.

First-year medical students are, therefore, outsiders to a system where your presence is only justified by the part you play in the care of patients. Nurses, doctors, janitors – all individuals in a hospital are expected to engage directly in the business of helping patients. If you cannot, then you are not really welcome. Third-year students are involved to an extent – they present information, write (inconsequential) notes in charts, follow up on labs. Second-years are at least able to lend a somewhat informed ear to the patients they see. What do we do that justifies our presence? Nothing. We are selfish, we are there only to benefit ourselves; we cannot give anything back.

I see these thoughts flash through the eyes of the patient who groans involuntarily when he sees another first-year student has come to harass him. I believe that this latest pedagogical vogue to grip medical educators, the idea of clinical experience from day one, although valuable in some ways, poses its own problems. The challenge of allowing the system to accept new, inexperienced trainees is not solved by throwing them in earlier, with even less knowledge. Doing so further alienates students from a system that is inherently hostile to individuals who cannot contribute to it. The interaction first-years have with patients and the hospital is distinctly different from clinical interactions at all other levels of medical education – as we have nothing to offer, there can be no give and take, only take. The interaction would not be so one-sided if we spent a part of our medical education learning knowledge and skills before jumping into hospitals, such that we might be introduced to patients at a time when we were more ready, more able to offer them something.

If any of this sounds familiar, it is because medicine was taught in exactly this way – until recently. Universities used to equip students with a basic level of knowledge before lobbing them into the deep end. It was, however, argued that this system graduated doctors lacking sufficiently honed communication skills. And without question, starting on the wards early gives students greater confidence and facilitates communication with patients – a real upside to the new system of clinical experience from day one.

The real challenge in early medical education is getting the balance right. The possession of some knowledge when commencing clinical exposure is needed to allow students to feel accepted rather than burdensome, and to get the most out of their interactions with patients. Delaying contact for too long compromises communication skills and paints medicine as unnecessarily abstract. Medical faculties need to meet in the middle of these two extremes. This latest upheaval in medical education is only twenty years old – it is early days yet. The wrinkles will be ironed out in time. But long after our time, of course.

- *Srihari Mahadev*
Med I (USYD)

A NUISANCE IN THE CITY THAT MUST BE GOT RID OF.

The Inspector of Nuisances. "HALLO! HERE'S A VERY BAD CASE—A ROOM FULL OF PIGS I DECLARE, AND AN IMMENSE QUANTITY OF ANIMAL AND VEGETABLE MATTER!"

Welcome to Med

No doubt you have already told 100% of the people you know what you are studying, and your pride is matched only by your reluctance to tell people that you got 99.95, thereby eliminating any doubt that you didn't smell anyone of the opposite sex throughout your high school career.

You have a lot to look forward to in Phase 1. Like buying $300 stethoscopes and wearing them around your neck to every clinical session even though it could go in your bag and you don't need them yet, and even if you did you wouldn't know how to use it, and anyway your clinical tutor isn't going to show. You will also find yourself wearing a purple lanyard everywhere, i.e. to bed, to the gym, to the brilliant med "Yeah I'm studying medicine but I'm still really fun and cooky" pub crawls. And enduring the nasal screams of medsoc enthusiasts shouting at you between lectures to eat gelato.

Medical students are the worst people in the world, let alone the uni. They are arrogant, boring and lack remedial social skills. They are all short. They wear polo shirts every day. They all get HDs in everything, including gen eds. They cannot talk to patients. But boy, can they organize a charity head shave.

- Josh Hopp
Med III

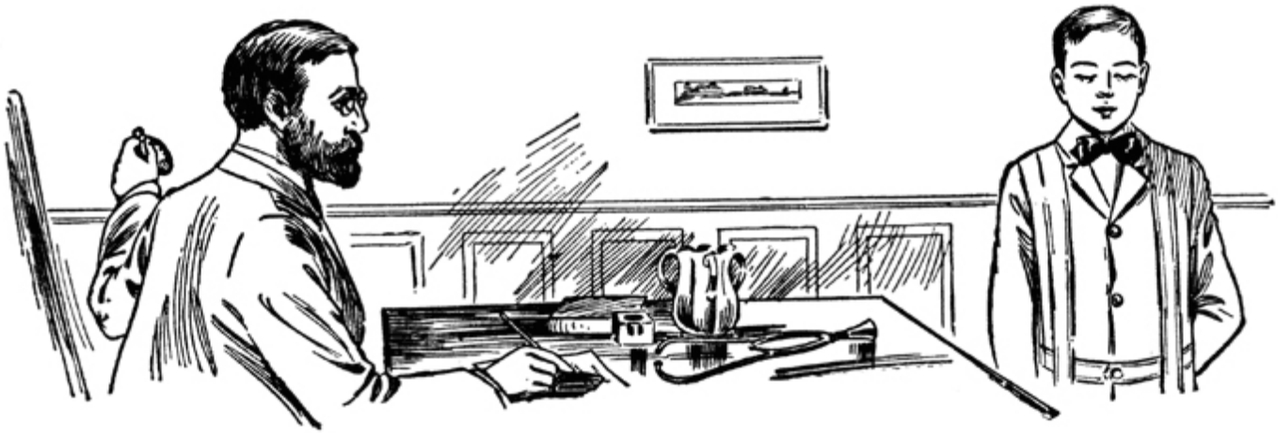
"BACK!"

An exercise in transposition - if the avant-garde artists were doctors

Professor Peaknuckle,
I am distressed, my little grapefruit.
No one here understands what I am trying to achieve. They are all mired in their dreary modernist mindsets and see medicine merely as an interaction between doctor and patient. When will they conceive of the inadequacy of their relational concepts? With their crude minds, my clinical techniques seems strange to them - they give me funny looks, roll their eyes and occasionally call the police. When will they understand that cruelly taunting old ladies, and rearranging tubes amongst patients (today I had Mr Henderson connected intravenously to Mrs Jones' in-dwelling catheter, and I gave Mrs Jones a blood transfusion from Mr Henderson's colostomy – they must learn to understand one another, or they will never be well) is the only sure route to purity? They do not understand my medicine. They find my method of giving faecal samples to patients, rather than taking them from patients, and conducting my clinics in the women's bathroom on level three incomprehensible. They do not see that these are the only things that make sense in a mad world. Why was I cursed to be privy to medical insights decades ahead of my peers? Such is the fate of the true doctor, I know. But it is a lonely road.
I am haunted by visions of the perfect discharge summary and know that everything I do is marred and inadequate by comparison. I list medications in every conceivable permutation but nothing is ever quite right – instead I have taken to discharging patients on a homemade compaction of cheese and doxyrubicin.
I yearn to do real medicine.
Smith.

Prof. Smith,
I understand, my little poodle - I am in a similar situation. Even though I think your ideas are inherently flawed (in the dialectical rather than the normological sense) I understand your alienation. I have decided to practice only as I feel – all dogmatic ideas impede the beauty and freedom of our natural lived experience. Today I stented Mrs Peabody using bright red and blue pebbles I had collected from Mauritius. They are a symbol of strength and fertility. Her family is angry at me. When will people understand the power of the metaphorical? Yesterday, I stented Mr Johnson's nose. My registrar kept insisting that the appropriate measure in the context of coronary ischaemia would be stenting of the coronary vessels. Typical, but sad - he is still young and takes textbooks and research at their word. He does not feel as I feel. Mr Johnson's nose was the problem - I cannot articulate the reason but I am sick of having to explain what I feel – is it not enough that I feel it? They cannot understand that cold logic and levels of evidence simply do not enter into it at all – I felt as if my heart apprehended his heart directly – as only two free hearts can do. I must be allowed to express what I feel, else what is life? What is life, my dear poodle?
P.

