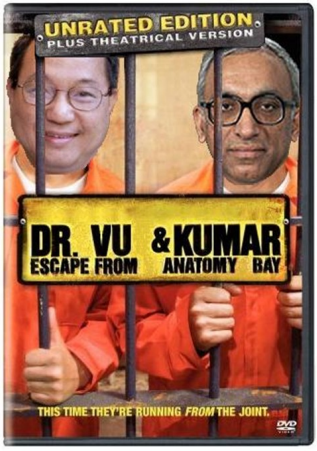
university of new south wales medical society

Idioglossia 2010

Official Journal of the
Medical Society of
The University of New South Wales



UNSW's favorite medical pals, Dr. Vu and Prof. Kumar, return with an uproariously un-PC sequel that starts with an impromptu trip to the Mecca of Medicine. There, Dr. Vu will unite with the cadaver of his life and Kumar will achieve pathological bliss.
The two soon find themselves in hot water when Kumar sneaks a microphone onto the flight and is mistaken for a bomb-wielding terrorist. This leads to the two landing in the hottest water of all: Anatomy Bay, Wallace Wurth.

Frequently raunchy but reveling in the bonds of education and teamwork, DR. VU & KUMAR ESCAPE FROM ANATOMY BAY is a madcap romp that delivers plenty of humorous manic highs.

"Kumar and Vu's appeal as a bickering duo is undiminished... reflecting on the emotional depth of the story gives one a case of cutis anserina. P+."
- Justin Chau, EMPIRE.

Editor: Claire Ruan

Acknowledgements

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President's Report - 2010 According to Vekram

Tumultuous, controversial, exciting and pioneering are just some of the words that come to my mind when I look back at this year. Our major aim was to increase the collegiality within UNSW Medicine and add more life to our course. Several new events were organised and many new initiatives were enacted while we retained all of our Medical Society's most treasured traditions.

We opened the year with Jazz on MedLawn – a new event designed to kick start the year and embrace our newly restored (and slightly minimised) MedLawn. MedCamp returned to the wonderful location of Wiseman's Ferry after an exodus of many years. The second year leaders rocked. The first years rocked. MedCamp rocked. Our social events were well organised and amazingly attended. MedBall was phenomenal with the inaugural college cup presented for the first time. There is no doubt that College C will win next year.

Our charities team organised several events including the amazing raise. On a personal note, I'd like to congratulate my fifth year team for finally breaking through and winning the race after so many years. Altogether, charities raised over $10 000. This figure does not include the thousands of dollars donated by Medshow through its incredible production of *One Flew Over the Neural Crest*. Academically we hosted several events and this was supplemented by the many special interest societies created by enthusiastic medical students. Communication between students and the faculty continued well this year and we were very grateful to be able to contribute to faculty planning.

The year has not been without controversy though. My opening speech to the first years was colourful and so were the reprimands that I received afterwards. I still stand by everything that I stated. We do have the best medical students in the country and for the rest there are second-tier universities and/or graduate medical degrees. . It seems, new medical schools have been popping up at any tertiary institution that wants to increase their prestige. UWS, Wollongong, Notre Dame and New England have all opened medical schools since 2007. As a result UNSW has lost teaching places at many of our previous clinical placements for students. Since this surge of medical students, we are also witnessing the bottle-neck for internship places with many of our own graduates uncertain about internship positions. As I write this article there is discussion that Charles Sturt University may also be opening a medical faculty to address the problems of rural medicine. It really is quite worrying, not just at the medical student training level, but also at the vocational training level.

President's Report - 2010 According to Vekram

On a lighter note, the controversy surrounding the now infamous Medshow promotional video was unbelievable. The satirical video starring a former legend of Medshow '06, me, made reference to the fact that Medshow does not feature any non-medical students, or 'defects' as they were referred to. The furore from some angry yokels was incredible. The sentiments were particularly rich considering that these people recycle the same jokes about sex, masturbation and menstruation while simultaneously making outrageous jabs at every group under the sun, with their favourites being the disempowered. They may be proficient at delivering these jokes, but they don't receive them well at all. Honestly, just lighten up.

If there is an area that has room for improvement it is our enthusiasm for medical student life. We have the intelligence, the skills and the charisma to do so much more for our cohort, our faculty, our university and our fellow neighbours. At AMSA Convention this year I saw this enthusiasm in the 80 delegates that we had. We need all our members to transform this energy into day to day life at our university. We should be able to take risks and not fear failure when we are reasonable in our expectations. I can see glimpses of this drive to change in the younger years and I honestly hope that it will continue to grow in subsequent years. We study at an amazing university, but it is amazing because of us, its graduates.

I would like to thank my Medsoc Executive, Council and Warrane College for all their help this year.

I will end by stating what an honour it has been to serve as President this year. As a final year medical student in 2011, I will take a backseat to all the awesomeness that I can expect in the coming year. I am certain that Michael Chan and his team will deliver.

Best of luck,
Vekram Sambasivam

UNSW Medical Society President 2010

Academic Events - Lokiny Gnanendran (Med IV)

MILITARY MEDICINE NIGHT

14th of April, 2010

Military Medicine Night informed the students as to what is involved in working as a doctor in the army. A medical professional in the army faces a multitude of challenges of war, humanitarian relief, quality medical practice as well as peacekeeping. This night touched on values of duty, service, courage and honour. Guest speakers, Dr. Mary Langcake (Air Force), Dr Peter Smith (Navy) and Dr Michael Campion (Army) informed and inspired us, and made us all consider life as a military doctor.

WOMEN AND CHILDRENS' HEALTH NIGHT – Obstetrics, Gynaecology, Paediatrics and Sexual Health

3rd of August, 2010

A much awaited night on the Medsoc academic calendar, Women and Childrens' Health Night was a night to remember! With inspiring and entertaining speakers, Dr Julee Oei, Dr Terri Foran and Dr Neil Campbell, the students were given a realistic view of what working with women and children entails. This night informed students of the specialist pathway and work they will be involved in if they choose to go down the path of Obstetrics, Gynaecology, Paediatrics or Sexual Health.

ACADEMIC SYMPOSIA and UNSW ORTHOPAEDICS SOCIETY OPENING NIGHT

5th of August, 2010

Orthopaedics Night was a great success with reputable guest speakers Prof George Murrell, Dr Stuart Myers, Dr Bernard Schick and Anne Gibbons. They discussed their experiences in orthopaedics, the pathway they took and what made them choose the specialty. The pathway to becoming a referring consultant for a sports team was also discussed! Overall a great night that was both informative and motivating!

MEDBALL 2010 - A Parisian Affair

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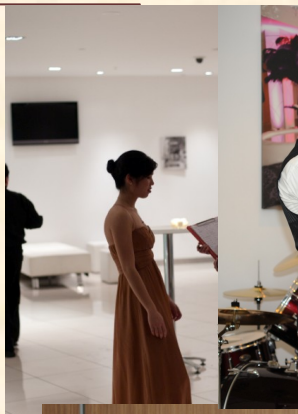


MEDBALL 2010 - A Parisian Affair

AMSA Report - Tess Kennedy (Med VI)

Last year, I had a dream: to make 2010 AMSA-licious. And that it certainly was.

Quick facts:

3 National Councils, with up to 4 UNSW reps in attendance

35 new AMSA Subcommittee members

80 Avatars descend upon Hobart

14+ new policies passed, even more updated

1 top priority in advocacy: Internships feat. quality medical training

Not everyone knows what AMSA is, what it does (NOT just Convention!), or why you need it. I put it to you that those questions are worth answering. For one, AMSA has identified the 'Internship Crisis' as a key target area for advocacy.

What's the deal?

From 2005 onwards, medical student numbers have been increasing – bigger intakes, more schools – and NSW is feeling the heat. For the first time, internship in 2010 was not assured to graduates. IN fact, across the country, around 80 grads, mainly international students, won't have jobs next year. And this number will rise in the next few years, possibly to include local graduates (who are currently guaranteed places only until 2013). Also, you aren't a fully qualified medical practitioner until you've undertaken internship here – which means it aint as easy as "oh well I'll go work overseas".

What's AMSA doing?

In short? Making noise where the people who matter will hear it. Press releases, creating policy, discussion papers, all to make sure that our cries to ensure the ability to complete undergraduate studies to become a fully registered medical professional are heard and met, without sacrificing the quality of those training places.

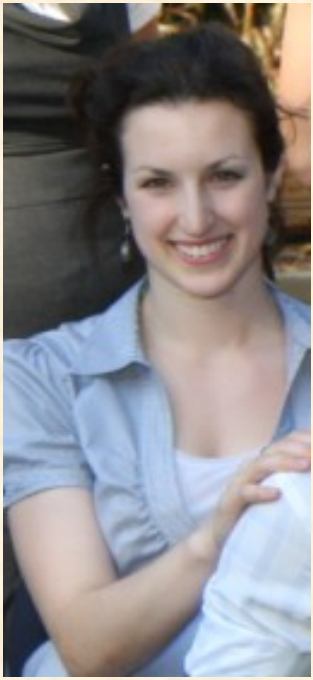
In long, a hell of a lot more! I don't have the space here to detail what goes on behind the scenes, but suffice to say this year AMSA reps received 146 specific tasks to complete from the AMSA exec, and I have dealt with over 500 AMSA related emails, according to my Gmail labels: everything from commenting on AMC accreditation standards to sorting out team jumpers for Convention delegates.

AMSA Report - Tess Kennedy (Med VI)

What do I do to get involved?

This year the AMSA Subcommittee got up and running in a somewhat more regular way – we focused on the internship issue and commissioned a group to help with the Medical Student Survey for the NSW MSC. However the ongoing usefulness of the groups relies on students interested in medico politics, policy making and advocacy to step up and make sure UNSW, as well as med students at large, are heard. Here's a practical checklist:

- Go to subcommittee meetings
- Apply to be an observer at Council
- Write policy on an issue you are passionate about
- Go to Convention / GHC
- Check out the AMSA website for competitions, community initiatives and more
- Contact the Medsoc AMSA Rep for more info. For 2011, it will be Henry Ainge Allen, amsa@medsoc.org.au.



So on that note, I want to thank Medsoc, AMSA and all those involved particularly in the executive and councils of both organizations for an AMSA-licious year, and say farewell to UNSW for now as I head out into the big wide world of doctoring. It's been an honour to work with and represent you in various capacities over the last 6 years.

Over and out.

Tessa Kennedy

UNSW AMSA Representative 2010

Going Rural - Is it really as bad as everyone thinks?

Holly Manley (Med IV)

Despite rural campuses being highly sort after clinical placements at other universities around New South Wales and Australia, at UNSW the rural clinical schools are always undersubscribed. We still don't have a complete understanding of why so many students are reluctant to go to a rural campus.

This year MedSoc and RAHMS were able to offer rural students financial support to organise social and academic events at their campuses. Rural students were also given the opportunity to video conference into academic events such as exam information nights, elective information nights, Orthopaedics Night, Women's and Children's Health Night, Military Medicine Night and Emergency Medicine Night. Video conferencing means that rural campus students can see the power point slides, hear and see the lecturer and ask questions over the microphone.

Past rural students have told us that they really enjoy their experience. *"There are fewer students to compete with for ward rounds, clinics and surgeries."* (Albury Student) *"You get lots of tutorials from consultants."* (Port Macquarie Student) *"The administration staff at the clinical school are really helpful and supportive."* (Wagga Student) *"You get really good experience and make great friends."* (Coffs Harbour Student)

However, not all feedback is positive: *"It was really hard to adjust and move to a new place after living in Sydney for four years."* (Port Macquarie Student) *"I didn't like how the courses were timetables throughout the year."* (Wagga Student) *"I didn't want to go at first but after a while I started to enjoy myself and now it has been a good opportunity to try something new."* (Albury Student)

There is always that group of students who want to go to a rural campus for phase 2 or 3 – most are going because they have organised it with friends or family. But as rural clinical schools are undersubscribed, there are often many

Holly Manley (Med IV)

students who are allocated who had rural campuses low on their preference lists.

This year we introduced a new event targeted at all students going rural but especially for those who did not have a rural campus as their top preference. The information evening was held on the Kensington campus and involved video conferencing with students who currently studied at each of the rural clinical schools. New students were able to ask questions and hear about the current student's experiences moving to, living in and studying in the rural areas. The new students also got to meet other students moving to their rural campus.

This event received excellent feedback and I hope it is continued in the future. I believe that if UNSW medical students understand that rural campus students are just as supported as their metropolitan counterparts and can hear the experiences of previous rural students, we might be able to change the stigma associated with studying at a rural clinical school.

MedSoc and RAHMS offered a lot of support to rural students this year and I know this will increase in years to come.

Faculty Liaison Report - Katie Chen and Arushi Madan

Faculty Liaison Officers (FLOs) are essentially the bridge between Medfac and student opinions and needs. 2010 saw many things happening for the FLOs.

Most notable for the med student body are changes to Phase 2. We have listened to your feedback and as of 2012:

- As Phase 2 will be run through calendar years, there will be no summer teaching period for coursework and no ILPs will be run throughout the summer.
- There will be 6 wks of SH3 and BGD3 in order to give more time to the core medicine areas.
- There will be two HM courses of 6 weeks each and AE will be run as two separate 4 week blocks at different times of the year.

