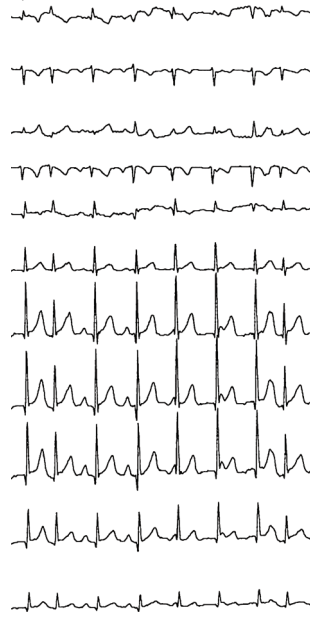


idioglossia 2011

issue one
a medsoc publication

from the editor



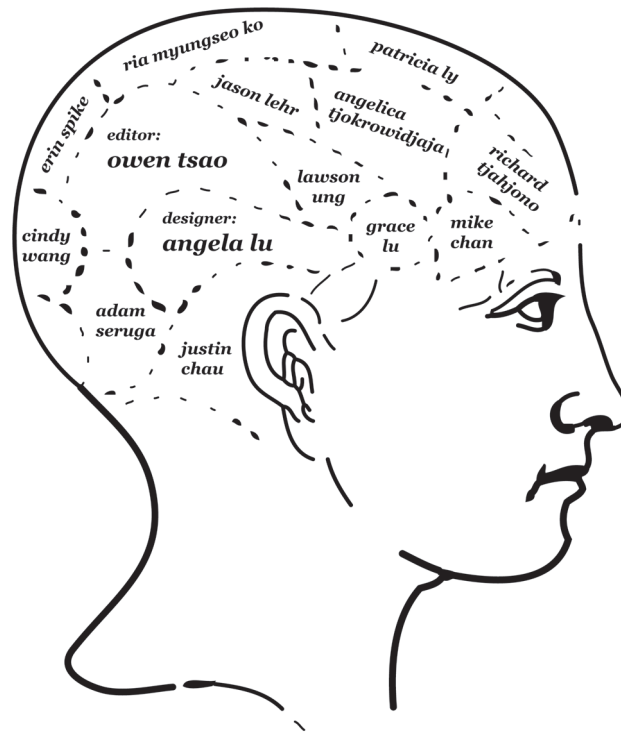
Welcome to the first hard copy issue of Idioglossia since 2007. Although Idioglossia has changed its shape and form greatly over the years, my dying wish is to make the important issues of the medical community a forefront in the mind of the medical student. Hopefully this publication will blossom into a primary medium in which medical students can find a voice in the wider community.

The following pages will update you on the happenings of the UNSW Medical Society, and press upon current issues facing medical students today. In this issue, we will also delve into the minds of the witty and absurd, driven mad evidently by the constructs of the under-graduate medicine course.

Feel free to send any letters, responses and comments to publications@medsoc.org.au

Language is a powerful tool. Use it.

Owen Tsao



WHAT I WAS DOING WHEN I FOUND OUT I GOT INTO MEDICINE	richard . . .	4
A SCOPEFUL OF PRIDE	justin	5
TWELVE TIPS TO AVOID TRAUMATIC ILPS	angelica	6
A DUMMIES GUIDE TO THE INTERNSHIP CRISIS	grace	7
OLD VS NEW	owen	10
INGENIOUS THERAPIES IN THE HISTORY OF MEDICINE	cindy	11
UNSW TEACHING HOSPITALS FOR DUMMIES	ria	13
THOUGHTS ON EXCHANGE IN NORWAY	adam	14
WHY MEDICAL STUDENTS SHOULD BE MORE POLITICAL	erin	15
GETTING THE MOST OUT OF YOUR APPLE IPHONE IPOD TOUCH	jason	16
MEDSOC REPORTS	18

What I was doing when I found out I got into Medicine - Richard Tjahjono (Med I)

If I had to summarize what I was doing when I received that ‘momentous’ message, I would describe it as ‘very, very unique’.

Yes, I wanted to get into a med school, but I didn’t want to attend a med school at Jakarta. Undergraduate Medicine is very uncommon in other countries, so I applied for Biomedicine at various universities in the United Kingdom and Australia (and also applied for Med in UNSW.....on a whim).

Accepted in a university at Manchester, I arrived in London 3 days before O-week around mid-September, to travel and see new places with my family before I began my college life. Packed up and ready to travel by train to attend O-week at the University of Manchester, I casually opened up my laptop and checked my email. And guess what I got?

An email from Mr. David Boothey telling me that I was accepted at UNSW Medicine.

The sudden surge of excitement that I got from reading that email made me jump in happiness. The moment I arrived at Manchester, I wasted no time in going to the university’s admissions office, withdrawing myself as a student at the university. The news eventually spread to my friends and they humorously mocked me for having ‘sad’ farewells; the notion of finally leaving overseas for college and returning back again in a time span less than 3 weeks was absolutely ridiculous. I spent the rest of the 4 months filled with boredom (since there was nothing to do), and excitement by the prospect of my life as a med student.

Thankfully the university in Manchester hasn’t asked for a deposit fee, so my withdrawal was really, free of charge.

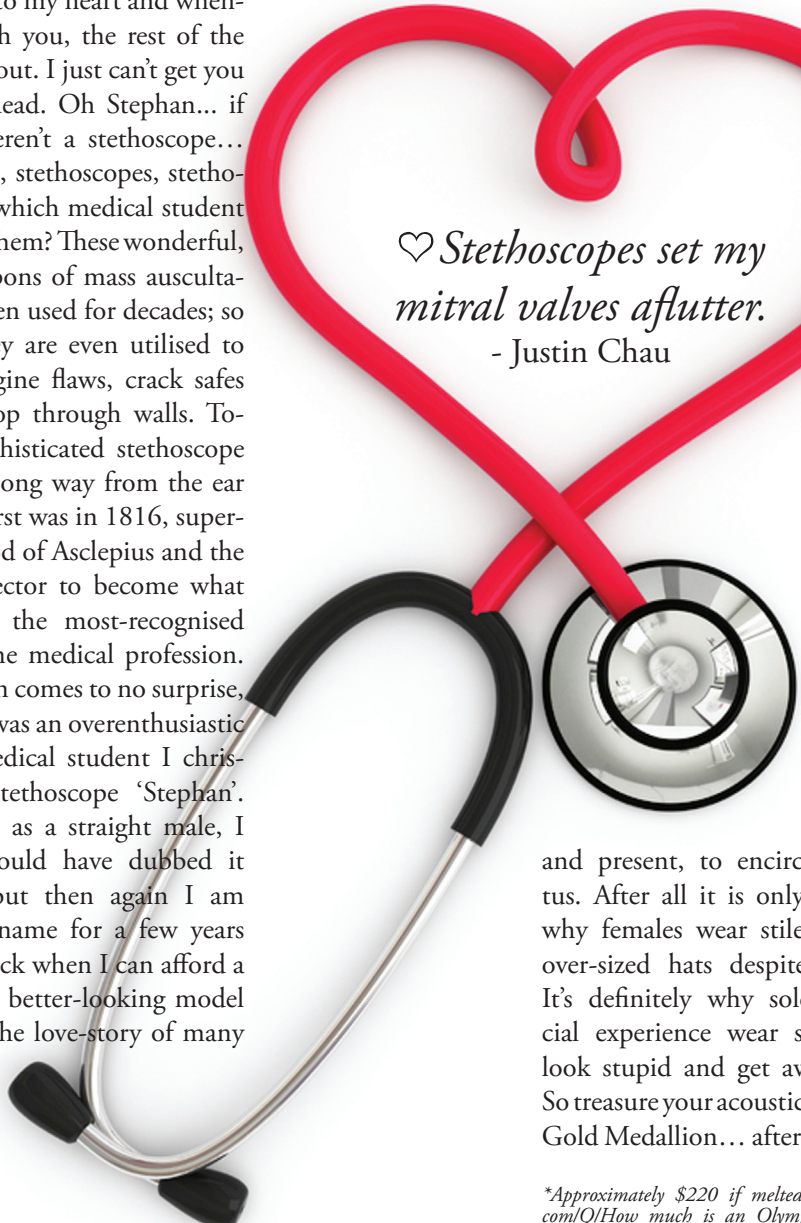
A SC♥PEFUL ♥F

PRIDE

justin chau (med iv)

