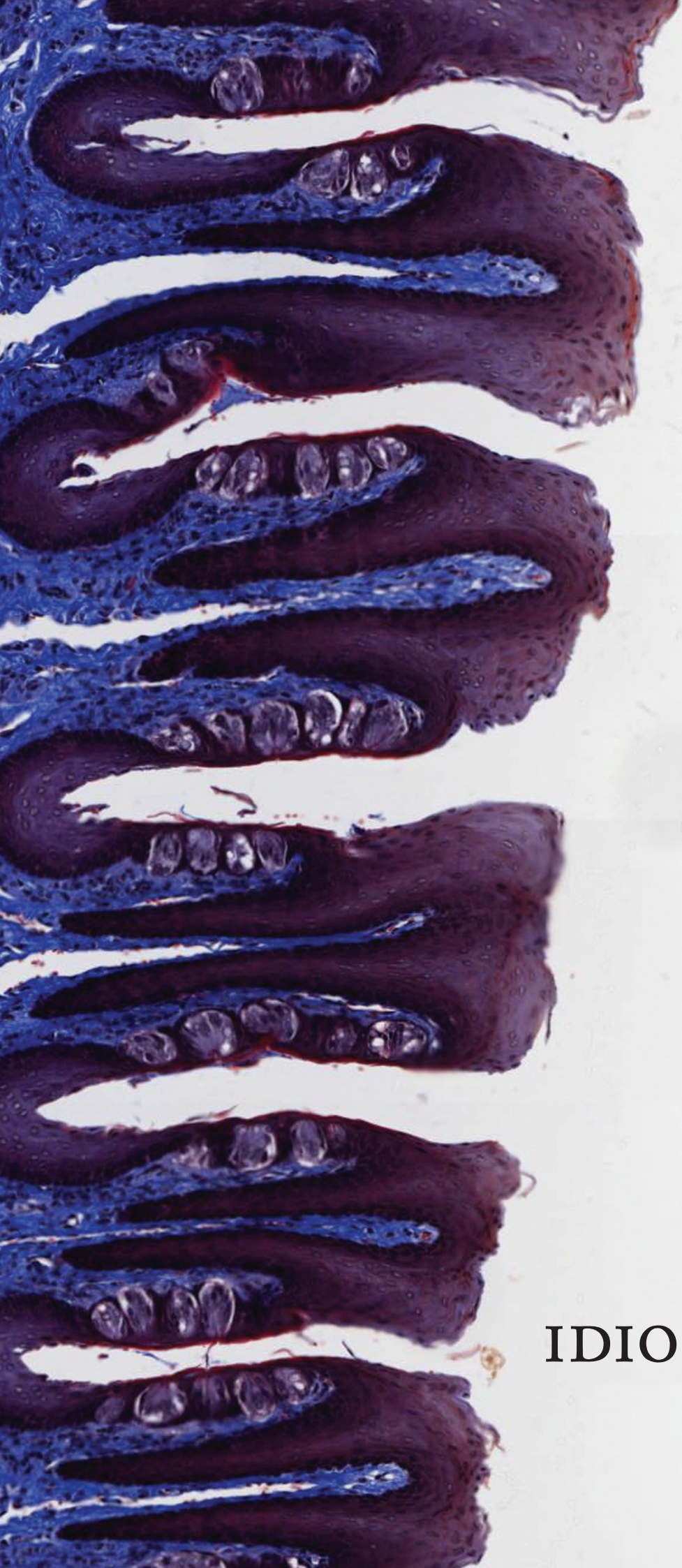
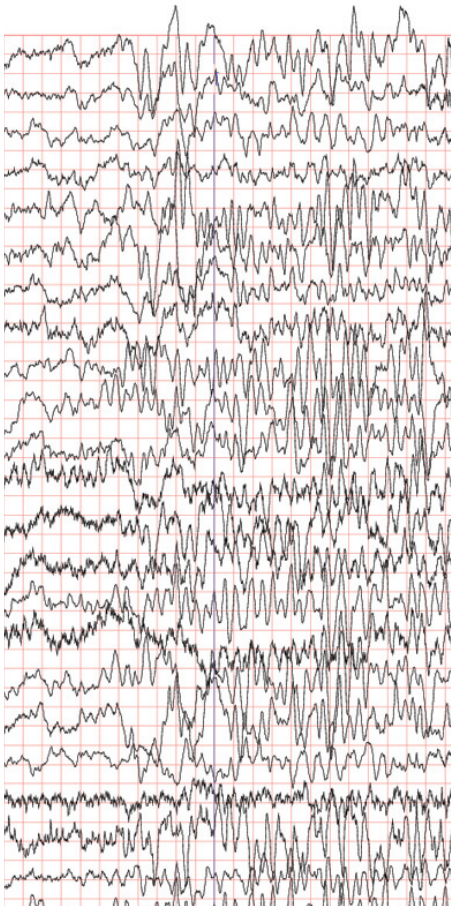


IDIOGLOSSIA 2011

issue two



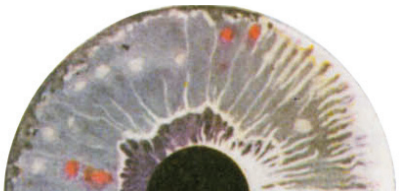
from the editor

Wikipedia states that *idioglossia* is an idiosyncratic made-up language spoken by one or few people, deemed nonsensical by others. Like being in a very exclusive club, it is most commonly found in twins, as you might have figured from The Simpsons twins Sherri and Terri, and famously portrayed in Jodie Foster's Nell.

I guess then, it is not uncommon to find the typical medical student engage in their own form of cranio-megalo-spastic idioglossia. Maybe those we deem mentally disadvantaged are simply engaging in their own idioglossia, uttering to each other how silly and verbose the English language is.

Whatever the cause, I hope this publication may decipher this idioglossia for all and let those, from the neanderthal grunting first year to the finely sculpted inner auricle of the communications tutor understand the issues and opinions that plague the medical student of today.





Feature Articles

UNSW Medsoc Reports

Conferences

Edited by Owen Tsao | Designed by Angela Lu & Owen Tsao



HALF YEARLY REPORT

FROM VISION TO IMPLEMENTATION

Outline:

- More events & student participation to come
- Student Academic Support & Special Interest Group development
- Sports and Social update
- Branching out Medsoc to other universities
- Internship: Updates & Changes
- Updates on Rural Placement and Policy
- Consolidation & correction of financial position

Since the end of 2010 as the Medsoc Council-elect, there were many new and revised plans to try and 2011 has been a very unique direction for Medsoc. First and foremost I would like to congratulate the highly motivated Medsoc Council in the work that has been done so far this year. We had set out an agenda to become more inclusive, more involving and more dynamic by implementing many new events. However there has been an element of what can be described as "growing pains" for our society as the reality of running up to 4-5 events or meetings a week catches up with our elected members.

-

I have been extremely happy with the development of frequent grand rounds and large-scale mock-ICE/mock-OSCE. Although these were initially a logistical nightmare, many students have given Medsoc extremely positive feedback and should be a regular expectation for students to come together and help each other in a professional manner and develop inter-year camaraderie.

UNSW Medsoc, particularly through open discussion and frequent meetings with students and the Faculty of Medicine, have taken significant steps to reform Special interest groups. With Navid Ahmadi (VP) drafting a code of conduct, there are now key standards to provide a way for more students to do something that helps other students consider professional and academic interests beyond the curriculum. We have been keen to stamp-out SIGs that do nothing but become vehicles for CV-stacking, and been unapologetic in removing/suspending three SIGs this year, whist encouraging growth in this area. I am very proud that UNSW Medsoc has one of the largest, if not the most, number of Special interest Groups of all medical student societies. Our framework has been commended by other Medsocs at AMSA's July council as a sustainable manner to address growing student activities.