Furthermore, the current ICE will be converted to an OSCE Exam and a computer -based Biomedical Sciences Exam consisting of 60 MCQs and drag-&-drop questions. This change was to breach the Phase 2 gap between the Phase 1 End -of-Phase practical exams and the Year 5 Biomedical Vivas.

The changes to the Phase 1 structure are already in place, including the calendar year format and the incorporation of the Foundations Exam as an assessable Phase 1 Exam.

Another of our major roles is organising Phase, ILP, portfolio, exams and elective information nights and we hoped these were helpful. A big thank-you to Medsoc exec and council for all your support throughout the year. We would also like to thank Medfac for involving us in faculty meetings and seeking our opinions.

Medsoc 2011 would like to encourage feedback and comments from students because the FLOs will be better bridges if we know what the student body thinks!

Katie & Arushi

RAHMS Report - Nathan Mortimer

The first half of the year has been full of non-stop action for RAHMS with a plethora of events being run and even more on the horizon. Additionally, this year RAHMS has expanded to include an Allied Health portfolio with representatives from Allied Health degrees joining the team. This has allowed RAHMS to design and promote events that are more targeted and inclusive of students from the other professions .

Early in first session RAHMS held an information evening about the John Flynn Placement Program where current JFPP scholars shared their amazing experiences and encouraged new students to investigate the program and the opportunities it offers.

Also during first session, a few lucky RAHMS members took part in an awesome guided tour of the Sydney Royal Botanical Gardens where an experienced guide taught about traditional indigenous bush medicines, foods and culture.

Later in the session, just as things were getting a little tense with exams and assessments on the horizon, RAHMS came to the rescue! Like-minded students with an interest in rural health got together to learn some basic skills in unwinding the nerves and loosening some muscles as they were led through a massage whilst sipping some delicious green tea.

RAHMS finished up first session with our usual end-of-session party where members enjoyed some snacks, a few beers and some great company at the Doncaster Hotel; a great way to unwind before the break and the session ahead.

Of course, there were those who just couldn't wait to get another dose of rural health goodness so, not liking to miss out on a good party, RAHMS was out in force at the National Undergraduate Rural Health Conference (NURHC) with a good portion of the exec and a few lucky members attending the much lauded rural health conference. Our own Matt Irwin gave a presentation and a great time was had by everyone who attended!

Getting back from the break with a full tank of energy and some new ideas RAHMS wasted no time getting stuck straight into second session. The Indigenous Health Night saw some inspirational speakers, including the first indigenous surgeon in Australia (and a UNSW graduate!) Dr. Kelvin Kong, present to a crowd of inquisitive students regarding their experiences and the challenges faced in indigenous health. This was a great opportunity for students

to broaden their understanding of indigenous health and to munch on some delicious bush tucker (kangaroo and damper always go down a treat)!

The second Clinical Skills Night for the year was a great success as eager medical students once again gathered to have some fun and learn some valuable skills for their future careers. Over the course of a couple of fun-filled hours the students made their way through stations of suturing up an unfortunate pig's trotter, measuring blood pressure, performing a cannulation on an artificial arm and the always messy art of plastering each other.

Looking ahead; preparation for this year's RAW (Rural Appreciation Weekend) is now in full swing with the event to be held from the 1st to the 4th of October over the long weekend. As medicine and allied health students from all across Australia prepare to descend

on Dunedoo for a weekend of rural experiences, tidbits and lots of fun and frivolity we at RAHMS have high hopes that this may be the best RAW yet. To learn more about RAW and to sign up for the weekend of a lifetime just head on over to ye old website at www.rahms.org

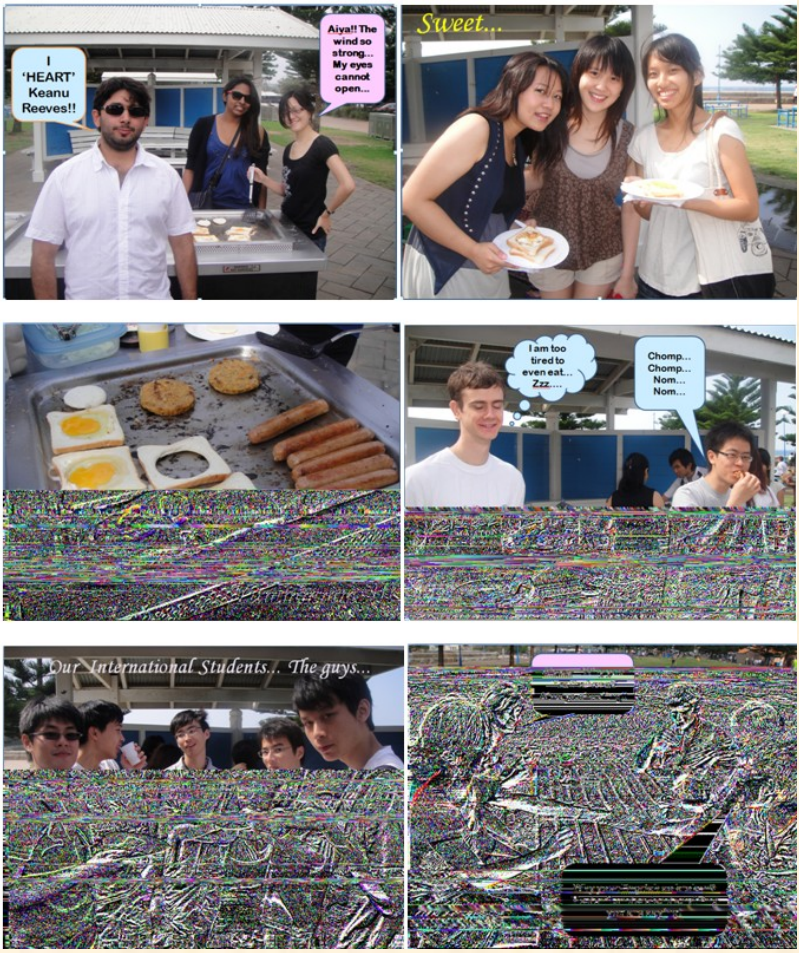
Overall, it has been a great few months and with several months and some of our biggest events yet to come we are confident that the remainder of the year will provide a lot of learning and entertainment opportunities for RAHMS members.

International Report -

Steph Salim and Eileen Phuah

International Students BBQ

Our inaugural event, the BBQ, kicked off on the beautiful beach of Coogee in March before the weather took a colder plunge. Despite it being an international students event, some local students turned up with much appreciated help. The turn out of around 40 students was pretty good, so we were told. It was a great time catching up and getting to know our international students better, under a lazy Aussie afternoon.

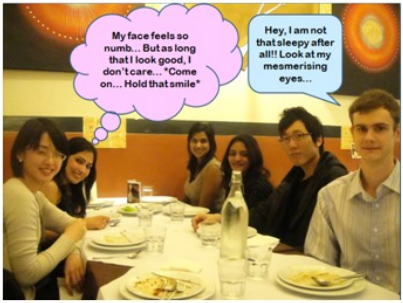


International Report -

Steph Salim and Eileen Phuah

International Students Dinner

Our second event for the year, the Dinner, , was held in August at Thai Pothong in Newtown. We had quite an intimate dinner with 25 students turning up for the event. The ambience was lovely and the food not disappointing. We ended the night with some ice-creams around the Newtown area. A note to future international reps: Pick a place that has easier access... We learnt this when one of our reps was lost herself whilst looking for the venue :P



Medski 2010 - Chris Mulligan (Med V)

Taking leave without play since 2006, the hallowed tradition of the annual UNSW medical students ski trip was, like anatomy, an unknown quantity or a distant memory to today's medical cohort. Those old enough to remember it thought it would never happen again. And were it not for a few semi-inebriated ideas and promises, they would have been right.

Luckily, like many good ideas, and some great people, the plan for MedSki 2010 had its conception at a pub one night when three 5th year students, Pat Stewart, Chris Mulligan and Adam Seruga thought that 2010 might be their last chance for a big ski trip before the realities and responsibilities of being a doctor set in.

Originally planned as only a three man trip, the decision was quickly made to open it up to all UNSW students. Soon enough, our 3-man wolf pack had blown out to a group of 52 people, including students from 5 separate years of the medical program and with a good mix of the sexes and skiing abilities, not to mention an eclectic mix of non-med friends and seat warmers.

A number of respectable companies even stepped into the breach to join us on what they clearly knew to be a week of unabashed debauchery. From the cases of free Hydralyte and Red Bull, to the Fitness First awards and gold partner, MDA National, the trip sponsors made MedSki just that little bit more 'gnarly'.

To embrace the inner nerd and avoid potential lawsuits, the organisers also put together a snow-sports 'lecture series' just before the trip, to teach all students about common snow sports injuries and how to deal with them. Dr George Murrell, a Rhodes Scholar and internationally renowned shoulder surgeon talked about dislocations and re-locations, and Dr Ken Crichton, doctor for the Australian Olympic Team (and, indeed the whole 2000 Olympics), talked about the

damage we could do to our knees, limbs and brains. Despite a few close calls, it turned out we didn't need their advice after all.

The bus trips to and from the snow were notable only for the lack of toilet and consequent substitute: a small funnel near the door draining (mostly) to the outside of the bus. Fortunately for us all, only one brave but weak bladdered soldier needed to relieve himself whilst we were speeding down the highway.

The snow itself was initially fairly dicey (one could also say liquid), so we were as happy as someone with a bowel obstruction when we had a huge dump of snow on Tuesday to last us the rest of the week. Catering for a group with complete first timers to semi-professional wasn't easy, but with a few lessons on board everyone was feeling pretty confident on the slopes by the end of the week.

While our accommodation could at best be called 'rustic', our social program meant that total hours spent sleeping there were kept to a minimum. Themed nights, alpine pub crawling, trivia, karaoke, picking up desperate and dateless cougars (or Snow Leopards, as they are in Jindabyne) – we had it all. With over 50 people on the trip, there are far too many stories to tell, and many of them not fit to print. Suffice to say a great trip was had by all, and with lessons already learnt, next year's trip should be even better.

The hardest part of the trip was getting back to grim reality the week after, particularly as half the crew seemed to be violently ill the week following the trip with 'Thredbo throat'. Perhaps it was the adrenaline and endorphins pumping or the antiseptic properties of alcohol, but everyone was able to delay their symptoms until after the trip finished. But all the URTIs, bruises, muscle aches and contusions were well worth it. We all agreed that for half the fun we had that week, we would happily be doubly as sick and injured.

Special Interest Groups (SIGS) - Sunil Gupta

Earlier this year, a group of medical students formed this society with the aim of introducing medical students to some of the popular medical specialties out there. This would be achieved through information sessions, clinical workshops and research opportunities for students. For efficient management, four sub-societies were created, being the *UNSW Gastroenterology Society*, *UNSW Cardiology Society*, *UNSW Orthopaedic Society* and *UNSW Plastic Surgery Society*.

In the lead up to our first event, the UNSW Gastroenterology Opening Nights, we were uncertain as to the response we would receive, but all nerves were dissipated as the students slowly started trickling in. Our guest speakers on the night were of the highest calibre, with A/Prof. Michael Grimm (President of the Gastroenterological Society of Australia), A/Prof Rupert Leong (Executive of the Australian IBD Association) and Dr. Alissa Walsh (Gastroenterologist at St. Vincent's Hospital) sharing their experiences of working as gastroenterologist. All three speakers stressed the importance of senior medical students and junior doctors becoming involved in research, as we learnt it was a crucial element for selection into any specialty course, not just Gastroenterology.

The UNSW Cardiology Society also kicked off with its opening night featuring three brilliant and extremely entertaining cardiologists - Dr. Anil Aggarwala (Director of Cardiology, Norwest Private Hospital), Prof. Hosen Kiat (Director of Cardiology, Macquarie hospital) and A/Prof. Craig Juergens (Director of Cardiac Catherisation, Liverpool Hospital). The topics of discussion included life as a Cardiologist, entry requirements, new frontiers and research in Cardiology.

The final event for the year was the opening night of the UNSW Orthopaedic Society, which was hosted together with UNSW MedSoc. The prized speakers at the event included Prof George Murrell (Director of the Orthopaedic Research Institute at St George Hospital), Dr Stuart Myers (Consultant doctor at Prince of Wales), Dr Bernard Schick (Fellow at Prince of Wales) and Annie Gibbons

(Education manager at Australian Orthopaedic Association). They described their reasons for choosing the specialty as well as the pathways they took to achieve that goal. Annie Gibbons described the changes to the requirements for the SET program in relation to orthopaedic surgery, and we also learnt how to become orthopaedic consultants for sports teams.

In a bid to promote cooperation between the various medical societies in Australia, we have invited medical students from other universities. In particular it was pleasing to see the great attendance made by UWS and USYD Medical students.

With the importance of research being stressed at the various opening nights, we thought it was a good idea to set up a Research Unit. We hope to be able to provide medical students with the opportunity to engage in research with other students and senior doctors. The aim here is to improve research skills as we recognise that research is an important to the holistic development of medical students.