Ohh Stephan... the curve of your chest-piece delights my eyes... incredibly flexible and steely-hard in the right places, your non-chill rim sends shivers down my spine. You are so comfortably-angled and your tubing so anatomically correct, that as I nibble on your soft-sealing ear-tips, 28 inches of non-latex love is always guaranteed. You're so sensitive, you never fail to listen to my heart and whenever I'm with you, the rest of the world tunes out. I just can't get you out of my head. Oh Stephan... if only you weren't a stethoscope... Stethoscopes, stethoscopes, stethoscopes. Ah, which medical student doesn't love them? These wonderful, clinical weapons of mass auscultation have been used for decades; so versatile, they are even utilised to diagnose engine flaws, crack safes and eavesdrop through walls. Today, the sophisticated stethoscope has come a long way from the ear trumpet it first was in 1816, superseding the rod of Asclepius and the doctor's reflector to become what I believe is the most-recognised symbol of the medical profession. I guess it then comes to no surprise, that when I was an overenthusiastic first year medical student I christened my stethoscope 'Stephan'. In hindsight as a straight male, I probably should have dubbed it Stephanie, but then again I am saving that name for a few years down the track when I can afford a younger and better-looking model (much like the love-story of many

divorced men). In the mean time, I am quite content and after a smattering of clinical tutorials will confess to possessing a degree of proficiency in using him. However, I must confess the pleasure of Stephan's company does not solely derive from the fact he's a tool, but rather from the prestige evoked from carrying such a stylish neck accessory. This crest of honour and authority is unmatched in any other profession in this day and age except perhaps by the much-decorated chests and striped shoulders of army generals. In fact, ask any fresh-faced medical student and most will admit enjoying the feeling of power it conveys. Nonetheless, through acute observation and inquiry, I have discovered that those not so wet behind their stethoscoped ears have actually lost this proud habit of displaying the stethoscope as a neckpiece. Rather than wearing it like the phallic symbol it is (alike ties and cravats), these jaded practitioners thrust their tool into their pockets, desperately hiding away their medical tubing in fear of being encroached upon by annoying patients, families and interns. But personally, I think this is a small price to pay for the great feeling of supremacy. If you really don't want to be interrupted by the irritating public, wear a bloodstained coat, or better yet, say you come from UWS. Ultimately, I feel that despite the frequently unwanted attention, all of us are obliged as medical students, past and present, to encircle our neck with this earpiece of status. After all it is only a bit of pain, for so much power. It's why females wear stilettos. It's also probably why chefs wear over-sized hats despite being surrounded by blazing ovens. It's definitely why solemn, wise men with decades of judicial experience wear silly wigs and dress robes. If you can look stupid and get away looking superior... why won't you? So treasure your acoustic device and flash it around like an Olympic Gold Medallion... after all it costs as much if not more than one.*



♥ *Stethoscopes set my
mitral valves aflutter.*
- Justin Chau

*Approximately \$220 if melted down, according to WikiAnswers: http://wiki.answers.com/Q/How_much_is_an_Olympic_gold_medal_worth

twelve tips to avoid traumatic ilps

Angelica Tjokrowidjaja (Med IV)

The process of selecting and completing an independent learning project (ILP) is often tedious and fraught with uncertainty, however following just a few helpful, commonsensical tips may ensure that your nine month stint doesn't end up in tears.

- one { Consider whether you want to negotiate or submit a preference form for your ILP. If you don't want to risk getting your last preference for an ILP, you may want to negotiate.
- two { As obvious as it sounds, choose an ILP that interests you. Don't do a lab-based project if you aren't interested in basic sciences. You'll have to work on this project for the greater part of one year, so give it some thought.
- three { Ask your potential supervisor about the hours and number of times per week you are expected to come in for ILP; trust me, realising that your ILP supervisor expects you to come in 9am-5pm Monday-Friday on your first day will not make you a happy camper. You might also want to find out how flexible the times are; this could help you pursue other activities and part-time work more easily.
- four { Try to find a supervisor you can get along with, because that is the sole independent factor that can make or break your ILP. Scan through the list of potential supervisors on eMed and bookmark those in your interest area. You can then start the negotiation process by emailing prospective supervisors and meeting up with them (but remember to only email one at a time!).
- five { If possible, find previous students in upper years who can give some insight into their ILP experience. You may even find some who have worked with your potential supervisor.
- six { Once your ILP has been decided, check if ethics approval has been sought; if not, make sure you get started on this quickly so that it is completed by the time your project starts, or at least soon afterwards.
- seven { Take into account where you would like to spend your ILP; is it a hospital near your home for transport convenience, or near UNSW so that you can see friends more easily?
- eight { If you want your work to be published, ask about the likelihood of this happening and investigate your supervisor's published work.
- nine { If you choose to do a more clinical ILP, take advantage of any opportunities to sit in on clinics or watch surgeries.
- ten { Keep a short record of your weekly progress once you start ILP; when you start your final report, you'll be glad you don't have to rely on your short-term memory. The Med-Fac also encourages you to write in your journal in the event of a dispute with your supervisor.
- eleven { Make sure you use your free time during ILP wisely; take advantage of any days free for part-time work, sign up for those dance classes you've always wanted to join, and revise your phase 1 or coursework notes so that your brain isn't turned to mush by the end of ILP.
- twelve { Most importantly, meet up regularly with friends, or better yet join a club, revue, medshow or society. You may often feel isolated and ILP is quite different to the Phase 1 days where you see your friends everyday so make sure you keep that social life thriving and avoid any ILP-induced hermit-like tendencies.

While most people can't wait for their misery to end, it'll be over before you know it and if you use your time wisely, you'll discover it's almost like the part-time gap year you never knew you actually needed (at least that's what I told myself during ILP). To the poor souls commencing or already part-way through, enjoy the 'bludge' year that is the ILP.



The leading political issue for medical students of our time
 - your quick fix to sounding savvy, stupid!

A DUMMIES GUIDE To The Internship Crisis

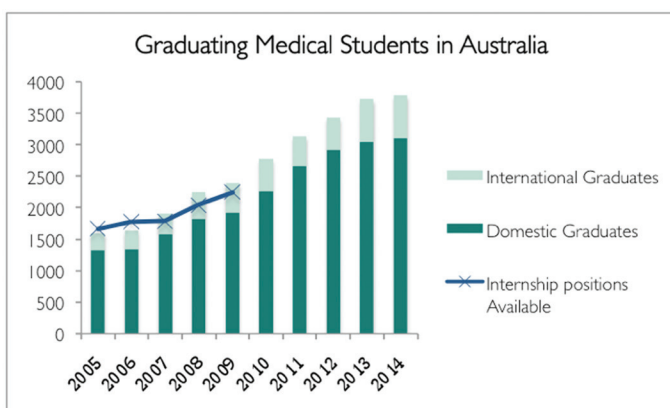
Grace Lu (Med III)

The Problem?