-

With the raging success of AMSA convention this year, for which a record number of UNSW students participated in, one unintended consequence has been renewed vigilance for the consumption of alcohol at social functions. The continuation of classical quest, talent quest and development of alternative social-themed nights such as trivia night and a potential jazz night illustrates a developing maturity in Medsoc social events

other than End of Session parties, pubcrawl and Medball. I hope you enjoy the photos and reports from these events.

I would also like to commend our inaugural sports representatives who have pulled off many sporting events throughout the year as well as organise UNSW Medsoc's teams for inter-campus events. Although we were narrowly pipped at the end at the NSW MSC sports day, there is no doubt that with the groundwork that Josh and Ben have done, that next year will be more successful.

-

Cooperation beyond our Medsoc, but with other universities has been another goal for this year. The fourth SB Dowton Leadership Seminar is one key example where cooperation with NSW MSC has led to increased participation and sponsorship. Furthermore a number of students from multiple universities in NSW have enquired and attended about our UNSW Medsoc Grand Rounds with a view to videoconference to interested students studying medicine at the University of Wollongong and University of New England, once issues with videoconferencing to UNSW Rural clinical schools are ironed out.

-

Calvin Park and Ria Ko have provided a number of initiatives at the university level to inform students about the potential shortages of places, which have included the well-attended international students' night. Furthermore they have been key advocates, coming with me to NSW MSC meetings to have a statewide body truly examine the issues of international medical students and providing solutions, rather than being fudged off. I am somewhat dismayed at the complacency and insensitive comments made by some local students of various universities: because beyond 2012, there is no written guarantee that local students will receive a placement.

We have worked with Kyle Sheldrick of NSW MSC to draft up policy that includes all students trained in NSW should be able to receive an internship. Although it may seem far away we have worked to extend the bare minimum: local students guaranteed places to 2014 – the end of the state electoral cycle. This still means that first and second years miss out, and having been in that position in my first year, it was quite concerning and certainly knowledge and involvement in the issues lead to better outcomes.

It's still after 5 years: watch this space and get involved with future discussions in AMSA think tank and international student nights. Also there is an upcoming international students' dinner – see mailouts for more details!

-

This year, thanks to our rural representative, Hanna Grimson, I felt that we are developing traction to better address concerns of rurally allocated students and the perceptions of rural placement. A number of key issues such as how extended rural clinical rotations are allocated will remain contentious for any student involved and there is a risk of alienating a large group of students. Rather, we need to work on our poor institutional knowledge about rural issues and a number of active rural representatives need to closely work with RAHMS, Medical Faculty and the Rural Clinical Schools to promote optimal outcomes.

Long term vision

Our Medsoc has been under consistent financial pressure with increasing dilution of traditional sponsorship revenues directly related with the establishment of three new medical student societies since 2007. I am wary of a longer-term outlook as to maintain quality events to students.

We had two options:

1) Charge a fee for membership (ranging from $50-100) and pass on costs accumulated by UNSW Medsoc, including charges for AMSA membership fees.
2) Maintain our policy of making events as free and as accessible as possible.

We remain committed to providing a low-cost but highly effective Medical Student Society, however this requires a number of changes, as a few wonderful ideas, particularly workshops focused on improving communication and dealing with bad news were not realised due to being extremely cost-prohibitive.

I advise that UNSW Medsoc needs to continue creating challenging, new and low-cost events that appeal to both traditional medical defence organisations and new sponsors. Furthermore, while ARC incorporated have been extremely beneficial in regards to fiduciary and legal advice, UNSW Medsoc needs to embark on capital protection in the next year to guarantee revenue streams in what is considered an unstable economic period.

One year is not enough to address this key issue, but the ground-work for this has been laid out in 2011:

- Re-organising the work done by Medsoc in 2008 in establishing a Trust Fund with UNSW Medsoc as the beneficiary.
- Advice has been sought from

multiple financial institutions in regards to low-risk capital management.

- Establishing a sponsorship team, rather than an individual. This will bring UNSW Medsoc into line with other Medsocs of similar size. A constitutional amendment has been suggested for the next EGM/AGM.

Furthermore institutional knowledge is a key factor to coherent changes from year to year. 2011 has been a peculiar year in that very few council members had held any previous council or executive position. To rectify this, we are establishing a 2-3 month shadowing programme at the end of the calendar year for the Council-elect to join in on meetings and events with the current executive.

-

At this time of writing with just over one teaching period to go, there will be a final buzz of activity and many opportunities for students to enquire, be concerned about issues and get involved, from Medshow, numerous academic events, Medball and Medshave. Whilst the book hasn't quite closed for 2011 just yet, it is wonderful seeing many younger students getting involved with an eye on shaping Medsoc in the years to come.

Michael Chan | UNSW V

Hitting the Button

Chris Long | UNSW

I'd always assumed that by the time I graduated medicine, my job would be conveniently handled by robots. Not an unreasonable speculation given the inhuman amount of time it takes to complete a medical degree. Perhaps for that reason I never felt an urgency to get my studies out of the way but rather adopted a "study of life" approach to university. Three years, two around-the-world tickets and an arts degree later, I returned to medicine to make the shocking discovery that the Sydney hospital system did not resemble the set of Bladerunner.

It was time to take out an insurance policy: become a real student. After a year of living dangerously overseas, I had to make a few changes to create an environment where some level of learning could occur. Some of these will seem obvious, some may not. I don't pretend to be the authority on being a student. However, I found this handful of simple concepts, once implemented, was profoundly helpful in getting back into the rhythm of med studies without having to become a robot myself. If, like me, you're returning to full blown medical studies after a year away, ILP, or perhaps just a no-show first year then perhaps these will help you too.

Make a routine and stick to it. Good habits are far more useful than one-off bursts of effort. You'll find your working life is made up of both, but its far more valuable, not to mention less effort to develop a routine and stick to it, than to have to motivate yourself from scratch every time you need to get something done. Once established, a good habit takes care of itself with little conscious effort on your part. That frees up all that extra energy to focus on actually learning. Or relaxing. Either way a good routine is the closest you'll get to having an autopilot. Make a habit of collecting good habits. Here are a few more.

Stay on top. No surprises here. Staying on top of things is not only less stressful than last minute catch-ups, but it actually ends up being less work too. Take it from a serial crammer, I wish I'd gotten onto this one earlier I would have been able to enjoy a human sleep pattern and a better WAM. Getting that credit after one night's study on a 15% attendance quarter might make you feel like a god at the time, but your not fooling anyone. Next phase when you hit the exact same subject and you've only managed to retain 10% you'll lose any time you saved. It's been said that medicine is like learning a language. You don't get fluent by cramming the night of your exam. If you come up against something you don't know look it up while it's still on your mind. It goes in much easier now than three weeks later when you can't remember the context. Keeping up is worth more than the sum of its components. Turning up to class doesn't hurt either.

"...cramming is the reason why going out during the week or getting a part time job can actually help your studies."

Get organized. There was a time when I believed preaching about being organized was tantamount to announcing your retirement from dating. It's ironic then that getting everything together has actually given me more time to pursue extra-curricular activities. Regardless of what you do in your free time there's a lot to be said for not having to claw through a maze of lecture notes and expired paperwork every time something needs to get done. I'm not saying you have to divide your entire life into appropriately labeled boxes (although that might be a solution for some) but there's definitely something Zen about having a clear working space and being able to find things where and when you need them. Write a list, get a filing cabinet, use your calendar, break larger projects into small manageable steps and do something towards their completion every week.

Use your Sundays. A day traditionally reserved for mourning the loss of weekends and brain cells. But if you can scrape together what's left of your brain and get something constructive done you'll have that much more space to work with the rest of the week. No matter how good of an idea it seems at the time, when you look back on your Sunday the nine hours of Biggest Loser reruns you've watched never weigh up as nicely as you'd hoped. Even if you can't face any higher order thinking, use the opportunity to clear all the mindless upkeep and errands that accumulate during the week. Hit the reset button and tie up any loose ends so you can hit the next week with momentum behind you. Then enjoy the rest of your weekend guilt free.