Professor Peaknuckle,
You have given me hope, my little Aeschylus! Your work with the nose has inspired me – Mrs Livingstone has been troubling me with her peptic ulcer. It seemed untreatable. Then one night as I was stroking my rubber cat it came to me – I have to think above and not just through. I have suspended her from flaming pink tendrils of ribbon, arranged at positions that represents the constellations of the water signs, all over a fake pond (made out of a real pond, covered in glass, with all the fish and tadpoles individually wrapped) while I got my interns to fan her with their stethoscopes and my registrar to sing a B flat. The whole scene was breathtaking – I felt as if something I had produced was finally worthy of the visions I have in my outpatients' clinic. But these families! They are so restricted in their mundane phenomenology - they claimed malpractice because we forgot to take Mrs Livingstone down for a few weeks. They do not understand the existential significance – are we not all simply hanging? Some of us, however, are hanging from flaming pink tendrils of ribbon. This explanation seemed to enrage them further, the simpletons.
Yours,
Smith.



P.S. Today I wept while I was looking at Henry's blood film. The assistant asked me why I was crying and I replied 'because it is beautiful'. She replied, 'but I thought Henry has incurable leukaemia'. 'He does,' I said, 'he does.' A perfect quotidian moment wouldn't you say – a living haiku?

Peaknuckle,
I have decided to end it – even though our communication has sustained me thus far, I cannot live in so cruel and so cold a world. I am sick of what happens in this hospital – patient after patient comes in, and doctor after doctor treats them. Can they not see that this is madness? They know not what they do. I wonder what God thinks. Today they shut down my post-structuralist surgical wing – they think you need scalpels, and suction devices to do operations. Their dullness of mind horrifies me. All the different operations I did – conjunctive, disjunctive, and syntactical – will be lost. Where will language be without these operations? I will no longer ligate egos, internally fixate fractured souls or drain infected collections of denial. My work is ruined! And all by imbecility!

Tonight I shall cut my scalpel off with my ear, and then post it to the Nursing Unit Manager. She is the only one who understands me. People think her cranky and frightening because of her knee length armpit hair, and thick beard, and the way she shrieks, 'I'll kill you, I'll kill you, you goddamn thieving bastards' at all the patients, but I know that she is truly kind and gentle (those deep gashes of mine have almost healed, but sometimes I pick at them and think of her). Please be kind to her after I am gone – she has the soul of a research haematologist. You and she were my only true companions on this sad earth.
Your ever devoted little plum, goodbye.

Smith, Smith, my lubricated little catheter,
You are already gone. I have read the papers. Again misunderstood – they mistook your death by your own hand for a suicide, when I know you were simply trying to show that the ear is mightier than the scalpel. This surely is worth dying for! You are a brave man, and a wise one! I shall always hold dear those times we spent together as registrars when you showed me your new technique for the lingual examination of ears (I can now picture your hairy, fungating ear on the tip of my throbbing tongue and weep sweet tears – love, ah, love!), and your improved demonstrative pain scale (to this very day I still have a hutch of rabbits and a set of cute, little knives on each ward ready for patients to slaughter to reflect their level of pain). I am no longer embarrassed about what we did then – we were young, and walking all the forbidden paths of medicine together. Those nights in your arms are the sweetest memories of my life – some of the pictures we took I have hung in my waiting room – people must know of our passion.
Your medicine will live on long after you have passed on.
Adieu, friend.

- Mark Horowitz
Med VI

Cultural knowledge test (with accompanying German phraseology and explanations)

1. Hypercolour – what does this mean to you?

Ans: If you are not thinking of a T-shirt (alleged carcinogenic and teratogenic properties notwithstanding) then you should be thrown into the black hole of Calcutta/Wollongong, whichever is less convenient. As the Germans would say: **Sie konnen mich mal, wenn Ihnen mein Pfeifengeruch nicht passt** – translated: If you don't like the smell of my pipe, you know what you can do.

2. Is pog:
a) a humourous early 90s zany cartoon character,
b) modern internet slang,
c) a new hybrig dog breed,
d) a South East Asian inherited medical condition,
e) a pig dog (schweinhund),
f) a rather dull form of entertainment which got in the way of chip consumption or,
g) a poster boy for childhood obesity?

Ans: the answer is f, which is what you would get if you answered anything else. The other answers are bigoted and prejudiced, but on the down side, are also wrong. In german: **Sie haben Ihr anfanger schild verloren** (trans: you have dropped your learner plates)

3. Riddle me this: How many powers combined result in Captain Planet?
(a) 3 (b)4 (c)5 (d)6

Ans: This answer is (c) 5, although I will accept (b) 4, because that guy with the heart is just the result of television executives getting excited while high on a combination of methamphetamine, some unidentifiable white powder from South America (of course, snorted off the backs of Heidi Fleiss call girls, geisha and pygmies) and the meaningless ramblings of Bob Geldof. (a) and (d) are plain ludicrous you half wit, and to wit – **Lassen Sie Ihre Kinder gefalligst auf Ihre Fusse und nicht auf meine pinkeln** (Let your ghastly children pee on your feet, not mine)

4. The fire flower is better than the giant mushroom – true or false?

Ans: As anyone with even a rudimentary nerve network would appreciate, the mushroom merely induces Gigantism (and gives you an extra hit point) while the fire flower bestows upon you the power of flaming balls of vengeance with which to annihilate those hellish turtles and vile goombas (and even Bowser though I doubt half of you have the requisite coordination and opposable thumbs with which to reach him). The princess is mine, while all I have to say is: **Ich habe keine Lust, am Tisch des Kapitans zu sitzen mir sein uninteressantes Gequassel anzuhoren** (Why should I want to sit at the Captain's table? To listen to his damn-fool ramblings?)

5. 'Me no fry' was a successful campaign which advocated:
a) childhood obesity,
b) free frequent flyer points for people of Asian descent,
c) a pop release from MC hammer
d) the abolition of capital punishment or
e) sun safety

Ans: If you answered (b), the authorities will soon be knocking on your door – please remain calm and follow instructions. Clearly our educational system has failed you, and you will soon undergo a retreatment not dissimilar from that presented in A Clockwork Orange. Do you like Beethoven? Why do I ask? Oh never mind… (e) is far and away the correct answer, and if you were not correct, the Germans (as always) have a sagacious rejoinder: **Porbieren Sie doch □mal ein Desinfektionsmittel gegen Ihren Korpergeruch** (Try disinfectant to get rid of your smell)

6. Happy healthy Harold was:
a) that disheveled man who hung round your school in a trench coat carrying paper bags,
b) a man ASIO is currently investigating,
c) the most popular stimulatory item in a small upstairs nondescript store in Fyshwick,
d) the ironic name of the most popular cadaver in WW 101, or
e) an animatronic giraffe with a conduct disorder and a penchant for young children

Ans: while we cannot dispute that the first 4 may indeed have an element of truth, (e) is indisputably the correct answer, you jack-a-ninny. **Trinkgeld erwarten Sie? Einen Tritt konnen Sie haben**. (Yes you deserve a tip – the tip of my boot)

7. What is a supersoaker?
a) another item from aforementioned store in Fyshwick,
b) an item listed as contraband by Sydney Water,
c) what you give your sheets after an intense nightmare,
d) otherwise known in Japan as (loosely translated) super-happy-hyper-wet-time!!!:)!! (collect them all)
e) a somewhat irritating and overrated pressure based water pistol/WMD (weapon of minor dampness)

Ans: again we are unsure of the veracity of options a-d, but e is the correct answer, punishable by fun! If you missed out on the damp joys of wet denim and cotton/polyester blend you have not yet lived. But the Germans have some consoling words to soothe you: **Das Omelett werde wohl mit Eiern von vorsintflutlichen Reptilien gemacht?** (Was this omelette made with pterodactyl eggs?)