An internship is the 12 months of full-time post-graduate training in the medical workforce, which predominantly occurs in major public teaching hospitals. What's the big deal? Only upon its completion are you able to obtain registration as a medical practitioner with the State Medical Board or Council. Slogging six years at UNSW to procure an MBBS certificate only to be denied internship, is therefore even more devastating than the time my culinary-challenged friend spent hours baking "cupcakes" that sunk to form a jaundiced goo because she didn't measure out the ingredients (we told her it was probably the oven).

In a way, this example is analogous to the haphazard system of medical workforce planning by the government. The recipe for malfunction begins with the essential disconnect between the Commonwealth and State governments, which fund and control the number of medical school graduates and internship positions respectively. The ingredients don't balance out – the growth in internships is being eclipsed by the growth in medical school graduates, creating a training bottleneck effect.

Graph 1: Graduating Medical Students in Australia



Source: MTRP 13th Report 2010

i) The Training Bottleneck

From 2005 to 2009, the number of internships grew 38.3%, stopping short of the 50% growth in total number of medical graduates.^[1] In 2010, 400 more intern places were needed to provide for the 2776 graduates of 16 medical schools, and once again 400 more places are needed for 2011. In 2012, competition will be accentuated through graduates produced by the new medical schools Notre Dame, Wollongong and University of Western Sydney.

ii) International Students and Internship

In response to the shortage, the NSW Health Priority List has been implemented since 2010 by the State government, as a preference system for internship allocation. In 2012, **internship has been guaranteed for domestic graduates** from NSW, but there is no such luck for international graduates^[2]

International students represent 17% of all medical students in Australia – 512 in 2010, which will increase to about 700 by 2014. At least 80% of these students have indicated in surveys they wish to undertake their internship in Australia, having already made a home in Australia throughout six years of study.^[3] In 2009, two international graduates offered to work for a year without pay in order to secure a place; reasoning that the salary of \$55,000 was a small sacrifice compared to the alternative of having no way to repay the \$400 000 spent on their education. Another considered the debt so high that an extra \$20 000 in living expenses would not make much difference.^[4]

It is also no secret that international students' fees form a substantial component of medical school funding, and cross-subsidise Commonwealth-supported students. The possible butterfly effect from a shortage of internships, to a decline in international student numbers, and finally to substantially less international economic support, highlights the weakness in the medical school business model.

Now if you are a local student and feeling like this is all somewhat irrelevant for you – don't put your feet up, because if the current rates of expansion continue, by 2014 there will be only 3200 internship places to accommodate 3,786 graduates. And because medical training is a progressive process, the problem doesn't stop there.

iii) Specialist Training Shortage

The state public health system funds both internship places (known as prevocational training) and the subsequent places in specialty medical colleges (vocational training). The growth in intake of about 8.2% pa in vocational places since 1999 cannot support the expected growth in medical graduate numbers. We need an additional 1200 first year vocational training places by 2015. Training posts must also increase over the next several years to enable continuity of training throughout the (generally) three to eight year program. There is no current reliable data on how the increased number of medical graduates affects progression from prevocational to vocational training.

Where did it begin?

Whilst the Federal Government's funding gives birth to medical school places, it is the State Government that employs the interns, thus breeding a fertile ground for mismatch and blame shifting. But what were the contextual factors driving such actions the first place? To be blunt – what the hell were they thinking?

Historically Australia has consistently shown short sighted and reactive medical workforce planning. Throughout the late 80s and 90s policies were based on the assumption of an oversupply of doctors, with capped student numbers and stringent regulations on internationally trained doctors.^[5]

Lo and behold, a shortage 15 years in the making has rudely blustered its way into the political landscape, with a deficiency of approximately 6300 **medical practitioners** across the country in 2009.

Since 2004 both attitudes and policy underwent a 180-degree shift, with the Commonwealth **increasing the numbers of medical students** at full speed ahead. Numbers of domestic places increased (both Commonwealth Supported and full fee paying), and eight new medical schools were opened. In 2002 policy changes enabled international students to stay in Australia for internship and achieve full registration, which

successfully led to an increase in their numbers.^[6] However, these policies have failed to address health delivery requirements because there has not been a coordinated increase in intern and specialist training places.

Australia also facilitates **recruitment and retention of international medical practitioners** while our system is still incapable of supplying sufficient practitioners. Currently international medical graduates significantly allay workforce gaps, with around 6100 working on temporary resident visas in rural Australia, the public hospital system, and other areas of need.

Knowing this context, it is bizarre that international graduates trained in our medical education system are being turned away, when all signs reveal that every attempt should be made to retain these students upon graduation. Having been trained to our national standards, they represent significant productive potential to meet our future health delivery needs. We need better access of internship places for locally trained medical practitioners regardless of their residency status, to preclude depriving Australia of skilled new doctors.

Where to from here?

The aim now is to prevent a situation where long-term quality community healthcare is compromised by inappropriate or lack of post-graduate training and clinical experience. Planning for workforce requirements and training places must be improved to avoid previous boom-bust cycles.

Through the Council of Australian Governments (COAG), an agreement was formed that the goal is to **provide all Australian medical graduates with prevocational and vocational training places**, including both Commonwealth-funded and full-fee paying students. In 2008, COAG announced a \$1.64 billion package to support undergraduate clinical training for the health workforce and committed \$640 million to fund a significant increase in prevocational and vocational GP training positions.^[7] Training places have increased within Emergency Medicine, and have expanded into specialist-training positions within the private sector. In March 2010 the government doubled the number of GP training places from 600 to 1200 by 2014.

In September 2010, the Australian Medical Association (AMA) was forced to hold a "Medical Training Summit" between key stakeholders to discuss and develop solutions to the crisis.^[8] Australia needs a national medical training framework with significantly improved funding, planning and coordination between all stakeholders to deliver the right number to areas with most need, more efficient use of private and community settings, and to be held accountable through a transparent and measurable monitoring framework.

Key targets from the AMA Medical Training Summit:

- Provide all domestic and international full fee medical school graduates with internship
- In the next five year period any decision on new medical schools or places should be informed by the advice of the Health Workforce Australia (HWA) Medical Workforce Planning Advisory Committee on required numbers of prevocational and vocational places. HWA will analyse demand for more domestic and international students, and for services by speciality and location.
- Medical schools and student numbers should be capped until training places are sufficient as per the HWA analysis, to cater for future community demands and downstream training availability.
- A Medical Training Review Panel will monitor and identify any unanticipated gaps between demand and supply of number of prevocational and vocational training places.
- Review of the Commonwealth funding system
 - Funding (and therefore quality) of undergraduate medical training must become less reliant on international full fee paying students, to achieve a more sustainable system
 - Federal funding of 60% of public hospital teaching should be conditional on the State providing the recommended number of training places to 2020.
 - Funding for public hospital teaching must include cover costs to protect teaching time for doctors
- A national system of internship allocation with sharing of application information to prevent the current situation where some hold multiple offers across states for extended periods of time, while others wait for a place.
- Training should be innovative and broadened
 - Training junior doctors to teach medical students and other junior doctors
 - Continually include general practice, hospital, private and community settings

Amidst the numerous facts, figures and venerated discussion it is ultimately essential to cast our eyes to the original purpose of the workforce-planning recipe. What will permeate as the backdrop of all subsequent reform is the need for high-quality, efficient, and accessible health care for better outcomes for our friends, family, all Australians and ourselves. By this simple principle, it makes sense to shift to proactive medical workforce planning underpinned by hard data instead of vague actions that dispel voter discord for short-term political agendas. It makes sense to advocate with full-force for international Australian medical school graduates to remain in Australia, and to avoid complacency in lobbying for prevocational and vocational training expansion regardless of our personal guarantee-status. Getting involved with your UNSW Medical Society and supporting events which link students to consultants and those downstream in the training process such as Grand Rounds is a simple way to start. Given the past blunders, we must maintain a healthy scepticism regarding our future and workforce planning and hope that Australia can have its cake and eat it too.