All the donations and proceeds from our events go to the following programs and charities:

UNSW Gastroenterology Society – UN World Food Program

UNSW Cardiology Society – Victor Chang Institute

UNSW Orthopaedic Society – My Village Program

UNSW Plastic Surgery Society – My Village Program

We are planning information nights, clinical sessions, and research programs for next year, so be on the lookout for announcements!

Sunil Gupta (UNSW MBBS II) – Chief Education Officer of the *UNSW Medical Special Interest Groups Philanthropic Society*

MedCamp 2010

MedCamp 2010




5 Tips for Surviving SG - Lauren Malouf

For all the Phase 1 students out there –

5 useful but possibly uncool tips for surviving scenario group sessions:

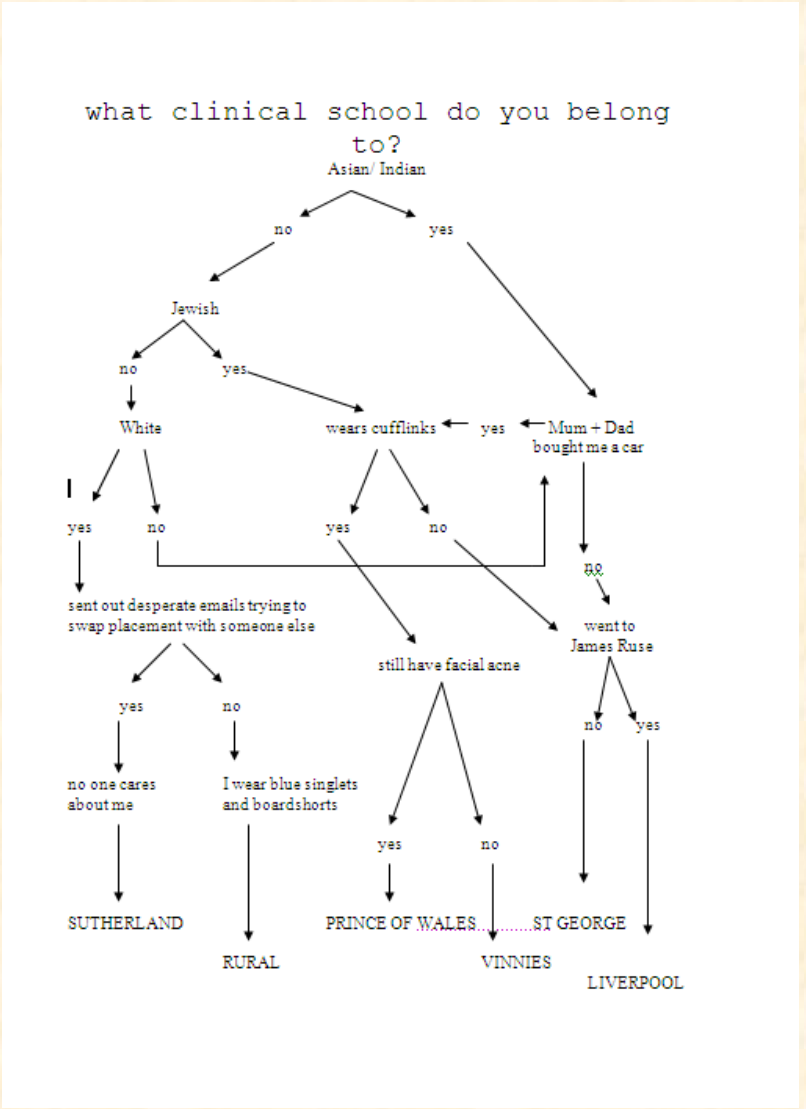
- Actually do the work allocated to you for your group project. Yes often it seems mundane and your parents might wonder why on earth they are funding your medical degree so that you can be assessed on your website construction abilities, but you have a year with your group and you will be avoided like the plague in future group projects if branded the lazy one of the class.

- Do remember the 80% attendance rule even if boredom often drives you to start writing multicolour notes and figuring out a new signature – they do check how many classes you went to.

- Something I should have done more often: If you notice that your next SGS might possibly be more on the "socio-cultural" than "basic sciences" side of things, and you have a facilitator who might be expected to be able to help, gather some questions beforehand that you have from lectures and use the time to ask your facilitator.

- Go to the last SGS of the course, even if you've already made your 80% and your inner nerd is trying to convince you that to be socially acceptable you must not attend 100% – the wrap-up quiz may be helpful for the exam, and again it is a good chance to ask questions.

- Try to spice up aforementioned last SGS through organising a junk food-fuelled "party" – thrown in honour of your facilitator, of course.


what clinical school do you belong to?
Asian/ Indian
no
yes
Jewish
no
yes
White
wears cufflinks
yes
Mum + Dad bought me a car
yes
no
yes
no
sent out desperate emails trying to swap placement with someone else
went to James Ruse
still have facial acne
yes
no
no one cares about me
I wear blue singlets and boardshorts
no
yes
yes
no
SUTHERLAND
RURAL
PRINCE OF WALES
VINNIES
ST GEORGE
LIVERPOOL

10 Tips for Obtaining Ethics Approval for ILP/ Hons and Beyond - Holly Manley (Med IV)

Early on in our medical course we learn about ethics in medical practice. But when it comes to conducting human based clinical research what we learnt in these two or three year means absolutely nothing. I have completed my Honours year and spent half the time struggling through writing, submitting and obtaining ethical approval for my research rather than actually doing it. I don't want this to happen to others so I have drafted some helpful hints for students doing research.

1. Start early and know what you are doing– Start least six-twelve months prior to the start of your research year. Have a really clear idea of the research methods because if you change your study design you will have to go through the whole ethics process again.

2. Just do it yourself - Either write the whole application yourself or review the application prior to submission if your supervisor writes it. No one knows your study better than you do.

3. Ask for help – Ask your supervisor or other researchers for advice about getting started and throughout the application process. If this is not enough, you can contact the ethics committee to whom you are submitting your application and they will answer questions you may have.

4. Put in the right application, in the right place and the right time – Visit the NSW Health Human Research Ethics Committees (HREC) website to get started. This will tell you which is the correct ethics application form and the correct committee for you to submit to. Then go to the individual committee websites for due dates . Individual websites also have templates for how specific committees like their documents structured.

5. UNSW based research – If you are conducting a study at UNSW that does not involve hospitals, medical records or patients then you can go through

the UNSW ethics committee alone.

6. Single site research – If you are only conducting your study at one site (then you submit one National Ethics Application Form (NEAF) to that hospitals corresponding committee.

7. Multi-site research – You must submit one NEAF to one of the hospitals involved in the study but this has to be a Lead HREC (authorised to approve multi-site studies). Within this application you must provide all necessary documents with footers that state : *Name of document, NSW Master Version number, Date*

8. Site Specific Application – After receiving ethical approval for your NEAF you will need to submit a Site Specific Application (SSA) to the one or multiple hospitals where the study is being conducted. This must contain documents with footers that state: *Name of Document, Site Specific Version number, Date, Based on NSW Master Version number, Date*. Any documents used at one hospital must have the same wording as the Master version addition information just as the specific hospital letter head and logo, and contact details for the local ethics committee.

9. Originals – Despite having to the write the application forms into an online system known as "Online Forms" everything must be an original. You need to print out forms and get original signatures before sending away the application. Print outs must be in colour for additional documents.

10. Follow Up – Don't' be afraid to follow up on your application with the ethics committee. When submitting the application ask what is a reasonable time period to expect a reply and then call back if you have not heard anything. This will help to reduce stress.

Ten Things: How to Survive Phase 3 and Full Time Hospital – Abby Chen, Med VI

1. Eat lunch at the first opportunity you get

In my experience, if you think you can probably get a chance to eat lunch later, it most likely won't happen. Better to have lunch at 11:30am than at 3:00pm. Free lunch is also good too. Keep an eye out for grand rounds and JMO teaching.

2. When you go to the lab for pathology tests and to pathology/morgue for cut ups for your logbook, keep it simple

Don't choose a case or a test that's ridiculously complicated. Your pathology section in the biosciences exam is your gift station, the one where you'll know pretty much what they're going to ask you. Keep it simple: a blood film, an ESR, a gallbladder or a mitral valve. Don't write up that crazy rare tumour or an EUC, you'll have to know all about it and you're making life more complicated for yourself than it needs to be.

3. Wear comfortable shoes

Full time hospital means a lot more walking. Limping awkwardly down the corridor after your team because your shoes hurt is neither a good look nor good for your feet.

4. Always have something to keep you occupied in case of unexpected breaks

It's good to have something productive to fill the time if for example:

Your tutorial gets cancelled
It's a slow day at the hospital for your team
You're sitting in clinic waiting for patients to arrive
You're in theatre and not allowed to scrub
Your registrar has told you to go away

5. Don't piss off your superiors

You need your consultants, registrar and intern/resident to like you. Then they're more likely to teach you stuff, or let you go early if there's nothing happening, or sign you off for the term early. So tell them when you're disappearing for tutorials and help out when you can. This sounds like sucking up but if you can get a couple of extra days off at the end of term or a P+ on your learning plan, it's worth it.

6. Learn to prioritise accordingly

If you're on surgical term and you have a choice between a mediocre non-compulsory tutorial and seeing a procedure that you'd hardly ever see, stay in theatre. Just remember, not every class in medical school is useful, but attendance is non-negotiable.

7. Remember to take time to unwind

There are people who can eat, breathe and sleep medicine. I'm not one of them and time (and activities) away from medical school are what keep me going, and what keep me sane. You're not a bad student if you take the occasional evening off and don't study.

8. If an assignment is due on the last Friday of term, and you have that day off, finish your assignment by Thursday night or at the very latest early Friday morning

Not only will you have spare time to submit it, you'll have a three day weekend which sometimes is the only break you get between rotations. Days off are harder to come by in Phase 3 unless you happen to be on a really quiet rotation.

9. Keep stress in perspective

Don't stress out about a test or assignment that's worth a minuscule amount of your grade. I did this in psychiatry term, getting all wound up about tests that were worth about 4% of my term mark each, in the end. You'll be stressed out enough about the big stuff, so don't sweat the small.

10. Know where you can go to chill out (and take time out from your hospital team)

It's good to have a place to go to relax where you know you won't be caught slacking off by your hospital team. 99% of the time this is the student common room. Keep something in your locker that can cheer you up (for me, it's Twinings Earl Grey tea bags so I can make myself a cup of my favourite tea). And don't forget about away from the hospital campus too, a fair few of the places I've been attached to are within walking distance of the local Westfield, which is also a good place to go to get a break away from the hospital!

Abby Chen

Advice for Phase 3 – Monica Tang, 2009

Tip #1: Be organised

Without many formal learning activities or assessments throughout the year, it's important to know what is expected of you early on (and not be surprised two months before exams). This means that you should thoroughly read all assessment information and talk to past students about what can be expected, so that you know how to structure your study.

Familiarise yourself with the case protocols (med V) and released viva questions (med VI) as early as you can, and try to get your hands on notes written by past students if possible. Read the course guides on Vista before starting each term so that you know exactly how many mini-CEXes and case presentations you have to do. Take advantage of quieter terms by negotiating assignments, which will not only look good on your Portfolio but impress the doctors with your enthusiasm.

An Excel spreadsheet listing descriptors, previous Portfolio feedback, learning plan and assignment results, 'significant clinical experiences' and other evidence for each capability can be a lifesaver when preparing for the Portfolio Interview. Like the HSC, Phase 3 is a marathon, not a sprint, so you want to make sure you're on the right track before running off anywhere.

Tip #2: Take the initiative

Like most things in life, you will only get as much out of medicine as you put in. This is especially true in Phase 3, when the onus of learning rests heavily on each student. Some doctors make this easy by engaging with students, involving them in clinical activities and bursting into spontaneous fits of teaching. In other cases, it's up to you to do the relevant reading, ask questions, see patients, ask for assessment and feedback, go to clinics and the OT, and generally make yourself useful to the team. The less busy an intern or registrar is, the more likely it is that they'll teach, so offer to help the junior doctors (no matter how menial a task may seem).

Tip #3: Be a people person

Before starting the internship year, countless people will tell you about the importance of having good relationships with those around you. This advice is equally applicable to medical students. Common courtesy and consideration doesn't just make the hospital a nicer place to be, it also helps your learning and your future work as an intern.

Offering to help a nurse re-site a cannula today may mean that she convinces a grumpy but highly examinable patient to see to you come pre-exam time. And it doesn't hurt to have a few physios, OTs, social workers or pharmacists as friends when you're tearing your hair out over teamwork, Indigenous health and QUM assignments.

Tip #4: Don't go it alone

Medicine can seem huge, daunting and insurmountable, especially when you realise that you are soon expected to be a doctor. Remember that those around you are going through exactly the same thing and take advantage of this. Use study groups to share the burden of writing notes and to practise examination technique. If you share the lovin' when there's extra teaching at hospital, you'll find that what goes around comes around. Sharing patients and seeing them in pairs or trios means that you'll see more patients, perform more thorough histories and examinations, and discover (and fill) gaps in your knowledge. And if everything begins to get a bit too much, find someone to talk to – be that another med student, non-medical friends, family, or even a sympathetic doctor or clinical school staff. You'd be surprised how many other students feel exactly the same way, and how much help and support is available.