Work short hours. The less time you allot to a task the faster you get it done. If you have all night to do a reading guess how long it's going to take? That's why cramming is so popular. It's the reason why (done correctly) going out during the week or getting a part time job can actually help your studies. Having less time to work with squeezes out all those procrastinating excuses and sharpens up your focus. I actually learned the name for this phenomenon the other day. It's called Parkinson's Law. Look it up. Then stop doing it.

Start strong finish easy. All too often, unappealing tasks are left to the end of the day. The harder the task the longer the list of "important errands" that inevitably materialise. Usually you don't even know this is happening until you come out of a daze and find you've spent the last two hours alphabetising your DVD collection. As a general rule, if cleaning your room sounds like a good idea there's probably something important you should be doing. Problem is, by the time you get to that important Teamwork Assignment you've expended your mental energy on your new DVD catalogue and can no longer read. Cluster your most challenging tasks towards the beginning of the day when you're fresh and alert then work your way down.

Get a life. While it might sound at odds to everything above, it's really one and the same. Everything mentioned ultimately comes down to being more efficient so you can do what needs to be done then get back to everything else. Keeping the balance is important not only to staying motivated long term, but also for your day-to-day productivity. You get things done a lot faster when you're friends are waiting for you at the local, than when you've planned a night in with your Pathology textbook. Get a hobby and get involved in co-curricular. The intangibles gained here are often worth even more than the weight they add to a resume.

Look after yourself. Eat well and exercise regularly. We're meant to be championing good health after all. Any time expended on exercise will be repaid in longer better waking hours. Most importantly, socialise! This isn't an excuse to party eight nights a week then come crying to me when you fail A&E. Everything comes down to balance. Look out for the people that matter to you. You should have done enough aged care by now to know what happens when people don't. Enjoy your life and the people in it. Otherwise we're no better than the robots.

These simple strategies only scratch the surface of what it takes to be a good student. However for me they've provided a helpful baseline to build up from. If you're in undergraduate medicine, you're already among the top students in the state. There's no substitute for hard work. But good strategy ensures your efforts never go to waste. Consistently make small adjustments and improvements and you'll find that over time you are able to create dramatic improvement almost without noticing. At least until the robots put you out of a job.

A Kind Of Death: personal memoirs through six years of medical school

Jason Lehr

Life is a process of becoming, a combination of states we have to go through. Where people fail is that they wish to elect a state and remain in it. This is a kind of death.
Anais Nin

Six years is a long time. I thought about this today, in all its melodrama, after questioning how pretentious one could be writing my memoirs at 24. But I'm going to write to you anyway, because I've always written a column here.

I've come to the conclusion that after six years of study and maturity, I'm barely in any better position than I was leaving high school. As said before, six years is a long time: the world changes drastically at this resolution. I've felt myself stuck in the cultural vacuum of medical school, watching my friends go on to live lives and work ho-hum nine-to-five jobs, earning money to spend in their eight-hours of downtime.

You ever played a Japanese RPG like Final Fantasy VII or the Persona series? You're given a bunch of characters and forced to grind through some linearly designed world, gaining enough levels to face off against an arbitrary boss. Upon victory, you're treated to a forty-five minute cut-scene with the worst voice acting conceivable, before you repeat the whole cycle again.

This is what medicine is like. I have come to realise this, and looking at things now, I realise don't want to spend the next decade studying for tests where the reward will be more, tougher tests down the line. I wish I'd known this much earlier. I also wish I'd figured this out during a marathon session of Persona 3 back in 2009, but alas, the knowledge was the result of a much quieter epiphany. I just wore myself out as the years crawled. As least in Persona 3 I had cooler hair. And we got to fight robots and shit.

2006 Hard Dance Save Your Soul

Do you see how I'm using past Idio articles as framing devices for my narratives? Ooh, aren't I clever? In 2006 my friend was Idio editor and asked me to write an article on whatever I wanted. I believe this was back when Idio was just a publication by people who studied medicine, rather than a publication about medicine by people who don't have anything better to write about.

So I wrote about rave, because that was what I lived and breathed and annoyed-everyone-the-f***-out-of at the time. Rave was the culture surrounding all-night dance parties of electronic music and drugs, and I had discovered both then. What a time it was!

It started as a drunken invitation to go to a local club, and the rest—as they say—is history. In 2007 I travelled to Amsterdam to pursue a love of Trance, House and Progressive, and along the way had met amazing friends who shared nothing else in common with me. My article even served as passage into the scene from another student, who approached me a year afterwards to tell me of his own experiences—a passing down of my own initiation.

But over six years, things had become nigh unrecognisable. I remember Future Music Festival debuting on the heady year of 2006, headlined by Armin van Buuren and an intimate crowd of 3000... And I remember four years later, reading Ke$ha on the 2011 line-up, and immediately wanting to going to bed at like 7:30.

2007 Lifehacker

While this piece borrowed its title from an internet term meaning "a productivity trick or technique aimed to improve organisation or workflow", what it devolved into over its countless (two) drafts was an extended bitch-session about people with expensive phones, Mac users, and people who break my evening plans to get stupidly drunk with their girlfriends.

Needless to say, this piece is not making it into the Anthology of Jason Lehr. Back then, I had gotten so caught up being an elitist piece of shit that I alienated everyone who knew me. Lost quite a few friends this way.

Despite this immaturity, 2007 was paradoxically the year I did the most growing up. I'd moved to an inherited inner-West apartment where I currently reside, sublet the spare room, and took an active role in home-ownership. I learnt to love cleaning my apartment, and furnishing it with products I paid for. I learnt to love cooking, and paying bills, and balancing a budget spreadsheet so dense it routinely crashed my PC. I felt confidence in my ability to survive this adulthood.

2008 Games Without Frontiers

This unreleased piece consisted of a retrospective of 3 computer and video games that changed the way I felt about gaming as a medium and an art. More than anything, gaming is a personal art: a way to tell our own stories. It's also a way of making choices, and exacting a degree of control over a makeshift world. To a kid fumbling through teenage-hood, feeling helpless in the transition, this was a powerful thing.

Gaming helped me understand the con-

flicts of growing up. Deus Ex taught me the philosophy of government, and of power-differentials, and within its Cyberpunk universe I explored a world much bigger than my own in the Canberran suburbs.

Shadow of the Colossus revealed its deep, understated morality and made me question mine: was I too caught up in forcing my way through the world, that I'd failed to see what I was doing, and whether it was the right thing? And through Homeworld, I lead a race of exiles through the galaxy in search of home. Back in reality, I lead my 13-year old self in search of the person I would eventually be.

Games Without Frontiers was going to be my revelation to you, reader, that games can be more than bloated space marine power-fantasies. I owed gaming so much, and yet abandoned it after high school, convinced I had "better things to do". I didn't.

2009 The Year I Left Medicine

While 2007 was me growing up, 2009 was me breaking down. My Phase 2 ICE did not go well at all, due to a combination of mispreparation, poor luck, and not enough giving-a-shit. And yet, the notice of failure took me by surprise. I rechecked that email repeatedly, looking for inconsistencies, convincing myself less and less each time that they had somehow got it wrong. Then, the truth settled in. Softly. I spiralled down.

Coming face-to-face with my fallibility forced me to deconstruct my sense of self. I was brought back to the basic questions of: what was I doing here? Where do I want to go? And what really makes me happy? I spent this year consuming judicious amounts of video games, refreshed my love of art and prose, became a better brother and son, worked menial jobs and lived a life entirely without consequence.

Well, partly without consequence. In late April I bought my first car, a 1989 BMW 5-series with over 300,000km for all the money I had at the time (which was $2000). It was a bizarre and audacious purchase, and after several expensive attempts to revive the failing engine, it gave out just shy of our one-year anniversary: boom.

You know what? Growing up is about accepting failure. My parents offered to donate me a new car, and I said no—it was after this decision that I looked back and realised that I'd never felt better.