8. Who, or what, is 'Hammertime'?
a) it is a state of mind somewhere on the path to nirvana,
b) a particularly nasty form of headache,
c) the aftermath of an unfortunate trip to the dentist,
d) a sinister cabal of hardware manufacturers who rebel against GMT or
e) a difficult to describe gyration, the 'running man', which resembles a rather severe movement disorder (should only be attempted with an afro flat top, parachute pants and a badass attitude, later to be reformed into a Christian

minister)

Ans: Despite his recent foray into grassroots Christianity, people still talk of a man, nay, something more than a man, who in the early 90s took the world by tsunami and unleashed a new age of civilization, and, I believe, helped bring down the Berlin wall and single-handedly save a then-languishing synthetic textile industry, saving thousands of jobs and helping families the world over. Shout out to the JC for the MC! (the answer is (e) my children). The legacy of MC is immeasurable – and we will know that the new HSC has redeemed itself once 'Can't Touch This' takes its rightful place in the cannon of English literature. Now for some German: **Nehmen Sie den Zerstauber weg, ich will ja nicht wie ein Strassenmadchen riechen** (Take that spray away, I don't want to smell like a call-girl)

9. There was a world before Google; true or false?

Ans: The proof goes as follows: if we accept that 1. Google is indeed the world and 2. A world without Google would be uninhabitable and Dantesque, it therefore follows that the world cannot exist in the vacuum left in the absence of Google. I google, therefore I am. QED. As some great German philosopher said: **Da klatscht keener Beifall – das ist das Ungeziefer, das mit den Flugeln schlagt.** (That's not applause – it's the insects flapping their wings). Despite the above, incredibly rigorous proof, which I've submitted to a reputable philosophy journal, the answer is true, I'm sad to say. I saw it with my own eyes – the horror, the horror…

10. Certain radio stations proclaim that they play the best of the 70s, 80s and today. What is missing?

Ans: we're stumped, but something deep in our reticular formation tells us there was indeed a period in between, hence the question. If you can remember, please forward your answers and any actual evidence to: gnarlytubularrad@ninetiestoyou.com.au

A 21-gauge needle or a 23-gauge needle?

It's a debate that has raged throughout the centuries. Taken out of context, one could say that it transformed the nation and made us who we are today. Allowing society to evolve from the uncivilised animalistic hierarchy it once was to the civilised animalistic hierarchy it is today. However, its importance has often been overlooked, passed by and glossed over with various other similarly worded clichés by doctors and medical students alike. Sure, to the medical student, with naïve optimism and genuine innocence, the problem may seem trite and pedestrian. But to the experienced and hardened medical professional the issue creates many sleepless nights littered with horrifying nightmares, if such a situation were even possible. Some would have you believe that dilemmas such as euthanasia and abortion are more important to the medical field. However, in regards to the issue of needle size, Samolesky et al (2006) stated that to come to a conclusion could very well end time itself. If this is not enough of an indicator by which to gauge the level of importance then you need not read further. I implore you to continue reading though, even if this sentence has become inherently obsolete. But in the interest of time, in both a literary and literal sense, I shall say one last word on the issue. It is not the size of the needle that counts; it's the size of the syringe.

- *Chris Hannah*
Med II

The University of the People's Democratic Republic of ИSШ Medical School Prospectus

Comrades! Work continues apace in our five year plan of construction. You are indeed a fortunate citizen to have been forcibly chosen to work for the betterment of your motherland. Without teaching staff or even proper facilities, we nevertheless proudly move forward under the banner of self-directed learning, and indeed, we have recently started incinerating a small number of counter-revolutionary books (all those between MB 000 and MB 999 inclusive) for the purpose of warming the feet of our glorious leaders in the faculty office. Mmmmm, I can smell the knowledge burning.

Located in the former gulag of Kensington, we have used vile kulaks to fashion a medical school which shall compete with those Bourgeois capito-imperialist strongholds also dubbed thusly. By recycling match sticks, left over balsa wood from discarded school projects, packing Styrofoam, pre-popped bubble wrap (unpopped is a needless Bourgeois extravagance) and paddle pop sticks, we have built an architectural wonder that is an exemplar of the pre-post-industrial style, and at a fraction of the cost. As a further bonus, we are totally buoyant in case the water level in med lawn rises any further – we will simply float downstream until we run aground in some new surrounds.

Our staff is only too happy to help you with any inquiry you might have, so long as you can find them and they're not otherwise engaged in 1) defending themselves from unfounded charges of malpractice, idolatry and treason, 2) experimenting with new techniques in incineration and shredding for rapid document disposal, 3) breathing or basic life sustaining functions, 4) attempting to build the world's tallest card tower from Snellen charts, 5) the difficult and complex task of redating lectures from previous years, 6) feeding computer generated answer sheets into a random number generator or, 7) otherwise engaged in self reflection, with or without a mirror and a light source.

We also are proud of our traditional Med Camp, where through highly sophisticated subliminal techniques (such as toga night and goon) and Pavlovian conditioning through feats of strength, we fashion a new medical student from the ashes of the old (did I mention we use a lot a fire and electrical equipment in our camps as well?) – through the use of guard towers, german shepards and high voltage fencing, we ensure a safe and secure environment, away from the prying eyes of the U.N., amnesty international and other human rights bodies. Yes, bodies. I've seen a lot of those.

Should you survive Medcamp, your first day of medicine will be one that you shall remember always. Your first trip through the Desolation of Smorg, the acid flats and toxic wastelands in order to reach the faculty building can be a bit daunting at first, but you will soon get used to the journey, as you will make it many, many times. Familiarity breeds contempt, as they say. Former medical students, otherwise known as the Fallen, who were unable to complete the course can be found living in loose tribal systems throughout these environments. It is best to avoid them if possible, for they do not always resemble human beings, and have a strange, droning, primitive language which sounds much like a song by a generic blonde female poplet from the early naughties – think of the siren's song, but without the appeal (equally fatal however). Your 'hospitals' on the other hand are located in other, sometimes less hospitable environments, even beyond the pillars of Hercules in some cases (Charon is your man for those going to the Greater West – he now has a bus service).

Our course has been developed from the ground up as a totally new paradigm of education, free from the fetters and shackles of contemporary 'knowledge' and 'evidence', and even 'thought' and 'reason'. Instead we choose to answer questions through novel techniques such as coin-flipping and the reading of tea leaves and animal entrails; moreover we teach according to the lunar cycle and signs of the zodiac. Our school of Divination is the most advanced in the world, and has demonstrated for the first time that standing on your head can increase your chance of conception and that doctors are indeed terrified of apples consumed on a daily basis.

Upon graduation, you shall be awarded a Bachelor of Charlatanism and Quackery, and will be licensed to practise the noble art of Chirurgery and Mountebank-ism. An optional honours year in Chicanery is available for advanced students.

Some of the courses unique to this institute

Faith Healing 101

Devil be gone! You're already halfway there to effective faith healing.

Pre-requisites: Fake tan, gold plated house, personality disorder

Pharmacolo-whatsit without names 101

Do you hate learning all those pointless drug names? This course was specifically designed for you. By learning sophisticated distraction techniques and Jedi mind tricks ("You never asked me which drug he's taking") your worries will be a thing of the past, much like our course. Devil be gone!