Tip #5: Keep it in perspective

Obviously, graduating from medical school is important if you want to be a doctor. But of the six billion people in the world, the vast majority neither know nor care about the histopathology of membrano-proliferative glomerulonephritis, and they still live happy and fulfilling lives. As self-evident as this may sound, it's worth stating that assessment results are in no way any indication of your worth as a person (or even necessarily what kind of doctor you will be). Having gained entrance to medical school and made it as far as Phase 3, nearly all students graduate and become doctors (so in most cases, any fear of failure is largely delusional). Medicine in Phase 3 requires persistence and hard work, but it should not take over your life. As your diary fills up with assignment deadlines and study group sessions and extra tutorials, try to also fit in friends and exercise and other things that keep you sane. Remember that medical school is not an end in itself, but a means to an end – namely, to become a competent, compassionate, well-rounded doctor and person.

Internship Year -Myths and Tips, Dr Ken Liu (UNSW Class 2008)

So you're in year X of med and have (6-X) years to go. You know that after sixth year, you'll become an intern and have a few letters before and after your name. But what's waiting at the end? What's internship *really* like?

Here are a few common myths about internship explained with a few tips along the way.

Myth #1: Internship is incredibly busy and I won't have a life or see my friends

This one is half true. It really depends on what term you are doing. Some terms require you to be at hospital 7am till 7pm! But other terms allow you to take long lunches and afternoon naps, while you wonder if the furniture around you gets paid the same wage as you. The truth is you will get a mixture of busy and bludgy terms; and in any term, you will get a mixture of busy and bludgy days. Also there is no more study or assignments when you get home! Overall, it is still *very* possible to be an intern and still juggle two or three extracurricular commitments. Whilst there may be times during the year when you might have to cut back a little, there are still plenty of hours outside of work for you to exercise, see friends, go to church, and do whatever else!

Tip: Have a life outside of medicine! This cannot be stressed enough. It gives you an escape from work and something else to talk about with friends for once.

Tip: Organise regular events (e.g. dinner every three weeks) with friends. Although odds are not everyone can make each outing, you will still get to see most of your friends throughout the year. The RMO Association at every hospital puts on regular social events for you to see friends or meet people.

Myth #2: Now that I'm a doctor, I can diagnose and make decisions!

As an intern, your job is that of a glorified secretary. You scribe for your consultants on ward rounds, order the investigations they want, put in cannulas, and write discharge summaries. Some of you will find it frustrating that you aren't using much of what you learnt in the last six years. However, during your emergency term or when you are seeing patients during overtime shifts, you are expected to come up with your own diagnosis and form a management plan.

Tip: Read over your notes once in a while or better still take some med students on a tutorial. You find you'll lose your knowledge and skills pretty quickly if you stop using it!

Myth #3: Overtime is scary

The average intern does an after-hours shift (5pm - 11pm) every six to eight nights and a weekend shift (8am - ~8pm) once to twice per month. Most hospitals also roster interns onto nights (11pm - 8am). During these shifts, you are the doctor covering (part of) the hospital and you're the one who nurses call if someone is sick. Suddenly chest pain, acute pulmonary oedema, hypotension, low urine output, etc are no longer vivas you practiced, but a real patient in front of you. And this happens while there are also three cannulas, five med charts and four fluid orders to do! This is quite intimidating for *any* new intern. Luckily, there is good support from senior doctors around (medical registrars or even consultants in some hospitals) most of the time to give you advice. Also, after a few overtime shifts, you'll find you become more confident and efficient as an intern, such that fewer things stress you out. Somehow, the 30th person you've seen with hyperkalaemia isn't that scary anymore. The consensus amongst fellow interns is that overtime is not that bad!

Tip: At the start of internship, many of you (especially the keen ones) will think "I'll do all the extra overtime shifts people give away and make heaps of money!" What you don't realise is that overtime is quite tiring and often stressful, *on top* of your usual daytime intern job. Try to keep your free time just that – free! Same with annual leave, have a proper holiday from work. *Everyone* needs time to unwind otherwise they'll burn out. The extra money is not worth losing your sanity!

Myth #4: Interns don't get paid much

In year 2009, an intern in NSW got paid an average of $26.17 per hour. This equated to roughly a $51,500 per annum base salary. With the addition of overtime, this brings your salary up to easily >$65,000 before tax. While this might not be as much as your investment banking friends or your old maths tutoring job it will be more money than you know what to do with! Especially since you don't have too much free time to spend it! You'll find yourself ordering a main *and* dessert at a restaurant, or a drink instead of just table water. Big purchases amongst fellow interns have included: their own apartments, new cars, holidays and laptops/iPhones. The best thing is your income is secure in any economic climate and it grows from internship onwards!

Tip: Look into salary packaging or investing to minimise your tax when you start working. It makes a difference to your payslip!

Myth #5: You should know what specialty you want to do by internship

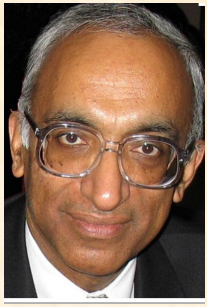
Most colleges are encouraging doctors to apply earlier. You can apply for Surgical Education and Training (SET1) and Physicians training programs at the end of RMO year, and even earlier for GP training. Whilst there is no real deadline by when you need to decide, it is good to start thinking about this early. With the number of junior doctors increasing over the next few years, competition for training positions or even SRMO jobs (which you take while you decide what to do) will also increase.

Tip: If you know what you want to do, make sure you do a term in that specialty as an intern or RMO. Your experience as a full-time intern in a particular specialty may be very different to your student experience. Many people end up changing their minds!

Tip: If you aren't sure of what type of doctor you are yet, make sure you do a wide variety of terms (medical, surgical, O+G, psychiatry, paediatrics, acute care, etc). At least try to narrow it down to the college that best suits you. It's much easier to change specialties within a college (e.g. general surgery to plastics) than to change fields altogether (e.g. physicians to surgery).

So you see, even though interns enjoy complaining, you'll find that most of us find being an intern quite enjoyable! You get paid, you have a purpose for being and responsibility at hospital and other staff and patients treat you with more respect. The good points far outweigh the bad points, which is just as well after six long years at university!

Professor Rakesh Kumar (Pathology Professor and Director of Academic Projects, Office of the Dean)



Pet peeves: People who don't (won't) think. People who can't spell. People who misuse apostrophes.

One of your favourite movies: From more recent times, the 2-hour pilot of Stargate -- which considering I don't usually like science fiction is quite remarkable.

Pick of UNSW campus food: Beef ball soup from Satay Delight. Most of the lunches at Bluestone are pretty good too.

Favourite/ultimate travel destination: Hermitage Musuem in St Petersburg is at the top of the list of places I must visit before I die....

If you could have one super power, what would it be and why? Faster than a speeding bullet ... wouldn't it be nice to save some time and avoid Sydney's traffic?

Best part of your job: Teaching! Especially in practical classes. This is my 34th year as a teacher and I still love it.

Associate Professor Gary Velan (Head, Department of Pathology)

Pet peeves: Answering questionnaires!

One of your favourite movies: Dead Poets Society

What would you order at a bar or a pub? Lemonade – in a dirty glass!

Pick of UNSW campus food: Anything high fibre, low fat and low in pathogens!

Favourite/ultimate travel destination: Scandinavia, although I've never been – there's Norway I could afford it!

If you could have one super power, what would it be and why? The capacity to relieve all suffering (perhaps using fewer puns would be a good start!)

Best part of your job: Helping students to learn in an enjoyable way, and working collaboratively with my colleagues to enhance student learning.

Associate Professor Phil Jones (Associate Dean of Education, Director of the Clinical Teaching Unit of POWH, senior infectious diseases staff specialist)

Pet peeves: None really – I don't want to become a "grumpy old man".

What would you order at a bar or a pub? A beer (nothing fancy)

Pick of food near POWH: High Café, opposite the POW Hospital.

Celebrity crush: I don't do "celebrity crushes" but Keith Richards (lead guitarist with the Stones) is a legend.

If you could have one super power, what would it be and why? Reading a student's mind so as I can tell when I'm being conned.

How would you spend a million dollars? Quickly before my wife finds out.

Best part of your job: Meeting and helping students (what else can I say?)

Joanna Tjojoatmodjo (Administrative officer, Faculty of Medicine)

Pet peeves: Don't really have one, but I remember being chased by a rooster that belonged to one of the guy who used to help in my family's store back in Indonesia. Either it did not like me or it was after the food I was having. Either way, no rooster is good rooster

Favourite movies: Anything that makes me laugh after work is always appreciated. Pirates of the Caribbean is definitely at top of the list.

What would you order at a bar or a pub? Well…I don't drink so much but I won't say no to Baileys or Midori though. Any offers?

Celebrity crushes: Johnny Depp is not too bad (What?!). But he will have to dress up like Captain Jack Sparrow and has to be as smart, annoying and funny as him. Otherwise, sorry…I am too busy chasing up ILP marks!!

Best part of your job: The best part of my job? Got to boss people around! Just kidding. Best part of my job is when I know I give positive contribution to a student's life somewhere in their journey to become a good doctor one day. Although I would prefer not to see any doctors, but I would be very proud if (and only IF) one day I have to see a doctor, I can say "Hey I remember you from my days back at UNSW". Just make sure you don't use big needle. I hate needles!

Dr Tony Grabs (Conjoint vascular surgeon, St Vincent's Hospital and former course convenor of Health Maintenance 2)

Pet peeves: A dog that shows too much love and kissing to older dogs and fish that survive for one month and then die.

One of your favourite movies: Any of the Bourne movies

Pick of food: At Uni, a toasted Chili chicken roll, at the hospital any of the local soups with some bread. Soup is a good light choice so you don't get sleepy in the afternoon

Celebrity crush: Although she is getting older its hard to go past Elle (the body) MacPherson

If you could have one super power, what would it be and why? The ability to create time, I always need more time in the day, also to have permanent day light saving.

Best part of your job: I think the unpredictability of my job is the most exciting, meetings one minute, operating on shark attack victims the next!

Associate Professor Peter Gonski (Conjoint geriatrician, Prince of Wales Hospital and former Director of the Clinical Teaching Unit of Sutherland)

Pet peeves: Students and junior medical staff don't go back to basics-good history and full clinical examintaion give you most of the answers

One of your favourite movies: The Castle, an Australian icon that I could actually understand

What would you order at a bar? Lychee martini

Pick of food near POWH: Cold rock near the Ritz - my nephew works there

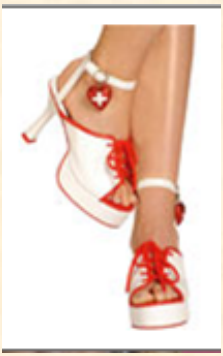
Celebrity crush: Jacky O

If you could have one super power, what would it be and why? Clairvoyance-then I would get all the diagnoses and management plans right first time

Best part of your job: Grateful patients and families, and of course content students

Open Wide and Say 'Mmm' - Trent Evans, 2008

'The next patient walks into the consulting room, her wavy blonde hair cascading down over her ample bosom. She takes a seat across from the ingenuous young doctor, and crosses her legs to reveal her long and tender thigh. "So, uh, why have you come in today?" the young male doctor stammers, fighting the distraction as he feels the anticipation rising in his throat. "I have an addiction", she states through her full, pursed lips, "an addiction to sex…"



It's a scene that has played through the mind of many medical students. But alas, in reality, the next patient in the waiting room is not here to fill their prescription for a hot beef injection but is, in fact, a 74 year-old gentleman complaining of something much (MUCH) less sexy. In this article, we will be taking a revealing look at the world of medical fetish pornography and exploring ways to satiate these salacious Aesculapian fantasies.

Perhaps the most classic fantasy is that of the 'naughty nurse'. This fantasy just might be closer to reality that you may think: let's face it – the only reason women do nursing is to marry doctors, so this definitely plays to the advantage of male medics. However, in my experience, the only thing nurses are willing to do is complain and be fat, which makes for a rather unappealing trade-off.

And no, I haven't forgotten the throbbing, mucousy sexual needs of female doctors but their prospects are decidedly more unappealing compared to those of their male contemporaries. If the ticking of your biological clock haunts you like the *Tell-tale Heart* and you fear that pursuing a career will leave your uterus more sterile than an operating theatre scalpel, consider casting your hungry eyes beyond the clinical milieu. Fantasising about the male nurses will at worst end in heartache and at best end in getting a shot at the catching bouquet as he marries a flight attendant named George.

So if you're far too fragile to withstand the harshness of reality, perhaps it may be best to explore your sexual fantasies through role playing (and I'm not talking about a communications tutorial). Medicine offers a glut of equipment and accessories that when used creatively can ignite a burning passion in the darkest part of your soul. Just use your imagination…

I must admit, while researching this topic at 2am (and after about six Harvey Wallbangers) I was inspired to create a new form of fetish pornography: alien abduction erotica. Basically it's a standard gynae exam but the doctor is wearing a papier-mâché helmet shaped like oversized brain festooned with green pipe-cleaners.