REFERENCE LIST

- [1] Medical Training Review Panel 13th Report. Commonwealth of Australia 2010
- [2] NSW Government Clinical Education & Training Institute. NSW Health 2012 Priority List [Online]. 2011 [cited 2011 Mar 28]. Available from: URL: <http://www.ceti.nsw.gov.au/www/472/1001127/displayarticle/1001211.html>
- [3] Robinson, B. International Internships: The big disconnect. Radius 2010 Nov
- [4] Cresswell, A. Medical students in no-pay offer as intern crisis bites. The Australian 2009 Nov 4 12.00AM
- [5] Australian Medical Association, Australian Medical Students' Association, Medical Deans Australia and New Zealand, and Confederation of Postgraduate Medical Education Councils. AMA Medical Training Summit Joint Statement. Action on Medical Training 2010 Sep 29
- [6] Ibid.
- [7] Ibid.
- [8] Ibid.

We are living in an age where everything seems to be improving. Pens and torches have become pen torches and giant bedroom-sized Macintosh monoliths have become iPhones. So why is it when we look at UNSW's brand spanking new 7-year-old undergraduate medicine program we cringe at the word improvement?

It's almost jovial to think that as a Phase 1 student, I craved the hospital environment, seeking SSRI treatment for the sedentary life of basic sciences. However, fast-forward to Phase 2 Coursework, and clinical tutors are ridiculing us for our supposed lack of knowledge in fundamental physiology and pathological processes. So where did my two-year fulminating knowledge of basic sciences go?

We cannot learn clinical medicine without a solid foundation in basic sciences first. In my view, the old program built its house from the inside out, placing fundamental framework before working on the aesthetics of patient communication and clinical proceedings. The new program on the other hand aims to integrate everything into a mangled up fur ball that my cat coughed up last week. It's kind of like making a house from front to back, which is not very plausible if you ask me.

In all justification, I'm sure the old program did have its weaknesses, addressed in the new program by introducing concepts such as integration and self-directed learning.

Old vs NEW

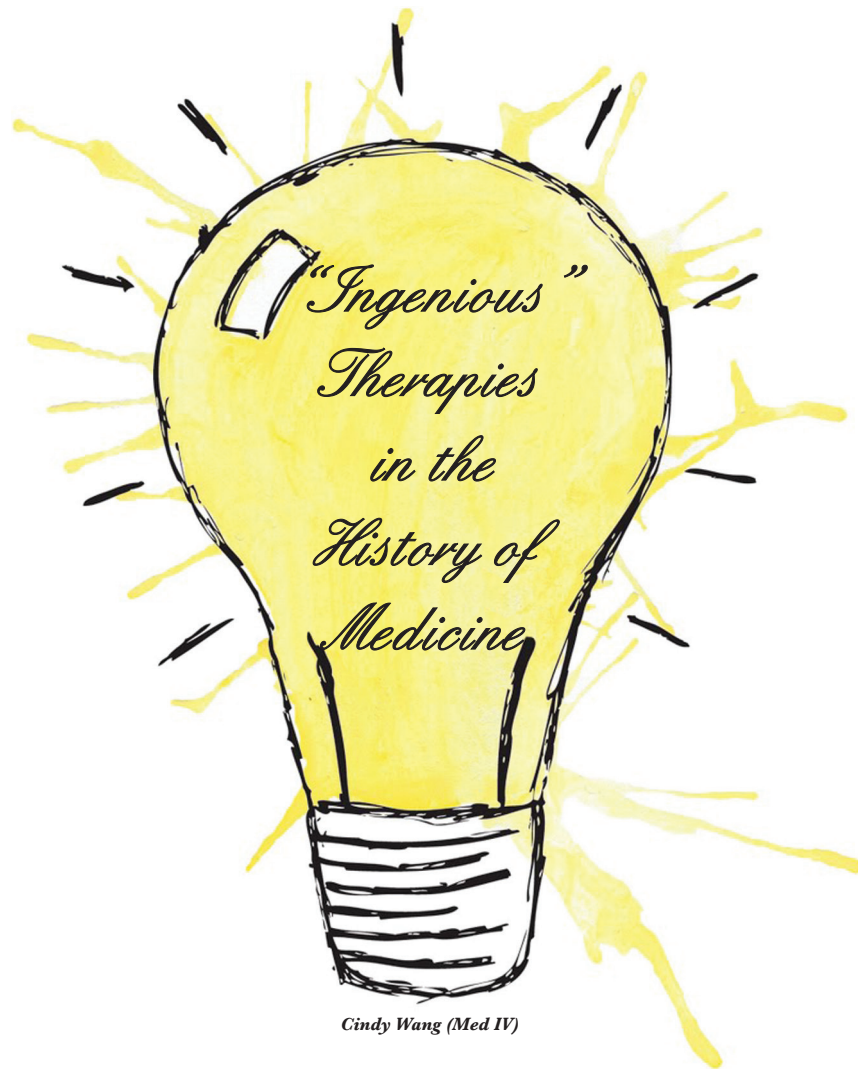
OWEN TSAO (MED IV)

Was there a knowledge abyss between Phase 1 and Phase 2 guarded by none other than the infamous Gandalf the Grey? Was I a college student who gave my hepatocytes a trip to lipid heaven the moment end-of-phase exams had finished? Well, possibly, but let's not go into that.

It is normal as a Phase 1 student to demand relevance in their day-to-day learning, but this "relevant", or integrated approach deeply compromises and takes away the stepping-stones to a sound basis of scientific reasoning in clinical medicine. The point I'm trying to make is that as Phase 1 students: we have no idea what we are talking about (and no I am not being an elitist Phase 2 balloon head as I also admit to being one of those Phase 1 kids once upon a time). Right now I'm telling any MedFac staff out there reading this article: Don't listen to Phase 1 students because they don't know any better! And you will understand what I'm talking about come Phase 2, as you will not have time to look up the mechanism of vitamin K in the coagulation cascade with a clinical tutor breathing down your neck expectantly.

However in doing that, I feel that the Medicine Faculty has forgotten and taken for granted the importance of a solid knowledge base in which one can form their own clinical conclusions and integrate a clinical approach afterward.

Yes you will probably love the less scientifically-intensive side of the new program as a Phase 1 student, but I don't see the point in fortnightly hospital sessions when that time could be used to further knowledge in say anatomy which we clearly need more of. I mean sure, by the end of the degree we should all be in the same boat with the same pool of knowledge, but heck, they sure made it that much harder getting there.



Cindy Wang (Med IV)

Human beings are indeed creatures of wondrous creativity. Afflicted by ailment & disease, we attempt to overcome these inevitable life barriers with an invention we call Medicine. In the battle against death and sickness, sky is the limit when it comes to imaginative medical therapies.

In prehistoric times even before the advent of writing, medicine was largely integrated with the religious and societal values at the time. Healers used magic and rituals to combat illnesses. Indian shamans for instance ‘captured’ animal powers by dressing themselves in animal skins. If dancing around a fire wearing animal skin sounds like your type of medical specialty, you are in luck – some genius is reconsidering shamanism as a medical option due to its “psychosocial benefits.”

Another ingenious practice in medicine was the earliest known surgery performed on mankind. This was trepanation, which basically involved drilling a hole in your skull to release the “evil” spirits that caused you physical and emotional

discomfort. Now if you ignore all the deaths caused by those pesky minor side effects such as infection etc., trepanation can have the benefit of releasing a blood clot or decompressing your brain tissues. Trepanation may sound like a gruesome procedure but a few brilliant individuals still believe in its power to enhance brain function. “Doctor” Hugo Bart Hughes is such an individual and has published on the benefits of trepanation, including an appropriately named autobiography “The Book with the Hole.” Before you go drill a hole in your skull as a last-minute ditch effort to pass your exams, let it be known that “Doctor” Hughes went to medical school and never really quite finished.