Mind reading, ESP and divination – communication studies taken to a new level

classified

'I wasn't there – how could it be me? You can't prove anything – I know the law' 101

Interactions with the Law have been a common finding of our newly graduated doctors/mountebanks. Therefore, being the responsive and advanced faculty that we are, we have come up with this exciting new course. You will learn the lost arts of transferring assets to Swiss bank accounts, putting all your assets under your wife's name, and denial in the face of watertight evidence. Some further skills – booking airline tickets under a pseudonym, glossolalia, polygraph wrestling,

how to choose the right beard and glasses so that friends and relatives can't recognize you, and how to get a puff piece on Today Tonight – are available for advanced students or those with a previous background. Previous students have claimed that this course is more important than basic life support! Devil be gone!

So concludes our prospectus.

Why I should be batting for the other team (no, not that team)

I'll admit it. I hate medicine. And not just a bit. A lot. More and more I feel that I'm stuck in a godforsaken six year long ordeal with no way out. As much as it pains me to say so, I've realised that all along, medicine was not my destiny – it was the dark side of the force – law.

There has always been a strong professional rivalry between law and medicine. Doctors and lawyers are society's elite. We on the medical side of things have always been quick to claim the moral high ground. We are the ethical, altruistic ones who truly care for people. We communicate and empathise. We heal. On the other hand, lawyers are professional scum; backstabbing, morally bankrupt people whose insatiable avarice leads them to commit acts of sheer barbarity. Like many of my peers in the medical fraternity, I once shared this opinion. That is, until recently.

No, it was not by the grace of a divinely inspired epiphany that I started to question my belief in medicine. Rather my old sentiments of righteousness and optimism about my colleagues been gradually chipped away by the pickaxe of cynicism.

Lets face it, as much as med students at Hilmer Corp. Med School say it's not about the money, it really is. When the inevitable salary comparison comes up, doctors never come out on top, acknowledging that 'helping people' might make us well off - but I say not nearly rich enough. Even in private practice, the top medicos can only hope to earn a fraction of a mid-tier lawyer or law-dropout investment banker. Yes we'll be flying business class and driving 3-series BMWs, but we save people's lives for God's sake! We should be flying first, and shouldn't be caught dead in anything lower than a 5 series Beemer.

People tell me "oh, but it'll be worth it in the end, because you'll be a doctor!" Wrong. With the insight of a deaf, blind mute, they tell me that the warm, fuzzy, inner satisfaction that I may experience in over a decade's time will compensate for the myriad of grievances I have now, and will have in the future. Unfortunately, I can't pay my HECS debt with my 'inner glow' or 'pizzazz'. I can't get wasted at the pub with altruism alone. Few landlords accept 'verve' or professional self-satisfaction as suitable payment for rent.

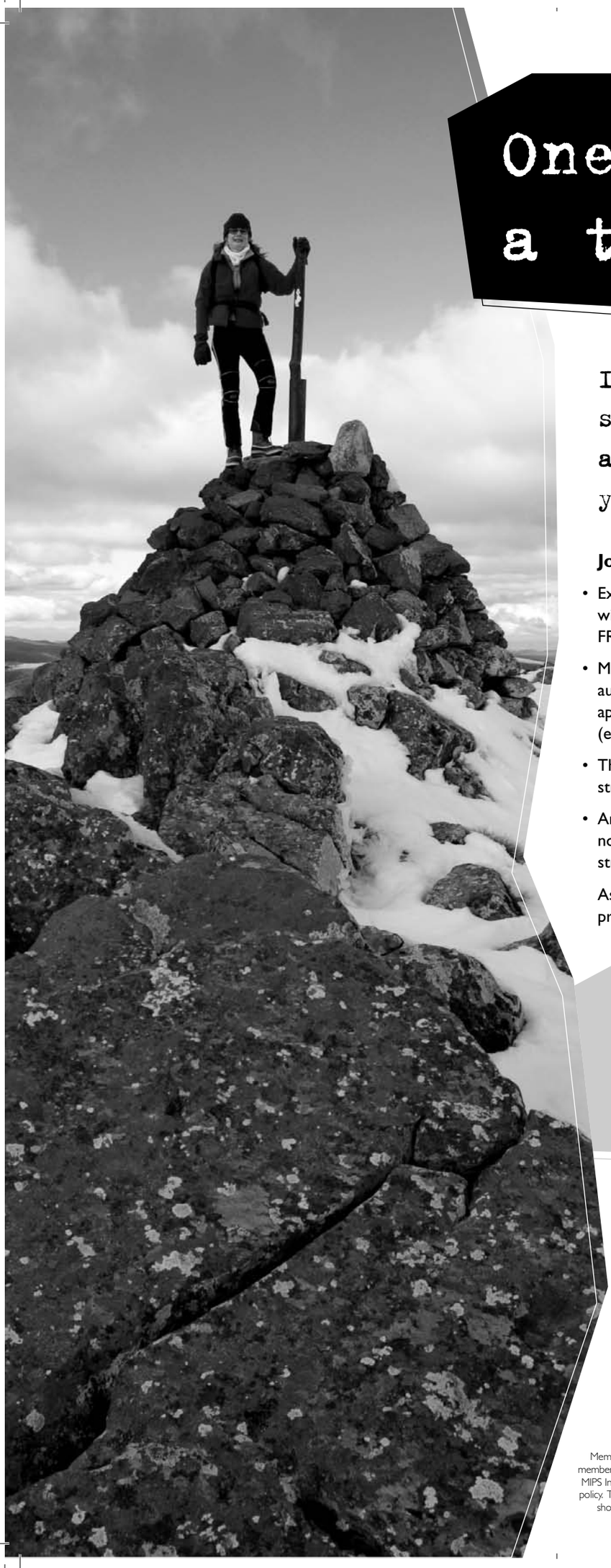
And these gross inequities won't be fixed once I leave med school either. Ten years from now, when we'll all have 'real' jobs, the lawyers and the investment bankers will be living la vida loca on their high six figure salaries, enjoying a nice office in town with a good view and a smoking hot 22 year old secretary; their days filled with whimsical jollity interrupted only by the obligatory lunchtime line of blow. Meanwhile, I'll be slumming it on my 36 hour shifts as an under-appreciated intern at some two-bit hospital in the sticks treating some ungrateful derro who'll either stab me or bleed/vomit all over me.

And let's face it, law students are just hotter. While medicine has the unwashed masses of socially inept nerds, law has the crème-de-la-crème of gorgeous daddy's girls and kept men. The best and brightest of Sydney's WASP beautiful-people set is concentrated in the lecture theatres of law school. Compare that to med school, where I'll be the first to admit that when I'm slaving over the books, falling asleep in Clancy or getting splashed with cadaver-juice, I'm not exactly dressed to impress.

Those who don't believe me would say that like doctors, there are some pretty humble lawyers, they're not all hot shots. But to them I say: they don't count. Just as if you don't do med at UNSW you don't figure as a medical student, if you don't do full-fee-paying law at Sydney Uni, you aren't important. If you aren't smart enough to qualify or buy your way into the best sandstone uni, you obviously haven't got what it takes to be a decent lawyer.

So, now that I've touched on why I think my life as it stands is an inescapable prison of tedium, monotony, hellish hours, overwork and under-appreciation, what are my options? Well, I could always drop out and do law. But that would mean I'd have to mix with all the North shore, full-fee, daddy's boys and girls in first year law. No thanks. I could do graduate law after my med degree, and waste not only 6 years of my life as an undergraduate but then another 4 with idiots in grad law school who weren't good enough to get in as an undergrad – no thanks. Or, like an emo at Town Hall after dark, I could just keep whining about how hard my life is and how no one loves me. Yep, I'll do that.