2011 Memento Mori

In my heart of hearts, I hope I'm wrong about everything. I hope more than anything that when I get out, things will improve, and I'll love earning money and being independent and having a job that actually has some relevance beyond selling someone a nice set of pants. I hope that in another 6 years, I'll finish my Psychiatry training

"Coming face to face with my fallibility forced me to deconstruct my sense of self...what was I doing here?"

(which I actually look towards), and think back on how stupid and immature I was today, just like I do with my 18-year-old self now.

When you get further into this course, you'll meet these senior doctors who tell you "I had so much fun in medical school, enjoy it, because it's the best time of your life." This deserves an answer to the effect of "no way," or preferably, "no way, f*** you, and why are you lying to me, AAAAHHHHHHHHH?!?!"

Discovering uni culture is fun. Moving out of home is fun. Making a risky, consequential car purchase is fun. Video games are fun. Loud music is fun. Balancing your budget is fun. Growing up is fun. Medical school? Medical school is just another state we must go through. Don't get stuck in this life; don't let it make you forget about being young.

AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION TRAINING NEW TRAINERS TNT WORKSHOP 2011

Whilst some of us were skipping class, others were taking time out of our holidays to attend the Training New Trainers (TNT) Workshop. Jointly coordinated by the Australian Medical Students' Association (AMSA) and the International Federation of Medical Students' Associations (IFMSA), this three-day workshop was held in Sydney prior to the AMSA Global Health Conference (GHC).

Initially, we did not know what to expect, other than that by the end of these few days, we were going to present a workshop at GHC from one of the following topics; Media Skills, Presentation Skills or Campaigning and Advocacy. However, with people from all different universities across Australia and New Zealand, from different years and with a wide range of life experiences, this workshop was a great opportunity for learning about new initiatives and networking.

But just as importantly, we learnt to be trainers - how to facilitate group discussions with a range of personalities, (devil's advocate, the quiet person, a feuding married couple and two people falling in love with each other, all whilst discussing issues like whether New Zealand should be a new state of Australia.

Throughout the three days, we learnt a lot about general preparation and logistics and all the things that could go wrong when presenting, including bomb threats and nobody turning up - you can be sure to say that we were prepared for all situations!

But there's so much that you can teach without people becoming bored, and it's always important to have energisers to liven the place up - getting people to stretch, or playing a few games. Have you ever tried selling a stool to a herd of giraffes? You should try it sometime. It's surprisingly fun. But not quite as terrifying as selling a towel to frenzied sharks.

So from knowing nothing about our subject, in three days, we put together a comprehensive, enjoyable and interactive presentation complete with fun, games and chocolates. The three presentations were:

- Campaigning and Advocacy: Learning about the basics of campaigning and advocacy, and strategies and techniques to help you run an effective campaign.
- Media Skills: Learning about how health issues are influenced by the way that they are portrayed by the media and skills to use the media effectively for advocacy, health communication and public health campaigns.
- Communication Skills: Teaching in a Clinical Environment: Learning about the principles of teaching and tips how to teach effectively in a range of settings. This included a scenario on teaching on an elective as a medical student in a developing country.

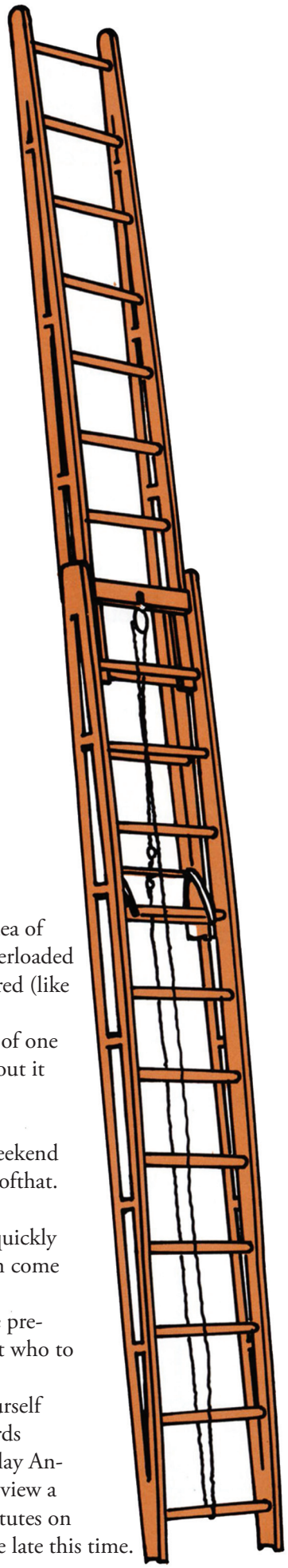
But it doesn't end at this workshop. We are now accredited as IFMSA trainers and have a wide range of opportunities to train other medical students. And who knows, in the near future, we may be running our own workshops at a MedSoc night!

All in all, it was a lot of fun, and we recommend everyone to get involved. Not only do you meet a lot of new people, but of course, you gain a lot of inspiration and confidence. Be awesome and apply.

For more information visit the AMSA website at: http://www.amsa.org.au/content/amsa-workshops-june

Phase 2 Coursework: a rundown

Dear Phase 1/ILP-ers about to enter Phase 2 Coursework, this article is for you! Together your Coursework Reps 2011 have put together an 'all-you-need-to-know' to give you an introduction to the ins and outs of your Phase 2 courses before you start.



BEGINNINGS, GROWTH & DEVELOPMENT

My piece of advice for coursework is to *be a little shameless, and don't be afraid to get your hands dirty*: shameless, because you're not going to know the answer to every question a doctor might ask you (I would advise smiling and replying with something like "I'll read up on it so you can ask me all about it tomorrow"), you will feel noob putting your first cannula in… and probably missing (try poking your peers and letting them poke you a few times first), and you will feel small when the surgical nurse shouts at you for nearly touching the sterile areas (stay CLEAR of the GREEN!) – and you need to be okay with that.

You will also find yourself constantly introducing yourself and asking about everything. Some say the pecking order of the hospital goes doctors, then medical students… but in reality… everybody else has been there a LOT longer than you and know a LOT more than you. So don't be cocky, or you will risk being stamped as the annoying medical student. And trust me, just like any human society, people talk.

As for the "getting your hands dirty" part…. Well, you can't exactly expect to do a bimanual palpation (vaginal exam) without doing so…But my point is, if an opportunity presents itself to you… GO FOR IT, or even ask the doctor if you can have a go at it. A papsmear, inserting a catheter, palpating a pregnant lady's abdomen… Even though you're at hospital a fair bit now, these opportunities don't come your way often.

By the way, whilst you will do a fair bit of baby-sitting in the last four weeks (paediatrics), no one babysits you. I have honestly often thought that I could not come into hospital at all and no-one would care less. You actually learn the meaning of our graduate capability # 4 (made up the no.) to the full.

The above is definitely NOT recommended though, and why would you when one of the perks to coursework is: FREE FOOD from hospital! (And it's actually good quality!) Grand rounds, pathology meetings, specialty teachings… you name it! You can almost find somewhere to get free food every lunch time, and get a bit of teaching while you're at it – not to mention looking like a keen student so that the doctors will like you.

So, a few pointers for BGD specifically:

- Don't, I repeat -DON'T- get in the way of phase 3's in the birthing unit. They need to assist a certain no. of births to be able to GRADUATE. And if you "steal their births"…Well, you might not feel at ease in the common room (Thank me later phase 3's!)
- Pregnant women have big juicy veins – so it's a good time and place to practice your cannulations!
- Focus on what is COMMON (especially in paediatrics), rather than trying to learn everything.
- Be female (Sorry, can't help you on this one)

The course itself:

- Divided into 4 weeks of Obstetrics & Gynaecology, followed by 4 weeks of Paediatrics.
    - o This is enough time for you to get a good idea of each specialty, not too short for you to feel overloaded (like HM), and not too long for you to be bored (like another unnamed teaching period…)
- One project: Following the final stages of pregnancy of one lady (you do this in a group), then writing a report about it (done individually).

Hospitals

o Some hospitals require you to come in during the weekend or at late hours for you to see a birth, so just be aware ofthat.