Fig.1. Trepanation

Such is our resourcefulness that we even find use for our own waste. Some of the world’s earliest cultures such as Rome and India firmly believed in the healing properties of urine. Over the years, urine therapy has claimed to rid the world of cancer, acne and athlete’s foot. And despite the lack of scientific evidence supporting these beliefs, many famous figures still advocate the practice. An Indian prime minister for instance proposed on national TV that the solution to millions of poor Indians without healthcare was to drink one’s urine. Sarah Miles, a British actress, drank urine for over thirty years because she believed it immunised her against allergies. And Madonna still pees on her athlete’s foot.

But even with the miraculous curative properties of urine therapy, a disease so evil and widespread still affected almost half the population on earth. No, it was not the black plague, SARS, chicken pox or H1N1. It was “female hysteria”. Its dreadful symptoms seemed to affect women exclusively, and included insom-



“...the female would spasm violently, sweat a little but be momentarily cured”

nia, muscle spasms, dyspnoea and irritability. A procedure called “pelvic massage” was developed to combat this disease. By simply massaging the vaginal wall gently, the female would spasm violently, sweat a little but be momentarily cured! Of course, this only held a temporary effect – the female soon had to return to the doctor’s office for a second dosage. While the procedure was simple enough, these doctors (men only, of course) had much trouble administering this. Hence, a mechanical device was developed to sort out the problem. And this was how the vibrator came to be, successfully saving millions of females today from “hysteria.”

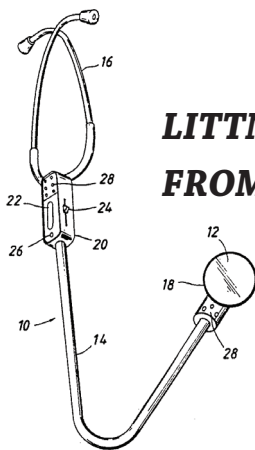
And the list goes on – mercury was pretty much the go-to medicine for every disease imaginable until the 20th century. Its main use was in curing syphilis and it was found to have a profound effect evidenced by a rapidly decreasing STI incidence. However, it was soon suspected that it simply limit-

ed spread by killing people infected by STIs one by one. Another “ingenious” invention was children’s soothing syrup in which the main ingredients were morphine, codeine, heroin, opium and cannabis. Needless to say, the children were deathly quiet.

Yes, these all seemed to make sense at the time. But all is not lost. We did some stuff right after all. The Romans contributed to the improvement of public health and the development of suturing techniques still used today. The Ancient Chinese invented the technique of taking one’s pulse, while the human anatomy was only mapped out through the studies of dissection over the length of history.

Despite some crazy inventions, there does seem to be some method to our insanity.

20 - 60% OFF ALL PRODUCTS



**LITTMAN STETHOSCOPES
FROM ONLY \$90**

WIDE RANGE OF BOOKS

OXFORD HANDBOOK OF CLINICAL MEDICINE
ONLY **\$31.96** - 20% OFF RRP!

**ALL YOUR
DIAGNOSTIC
EQUIPMENT NEEDS**

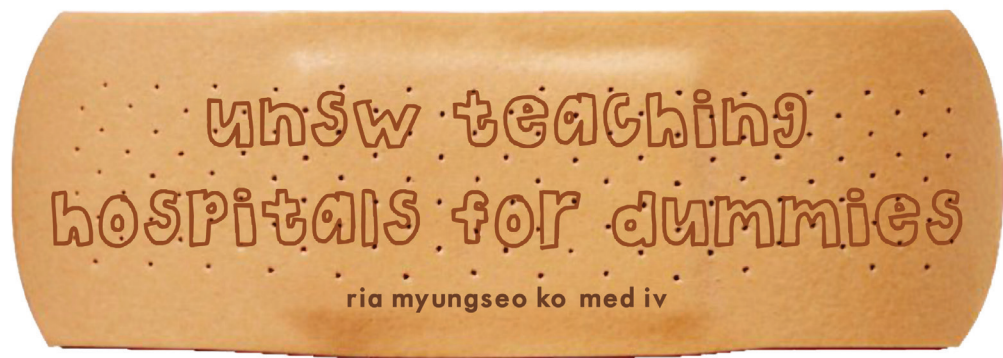
**TAILORED UNIVERSITY
BOOK PACKAGES**

TRADING HOURS
MONDAY - FRIDAY: 11AM - 2:30PM
WEDNESDAY: 3PM - 7PM

ADDRESS
OLD MORGUE BUILDING, BARKER ST
PRINCE OF WALES HOSPITAL, RANDWICK
NSW 2031

PHONE
(02) 9302 2121
EMAIL
BOOKSHOP@MEDSOCIETY.ORG.AU





Warning: Some of the information below may be biased, not the best option or incorrect.



FUN FACTS: 'Rumour' says the Edmund Blackett building is haunted by young children, who were experimented on long time ago.

HOW TO GET THERE FROM UNI BY PUBLIC TRANSPORT: Exit UNSW via Gate 9. Turn right and walk up the hill on High St. Enter via the High St. entrance.

STUDENTS' (WELL, MY) FAVOURITE DOCTOR: Prof. David Yeo (Upper GI Surgeon); some of my colleague says they like Dr. Shing Wong (Colorectal Surgeon)



FUN FACTS: St. Vincent's Hospital is the most posh-looking teaching hospital of all, thanks to the extra funding by a religious foundation. It is also the smallest of all clinical schools.

HOW TO GET THERE FROM UNI BY PUBLIC TRANSPORT: take any 39* bus that goes to Taylor Square (NOT 391), get off at the Taylor Square and walk along Oxford St in the opposite direction from the city. Turn left at Victoria St. Alternatively, you can catch the COFA bus from Gate 8 UNSW, and then walk down to Oxford St from COFA, turn right at Victoria St.

STUDENTS' (WELL, MY) FAVOURITE DOCTOR: Dr. Darren Gold (Colorectal surgeon) & Dr. Kumud Dhital (Cardiothoracic surgeon)



FUN FACTS: More than half, I would say, of patients in this hospital speaks either Greek or Arabic. The education building looks x10 better than the (public) hospital itself.

HOW TO GET THERE FROM UNI BY PUBLIC TRANSPORT: take bus to the Central station and take the train to Kogarah on Southern line (Platform 24/25).

STUDENTS' (WELL, MY) FAVOURITE DOCTOR: Dr Mark Dimitri (Resident)



FUN FACTS: Sutherland shire has the oldest population in Sydney – look forward to your geriatrics term here.

HOW TO GET THERE FROM UNI BY PUBLIC TRANSPORT: take bus to the Central station and take the train to Caringbah station.

STUDENTS' FAVOURITE DOCTOR: for you to find out



FUN FACTS: At the moment this hospital is in the process of grand renovation, after which it will become the largest hospital in the Southern hemisphere – apparently.

HOW TO GET THERE FROM UNI BY PUBLIC TRANSPORT: Train from Central and Liverpool station. It's 5 min walk from the station.

STUDENTS' FAVOURITE DOCTOR: for you to find out



FUN FACTS: There's nothing fun about this hospital.

HOW TO GET THERE FROM UNI BY PUBLIC TRANSPORT: Get the train from Central to Bankstown station, then a bus.