- Anon Y. Mus



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LIFEHACKER

I call this section Lifehacker, but it's basically an irritated bitch about my perspectives on people, thinly veiled as an article promoting self-improvement. A lifehack is a tech or technique that is designed to improve your productivity in life—these views are mine alone, but I hope that through this article I can spread a little more Jason into your lives. Let's start.

Hack 1 - Always keep your commitments.

I had a friend from my high school in Canberra, he's studying here and last October we were planning to go out to an event which I had bought tickets for months in advance. Two hours before it started I get a message from him, when I clean up the grammar it goes: "Hey dude. At Catherine's formal dinner; can't move, too smashed. Looks like you're going solo."

How did I react? I scalped his ticket and got the idea that to compensate for his absence I would instead get super fucked. That thought eventually led to one of the worst $180 nights I'll ever have. Basically, I think what I'm trying to say is: Andrew Tuckwell, 2nd year BSc major at the University of Sydney--you're not getting your goddamn money back.

Hack 2 - Why the hell would you purchase a phone worth more than $200?

I don't think I'm getting that old, but how come people these days don't seem to acknowledge what a mobile phone is designed to do?

"Oh hey Jason, what does your phone do?"

"Well if you must ask, it keeps my food cold, no wait I'm thinking of 'refrigerator', my bad."

Secondly, you should know that no matter how many megapixels the sensor is: shitty, miniaturised optics will always make camera-phones one of the most useless things ever. So if you're ever looking to buy a camera-phone, consult this handy flow diagram to the right:

Hack 3 - I'm not getting Facebook, you can all remember me in your heads.

This hack was originally going to be called "Fuck you, I'm not getting Facebook..." and I'll tell you why. 38 years ago the internet was born from the minds of men much better than you or I (back then it was called ARPANET). I'm only 20, but I remember a time not too long ago when it was still a gentle babe--as opposed to the many-headed, shit-talking hydra it is now. So what the hell happened?

It was Web 2.0, the era of social networking. I'm talking about sites like Myspace, Facebook, Twitter, Gaia, Youtube, and countless more. Where clueless, self-centred and disrespectful retards with no idea how the world works--now have a voice. Thanks, Web 2.0! Where I once saw the internet as a beacon of pure light, seeding knowledge and advancement… now: "OMG lulz!!!!11 i totlly <3 ur song u rite it juz 4 me yeh?? cuz it tOtAlLy wOz jUsT wOt i wEnT tHrU wif muh bf!! Plzplzplzpz AD mE!!!!!!111 Lub 2 chat! we cn tlk netime =P **ROFLCOPTER ^_^"

The information age is dead, collapsed in a ditch somewhere with a head full of .40 cal hollowpoints. And I never got the chance to tell it I loved it.

Hack 4 - People who have a lot of money should realise nobody cares.

For that matter, so should

- people who are in bands that list their genre as "alternative" or "progressive"
- people who spend an amount of money to customise their cars greater than or equal to the sale value of the car divided by 40 (Satnav or carputers do not count)
- Mac users

Hack 5 - Register as an organ donor at www.organdonor.com.au

Australia's donor rate in 2006 was still the second lowest in the developed world. Please consider registering, you get a donor card printed "I have signed on to save lives". Keep it in your wallet and urge others to register too. If they say no, ask them why. Do it to everyone. Do it everywhere you go. Good places to do so include blind dates, baptisms, and inside the homes of complete strangers at 3am. Even if you lose all your friends, and people start blackballing you for parties, I'll still think you're cool. You can be my friend. We'll watch DVDs.

Hack 6 - Find your passion.

I thought I'd end with something personal which I believe in very much. I believe we all have our calling--something that transforms us, that entices us to define our lives around it. Even if we don't make a living out of it, we make a living to pursue it; because we realise fulfilment isn't based on our jobs, bank balances, or reputations--but how we find individual meaning amidst our singular, fleeting lives. Even if you lose everything else, I hope it'll still be there with you.

You'll notice that once you find it, life becomes more positive, you become a more focused person and it will show. If the way I end this article seems lame, then that's your problem. Anna Eleanor Roosevelt: the future belongs to those who believe in the beauty of their dreams.

- *Jason Le*

PEOPLE WATCHING

"Come on, crazy, let's sit over here," says J, dragging me to front of the restaurant so that we can sit by the window. J is German, forthright, and has no qualms about plonking herself down on the sidewalk, to take part in this increasingly popular pastime: so-called 'people watching'.

Ah, people watching. Otherwise known as 'watching the world go by' or 'staring at people while having a coffee.' Frankly, I would rather drown myself in a tub of mouldy jam than join this particular revolution. Mothers, corporate workers and gay men are all privy to having a squiz. Even in the suburban shopping malls of Sydney's northwest, one is bound to find a flock of seated coffee drinkers scattered among square tables, exchanging gossip, stock exchange tips, and generally staring other shoppers down. Only when a wary shopper turns around to give the glare back, do people watchers retreat, glance quickly at their watch, or divert their gaze to their lightly dusted brownie.

As you can probably tell, I find all of this 'people watching' business rather disturbing. First of all, when I am at a café having a coffee with someone, it is courteous to actually concentrate on the person I am talking to. If I am alone, then I prefer to enjoy quality time with my trash magazine. Secondly, people watching at cafes, you as the watcher are stationary while the watched is not. A relationship cannot be developed between the watcher and the watched when one of them is moving at speed. Of course, the watchers also look ridiculous, as their heads move back and forth like clown heads at a fun park. If you are going to stare at someone, you should at least try and be graceful about it. And finally, staring is just plain rude, even if you are wearing dark sunglasses.

"In Germany, it's not rude to stare," says J. "So it's no problem when the watched person stares back."

"But, J," I say, "we're not in Germany. And don't you find it creepy when you see someone eyeballing you from halfway down the street?"

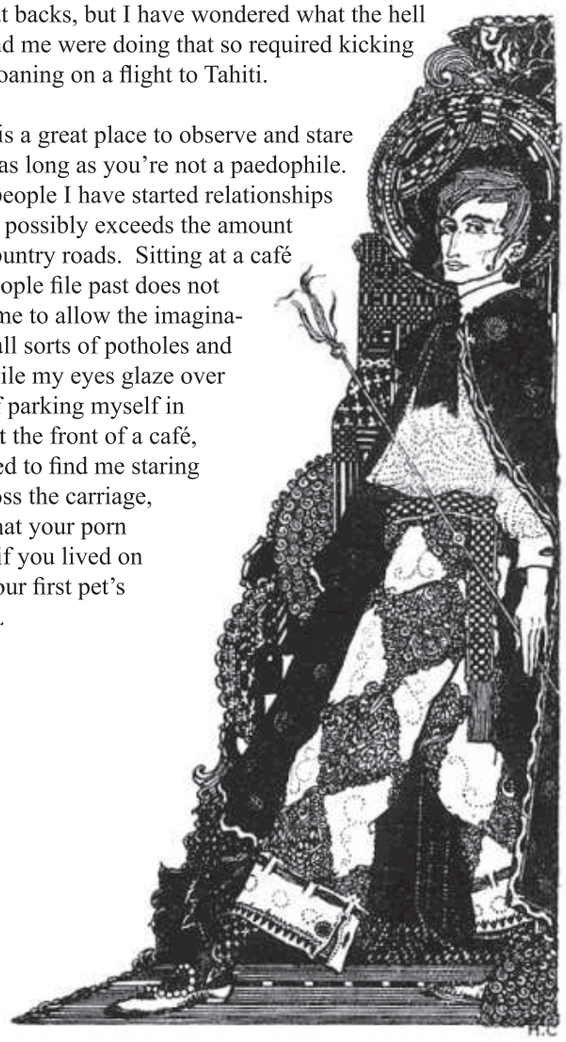
"But then I stare at them back," says J, licking the foam from her spoon.