Extra pointers:

- Ward rounds are a good way to see a lot of patients quickly in one go – note which patients are friendly so you can come back to see them later for a history.
- Handover meetings are a quicker way to find out the presenting complaint of each patient so you can scope out who to use for your assignment/project
- Specialty meetings are a good place to familiarise yourself with the doctors, so you know who to go to in the wards
- Always carry with you something to do/iphone to play AngryBirds on. Tutors will often be late being called to review a patient urgently etc., but you need to turn up to your tutes on time for that one in six chance that your tutor won't be late this time.

Finally, the beauty of coursework is that whilst it is infinitely interesting and if you're keen there is always something to do in hospital, there is no regular assessment! So you have the freedom to go all out at hospital/uni. Pursue other hobbies/interests and catch up with friends afterward – without the burden of study study study…enjoy it!

HEALTH MAINTENANCE

Health maintenance: what you will desperately need to do as you pull more late nighters than ever before, chase your unexpectedly speedy tutor up and down the hospital, and scull down your coffee in your measly breaks. Despite whatever changes Medfac may introduce to HM next year, you will need to bring your A game.

Course Structure
HM is currently based on weekly themes of common presenting symptoms. These are: exercise and health, syncope, dyspnoea, oedema, renal impairment, abdominal pain and diarrhoea, gastrointestinal bleeding. So as you can see, the general systems covered are cardiovascular, respiratory, renal and gastrointestinal, but there is significant overlap between weeks to integrate your learning.

Assessments
You will be required to do two assignments - one medical and one surgical case. As per usual, you will need a history and examination with systems review, as well as discussion of 2 capabilities. Plan ahead which capabilities you will need to use for later assignments (e.g. ethics in AE), and which are better to do in HM (e.g. anatomy/imaging for a surgical case).

Medical case: You need to look for a patient who is being managed medically, such as via medications. People usually start with this assignment as the most relevant systems for this assignment are those early on in the course – this means you should start looking for your patient early to beat the competition! Word count tends to be very limited, so it may be wise to look for a patient without too many comorbidities.

Surgical case: Patients who have recently undergone, or will undergo a surgical intervention may be found in just about any ward, so take a good look around. Post-operative patients tend to be discharged quickly, so it's advisable to plan ahead and try to get most of history and examination done in one sitting.

Tips to help survive HM
- Get a pocket clinical handbook (e.g. Oxford, Kumar and Clark)! HM covers a broad range of topics, so it's useful to have a guide handy to quickly check up something you need to know, or to get a quick overview before a tutorial. Read it during travel time, waiting-for-tutor time, any time!
- Study. What you get out of HM will vary hugely depending on how much effort you put in. Find out what works best for you - options include individual study to consolidate knowledge, pre-study for tutorials (especially the bedside ones - gaping blankly at a tutor's questions is never fun), and study groups to revise and practice examinations.
- Use your hospital time wisely. When you do get a break, it's a good idea to try to find some patients to practice your history and examination on. Asking the senior years or interns to recommend a patient with good signs can be very helpful.
- Get exposure! The benefit of having so many disciplines covered in HM, is that you get opportunities to go to a huge variety of places such as cath labs, echo, spirometry, clinics and operating theatres. It's a good idea to attend all your scheduled sessions, and if you do find something particularly interesting, pop in during your spare time - the staff are usually keen to keep teaching.

AGEING AND ENDINGS

Hello and welcome to the magic (and mayhem) of AE3! Building on from your AE background in Phase 1, where your eyes were opened to the musculoskeletal and neurological systems, many discoveries await you in the worlds of oncology, palliative care and geriatrics. The AE3 experience is a well paced course with interesting and relevant weekly themes that will both prepare you for and supplement the other Phase 2 courses, no matter what order you do them in.

Course Structure
- Weeks 1-3: an introduction to a patient's journey through cancer, which covers diagnosing cancer, curing cancer and living with cancer.
- Week 4: a special palliative care week which covers dying with cancer and end of life care.
- Weeks 5-8: an insight into common geriatric presentations including falls and fractures, pain, immobility and depression, acute confusion and other cognitive problems.

Assessments
The assessments in AE3 consist of two assignments- a case study in oncology and then in geriatrics. Four exemplary assignments from past years are available on Blackboard- check them out before you start!
- Oncology case study: see some cancer patients on the ward and choose one (your Course Tutor may be able to help). Remember to ask for consent and permission to write up their case and access their medical records! Set up a system with your hospital group to ensure no one 'doubles up' on patients- for example, send an email around after you've confirmed your patient.
- Geriatrics case study: you must visit your patient at home with nursing or allied health staff, which your Clincial School may organise for you. If you are

required to help with organising your geriatrics home visit, chase it up early as opportunities to see suitable patients in their homes on your clinic days may be limited. The earlier you do it, the more time you have to (procrastinate), research and write up your case.

General Hints and Tips in Oncology and Geriatrics

- Know the weekly theme before the week begins and give yourself an overview of the main topics that will be covered in scheduled learning activities. Focus on building your understanding of these areas when you see patients and to help you ask relevant questions of the clinicians you're learning from.

- If you have the opportunity to be attached to a team, make the most of it by attending ward rounds regularly and staying with your interns and registrars throughout the day to learn the bread and butter of the specialty.

- Take initiative to organise extra learning opportunities as people are usually more than happy to accommodate you. For example, in oncology, try approaching the radiation oncology department and see first hand the planning and preparation that goes into customising equipment such as masks for patients prior to their radiation therapy. In particular, AE 3 is an excellent time to gain a greater understanding of allied health!

- Make the most of Course Tutor sessions: prepare cases relevant to weekly themes to practice presenting as short or long cases, and try asking your tutor for some bedside tutorials as part of the session.

- If you come across any difficulties or problems during your time in AE3, your AE Rep is always eager to help, so don't hesitate to contact him/her.

SOCIETY AND HEALTH

SH3 is a course which has a strong focus on public health and its application to clinical medicine. While many medical students neglect this aspect of our course, keep in mind that they are all extremely important and form the basis of effective medicine. For instance, it's only through well-designed studies and a solid evidence base that we are able to choose appropriate treatments. Many of the other themes aren't covered elsewhere in the course and will likely be your only exposure in Phase 2, so don't treat SH3 like a break.

There are eight themes for each of the eight weeks:

- Screening and prevention
- Drugs and violence
- Mental health and well-being
- Environmental health
- Evidence based public health
- Cross-cultural and Indigenous health
- Occupational health
- Global health

These are reinforced in your Community Health clinical attachment, where you'll be able apply what you learnt in class. You'll also have a course tutor meeting every fortnight where you'll have case presentations based on weekly themes and how you've addressed them in your clinical attachment.

There are a wide range of clinical attachments. Some are more conventional like Endocrine or Respiratory Medicine, but there are also very interesting placements like Drug & Alcohol and Refugee Health. Your preferences here will of course depend on what you prefer – you have the option of a conservative placement, but you can also easily expand your horizons with something more unusual, which will definitely be a quality experience.

Your clinical attachments will be what you make of it. Oftentimes, they can be very disorganized, with large breaks or few scheduled activities. It's up to you what you do with this time, but it's highly unlikely you'll learn much if you take time off. It's generally quite easy during SH3 to conduct your own self-directed learning, as most clinical attachments will have opportunities for you to do so.

Assessments in SH3 include an assignment and your only group project in Phase 2.

- Mini-audit: You will need to evaluate current practices at your clinical attachment to see if they fit into recommended guidelines. You should try and audit something of appropriate scope – many students go into too much detail and forget it's a mini audit with a word limit of 750.
- Analysis of a health problem in a local population: Your only group project in Phase 2, and your only chance to get teamwork feedback – make sure it's a good one! It's a very difficult and complex project, involving a comprehensive literature search in addition to interviews. Choose your target population and interventions wisely – they have to exactly fit the criteria as set by Medfac otherwise it will be difficult to tailor your project. You'll also need to present your project twice – once at a progress report and a poster presentation at the end.