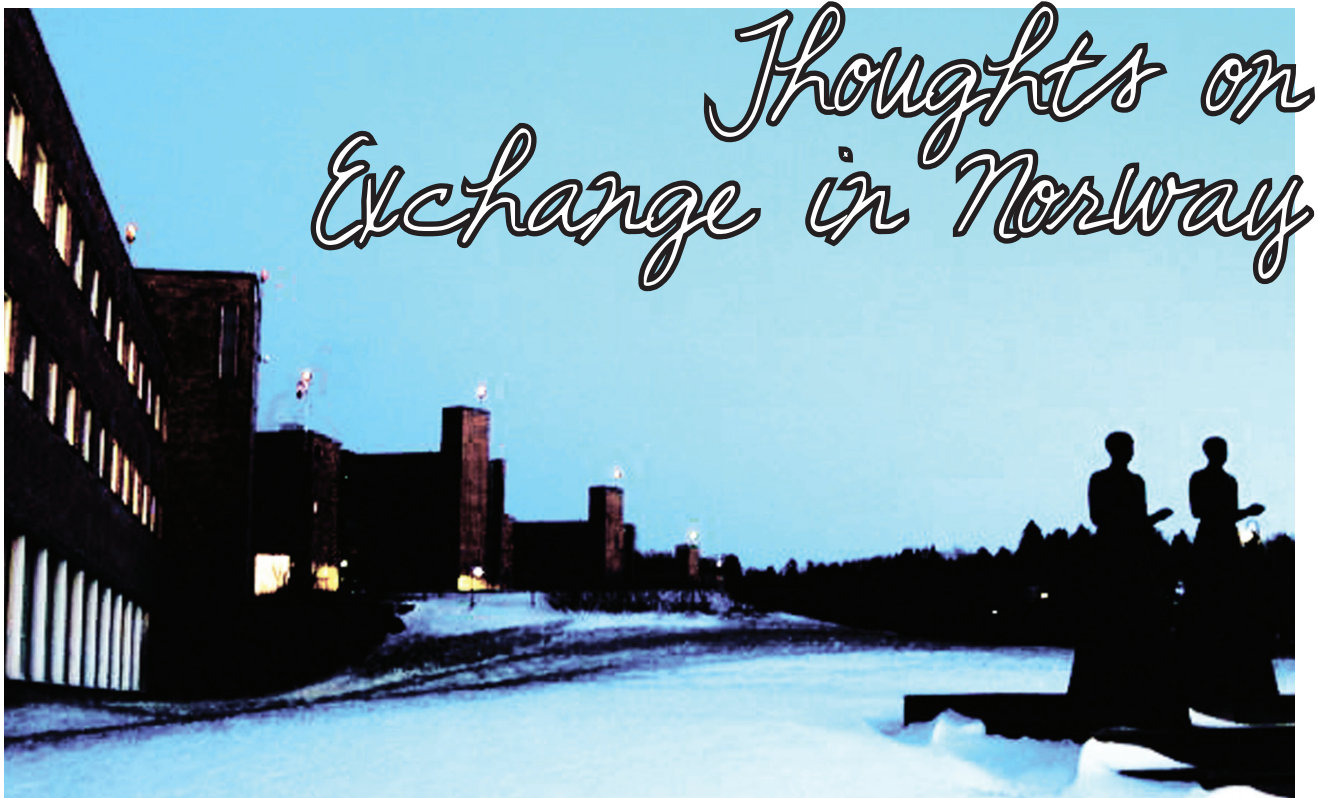
STUDENTS' FAVOURITE DOCTOR: for you to find out



FUN FACTS: It's in Fairfield.

HOW TO GET THERE FROM UNI BY PUBLIC TRANSPORT: I'm sorry but Fairfield hospital is the most pain-in-the-ass hospital to get to from uni. Go to the Central station, get the train to Fairfield, then another bus to Fairfield hospital. If you have a car, I recommend you drive; there are plenty of free parking.

STUDENTS' (WELL, MY) FAVOURITE DOCTOR: Dr. Albert Shafransky (Cardiologist)



Thoughts on Exchange in Norway

Adam Seruga (Med VI)

The decision to leave Sydney's familiar shores to spend a whole six months in the distant land of Norway seemed rather more difficult twelve months ago when I contemplated applying for the Oslo Exchange. I was cautious, about cost, about the length of time away, about leaving friends and family behind, and a whole range of other excuses.

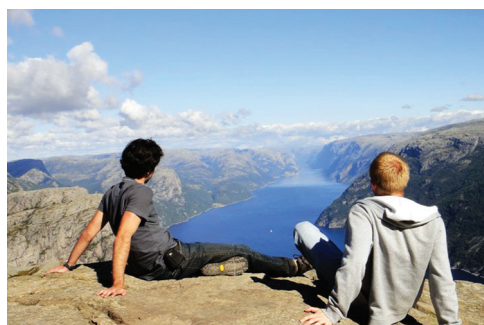
Fast-forward just a few weeks into the exchange and I'm sitting in a sauna in a cabin somewhere in a Norwegian forest or hiking through breathtaking scenery in the mountains or just sitting out on a new friend's balcony with some drinks and with the sun setting on the fjord in the horizon late in the night.

The next six months fly by faster than I could imagine. The excitement of experiencing new things was just as satisfying as the enjoyment I felt from slowly being able to call a new place home after such an extended period of time. Everything that had felt so foreign, like the language, the city, my apartment, the teaching at the university or the white scrubs and scooters in hospitals (which looked more like private facilities thanks to the Scandinavian approach to public healthcare) became familiar and welcoming.

And I even learnt a little paediatrics and O&G along the way.

People coming back from exchange might often sound clichéd when they say they had the time of their life or made amazing new friends, became more independent or any other such remarks. I'm no different and I loved every minute of it.

L-R: Overlooking Lysefjord, End of Semester Party



WHY MEDICAL STUDENTS SHOULD BE MORE

POLITICAL

erin spike (med iv)

“Medicine is a social science, and politics is nothing else but medicine on a large scale.”

These are the words of Rudolf Virchow. Sometimes called ‘the father of pathology’, you probably know him as the man behind Virchow’s triad, which describes the trio of factors that contribute to the formation of venous thrombi. When he wasn’t busy advancing the burgeoning field of pathology, he was a radical and progressive contributor to the 19th Century German political scene. Virchow was ahead of his time in realising that medicine is as much about social and economic factors as it is about the biomedical basis of disease. He believed that it is the duty of the doctor to point out the factors that compromise health and wellbeing, and to recommend ways of addressing them; it is the politician’s duty to turn these recommendations into concrete strategies.

On the one hand, we seem to have learned this lesson: we’re constantly bombarded with evidence that demonstrates the importance of the social and environmental determinants of health. We know that the poor in society suffer from more illness and die earlier than those who are materially better off. This is not just the case for the absolutely poor, i.e., those who are unable to afford the basic necessities of life; it also holds for people who are relatively poor compared to others. Relative poverty contributes to social exclusion and isolation, which in turn contribute to negative health outcomes.

And it’s not just economic: we also know that those who are discriminated against or disadvantaged - whether on the basis of gender, race, religion, or any other reason - also have poorer health and poorer access to health services. The tragic disparity in Indigenous health outcomes that persists in Australia is very much witness to this.

But what do we do with this knowledge? Most likely, not very much. There are, after all, plenty of public health experts whose job it is to highlight inequities wherever they exist, and gather evidence as to how they can be addressed. And things aren’t so bad - are they? It’s easy to be complacent about how good things are in Australia, but it’s not all progress. Income distribution in Australia has worsened in recent years, not better. And Australia is part of a global community that is facing an increasing number of challenges. Global economic instability and the impact of climate change do not have any respect for national boundaries, and, if unaddressed, will have repercussions for all of us. Then there is the matter of the shocking and inexcusable inequities that exist throughout the world and are, in some places, widening - not only in terms of income and a decent environment to live in, but also in terms of access to health care and education, and most importantly in terms of power and opportunities.