This is the issue. Staring at other people where the stalking is one way to me is offensive and uncomfortable. I do not, however, have a problem with people watching in circumstances involving mutual eyeballing. This is best represented by the situations created by commuters in transit. After all, when motion sickness is the menu du jour, there is nothing to do except watch other people. When in an enclosed space, fascinating events and insights can be observed. Below are some examples of places and situations where I believe people watching is completely acceptable:

1. The bus. This morning I caught the 8.30 bus to the train station. As I had an appointment in the city that was later than my usual leaving time, I ended up missing the work commute, instead crashing straight into the school commute. Not having had many opportunities to be around children recently, I put down my book and had a look around. Three Down syndrome children at the front teased each other with loud giggles. A baby cheeked kindergartener sat with her backpack straps pulled tight, her dangling feet not touching the ground. An African boy with cocoa bean skin rubbed his spongey hair into the arm of a mischievous blonde. The physical freedom and the lack of self-consciousness the kids had were spellbinding. I got off the bus with a reinvigorated faith in the openness of children's minds and bodies, as well as observation.
2. The train. Last week, despite my efforts to concentrate on the music I was listening to, I found myself mesmerised by a guy in his late teens, all beautiful almond coloured skin and electric blue eyes. His hair, which was naturally dreaded, sprung from his head like a palm tree. As I gazed openly at this creature, I found myself wanting to ask, who was he? Where did he come from? How did he get his hair all bushy-tailed? Was I a pervert for wanting to know what it would be like to make out with him? Would it be totally inappropriate to strike up a conversation? He got off the train at Central, but the dialogue in my head kept me highly amused until I reached my stop.
3. The car. At the traffic lights the other day I watched a middle-aged man and throw his hands up at the radio and a young Mediterranean couple start getting into some seriously heavy petting. The silent movie in the rear view mirror is truly fascinating. Once I even caught a co-worker head-banging to what was most likely Kylie Minogue on the radio. It's funny how people forget that windscreens are see-through.
4. The plane. This is slightly more difficult due to the height of the seat backs, but I have wondered what the hell the couple behind me were doing that so required kicking and orgasmic moaning on a flight to Tahiti.

Being in transit is a great place to observe and stare at other people, as long as you're not a paedophile. The amount of people I have started relationships with in my head possibly exceeds the amount of roadkill on country roads. Sitting at a café and watching people file past does not allow enough time to allow the imagination to run into all sorts of potholes and crevices. So while my eyes glaze over at the thought of parking myself in prime position at the front of a café, don't be surprised to find me staring at you from across the carriage, daydreaming what your porn name would be if you lived on Galore St and your first pet's name was Pussy.

- *Nicole Lee*



Faghag

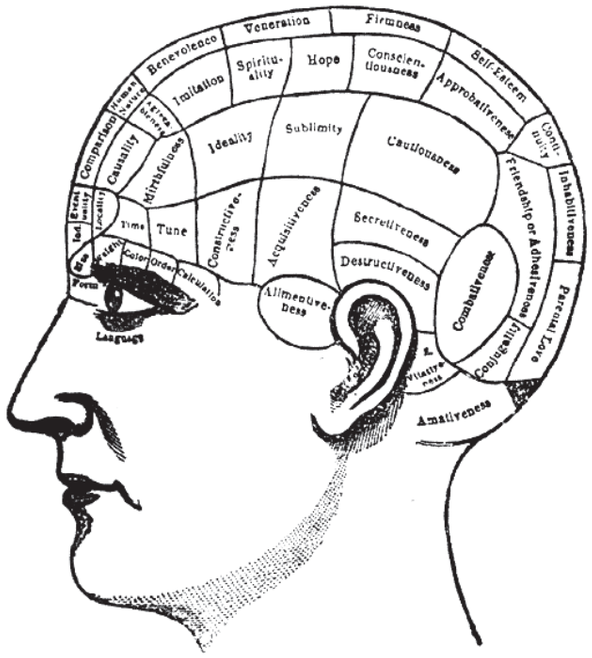
The perfect man is gentle,
Never cruel or mean.
He has a gorgeous smile
And keeps his heart so clean.

The perfect man loves children
And would raise them by your side.
He would be a good father
And a husband to his bride.

The perfect man is sweet,
Writing poetry from your name.
He's a best friend to your mother
And kisses away your pain.

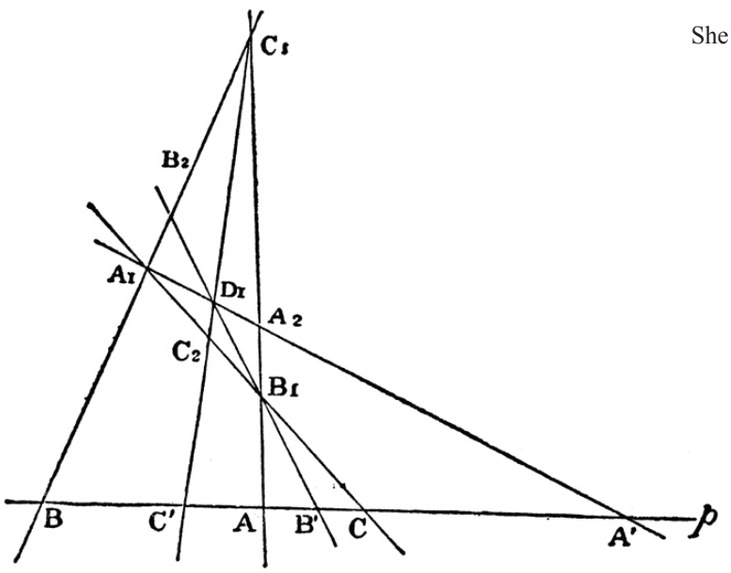
He has never made you cry
Or hurt you in any way.
To hell with this endless poem
The perfect man is gay.

- Aditi Vedi
Med VI



Strange! That such symmetry of form,
Such grace as might outrival cupid,
Should fail one female breast to warm -
Sure the girl's either blind or stupid.

- Anon



Poem

As sultry summer days become hot midsummer nights,
The moon beholds Sana's sleep,
Her tresses shining bright
A blade of blue-white starlight
Cuts sharply through the panes,
And Sana wakes with rosy stains
Like cupids blushing deep

White jasmines and gardenias, and crab-apples in bloom
send floating floral fragrances
to the sleepy little room,
they mingle gently, playfully with Sana's own perfume
Redolent Sana gazes round
Her lambent smiles are all abound
And warm with radiance

She's beautiful, her honey skin, her glowing, gleaming face,
Bow-like lips with doe-like eyes
And a nightgown full of lace
Sana holds her blanket with an innocent embrace.
But wait. Its night. Its time
For work, to sweat for gold, sublime,
She paints her face with lies

She sits before a mirror, her mouth a carnal red
Her eyelids shaded vivid blue
The eyes rimmed heavy lead,
The tubes from which these colours bled
Now roll along the floor
While Sana strides toward the door
To earn a buck or two.

- Anon

From The President

This is a very exciting time to be a medical student at UNSW!