SH3 is going to be overhauled next year, but the main ideas should stay relevant. And as again, SH3 is definitely a course which depends on what you make of it – for sure, some students will view it as a chore, but it's a great opportunity for you to be exposed to different clinical attachments not otherwise offered during the course.

If you're an UNSW Medical Student, chances are that you've spent a great portion of your late teens and early 20's studying to make sure you got that high HSC mark, did well in interviews and UMAT. I mean lets face it; you didn't get into the number one preferenced university in Australia without putting in at least some effort. But what will you do when you have to spend a year doing … well nothing! Here is a list of things to ensure you survive the ILP year:

Get Informed

The first main issue is what type of project do you choose. As a general guide the faculty encourages students to do clinical projects in 4th year, while those wishing to do lab based ones to do it either in 3rd or 4th year. You need to understand what your project involves. Not the theory behind it, but what you will be doing day-to-day. If your project is a lab based, get ready to pipette all the time; if it's a prospective clinical one, get ready to call and follow up patients all the time and if your project was a retrospective data analysis (like mine), get ready to spend all your day in front of the computer so bored that you end up writing an article like this! Familiarise yourself with the different types and make sure you can do what ever it is you're doing, for 9 months.

Get Stalky

Now this is probably the most important aspect of your project, choosing a supervisor. This person will be looking after you for the rest of the year and they can make or break your ILP experience. You can either use the list of supervisor's that MedFac provides or just approach incredible doctors you meet. Either way make sure that you research your supervisor. Just doing a Medline search of your supervisor can save you many days to weeks trying to come up with a project idea. If they publish 10 papers in space of few years about Abdominal Compartment Syndrome, chances are they are interested in Abdominal Compartment Syndrome. Next ask how many students are they taking on. Some supervisors take up to 8 students. Trust me when I say it's difficult enough getting face-time when you're the only student, let alone when you have to compete with 7 other students. Shop around. Make sure you try several supervisors. If you just approach the one, then if they turn out to be horrible, then you're stuffed! It's as easy as sending couple of emails.

Get Practical

Most students choose a topic that they find exciting, but are very rare. For example if you wish to do a prospective study of ruptured Abdominal Aortic Aneurysms, you're going to be out of luck, as you will be lucky to see one let alone ~100 you need to have a study of any significance. My advice is if you're going to be doing a prospective trial, make sure you find out how many patients you need, how long it will take to recruit, analyse each patient and how many patients you're likely to see in the 9 months! If you're doing a retrospective data analysis make sure you know how you will get the data, what will you have to do with the data and how many patients will it involve. Don't think you're superman, make sure that the math works out and that you're not doing all the hard work only for the next person to use it to publish and take all the credit.

Also, it would be good to get an idea of what things you can get exposure too. ILP would be a great time to get up-skilled in putting in cannulas, assisting in surgery or even physical examination/history taking.

Get Ethical

Now the official advice from MedFac is that your supervisor will need to do ethics submission and students should no be handling this, but from my experience it is often left to the student to do this. This can be a daunting task as the forms can take a very long time to complete and there is 64 pages of questions for a full ethics submission. But, all is not doom and gloom! Most of those pages wont apply to every research project!

So you need to first find out who will be doing ethics submission. If you're one of the lucky few, then you wont have to deal with it, but if you're not here is first hand advice to expedite this process:

Get ethics ASAP! Don't wait around for your ILP date to actually start before you think about ethics. If your research involves animals or human subjects getting treatment, it could take you months if not years to get ethics. You should get this started as soon as you can. If your project doesn't involve much risk, you can expedite things by doing a Low and Negligible Risk Application form. This is a much shorter form with only 10 or so questions. Most people don't consider the time it takes for ethics. This can seriously impact how many patients you can recruit for your research.

Get Reading

Ideally you should have done most of the reading for your research before choosing the topic. But, that doesn't usually happen. But my recommendation is to have something ready before your ILP starts. You can use this for your literature review, your ethics submission as well as forming your introduction for your publication. Most supervisors will give you 10,000 edits (most time editing their own words). Don't be disheartened! That's just how supervisors roll. Keep in mind that they are the ones marking it at the end so it pays to give extra attention to what they ask.

Get Published

Now this is a bit that most students don't think about. UNSW is one of the only undergraduate medical schools in Australia that requires a mandatory research period. Meaning if you can use this time to get publications, you are VERY AHEAD of other medical students competing for internship positions and post-graduate training spots like for Colleague of Surgery, Physicians etc…

Getting yourself published and presenting these at a conference will get you very ahead. Also, it means that you have got something very useful out of a years work as well as contributing to the scientific community… pretty cool for a 3rd or 4th year med student!

SOCIALLY SURVIVE ILP

by Navid Ahmadi | Kostas Brooks

We all know that ILP is the reward for just finishing End of Phase 1 Exams or ICE so why not have a little fun with this year. Despite how you've pitched yourself to your supervisor as a 60hr workaholic in almost all cases you probably can do most of your work in 20hrs and you get weekends back (remember those?). This year is your chance to experience University living as any student does but a diary or some sought of calendar is essential to stay organised. Here a few suggestions about how to spend your downtime (and you will probably have a lot of it) but really it's up to you, do what you want to do, be who you want to be, go where you want to go:

Get Active Now that exams are over, it's time to work off those kilos tubby. I know we've all been to or at least glanced this slide in a multitude of lectures but we all know any exercise is good exercise. Walk the dog, go to the gym, run around your suburb, go paintballing (laser tag if you don't have the moolah/ are too afraid). Get involved in a local sports team. Not only do you feel pretty damn good afterwards but you get to meet new people and learn about more fun things to do.

Get Cultural Seriously you are in the biggest/ best city in Australia (Melbourne can suck it), there are soooo many things to do and see. Even if you have lived your life here, there are always those things that you think of while procrastinating & then dismiss with "if only I had more time". Now you do. I suggest whenever these things pop into your head write them down & keep a list. If you bring these ideas up with your mates more often than not they seem quite keen for a change of venue from Greenwood Hotel on Thursday nights.

Get a Job As we are all too well aware of, things cost money and at the end of 5th Year the elective stands as a chance for all of us to get away. As our friends graduate after their 3-4 year stint at university and go out into the real world of employment and superannuation there is only so many times you can scab drinks off them before it becomes embarrassing. This year can act as a huge boost to your savings especially if you consider the casual employment opportunities available over the 2 summer periods and weekends that can amass to a small fortune.

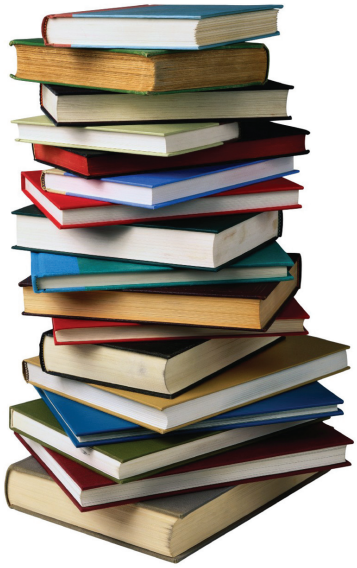
Get a Reputation Throughout Phase 1 and 2 in clinical environments it can make a world of difference in your teaching if the tutors/ consultants know that you exist and that you are actually keen to learn. Now I'm not saying that if you find yourself 10 free minutes that you should be on the wards but keeping a basic level of clinical knowledge can make that transition from 4th year ILP student to 5th year Phase 3 student a lot easier. The best way to find these activities is to talk to your supervisor (it always pays to look keen in front of them) or the clinical school staff. Not only does this look good to your supervisor but many of the Drs you meet in these meetings or rounds may pop back up in later years as well as legitimately being able to use the excuse "I've got to go to the Blah blah meeting at blah blah hospital" to take the morning off.