Back here on Earth, another tenet of the medical genre (and a personal favourite of mine) is the use of restraints. A popular choice in some of the more risqué pseudo-medical consults is the use of the straitjacket. The obvious disadvantage of this bizarre plaything is that it covers all the good bits (although more practical, modern designs are available).

Now finally let us roll up our sleeves and ready the spew-bucket as we delve into the sickest medical porn I could find. I am referring to the medical marvel known as the "Rosebud", or what the textbooks call as "rectal prolapse". This is definitely not for the feint of heart and it begs the question, "what next?" I shudder at the thought of the porno entitled, *Sexual Adventures with a Stoma.*

Although I usually hate it when pornos try to have a plot, medical-themed erotica unites arousal with anatomical education so jacking off is like doing homework. I hope this article has opened your mind like some kind of mental speculum. Have fun!

A Kinky Gynae Hypothetical—Anh Tran-Nam, 2009

A gynaecologist becomes sexually aroused while performing pap smears. He has never molested anyone and there is no prospect of him doing so in the future. The quality of his work does not suffer and his patients are completely unaware. Has he done anything wrong, and should he be censured?

(Here's to hoping the medical faculty won't de-enroll me…)

Before I go on to defend the gynae's kinky tastes, let's lay down the rules. The hypothetical reads "there is no prospect" of the gynae molesting any patient in the future and that the "quality of his work does not suffer". To me, this means that there is a zero probability that the gynae will commit some form of sexual assault on a patient or non-patient, and that the gynae's care remains professional – he performs the same number of pap smears for the same duration as he would if he did not experience any sexual gratification from the act.

Basically, what I've described above is that the gynae's sexual preferences, whilst excited through his line of work, ultimately does not affect the way the gynae performs his job as far as the patient is concerned. I would argue that there is little harm being caused in this scenario – as long as the doctor provides the care described above, he is respecting the bodily integrity of the patient and the pap smear can't really be thought of as a non-consensual sexual act – the primary aim is a medical test, and the sexual gratification is incidental.

The invasiveness of a pap smear can confuse the ethical question, so let's use a slightly modified hypothetical – I go to a news agency every day to buy a newspaper, and the guy behind the counter experiences sexual arousal from selling me the newspaper, but he keeps this sexual feeling private and does not overtly direct any sexual energy towards me (and thus I remain unaware).

First, although I would prefer to know, it is the right of the newsagent to have whatever sexual preferences he has and not to disclose them as long as he does his job professionally, even if those preferences (and the satiety of those preferences) involve me. It's just none of my business what gets him off, as long as I get my newspaper just like I would from anyone else. The situation is less than ideal, sure. I, like most people, would like control over and knowledge of who is sexually aroused by me and in what circumstances, but this is hardly a right – just a preference.

Secondly, if these preferences were somehow revealed to a superior, I think it would be wrong to allocate the newsagent to a different job or to fire him because of his sexual preferences that ultimately don't interfere with the performance of his job.

Third, even in terms of a more virtue ethics-type standpoint, there's not much of a case to be made that the secret sexual experience of the newspaper guy is a malicious one. I think most would agree that sexual preference is not a result of conscious decision by an individual. People do not have control over a complex interplay of environmental and cultural factors that result in them being attracted to tall guys, large breasts, lead guitarists, people of the same gender, cheating wives, or feet – it just is and we don't ask for it.

Having said all of that, the way this hypothetical translates in real life is a lot more problematic when you remove the certainty of these conditions – in real life, there is never a zero probably of an individual refraining from something like sexual assault and it is impossible to monitor whether the gynae's practices remain unaffected by his sexual arousal.

(Here's the bit where the med faculty re-enrolls me).

I think there are many situations where I think we can afford to give people the benefit of the doubt if they have committed not to let their sexual preferences interfere with their work – the newsagent scenario above, for example. Things get a lot trickier when we deal with professional relationships where there are distinct power imbalances, like doctor and patient or teacher and student. These special cases are particularly conducive to abuse because the capacity of one party to defend herself or himself is diminished, due to age (as is the case of primary or high school students) or because of differences in knowledge (patients rarely have the same medical training that their doctors do and so they trust their doctors to examine their bodies in appropriate ways). Although it offends the ideal of "innocent until proven guilty", I would argue that these high-risk situations warrant us to make the trade off: in order to protect safety of the vulnerable (students, patients), we should somewhat limit the job options of certain individual teachers and doctors who are at an increased risk of committing sexual assault.

Hypothetical gynaes who get off on pap smears but remain professional – go for it! Gynaes in real life who get off on pap smears – a call to the AMA!

Glamourising Medicine - Nivethi Chandramohan

Doctors who regularly appear on TV shows are the newest solution towards dispelling general medical ignorance, whilst glamorising medicine at the same time. Alongside their glossy hair and cheesy smiles, TV Doctors share many similarities. Here is a lowdown on the classic TV Doctor:

Goals:

- "To use television to educate and empower the people"

If asked about their motives, TV Doctors will most likely give you the afore-mentioned dry, cardboard cut-out answer. However, secretly all they want to do is prove once and for all that ridiculously good-looking doctors are not just confined to the worlds of *ER* and *Grey's Anatomy*.

Favourite hang-outs:

- Morning talk shows. Midday talk shows. Evening talk shows.

- From waking up on *Sunrise* to having lunch with *Oprah* to wrapping up the day on *The 7pm Project*, TV doctors are ubiquitous, possessing numerous regular haunts.

- Advertisements for personal insurance

TV Doctors pride themselves on their ability to regurgitate spoon-fed statements and get paid for it.

Favourite activities:

- Dispelling the latest myth about something that has the slightest risk of causing cancer.

- Talking about the next quick-fix drug/surgery to combat the "obesity epidemic" for people who oppose exercising and eating healthy.

Justifying (perhaps more to themselves than their viewers) plastic surgery for the already slim and beautiful.

Likes:

- Doogie Howser, M.D.

Before *Barney Stinson*, Neil Patrick Harris played *Doogie Howser*, child extraordinaire, who completed medical school at the mere age of 14. Needless to say, *Doogie Howser* was a role model to all TV Doctors who grew up in the late 80's – early 90's.

Dislikes:

- Dr Phil

Considering Dr Phil is not in fact a medical doctor, other TV Doctors feel irked when the general public perceive this imposter to lie among their own ranks. They are also jealous that he has his own show.

Future Job Opportunities:

- Children's Programs.

"No one is too young for health!" is an unimaginative slogan TV Doctors may possibly use in the future to infiltrate the children's television market, thus expanding their target audience. Children's television may continue along the downward spiral it has been enduring since our own childhood days, as the demise of junk-food-consuming critters like *Cookie Monster* leads to the introduction of vegie-obsessed cartoon characters (who despite their pro-health attitudes are actually sickeningly sweet).

It is easy to poke fun at TV Doctors with their handsome pay checks and faces to match. However, the reality is that after a hard day's work at the hospital, the last thing a lot of us will want to do is race down to the nearest TV studio to prepare for a live broadcast, get our hair and make-up done, choose an outfit…

This is actually starting to sound appealing so before I lose my train of thought, I think it should be said that (most of the time) TV Doctors cope quite admirably with the pressures of being under such widespread public scrutiny. With the public's thirst for knowledge and the ease of accessibility offered by the medium of television, TV doctors are becoming more and more relevant and necessary in the information age of today, providing their viewers with a home-delivered daily dose of health-related reminders and advice.

How to Profile Your Patient -

Nivethi Chandramohan

With the vast spectrum of illness and disease, the patients you encounter may seem enormously different. But after speaking to a few, you'll soon realise that they may be more similar than you think. So based on my experiences, here is a list of the stock characters you are likely to meet over the course of your clinical years.

<u>The Comedian</u>

Contrary to the title, this type of patient is rarely ever funny. The "Comedian" will establish his role quite early on into the consultation/interview. After politely asking them, "What brought you into hospital?" they will then proceed to reply with the name of the vehicle that they were driven in. Countless wisecracks will then ensue, possibly about how terrific the hospital food is or how trendy their gowns are. Although their jokes will make you groan, these patients are essentially making the best of a not-so-great situation, so please do try muster up a somewhat convincing laugh and/or amused expression.

<u>The Foreigner</u>

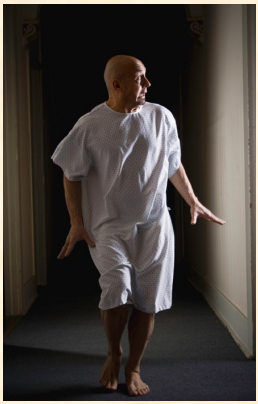
Despite being in the same room and under the same roof, you are miles away from the non-English speaking Foreigner seated before you. Left estranged by the language barrier that separates you, you resort to other means to facilitate conversation. Several strategies pop up: Charades, *Pictionary*, impromptu skit with a fellow medical colleague… But after attempting to mime diarrhoea or act out syncope, you realise that the best tactic is to wait for their English-speaking child to come visit.

<u>The Flatterer</u>

Since Flatterers are often elderly patients longing for the glory days of their

youth, they will love nothing more than to marvel at the youthful appearance of the young medical students (or "student doctors" as they like to call them) in their company. In their eyes, every one is an "absolute gem" who is "dressed smartly". They are usually quite sweet and if you are lucky they might share a story with you about their time as a surfer or member of a rock band, so that you too can accompany them on their joy ride down memory lane.

The Life Lessons Coach



These patients are normally big talkers who wear their heart on their sleeve. The tears which they are likely to shed at some point of the interview are juxtaposed with the laughter and good humour present throughout the rest of the consultation. Wise words and life lessons are thrown about haphazardly during the recount of their past medical history. With all the emotions and reflection going on, you will finally be able to put those reflecting skills to use, re-emerging as a mindful, self-aware medical student and possibly the future mascot of the New Medicine Program.

Although these may seem like caricatures, any patient possesses at least a few of these traits to some degree, making a long day at hospital just that little bit more enjoyable.

Today's dissertation focuses on the consultant, a position that is the pinnacle of all achievements in medicine and life for many. It is a position made all the more sweeter by the fact that it is the first time in a doctor's life that he is truly free of exams. Message to everyone considering medicine: never ever believe other people who tell you 'do medicine, people will respect you and you will live a comfortable life' because you're just an intern when you graduate and even patients have to think twice before taking your medical advice into consideration, more often than not tossing it into the 'extreme short-term memory' section right beside the daily gossip about Paris Hilton. And even the news about Paris Hilton stands a chance of being promoted to the long-term section. Go interns. But yes, it isn't after a few years of internship that a doctor gets to choose a specialty (or rather prays for a specialty to choose him) and slog through a few more years worth of exams before he finishes as a consultant and the medical board actually sends in some laurels for him to rest on.

Which one to choose?!

Consultants are easily identified by virtue of the fact that they often wear suits in the hospital, and patients often remember them as 'the people in suits who come on ward rounds early in the morning and ask weird questions when I'm half-awake' or 'the people who bark orders at the other doctors'. Consultants have the ultimate say in what should happen in the management of each patient, while residents, interns and nurses more often than not suffer from the consequences. I'm not discrediting consultants because it is obvious that the decisions they have to make tend to be extremely complicated rather than stuff like 'err doctor, his kidneys are smashed' 'well fix them!' but you have to pity the nurses who have to administer the 25mg of cyclosporine three times a day, but only twice on weekends and not if there is a full moon above the skies of Egypt or the patient will die and WHAT IS THIS WHY DIDN'T YOU TELL ME THE PATIENT HAD ANAEMIA THIS CHANGES THINGS COMPLETELY *&@#(&@.

As a medical student, opportunities for interaction with consultants tend to be

limited to stimulating things like following them around, answering (or attempting to answer) the questions they fire at you, and handing in the assessment form at the end of the rotation, fervently praying that he does not fail you or you'll have to repeat this god-forsaken geriatrics rotation (joking, no really). The amount of useful stuff you can learn from tagging along on ward rounds remains a subject of debate, with opinions ranging from 'oh it's really good I get to see how elderly patients with dementia are managed' to 'oh my god why am I learning about how to treat a patient with AIDS therapy induced pancreatitis when I don't even know what pancreatitis is QQ'. However, it remains true that no matter how fruitful your daily shenanigans (BIG WORD OOOO) with the consultants may be, most of them have the amazing ability to completely ignore you as they go about their business, yet sense your absence whenever you can't attend ward rounds because you have important stuff to do like clipping your dog's toenails and you can be guaranteed that when you return the next day, smarmy comments like 'oh did you have something else to do' will be hurled your way.

And if, by chance, a consultant asks you what specialty you intend to pursue after you graduate, never, EVER attempt to mention another specialty or (GASP) a RIVAL specialty because all you're asking for is for him to put on his monocle and get started on things like 'oh my how could you think of doing that specialty scoff scoff scoff eyebrow raise worthless peasants and our training is so much better we used to run to hospital uphill barefoot in winter carrying bags full of scalpels on our backs and we were thankful for it because that was all we had *sips tea* blah blah blah'.