As one of the 1,392 students currently enrolled in the Medicine course at our University, the representatives that you elected to our Medsoc have been working hard throughout the year to keep you informed of changes in medical education and provide events that are interesting and relevant to you. While many are willing to keep a distance when it comes to politics and policy, more and more students are becoming cluey to the fact that changes occurring in the coming years will not only affect their time as medical students, but also ultimately impact their careers as practicing doctors as well. In the face of the opening of new medical schools to address the growing shortage of doctors, students at our University must be aware of the need to continue our status as one of the most prestigious schools in the nation. Your input matters!

Medsoc has also made it a priority this year to ensure your thoughts about our course are considered. Together with the Faculty, which has put together a magnificent, newly-integrated curriculum with a much stronger research and teaching focus, we have established means for you to supply your feedback to us so that together, we can do our part to help refine and improve the course in a continuing and never-ending manner - and maintain the strength of the education you receive. Whenever you have a suggestion to make that you think might make a difference, you can contact your one of your Year Reps, who will then relay your feedback to our Faculty Liaison Officer. The contact details of your Year Reps can be found at our website: www.medsoc.org.au (in addition to many other goodies, which you may or may not have noticed yet!).

So, what else have we achieved this year as a Society?

If participation at our functions and events is anything to go by, 2007 has proven to be the most successful year we've had to date!

With each event, it seems UNSW students are continually breaking records. Over 162 first years came along to celebrate at our annual Medcamp at the NSW Sport and Recreation Centre in March - the largest number that has ever attended one of our camps! This was remarkably followed up by a turn-out of 65 students at the March Medsoc meeting, which many regarded as being less of a meeting and more of an event! UNSW Medsoc also had its biggest team attending the annual Australian Medical Students' Association Convention in Adelaide in July this year - the 63-strong delegation represented an increase of over 200% from the previous year! It appears more and more students are not only taking an interest in medical issues, but also seeking to squeeze as much fun out of their time at University as well.

It is also remarkable to see so many of you taking advantage of the recreational and career-enhancing opportunities in our weekly email newsletter! In addition to the many events that we regularly publicise, some students have worked with Medsoc to help explore their own areas of interest within Medicine. For instance, as they reported at our meeting in April, Dev Nathani and Amrita Ronnachit represented our University at the International Federation of Medical Students' Associations General Assembly in Mandurah, Western Australia. Both came away enriched with a greater understanding of international medicine. In May of this year, Michael Chan, one of our First Year students, proposed a head-shaving fundraising event to raise money for the Cancer Council of NSW. MedShave became a reality - and thanks to the participation of many of you (especially our First Years), Medsoc raised $3,300 to go into areas of research and supporting patients and families in need. At our May meeting, one of our Final Year students, Michael McKeough, requested Medsoc's assistance in producing a series of educational, entertaining videos teaching students how to perform clinical exams. Most recently, Halli Kleinig and Natalie Russell approached Medsoc to help assess interest in setting up a student-led and assisted medical clinic in Redfern/Waterloo, based on their analysis of models overseas. This will more than likely prove fruitful as they identify those interested students from our University. Medsoc is always keen to help promote student vision and initiative. Perhaps you are yet to realise how Medsoc might be of greater use to you also! Keep your eyes peeled to our weekly newsletter (which you should be receiving automatically) for even more opportunities. If you haven't been receiving our informative email digests, simply email askmedsoc@gmail.com and we'll make sure that you are not left behind.

Our Society is also very well represented at the State and National level. There is much anticipation going forward with the official launch of the New South Wales Medical Students' Council on the horizon early next year, which will function in cooperation with the other medical schools in our state. If the first meeting, which was held on August 18, is anything to go by, there is much to look forward to on both a social and educational level!

It has been truly wonderful to meet and get to know many of you in my role throughout this year. As a student body, you are represented by an amazing team of students with whom it has been a real pleasure to work alongside.

Although we may or may not have crossed paths yet, I want to wish you every success in your future endeavours as you strive to make a positive difference in the world.

See you at our next meeting!

In the moment, for the moment,

- Jason Kiang
President, UNSW Medical Society

IFMSA Report

Report from the March Meeting of the International Federation of Medical Students Associations held in Mandurah, Australia.

Few of you reading this would be aware of the International Federation of Medical Students Associations (IFMSA) or the fact that they held their 56th General Assembly in Mandurah, Western Australia from 7-12th March 2007. Three medical students from UNSW were given the privilege to represent Australia at this Meeting which attracted over 650 delegates from all over the world.

So, what is the IFMSA?

The IFMSA is an independent, non-governmental and non-political federation of medical students' associations throughout the world. It has more than 102 members from 95 countries on six continents and represents over 1 million medical students worldwide. It is the premier medical student organization devoted to international health, social justice and equality throughout the world.

General Assemblies are held twice a year, once in March and once in August in different host nations. Delegates meet to exchange ideas and discuss the various projects and initiatives that have occurred throughout the year in their respective countries.

The theme for this meeting was rural and remote health. Several prominent people were invited to address us regarding rural and indigenous issues including keynote speakers like Dr. Mukesh Haikerwal (2006-7 AMA President), Hon Tony Abbott (Minister for Health) and Prof Gavin Mooney (Professor of Health Economics, Curtin University of Technology).

IFMSA functions through it's 6 Standing Committees: Professional Exchange, Research Exchange, Public Health, Human Rights and Peace, Reproductive Health including AIDS and Medical Education. One of our delegates was assigned to the Committee on Public Health. Here, we were all divided into several small working groups to discuss issues like climate change, tuberculosis, malaria, smoking, road safety etc. Another was a member of the Committee on Human Rights and Peace where we discussed refugees, displaced peoples, environment and health and rape as a tool of war.

Training programs on a wide range of topics like fundraising, project management, leadership, conflict management, strategic planning, presentation skills etc are conducted at each assembly. The wonderful aspect of this training is that it is conducted by medical students themselves who have previously undergone similar training and thus know what kind of problems we face.

An hour is set aside every day for the delegates from each country to meet among themselves to discuss what they have learnt over the past day and how they can implement the ideas they have gleaned into their own medical schools.

Several three-day long workshops are held before the beginning of each general assembly. The topics of these workshops vary from year to year. This March, we had workshops on Training New Trainers, Tobacco and Chronic Diseases, Presidents Workshop and International Peer Education Training (which I attended). We were taught motivation and communication skills, project planning and management and using drama and theatrical art in peer education.

Overall, it was truly an amazing experience. Meeting motivated medical students from across the world was tremendously inspiring. We strongly encourage anyone interested in international health to attend this conference. Australia can send up to 16 delegates to each meeting and AMSA usually covers the registration fee that includes food and accommodation. Our University has been extremely generous thus far by paying for the registration and flight tickets for all 3 delegates to the March Meeting this year and the flight tickets for the delegate from UNSW who recently returned from the August Meeting in the UK.

We could go on and on about the work of the IFMSA but in the interest of time and space, We leave you with the following link which contains almost all there is to be known about IFMSA: www.ifmsa.org. Feel free to approach usme if you need more information about IFMSA.

- Dev Nathani
Med II

- Amrita Ronnachit
Med VI

MSAP Report

MSAP launches its 2007 flotilla of medical supplies for the developing world

The University of NSW Medical Students' Aid Project (MSAP) marked its sixth consecutive year delivering medical aid packages to under-resourced hospitals in developing countries at its Annual Launch on Wednesday 15 August.

Those who attended enjoyed dinner, drinks and live music before MSAP co-chairs Nikki Bart and Karl Ruhl announced the 15 health facilities that MSAP would be supporting this year. Three engaging and passionate speakers then related their own experiences in trying to make their world a more equitable and healthier place. Lucy Hobgood-Brown spoke of the challenges and rewards of her experience in establishing a development-focussed NGO in the Democratic Republic of Congo; Prof John McDonald spoke passionately about how medicine was an important part of a much broader solution to ending third world poverty and hardship; finally, Dr Rowan Gillies shared some fascinating experiences in providing emergency medical aid in his role as president of Medicins Sans Frontieres.