Get Volunteering I hope we have all gotten into this profession because we want to help people and this is your chance to donate your time and get a broader view of your world. First port of call should be the UNSW Arc Volunteer Army and Career Expo's at UNSW. They have done most of the hard miles by finding the organisations who need volunteers and just need you to sign up to view their data base. But don't just limit yourself to their suggestions, just talking to other volunteers and scouring the internet and local newspapers there's always a cause that needs man or womanpower in and out of Australia. I can tell you personally that this is not a waste of time, the events are lots of fun, you get a few freebies/ free lunches, get to meet lots of wonderful people and it doesn't look too shabby on your CV.

Get Friendly Being a medical student is a hard busy life, and it doesn't get any easier as you progress through the years into finally internship. If you have read 'House of God' you'll know the importance of staying connected for your well-being. With Phase 3 spreading UNSW medical students all across NSW who knows when you'll see each other. Also don't neglect your friends outside of medicine, they are the ones who will stop your neurotic listing of signs and symptoms of a pheochromocytoma and slap you back into reality.

Get Gone Dude, are you still reading this? Get going. There's so much to do and despite how slow the project may be going in the blink of an eye it's already September. But on a final note see more of this wonderful land we call home. It's amazing how often we look to distant shores for holidays when it takes less than 1 hour by flight to travel to Melbourne. Or if flying isn't your thing try a weekend road trip to visit your friends in some of the rural campuses.

AUSTRALIANS STUNG BY THE HIGH COST OF TEXTBOOKS



When is something you buy too expensive?

It is a strange concept that you should challenge the cost of something that is being sold to you. Sure, you might haggle at the Victoria Market over fruit but nobody would seriously contemplate having an argument with SPP books over the price of Talley and O'Connor's *A Systematic Guide to Physical Diagnosis.*

And yet there are questions to be answered about textbook prices in this country. Textbooks in Australia are remarkably expensive. Your average textbook is well above $100 and often beyond $200. Compared to other print media this is expensive. For those of us in the medical profession textbooks are far from being a frivolity; they constitute a critical basis for our craft both during training and during practice.

By the nature of their content, we rarely have a choice in whether to buy textbooks and we rely on them for years at a stretch. Textbooks are protected by copyright. The Intellectual Property is sold to a publisher in the form it will ultimately be sold to the consumer. When a textbook is produced in another country it is usually exactly the same in every way. Yet the textbooks we buy off the shelf in Australia can be up to double the price as in other markets, such as South-East Asia.

This isn't folklore; it is common experience among medical students. So why are Australian textbooks so expensive? Given that textbook prices can vary greatly between markets, the culprit tends towards being Price Discrimination. An example follows:

The cost of textbooks in Singapore is about 50% what they are in Australia. The GDP per capita in Singapore, as per IMF, is about US$44 000, down a mere US$10 000 from the Australian GDP per capita[i]. The tax rates are lower in Singapore; the highest rate is 20% and that does not apply until your income is above S$320 000. At the per capita GDP mentioned above, Singaporeans would pay about 7% income tax. Australians pay about 18% and this does not include GST.

The first thing this tells us is that, the textbook price difference between Australia and Singapore is not due to currency or purchasing power. Whatever the Singaporeans are earning, in equivalent terms, it is holding better currency with Australian wealth than just 50%.

Another point involves looking at that GDP closely. Thailand's GDP per capita is 10% that of Australia. Singapore's is at least above 75%. Relatively speaking, manufacturing will not be that much cheaper in Singapore than Australia; whatever tax incentives and IR laws there may be. So why aren't textbooks in Singapore costing Singaporeans a similar amount as in Australia?

The answer lies in the supply chains rather than currency. Local economic strength, high incomes, high taxes and powerful currency will affect the cost of producing an item locally. However, this is not the same as supply. Singaporeans are probably better able, with use of more liberal IR laws, to drive down production costs. But that's not where their low prices come from.

The current system of textbook supply constraints encourages price discrimination. Where wholesalers have a captive market, they can set prices based on what they expect consumers to be willing (or forced) to pay. Except, textbooks are unlike other market goods because the student does not choose to buy them; they are required, prescribed as texts or used as the status quo. They cannot often be substituted easily. By the same token, because a textbook always comes from a single publisher (whoever owns the copyright), the publisher can dictate the recommended retail price (RRP) to all retailers and thus all medical students as the end consumer.

The main reason that textbooks in Australia are so expensive is that 'local' publishers have a virtual monopoly on the Australian supply chain. This does not necessarily need to be the case, so the question becomes: Is it fair to discriminate in favour of publishers at the expense of the reading public (and book retailers); hundreds of thousands of Australians who use these books to further society, to educate themselves, to help others and to learn?

Books are an important part of the Australian economy. Overall, the new book industry's estimated value is $2.5 billion; this is 0.4% of total household expenditure[ii].

Textbook prices are something we all have a stake in. As students and future or practising doctors, as custodians of the health of millions of Australians, we have a legitimate cause in ensuring textbooks are no more expensive than they need to

be and that textbook prices are not dictated by suppliers seeking to avoid true competition. Ultimately, this is about patient care and the level of quality we bring to it from resources well allocated during our time in training. It is the objective of this medical student to further investigate the issue of textbook prices in Australia and inform you all in further medical student publications.

Grant Ross | Melb. Uni. VI

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i Data refer to the year 2010. World Economic Outlook Database-International Monetary Fund. Accessed on August 8, 2011; ii Productivity Commission 2009, Restrictions on the Parallel Importation of Books, Research Report, Canberra. pXV (overview)

Quotes From Medical Students asked on this subject

What do you think about the costs of textbooks?

I've only bought textbooks in Melbourne too. They are expensive yes. Especially when there's a lack of competitors.
- M.P. | Melbourne University V

...but sometimes you just gotta fork it out as a career investment, y'know. Or get the PDFs off the western clinical school computer.
- A.B. | Melbourne University VI

Australia is remote. But that still doesn't explain why it's >50% cheaper to order a book in from the US than to buy it off shelves here.
- S.O. | Deakin University II

Bought OHCS in Germany for two thirds the Aussie price.
- Y.Y.Z. | Monash University IV

...prices in Australia ARE among the most expensive in the world. prices in the US are significantly lower and Asia are 4-5 times cheaper. We pay about $180 per book. I'm not sure exactly why but the issue needs to be investigated further.
- A.W. | Melbourne University VI

Do NOT purchase textbooks for study here from Australian providers. If you jump on Book Depository UK, you can find that they ship to anywhere in the world free of charge and that their prices are lower than the ones at retail prices here.
- A.T. | Melbourne University VI

Prices in Singapore for some up to 50% that of Australian prices. But currency exchange aside, I'm still unsure why the prices still aren't 1 to 1.
- J.S. | UNSW IV

Opinions on:
The Future of Rural Health

Today's medical students will be (barring any grievous misfortune or a dalliance with the fairer faculties) tomorrow's doctors. It follows therefore, that the future of rural medicine lies with current rural students, and students with a passion for rural health.

Our university reserves 25 per cent of its medical places for students who enter through the Rural Student Entry Scheme (RSES). Until recently, the only difference between RSES students and their metropolitan counterparts, was the minimum time spent in a rural clinical environment, which was 12 months and 4 weeks respectively. This policy provided rural students with the opportunity for adequate metropolitan clinical exposure.