PokéMeD
UNSW Version
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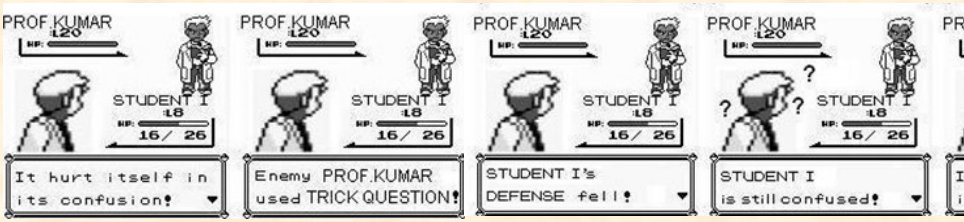
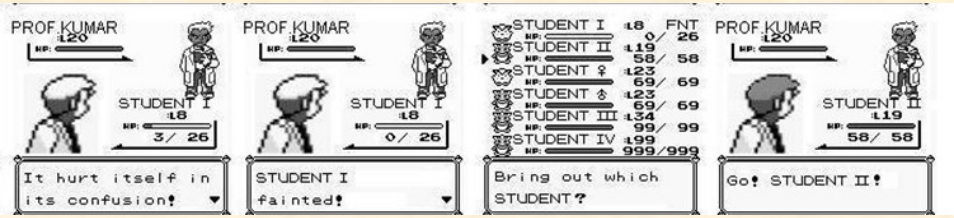
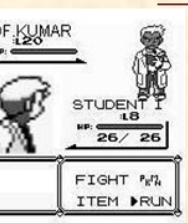
MEDFACULTY wants to fight!
MEDFACULTY sent out PROF.KUMAR!
PROF.KUMAR
STUDENT I
Go! STUDENT I!

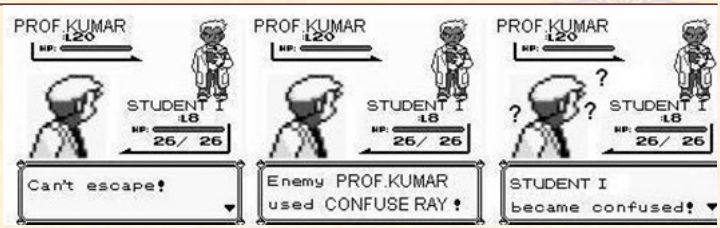

PROF.KUMAR
STUDENT I
It hurt itself in its confusion!
Enemy PROF.KUMAR used TRICK QUESTION!
STUDENT I's DEFENSE fell!
STUDENT I is still confused!

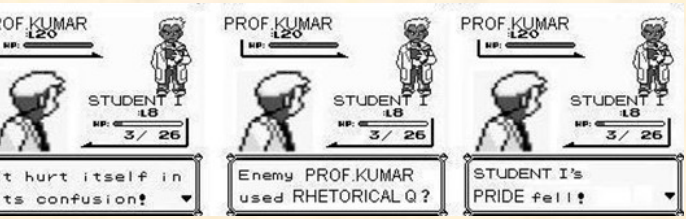

PROF.KUMAR
STUDENT I
It hurt itself in its confusion!
STUDENT I fainted!
STUDENT I
STUDENT II
STUDENT ♀
STUDENT ♂
STUDENT III
STUDENT IV
Bring out which STUDENT?
STUDENT II
Go! STUDENT II!

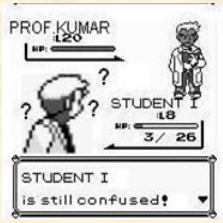

MARK HILL
STUDENT II
MEDFACULTY sent out MARK HILL!
Enemy MARK HILL used EPIBLAST!
STUDENT II is still confused!
It hurt itself in its confusion!

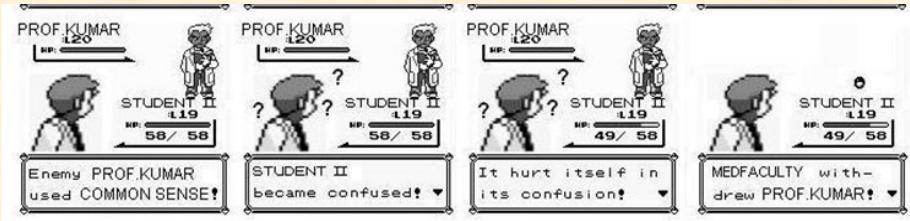

MARK HILL
STUDENT ♀
Go! STUDENT ♀!
MEDFACULTY with-drew MARK HILL!
ROSS GRANT
MEDFACULTY sent out ROSS GRANT!
Enemy ROSS GRANT used CHARM!


STUDENT I
L8
26/ 26
FIGHT
ITEM ▶RUN

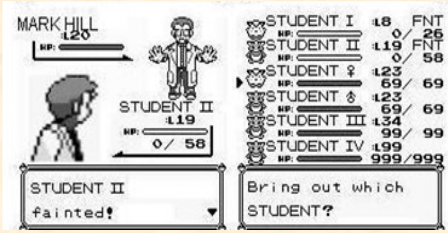

PROF.KUMAR
STUDENT I
Can't escape!
Enemy PROF.KUMAR used CONFUSE RAY!
STUDENT I became confused!

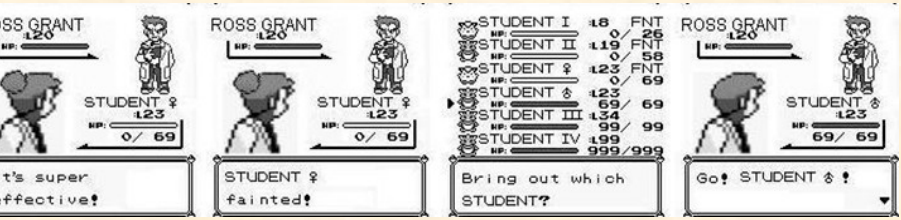

PROF.KUMAR
STUDENT I
3/ 26
Enemy PROF.KUMAR used RHETORICAL Q?
STUDENT I's PRIDE fell!

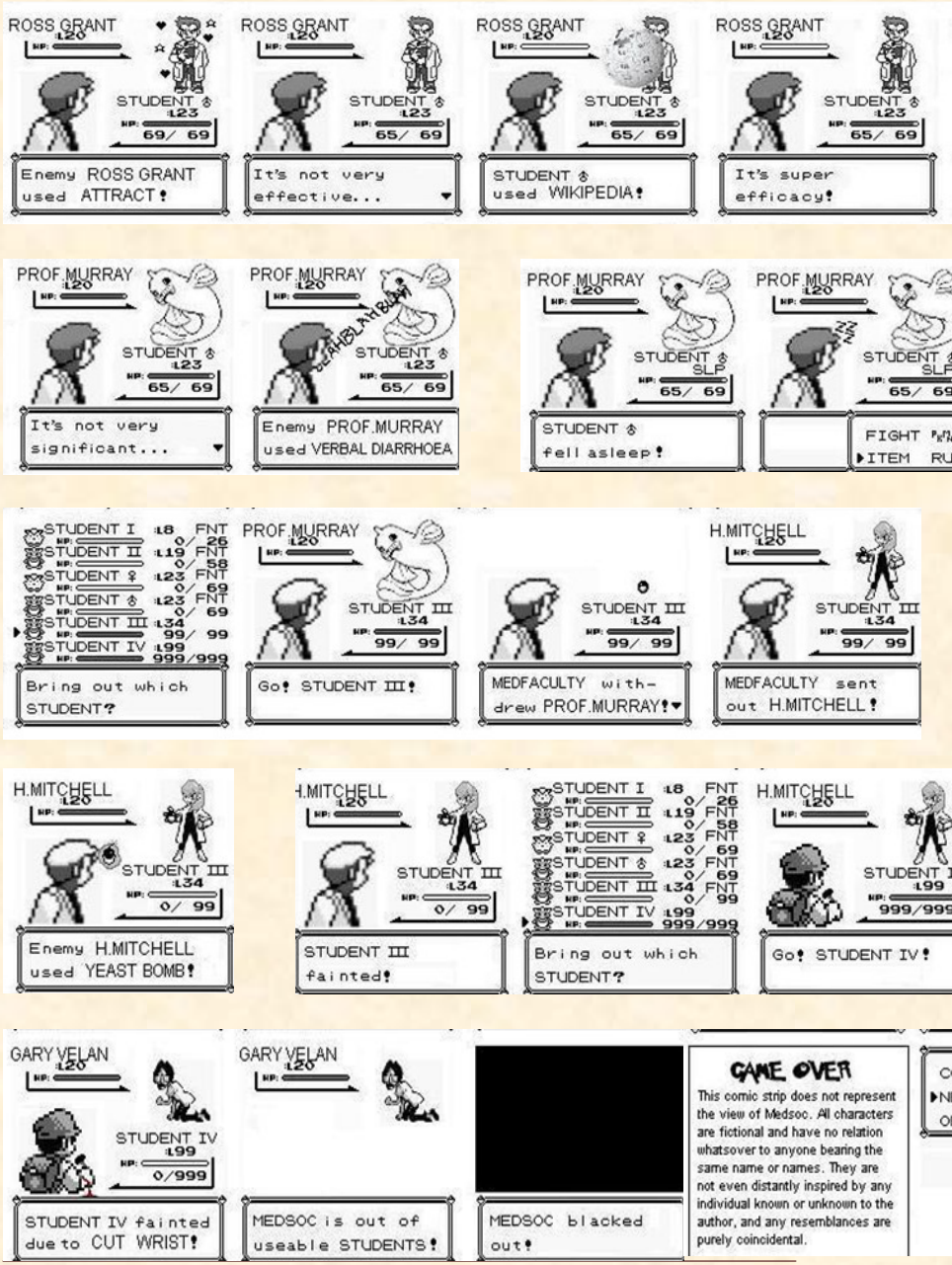

PROF.KUMAR
STUDENT I
3/ 26
STUDENT I is still confused!

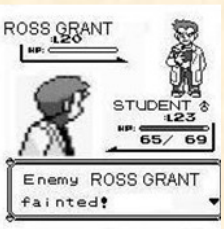

PROF.KUMAR
STUDENT II
58/ 58
49/ 58
Enemy PROF.KUMAR used COMMON SENSE!
STUDENT II became confused!
It hurt itself in its confusion!
MEDFACULTY withdrew PROF.KUMAR!


MARK HILL
STUDENT II
0/ 58
Enemy MARK HILL used HYPOBLAST!
Critical hit!

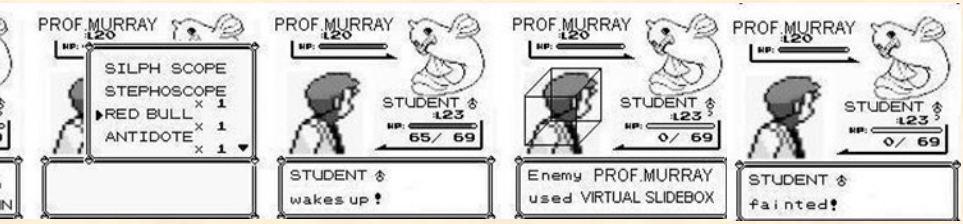

MARK HILL
STUDENT II
0/ 58
STUDENT II fainted!
STUDENT I L8 FNT 0/ 26
STUDENT II L19 FNT 0/ 58
STUDENT ♀ L23 69/ 69
STUDENT ♂ L23 69/ 69
STUDENT III L34 99/ 99
STUDENT IV L99 999/999
Bring out which STUDENT?


ROSS GRANT
STUDENT ♀
L23
0/ 69
69/ 69
STUDENT ♀ fainted!
Bring out which STUDENT?
Go! STUDENT ♂!


ROSS GRANT
STUDENT
Enemy ROSS GRANT used ATTRACT!
It's not very effective...
STUDENT used WIKIPEDIA!
It's super efficacy!
PROF.MURRAY
VERBAL DIARRHOEA
It's not very significant...
Enemy PROF.MURRAY used VERBAL DIARRHOEA
STUDENT fell asleep!
FIGHT
ITEM
Bring out which STUDENT?
Go! STUDENT III!
MEDFACULTY withdrew PROF.MURRAY!
H.MITCHELL
MEDFACULTY sent out H.MITCHELL!
Enemy H.MITCHELL used YEAST BOMB!
STUDENT III fainted!
Bring out which STUDENT?
Go! STUDENT IV!
GARY VELAN
STUDENT IV fainted due to CUT WRIST!
MEDSOC is out of useable STUDENTS!
MEDSOC blacked out!
GAME OVER
This comic strip does not represent the view of Medsoc. All characters are fictional and have no relation whatsoever to anyone bearing the same name or names. They are not even distantly inspired by any individual known or unknown to the author, and any resemblances are purely coincidental.

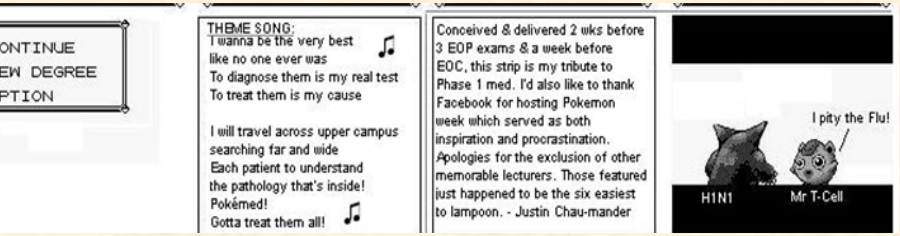

ROSS GRANT
STUDENT
65/ 69
Enemy ROSS GRANT fainted!