For MSAP, the year is divided into two halves with very different operational focuses. While the first half of the year is geared towards fostering greater awareness of the organisation, fundraising and collecting medical supplies from donors, the final months centre on the logistics of transporting the collected equipment to where it is needed and wanted most. The individualised nature of MSAP's operations, where equipment is not merely assumed to be needed, but is sent in response to requests by hospitals, is one of MSAP's defining and most valuable qualities. This ensures that all aid provided is appropriate to local needs, technology and expertise.

On 15 August MSAP marked the beginning of these final months, officially launching its 2007 aid program. Having spent many months collecting equipment and raising funds, the launch marked the beginning of the actual delivery of these much needed supplies.

MSAP is run entirely by UNSW medical students who collect used, expired and superseded medical equipment from Australian healthcare facilities. These supplies are catalogued, matched to hospital wish-lists and finally packed and shipped to their destination with a medical student on their elective term.

To find out more about MSAP or to make a donation of equipment, money or services, please email us (msap@med.unsw.edu.au) or visit our website www.msap.unsw.edu.au and help us make a difference to developing world health.

- *Karl Ruhl*

AMSA Report

The UNSW juggernaut has continued its stampede in semester two, making itself known to all medical students in Australia through a convention campaign that saw us in different positions that were impressive, strange or just downright disgraceful.

A record number of UNSW students descended on Adelaide in the early days of July, knowing that it was up to them to show that their university was a force to be reckoned with. The team was strong, and knew that by supporting each other, greatness could be found that hadn't been seen since the introduction of vaccination programs, not to be mention creating a love that would make Leo and Kate's on the Titanic look second rate.

The week started off with the customary disposal of Sydney Uni in the debating. There has rarely been such an enjoyable pastime for those of us that come from the greener pastures of UNSW, an enjoyment perhaps only matched by the great man from UQ, Nick Jorgenson, parading around all week in a mankini. The debate signaled UNSW's intent, and the team was to go on to narrowly lose a final to UWA. Jennifer Lim and Shree Basu were sensational in a team that will look to go one better next year.

Undoubtedly the highlight of the week, was the emergency challenge, where the UNSW team captained by Alex Splatt and including Johnny Hogden, Ano Navaratnam, Natalie Sancardi, Tim Cooper and Eileen Morrisroe, were able to communicate, problem solve, and diagnose their way to first place on the day. It wasn't all plain sailing though, and an inability to use a walkie-talkie hampered the team's efforts, but at the end of the day, the empathy and compassion of UNSW pulled through, and even if the patients were going to die, at least we were sitting with them, letting them know we understood. We also had the best costumes of the day (see the photos) but for some reason a mistake was made, and the award given to UWA.

The final formal moment of great pleasure came from taking the inaugural title of Australia's Nerdiest Med School, through Chris and Shanthi. The competition, hosted by HG, showed just how much we knew about unimportant political, geographical and historical facts. Out of the three major events (because only Adelaide cares about boat races) we had won two, and were runner-up in the other. Not bad for a university whose best result before had been a second place last year.

Perhaps most exciting of all though was the announcement at the end of convention that UNSW's first interstate engagement as a result of convention last year had been initiated. We are disappointed of course that the gentleman involved is from UTAS, but we have been given assurances that amniocentesis and CVS will be performed on all future babies to ensure there are none of the regular abnormalities that are commonly found among for apple Isle down south due to strange breeding patterns.

There are many issues that continue to dominate AMSA policy making. By far the biggest of these is the increasing number of medical students that positions have been made available for in Australia. While it is clearly in peoples' best interest to have more doctors, the lack of training places in hospitals to cope with these rises is worrying in the extreme.
Changes for the better have been made in the bonded medical places scheme, allowing for more flexibility and fairer conditions for bonded students. This progress is just one example of the work AMSA does in lobbying government to achieve a better outcome for medical students.

As always, if you have any concerns or queries feel free to address them to j.alexander@student.unsw.edu.au

Much Love,

- *Jamie Alexander*
AMSA Rep

First Year Rep Report

Hello UNSW Med! I'm Pearl, one half of the first year representative-ness. It all started with the traditional initiation dinner at pancakes on the rocks, where Jen and Minty handed over their years' effort and paperwork. From then on it's been an absolute crazy, fun, stressful time. Our first real job was to organise the phase one party where 200 first and second years partied it up.

This gave us some experience by the time the end of session party came around. Monthly Medsoc meetings and promotions have become part of our routine (Anthony and I scratch our heads furiously before lecture shouts to make them more interesting). The BBQ was also a unique experience - I apologise for the half raw sausages.

We are only the representatives of our awesome grade, whose support in the Medsoc events has been overwhelming. I was really encouraged by Mike & Maria. Their work with Medshave surpasses anything we've ever done this year! I'd also like to thank Anthony for being the more laid back and better half; you've become a great friend ;)

I've received so many comments from other years that Med 1 is both extremely studious and partylicious. I like to think we're a good balance! That's it from me. I'm SO excited about all the other events coming up such as medball, medshow and medcamp. See you there okay!

- Pearl Wang
Med I

Life in Phase One 2007

Aside from roughly 200 hours of lectures, 92 hours of scenario group and in some cases over 300 hundred hours spent on medlawn, the Phase One-ians have had an actioned packed year. We've had the privilege and opportunity to get involved in a heap of activities and events over the last twelve months.
After morning the loss of our 3rd year colleagues after Ageing and Endings, the second years were faced with 300 new first years. Integration party at Star Bar gave use the chance to check out each other (some to a greater extent than others) before starting teaching and learning activities together.
During the year the students of phase one took part in barbeques on medlawn (added excitement with the gas bottle running out midway through), were integral in organising and participating in fundraisers including the inaugral "Medshave" and the third Amazing Raise, attended academic symposia, a whole host of activities organised by RAHMS, AMSA annual convention in Adelaide as well as other conferences, participated in other uni-wide groups as well as more medically focused ones e.g. MSAP, MSC and GPSN. We played a key part in acting, dancing and laughing our way through Medshow.
Medball and End of Session 1 Party at the Beauchamp Hotel were attended by massive numbers of Phase 1 Students, a demonstration of the fact that despite multiple learning activities on the impact of drinking, we still know how to have a good time.
Phase 1 2007 has been an eventful year full of surprises from the existence of an almost regular timetable to the continual realisation by lecturers after photocopying sheets that there are in fact now more than 500 of us. Days consisting of class, playing the "guess how to get into bio-med" game and mysterious disappearances of SGS rooms, sitting in the sun, drinking multiple cups of coffee and maybe picking up a little bit of medical knowledge along the way, have been enjoyed by the Phase One-ians of 2007.

Good luck to the second years as they approach end of phase 1 and to the first years as they are attacked by a fresh onslaught of new faces next year.

- Claire Lawley
Med II

THE JAUNDICED SUDOKU

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- Aditi Vedi
Med VI

ADVERTISMENT

Frustrated that your registrars and consultants fail to turn up to teach?
Angry that they don't answer your pager calls?
We have the solution - presenting...

VMO V-Doo Doll '07 For Medical Students (Ironic Punishments Pty Ltd)

Instructions:
- Wait 5 minutes for page to be returned
- Wait another 30 minutes
- Breath and count to twenty
- If applicable stop swearing
- Insert pin into desired location, depending on your sadistic creativity
- Enjoy!

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