Accountability is one of the cornerstones of democracy, but true accountability can only occur when civil society is committed to scrutinising governments and pointing out their shortcomings - and doing it loudly. As people who are presumably concerned with maximising overall health and wellbeing, it is our responsibility to become more politically aware and to critically analyse the health impacts that policies will have both now and in the future. It is up to us to identify deficiencies in current policy, and come up with ways of addressing them - and making an effort to communicate these, whether it’s by writing in to the newspaper, sending a letter to a politician, attending a demonstration, or even just making our views known to another person. And it’s not just health policy we should be focused on. Whether it’s environmental policy, trade policy, immigration policy or tax policy - almost all political decisions will have a positive or negative impact on wellbeing for some groups in society; it’s up to us to think about what this impact might be, and whether it will be beneficial and fairly distributed. And if it won’t be, let’s make some noise about it.



The iPhone, and its stripped-down brother the iPod Touch, are amazing little mobile devices—by no means the first smartphone/PDA to hit the market, they are undoubtedly the first to bring smart, mobile technology mainstream. With the launch of the first-gen iPhone in 2007, Apple introduced to the world the importance of beautiful and intuitive interface design, using natural metaphors like swipe gestures and inertia-scrolling. With this watershed launch, the entire industry was forced to shift. And what a glorious thing it was.

This is my fifth and final Idioglossia article as I've been writing since starting this course in 2005, and hope to complete it this year. In the past I've brought you views on videogames as art, dance/rave culture, and general things that annoy me. Some of these articles I'm immensely proud of, others not so much, and while I doubt my readership had ever consisted of more than three people, I've certainly enjoyed my time here. My work, amateurish as it may be, has certainly improved for the sake of these editorials. This year, I've decided to shift gears—to mix it up, or break it down, or whatever the kids say these days. Here I offer practical advice on getting the most out of your iOS device, not just what to buy, but how to think when it comes to usage. So consider me your expert—nay—Champion in matters of technology, I've been using handheld mobile devices before they were cool. My first device was the Palm m505. Remember those? No, of course you don't.

iPhone vs iPod Touch

The iPod Touch, while retaining the screen resolution and A4 processor chip of the iPhone 4, still suffers from an older screen-technology, half the RAM (memory), a very substandard camera, no GPS, and obviously no cellular capabilities. While no-one knows for sure, you may consider waiting till later this year for the fifth-gen iPod to be announced, in the event that it inherits the iPhone 4's excellent camera. Considering how ubiquitous the iPhone is, it's safe to think that many of you have already made your choice. However, those who would rather own an iPod as companion device to an inexpensive smartphone do have their reasons. Firstly, this combination is an excellent way to get to use an iOS device without having to fence a lung or kidney. Also, keeping the two devices separate means less drain on each battery, with each device providing a bit of redundancy. Ultimately, it comes down to whether you like convergence-devices or not, and your personal usage philosophy. I love my iPod Touch, if only for the geeky nostalgia of my Palm PDA days.

The App Store

It often confuses me why so many iPhone users never go beyond the factory-standard apps that ship with their phones. I'm baffled by why these people will pay hundreds of dollar for a flagship smartphone and only use it as an entry-level Nokia feature phone. "Oh, but it's the user experience," they say in defence, acting as if paying \$800 for a glossy interface is somehow less deluded. But I ask, why not do more? I think many will agree that there's a whole lot more functionality to be unlocked. The App Store is home to millions of third-party programs ranging from games to productivity to medical references. While it's often a chore to sift through the endless expanses of cruftware to find that one amazing app, you will find a lot of good stuff here. I've pared down all my hours of browsing to a list of App Store Essentials.

Jailbreaking

Sooner or later, if you're into optimising your iPhone for better performance and functionality, you'll be thinking about jailbreaking. First off, jailbreaking has a very low potential for harming your phone, and is fully reversible by simply upgrading or restoring your device through iTunes. The process of jailbreaking is a safe and easy method of modifying your iOS firmware to allow the running of custom code. What this means, is that you will be able to tweak your iPhone in ways that Apple doesn't officially allow, including having the ability to download App Store apps for free. The latter is, strictly, a less-than-legal way of obtaining many expensive apps for no charge, and is not recommended unless you don't care about the law. However, jailbreaking itself is not illegal, and is simple to do. First, check your iOS version against the table on the Wikipedia entry for "iOS Jailbreaking". This up-to-date table will inform you of whether your version has been cracked yet. Note that if your version is "tethered", this means your device will lose the jailbreak every time it resets or loses power. This is extremely difficult to work with, and you should refrain from jailbreaking until an untethered version is released.

If your version can be jailbroken, it's time to choose an applicable jailbreak package. The most prominent release is known as "redsn0w", and is on both Mac and Windows. Once your jailbreak is applied, you should have access to an app called "Cydia". This is akin to the App Store for third-party tweaks and apps, and there is a lot to discover here. Using redsn0w and Cydia is more complex than the scope of this editorial, so I'll leave that to other internet-experts and friends-of-friends to help you out.

Some essential Cydia apps to look out for include:

// **Lockinfo**: while the default iOS lock-screen looks embarrassingly bare, with Lockinfo it hosts a variety of info panels, from weather to calendar appointments, missed calls, emails, etc. With an elegant presentation and high customisability, Lockinfo puts your info in a place where you can easily access it, without digging through dozens of apps.
// **Installous 4 + AppSync**: this combination allows you to install any of the huge library of pirate apps from a repository such as appttrackr.org. Your iPhone will still be able to download paid-for apps through the App Store, so this one is really something to consider.

Jailbreaking for medical usage

Ultimately, this is the reason I choose to jailbreak--the App Store is host to many invaluable medical references that each cost \$60 or more, produced mainly by Medhand and Modality. While we can debate the morality of this, buying these apps would cost us thousands of dollars just for the privilege of viewing some references on a phone. This happens to not be an option for me, and I also happen to think it quite ridiculous.

Thus, we have Cydia, and appttrackr.org, which has many of these references available for download. At the time of writing, there are 10 Oxford Handbooks (Anaesthesia, O&G, OHCM, Surgery, Clinical Diagnosis, GP, Paediatrics, Psychiatry, Critical Care, and Emergency) available, as well as 6 Netter's atlases, the Merck Manual, and Lexi-Comp: an up-to-date drug guide and clinical reference library containing texts such as Harrison's Practice and 5MCC.

I won't speak about how you can obtain these, as this may not be entirely appropriate. Let this editorial be my account of my experience with my iOS device, and allow it to guide you to make better use of your technology. Happy hacking.

App Store Essentials

// **TuneIn Radio**: the best app for listening to and recording internet and local radio, with tonnes of features and an extremely comprehensive database of channels.

// **Pulse News**: originally \$4, this fantastic graphical news-reader is now free! In my opinion, the best RSS reader out there: it's fast, easy to use, and very pretty.

// **Instapaper**: Save clippings online to your free Instapaper account, and sync them up with this app. Now you can read these articles anywhere. Probably more useful on an iPod.

News/Media

// **Wikipedia Offline**: If you're on an iPod Touch, you need this app. Pricey, but imagine having the entire Wikipedia in the palm of your hand! Requires 3Gb to install, but no joke, the whole Wikipedia is here (no images).

// **TripView**: complete Sydney bus, train and ferry times. Set up trips and get live timetables without having to go online.

Reference

// **Calvetica**: no doubt about it, the iOS default calendar oozes bad design, where adding a new appointment takes more than six taps, and a huge amount of fuxing-around. Here in Calvetica, a new appointment is as easy as tap, tap, type. The calendar looks sexy too.