STUDENT
65/ 69
STUDENT gained 24 WAM. Points!
PROF.MURRAY
STUDENT
65/ 69
MEDFACULTY sent out PROF.MURRAY!
PROF.MURRAY
STUDENT
65/ 69
STUDENT used QMP!


PROF.MURRAY
SILPH SCOPE
STEPHOSCOPE
RED BULL
ANTIDOTE
PROF.MURRAY
STUDENT
65/ 69
STUDENT wakes up!
PROF.MURRAY
STUDENT
0/ 69
Enemy PROF.MURRAY used VIRTUAL SLIDEBOX
PROF.MURRAY
STUDENT
0/ 69
STUDENT fainted!


H.MITCHELL
STUDENT III
99/ 99
Enemy H.MITCHELL used CHLAMYDIA!
H.MITCHELL
STUDENT III
99/ 99
STUDENT III's PP fell to 0!
H.MITCHELL
STUDENT III
99/ 99
STUDENT III can't attack due to 0PP
H.MITCHELL
STUDENT III
90/ 99
STUDENT III used STRUGGLE!


STUDENT IV
999/999
MEDFACULTY withdrew H.MITCHELL!
GARY VELAN
STUDENT IV
999/999
MEDFACULTY sent out GARY VELAN!
GARY VELAN
STUDENT IV
992/999
Enemy GARY VELAN used PUN!
GARY VELAN
STUDENT IV
992/999
STUDENT IV used CUT!

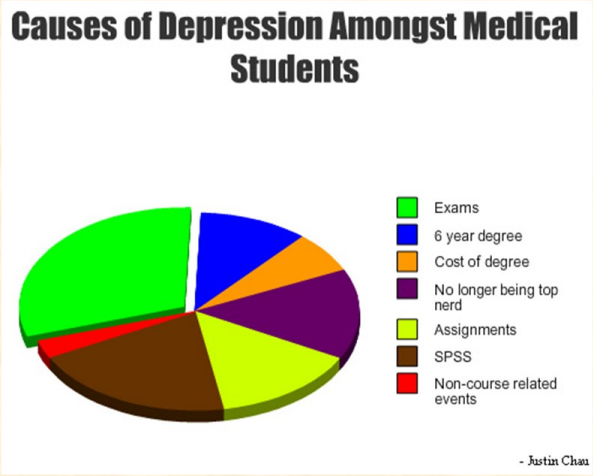

ONTINUE
EW DEGREE
PTION
THEME SONG:
I wanna be the very best
like no one ever was
To diagnose them is my real test
To treat them is my cause
I will travel across upper campus
searching far and wide
Each patient to understand
the pathology that's inside!
Pokémed!
Gotta treat them all!
Conceived & delivered 2 wks before 3 EOP exams & a week before EOC, this strip is my tribute to Phase 1 med. I'd also like to thank Facebook for hosting Pokemon week which served as both inspiration and procrastination. Apologies for the exclusion of other memorable lecturers. Those featured just happened to be the six easiest to lampoon. - Justin Chau-mander
I pity the Flu!
H1N1
Mr T-Cell

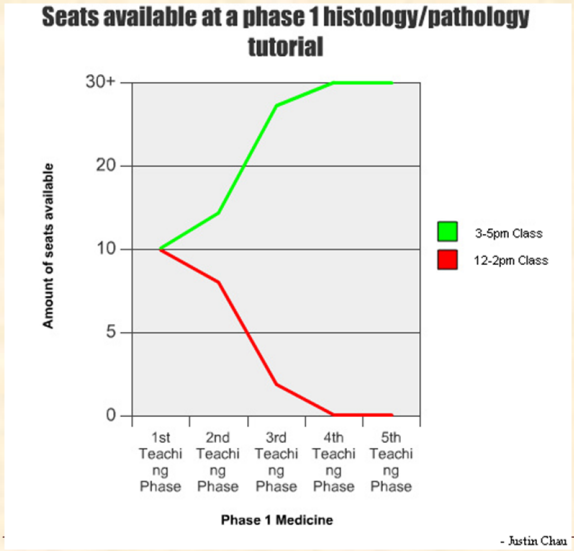
Lectures on Epidemiology are the Leading Care of Student Apathy -

Justin Chau (Med III)

The following six graphs are a few representations of life as a Phase 1 medical student from 2008-2010.

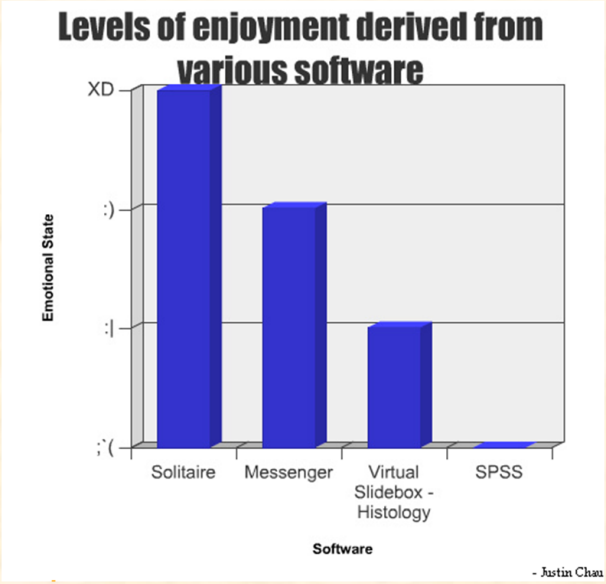
N.B. These were not made using SPSS, which stands for 'Stressing People Studies: Statistics', or more affectionately, 'Shitty Piece of Statistical Software'

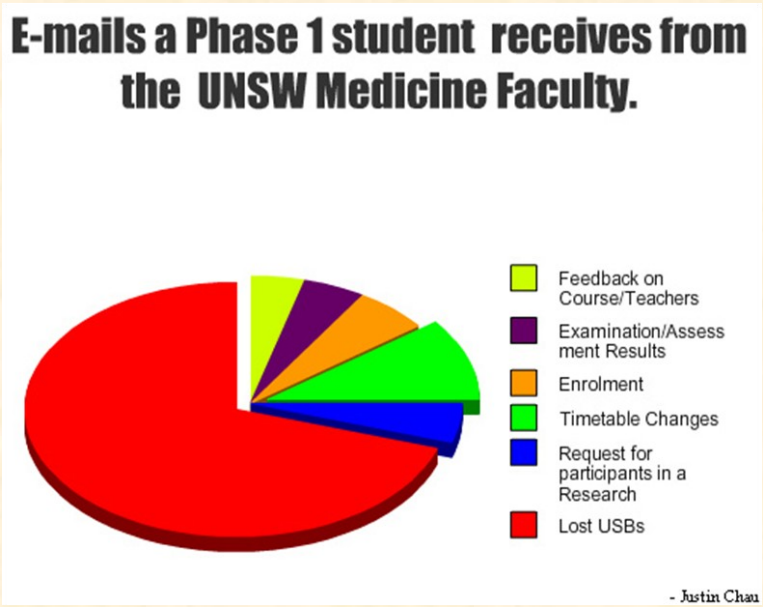




Editor's Plug: Justin Chau is directing Medrevue 2011, so join the facebook group 'UNSW Medrevue' to stay updated on how to get involved and/or watch the theatrical sketch-comedy spectacular of the upcoming year!'

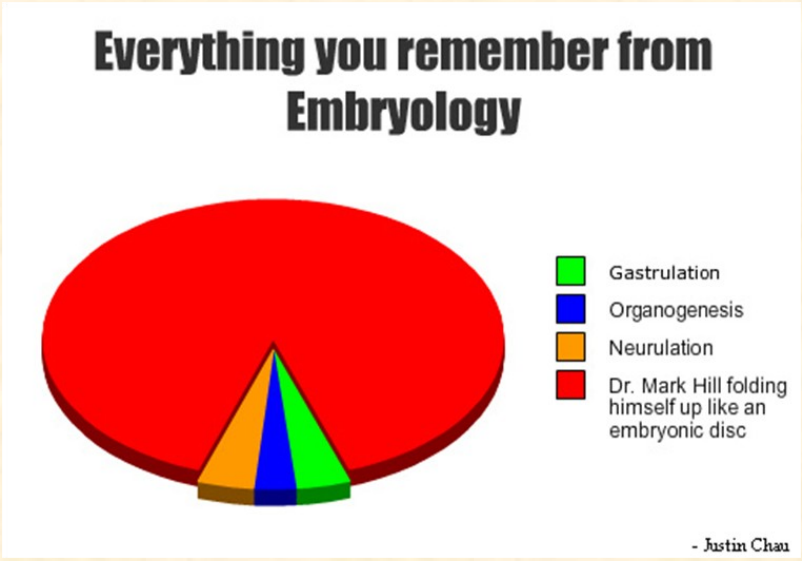
Justin Chau (Med III)

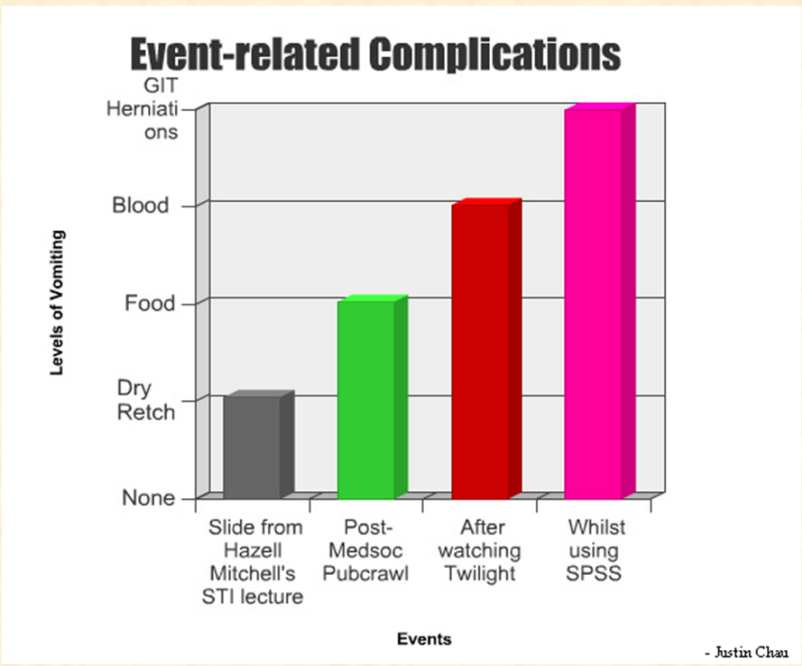


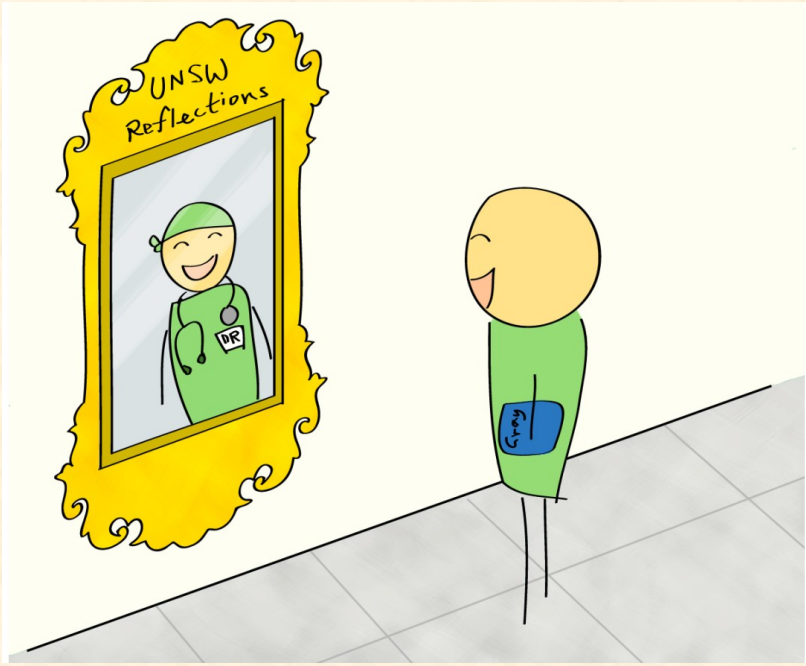


Lectures on Epidemiology are the Leading Care of Student Apathy -

Justin Chau (Med III)






UNSW
Reflections
DR
Grey

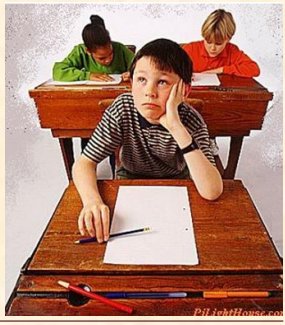
The weekend is near

The weekend is near,
Some of you may have a beer.
But not for lame chicks like me,
Cos I cannot handle it you see.
The weekend is near,
Friday is almost here.
This bloody assignment I have to write,
I might have to work through the night.

The weekend is near,
It's time to really mug my dear.
My term attachment is kinda fun,
My heart lights up like the sun.
The weekend is near,
Exams are coming but have no fear.
After that I can have a rest,
Mugging is boring but I need to do my best.

A poem for Monday

Oh Friday how my heart longeth for thee,
For I am goddamn sleepy you see.
I'm on auto-pilot while my mind starts to drift,
I silently sing songs by Taylor Swift.
I wonder what my superiors do in their free time,
I am sure they do not talk in rhyme.
Finally I say : "Sorry Sir, Can I go?";
He replies: "See you at seven tomorrow."



Oh end of May exams my heart yearns for thee,
Free as a bird my spirit would be.
"I'm a free bitch Baby" as Lady Gaga would say,
Everyone loves her be they straight or gay.
I'm so sick of hospitals and books,
But I need a degree cos I can't sell my looks.
I just need to get through May,
And hope that I find the right words to say.

A Guilty Deed - Gabrielle Matta

I was doing a term in the Coronary Care Unit at a certain Sydney hospital. Every morning when I saw my patient on ward rounds, I was faced with the same unsavory sight. He always seemed unchanged, somehow leering at me, mocking me, challenging me to outright express my disdain. He really was quite unpleasant. He disrupted the other patients throughout the night, creeping around, casting shadows on their walls. He even got into their food when they weren't watching, making it quite unpalatable one they knew he'd been at it.

The doctors tended to cast their eyes over him blankly, as if he almost did not register to them. Anyhow, there was not much they could do. I think the nurses took more notice, sending continual disapproving glances in his direction. They hoped they could get rid of him. The patient's family would come and visit, but they did not care for him. He was a nasty imposition on them, an annoyance. But he was a survivor. He was not going to go away on his own. I was appalled by his repugnance. He did not care for people, or things, he was devoid of respect. He was utterly abhorrent. Just being aware of his presence tormented me throughout my time in that ward.

I started to think of ways to be gone with him. No one had managed to eliminate him yet. It was unlikely that the doctors would tell him to go. I thought of ways to speed up the process, to persuade him to leave on his own accord. But he would not be swayed by me. I thought of sneaking in and bombarding him with a toxic cocktail of something to knock him off, even thought it wasn't my place. That seemed a bit extreme, perhaps unethical. Well, he had a right to life too.

One morning I saw him, nice and fat, well-fed, content, daringly perched on the edge of the bed. I began to lower the bed head to perform my clinical examination. The movement stunned him, he was momentarily caught off guard and with my deftly executed little tug on the sheets he toppled to the ground, hitting it quite soundly with a little "thwuck". He lay sprawled on his back, limbs twitching. I thought he may have seriously injured something, perhaps he was finally going to shuffle off this earth and rid of me of his insufferable presence on the ward. I decided to put my foot on his head and stomp it down, just to make sure the deed was finished off.

It was a huge relief to everyone when I finally exterminated him. Cockroaches are decidedly unpleasant. My patient could not have agreed more.

'Oedema', parody of 'Hey There Delilah'

UNSW Med Revue 2010

Hey there oedema
How do I tell if you're pitting?
I keep trying to palpate you
But you rise back up too quickly
Yes you do
How will I know what's causing you?
I've got no clue

Hey there oedema
Don't you have a diagnosis
Is it coming from the kidneys
Is the heart where I should listen?
Can't decide
Don't think it's meant to reach the thighs
Oh please don't die

Oh, can't find the JVP
Or, that pulse behind the knee
Oh, the physiology
Oh, always confuses me
Always confuses me

Hey there oedema
Why is draining you so hard
And that's what she said, but
I don't think jokes will help me get the marks
To pass phase two
The only thing I can conclude
Is that I'm screwed

Hey there oedema
Why won't you just go away
I would much prefer a patient who
Feels short of breath today
Or had a fall
Even a female growing balls

‘Oedema’, parody of ‘Hey There Delilah’

UNSW Med Revue 2010

Anything at all

Oh, can’t find the apex beat
Oh, never heard of bruits
Oh, what’s the pathology?
Oh, is it an STD?

A thousand signs to look out for
But ten minutes ain’t long at all
There has to be a much easier way
The surgeons all make fun of us
But we don’t laugh along because
Failing this course will cause our parents shame
Oedema I can promise you
That by the time this OSCE’s through
My marks will never ever be the same
And you're to blame

Hey there oedema
Why do you remain a mystery
It’s been sixty years since med school
And I still can’t take your history, yes it’s true
I’d far more gladly fondle stool
I let the interns deal with you
Hey there oedema, age 82
Now I’ve got you

Oh, can’t find the JVP
Or, that pulse behind the knee
Oh, now it’s affecting me
Oh, I guess that that must mean
I have an STD

Q: Did you hear about the kid who wanted to grow up and get a chest infection?

A: He had aspirational pneumonia

Q: Did you hear about the cross eyed teacher?

A: She couldn't control her pupils!

Q: How do cardiac patients get around town?

A: On the thrombus!

Q: What do people say when they get an acute episode of reflux?

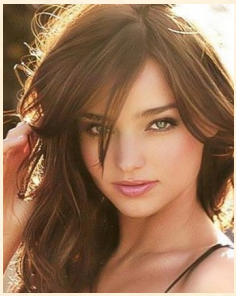
A: OH MY GORD!

Q: Why do cyclosporins guarantee dating success?

A: Because they're anti-rejection

Q: What did Miranda Kerr do after she broke her arm?

A: Some remodeling!



Q: Why are the kids who can't catch a ball more likely to get cancer?

A: Because they've got more uncogenes!

Q: When do astronauts get tachyarrhythmias?

A: On re-entry!

Q: Why are stabbing victims so angry?

A: HaemorRAGE

Q: What do you call a female to male sex change?

A: A strapadictomy

Q: Where do action potentials go to gamble?

A: Vagus

Q: What drug do you use to treat dinosaur cancer?

A: MethoT-REXate

Q: Why did the cough lose its job?

A: Because it was unproductive

Q: What is the drug name for Viagra?

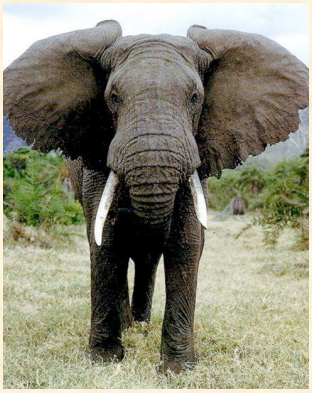
A: Mycoxaswellin

Q: What was the nerve doing before it was stimulated?

A: Just myelin its own business

Q: Why did the neurosurgeon stop doing decompression craniotomies?

A: He couldn't handle the pressure



Q: Why did the elephant cry?

A: Because he had a sympathetic trunk!

Q: Why do osteoclasts break down bone?

A: To satisfy their hydroxyapatite!

Hypothermia – all the cool kids are doing it!

Clothes are just materials you wear on your body, but *fashion* is an attitude, a lifestyle, a way in which you may express yourself... **but** when it comes to 'clinical clothes', you need to marry that up with practicality and respect for the clinical environment. Ultimately you should wear what makes you feel good, but here's a head-to-toe guide (literally) to dressing for clinical – to give you some ideas.

Head & Neck

GIRLS: Wearing dangly earrings is not a good idea because they are annoying, and because on the rare occasion that you come across an aggressive patient, s/he might grab them and pull. Accessorising is a great way to bring out your individual style. Pick a pair of cute studs that go with your outfit, or a simple necklace. I'd avoid rings and bracelets – especially if you're going to be examining or if you're scrubbing. To style up your hair, you could wear a headband à la Blair Waldorf, some clips on the side, or do your hair up in a 50s style pony and accessorise with a pony-holder.

BOYS: Wearing a fantastic tie brings you up in the style stakes straight away. Pick a tie which complements your shirt colour – there are many combinations that work. Mainly you should go with your instinct (or take along a fashionable female companion to the shops) – but a few rules include: opposite sides of the colour wheel, or analogous colour relationships. Don't go too crazy on the designs – pick something that is timeless. Also, you might want to invest in a tie clip… ties are very good at spreading MRSA – I've seen way too many ties touch patients during examinations. Yuck.

Cardie-ology

Cardigans aren't just for grannies. They make the perfect trans-seasonal outerwear, when just a light layer on top will do. There are some fabulous cardies out there – invest in a cardie made of good material like wool or a silk-cashmere blend for the cooler days. For

slightly warmer days you could wear a light cotton cardigan. Also pay attention to detail like cute buttons and clever knits. They look great on boys, too. Wear a cardigan or a vest on top of your long-sleeve shirt for a touch of preppy chic.

(not stoma) Bags

Having a good bag to carry around the wards is essential. You don't want to lug around a big bag all day. When it comes to ward bags, I'd suggest having an over-the-shoulder strap to keep things hands-free (unless you'd prefer to wear a fanny pack…). The bag should be small enough to carry around all day, but large enough to fit everything you need – the OHCM handbook / Talley & O'Connor handbook, torch, mobile phone, wallet, etc.

Shoes


Vintage inspired tan-leather brogues, from Shag

Got a long day ahead? Make sure you're wearing comfortable shoes! As a rule, heels lie along a spectrum, from short and fat = nice and comfy, to tall and skinny (stiletto) = excruciating. When you next purchase clinical shoes make sure you feel the inside of the shoe for adequate padding, especially at the balls of the feet and heel. You may want to buy Partyfeet gel inserts by Scholl for added comfort (but from my experience, they're not particularly helpful – you're better off buying a better pair of shoes!). You can get some comfortable AND nice-looking shoes from the Soft Soul, Hush Puppies, and the Supersoft Diana Ferrari range… and (dare I say it) Crocs! Sure, some crocs are ugly, but you'd be surprised to see the full range on

offer. You can get some decent looking flats, and the best thing is you can wash them if they get dirty.

It's all in the detail…

GIRLS: Details make such a difference when you're choosing a top. A white top instantly becomes more fabulous if it's got interesting buttons, a unique collar, pleating, or a voluptuous capped sleeve. Skirts should be selected depending on what suits your shape. If you're bottom-heavy, I'd stick to 50s style circle skirts that go out at the waist. Pencil skirts should be reserved for those with smaller hips. Buying skirts/pants with pockets is always a good idea – they stop you from digging into your bag a hundred times.

BOYS: Try and avoid the white shirt-black trouser waiter look, and be a little bit more adventurous. If you're feeling classy, get some French-cuffed shirts (Herringbone do a great range), and invest in some simple, classic cuff links. Not only do 100% cotton shirts feel better on the skin than their polyester counterparts, they look better too. The extra cost is worth it, believe me. For the pants, again, I would avoid polyester and other synthetic fabrics. Find pants that are well cut and tailored – avoid front pleats (they just make you look stuffy) – and always wear a belt, which should match your shoes. Both your shoes and belt should be made of leather if you want longevity out of your purchases.

Beauty is skin deep

Last but not least, take care of your skin. Doesn't matter how great your outfit looks if your skin looks dull and sad. Face washes with microdermabrasion beads tend to be good for winter, to scrub off dead skin cells from all the heating. That should be followed by a toner and a good moisturiser. But, as we all know, we must fit things into the biopsychosocial model – good skin also depends on other factors. You don't want to look like you haven't had sleep in 40 hours (which is sometimes the case) – even if it's just a 15-minute power nap between

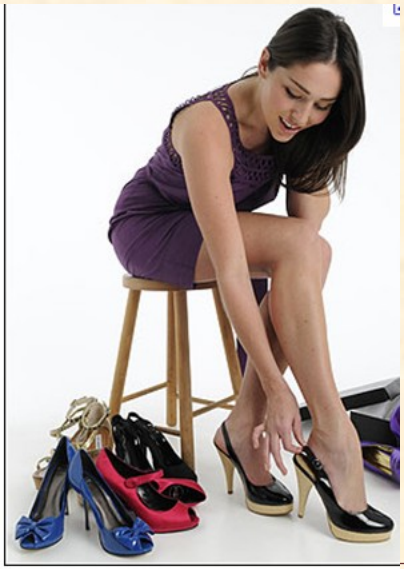
delivering babies on a night shift, getting as much sleep as possible is important. It's also good to stress less and drink lots of water… this is not only good for your skin, but well-being overall. And…SMILE – that always looks good ☺

Fashion Faux-Pas

1. Showing too much skin. Any girl who's watched *Grey's Anatomy* fantasises about getting their own McDreamy, but showing skin is a no-no. Do you want your 86 year-old patient hitting on you? …I didn't think so. Don't show cleavage, and make sure skirts are only slightly above the knee at the shortest.

2. Wearing too much make-up – some light foundation for coverage is okay, but drag queen make-up isn't necessary for hospital. Avoid colourful eyeshadows and bright red lipsticks. Stick to natural colours and keep it clean.

3. Sky-high stilettos. Make sure your shoes are comfy and well-covered – especially if you're spending the day in theatres. You could be standing for five hours or longer watching/assisting a CABG!



4. Wearing your newest Prada purchase. Chances are, you're going to get faecal matter, vomitus or <insert bodily fluid here> all over your new clothes. Keep your wardrobe treasures at home, and save them for special occasions.

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