// **2Do**: with iOS lacking a proper To-Do list, this app is probably the best-priced and most fun to use. Useful for shopping lists, or to-do planning that doesn't fit on the calendar.

// **Memento /Evernote**: both attractive diary/note-taking apps, use these for jotting down ideas day-to-day. They also may be repurposed to tracking expenses or receipts.

Personal Information Management

// **Documents To Go**: an office-suite for iOS that lets you create and edit Word, Excel and PowerPoint files. What sets it apart from other solutions is that it preserves all formatting, so you can rest assured that editing your case report won't mess up those line-breaks.

// **Air Sharing or ReaddleDocs**: both excellent document viewers, allowing you to sync files across onto your phone and view them in one place. Most importantly, these apps can deal with large PDF files that would crash the native renderer.

// **Perfect OCR or Genius Scan**: these apps make use of the iPhone 4's excellent camera to scan documents. Both take very readable scans under good conditions, and Perfect OCR can extract text, but takes much longer.

Productivity

MEDSOC

Presidents Report

Mike Chan

Change, Development & Renewal

Over the summer break the Medsoc Executive and Council have been developing a number of plans and events for 2011, based on the foundations of past Medsoc Councils/Executives. With an organisation that has spanned for decades with many different faces, it has been a privilege to talk to so many medical students who contribute with ideas that change, develop or renew the role of Medsoc.

Medsoc has traditionally been exceptional in its social-based and leadership-based events, as many had seen last year. We look to build upon these and add a greater number of academic events, and help promote events regarding social responsibility.

The existence and quality of a society of medical students is not based on sponsorship, spending, hype or the nice food platters that you sometimes see. Rather, it is the character of many students, not just elected medsoc members, but a plethora of medical students putting their time and effort to help each other.

Development

Grand round evenings (Fortnightly) – A combination of postgraduate specialisation information and integral/interesting clinical cases associated with the specialty Sign Language classes (TP2) – tailored for med students

Changes:

- More diverse first year mentoring programme
- Increasing the training of tutor/mentors for South Sydney Youth Services, and branching Medsoc charities beyond a fundraising group to include advocacy
- Increasing the volume of students to participate in Mock – ICE (MICE) and Mock OSCE (MOSCE)

- Special interest groups (SIGs) event promotion, mandatory events.

Renewal:

- Amazing Raise - New locations and challenges
- Medball - Different theme, different venue
- SB Dowton Leadership Seminar - Inspirational speakers
- AMSA subcommittee focusing more on internship and postgraduate problems
- Talent/Classical Quest – new and familiar people putting it out there!
- Life in the Real World – new format
- Medshow – what will it be about this year?
- Financial Planning Series

I'm looking forward to 2011 and seeing as many of you getting involved.

2010 –What a wonderful year for UNSW Medsoc Charities

Aditi Mahajan, Grace Leo & Lawson Ung

It goes without saying that medical students enter a field in which their social responsibility is emphasised, arguably more so than other professions. For some this can be daunting. After all, how can individuals possibly influence the lives of others in a meaningful, kind way, especially when there are so many who need help? 2010 proved however that these barriers to aiding others and fulfilling our own social obligations pale in comparison to the warmth and generosity shown by UNSW students.

The figures do not lie. We raised over \$10 000 dollars for charity as a group, funding a whole host of charitable causes, from the medically-related to helping remote communities all over the world. We've set the bar high: no longer was it enough to

raise \$20 for the Amazing Raise, this figure soared to \$100 per team. The reward for our faith in the hearts of all UNSW Medical students? Over \$7000 raised from one day alone, with all proceeds going to the Medical Students' Aid Project. Even the gods approved, giving us glorious sunshine on what began as a dreary, cold winter's day.

Our success did not stop there. We raised over \$2000 for Medshave, supporting the Leukaemia Foundation through innovation alone. Stores were set up, glitter was aplenty and hairspray abundant as we systematically sought to decorate our hair for a worthy cause. And what about selling merchandise for the NSW Cancer Council, where was received so well by our fellow university students?

The tradition of UNSW Medsoc being a generous, warm and giving organisation continues. In a world where much could be done to alleviate needless suffering and give a hand to those who need it most, we are glad we did our bit in 2010. We wish our current Charities officers, Kelly Chen and Lorraine Cheung warm wishes and the best of luck.

Congratulations go to Lilian Zou, Tim Nguyen, Alex Ngo and Vivian Yeung for raising over \$1000, the top fundraisers in 2010.

Australian Medical Students Association (AMSA) update

Henry Ainge Allen

I'm writing this off the back of what can only be described as the most intense rego for AMSA's National Convention yet, with over 2000 people trying for 1000 spots!!! Insider information is saying that Sydney2011 could have the largest number of UNSW delegates in Convention's history. All that I can safely say is that the

REPORTS



only thing more certain than my morning hangovers (and leftover bodypaint) when I hit up the 9am Academic sessions with Dr Brian Davey (Medical Director of the UN), Prof Vinay Kumar, Dr Nick Talley and Dr Simon O'Connor is that this year UNSW is going to be showing those other unis exactly how to party, since thats just what good hosts do[FM].

AMSA's Global Health Conference (hosted by UNSW this year) is set to be one of the best yet, with lectures, workshops and panel discussions focusing on the health of the developing world and marginalised populations. Speakers include Prof Patrick McGorry (Australian of the Year and leading International researcher on mental illness), Mr Julian Burnside QC (human rights and refugee advocate) and Dr Nelson Martins (East Timor's Health Minister).

Its not all fun and conferences however. AMSA is primarily an advocacy organisation for all Australian medical students and I wouldn't be my job if I didn't update you on what we are currently advocating for. Our biggest issue remains the continuing increase of medical student numbers without the infrastructure to support that number of medical graduates as Interns in the hospital system and AMSA maintains its position of advocating for quality Internships for all graduates from Australian universities and opposes any move that might compromise the quality of medical education, whether that be during medical school or after graduation.

If you have any questions or want more information please contact me at amsa@medsoc.org.au

The Medical Student's Aid Project

Patricia Ly & Andrew Iskander

What is MSAP?

Contrary to what many believe when they read our name, the Medical Students' Aid Project is NOT a fund to lend financial assistance to med students impoverished by the crippling study load. That apostrophe is very, very important. Nor is it Medical Students' Aids Project, as we have once been called. Rather, it is an initiative which aims to provide medical equipment to some of the developing world hospitals the fifth year students are hosted at on elective.

The UNSW Medical Students' Aid Project (MSAP) is a student-run initiative aiming to deliver vital equipment and medications to hospitals in the developing world. It was started by two UNSW medical students, Greg Fox and Greg Moloney, who returned from their electives in 2001. They were on an elective term in a hospital in Malawi, and while trying to attend to a patient injured in a car accident, they only found in the resuscitation box a band-aid and a dead cockroach. The realisation that much of the basic medical equipment which we take for granted at home is prohibitively expensive for many hospitals in less fortunate communities led to the establishment of MSAP.

Through MSAP, students have the opportunity to give something useful back to the communities that take them under their wing. From gloves and urine dipsticks to defibrillators and cardiotocograph machines, MSAP enables medical students to really make a difference in places of need.

What can you do?

It's all to easy to help out by attending meetings and MSAP fundraising events, As the Global Health group at UNSW,

we also aim to raise awareness on global health issues, so come along and help us decide what issues to advocate this year!

The fortnightly meetings are laid-back and jovial and there is a strong sense of camaraderie amongst the group – you're welcome to come join us at any time!

Get excited to be a part of one of Australia's largest and most well established student-run global health initiatives.



Proudly Supported By