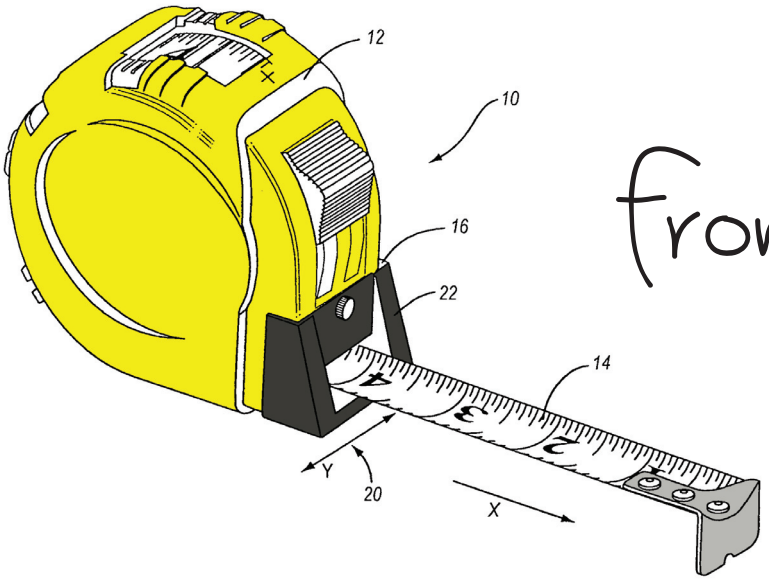
However, recent changes to the clinical allocation policy will have implications for current and future rural students. Under the new policy, rural students may have to complete the entirety of their clinical education in Phases 2 and 3 at one of the four rural clinical schools—Coffs Harbour, Port Macquarie, Albury or Wagga Wagga—if these campuses are under-subscribed. Since the government requires that 25 per cent of students be allocated to a clinical environment, the practical implication is that if not enough metropolitan students choose to extend beyond their minimum of 4 weeks rural clinical time, rural students will be compelled to fill the quota.

Which begs the questions: why are the high quality facilities and teaching at the rural clinical schools not being utilised? What could be done to increase the appeal of rural clinical school placements for metropolitan students? What incentives could be offered to students who may never have experienced a rural area first hand?

A recent initiative introduced by the UNSW RCS has been to conduct trips to the 4 rural RCS sites. Unfortunately this year, poor weather and other circumstances beyond human control intervened for the worse, and these trips were impeded. Initiatives such as these are a good start, but there is a long way to go in increasing the awareness of the rural facilities.

While I don't have all of the answers, this much seems obvious: metropolitan and rural medical students have an immense amount to gain by pushing the limits of their experience, and exposing themselves to new environments. If we wish to ensure the future of Australia's health, it is imperative that students are given adequate exposure to various clinical environments throughout the course of their studies.

Hanna Grimson | UNSW III



from apprehension to adoration

THE FOUR-WEEK RURAL TERM

Arthur Chee & Michael Chan | Med V

We couldn't say that we were thrilled at the beginning to be sent a 7-hour drive from Sydney, away from the conveniences of city life and everything reachable within a 5 minute drive. To top it all off there was an excruciatingly long but necessary introduction/orientation on the first day – the signs were ominous. But how wrong we were…

Obstetrics and Gynaecology

"Going rural" as they say, incites a fair amount of stigma from us metropolitan students. Resources? Probably few and far between. Funding? Miniscule. Social life? Country townsfolk have nothing on us (debatable, depending on the audience). But what they lack, they make up in heart, generosity and most importantly for us students, excellent teaching (I'm sure not what many of you had in mind). Hence began my four week stint in Obstetrics and Gynaecology. Gone were the large entourage of consultants, registrars, residents and interns. In their place, two consultants who rotated on a fortnightly basis, a single registrar and a formidable team of midwives who together offered the utmost care for women and soon-to-be-mothers. Acquainting myself with everyone was thoroughly enjoyable and their guidance and willingness to help was worth their weight in gold. The teamwork capability, check!

Being the only student there, I was given the opportunity to experience all facets of obstetrics/gynaecology under the guise of different professions (and in the process, be the only susceptible prey to all sorts of academic ambush!). This also meant I had much more contact with my consultant whom I saw everyday – a rarity in the city. The opportunity to get hands-on experience was incredible and witnessing and assisting in the miracle of life was amazing! Whether the same experience can be had in the city is somewhat limited by numerous variables – other students, increased staffing, increased patient numbers, etc. Did I also mention that getting all those skills and assessments signed off is a relatively easy task?

Surgery

A number of things struck me; firstly there were multiple consultants who did daily rounds together in a single surgical team for the whole hospital. Next were the diversity of cases from gastro/colonoscopies, laparoscopic +/- open hemicolectomies, hernia repairs, carpal tunnel release, venous ligation, cholecystectomies and of course, the acute appendix that required removal. Putting one and two together this meant that on a daily basis I was being grilled left, right and centre on almost any topic to the nth degree.

I believe that in comparison to urban surgical term, there are significant opportunities to actually get a more hands-on experience as surgeons develop their confidence in you. You're not fighting against the intern/resident, the registrar and the fellow to do something. Rather, there is a wonderfully controlled and supportive environment to assist and engage in many surgical and anaesthetic procedures.

Life outside the hospital

Fresh food and good wine were part of the unexpected delights. We frequently found ourselves outside of hospital for lunch in many well-regarded cafes, with everything located quite nicely in the town centre. Whether it was tasting some of the finest cuisine in Australia, discovering the history of the place and its people or learning what it means to work in the country, every direction was a wonderful assault on the senses. Exploration at the fringes of town had its reward of boutique and large scale vineyards, bush-walking hikes and scenic historic trails. If you have your doubts, "going rural" is definitely worth a shot, even if you're not grasping for more, just the experience will make you appreciate what we take for granted here in the city.

DOCTORS = MURDERERS

Traditionally, the practice of medicine is regarded as an occupation of compassion and empathy. When we committed ourselves to the medical degree, we swore the Hippocratic Oath that we shall practice the sacred art of medicine ethically. Hence, it is difficult to reconcile the fact that a small minority amongst us would one day make the word "doctor" synonymous with "serial killer."

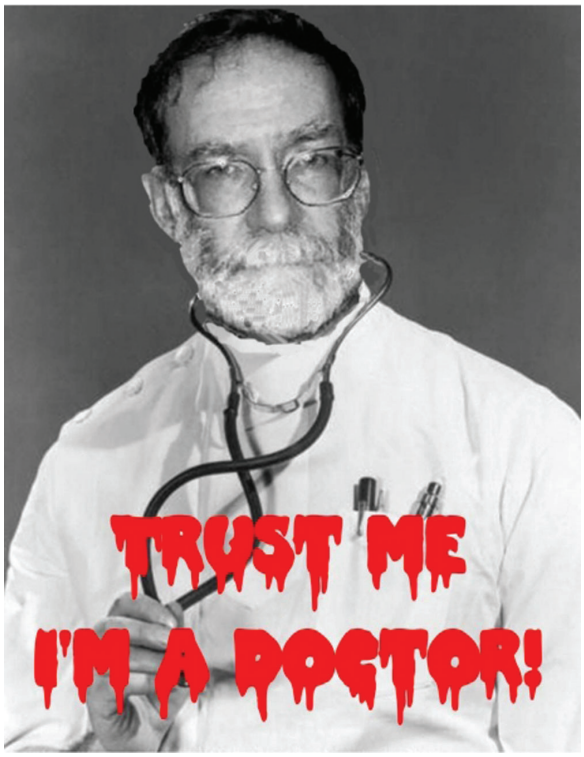
According to Yorker et, al. (2006), of all healthcare professionals prosecuted from 20 countries between the period of 1970 ad 2006, nursing personnel comprised 86%, doctor 12% and allied health professionals 2%. However, these statistics may not truly reflect the dangerous nature of a clinicidal physician. Compared to nurses and other healthcare workers, the physician leading the multidisciplinary team is in a powerful position to murder patients and almost always uses the euthanasia defence when discovered. (Kaplan, 2007)

Patients most vulnerable are those who are very young, very old, mentally handicapped or critically ill. However, there are cases where victims were hospitalized with intact cognitive capacity, demonstrating that no one is safe from serial medical killers. The main methods used were injection, followed by suffocation, poisoning and tampering with equipment. (Yorker, et al., 2006)

One must also distinguish between authentic euthanasia and serial healthcare murders. Charles Cullen, a male nurse practicing in New Jersey, claimed that he was alleviating the pain and suffering endured by terminally ill patients. However, upon review of the medical records of his victims, it was apparent that not all his victims were very sick – one was in hospital recovering from a choking episode. (Yorker, et al., 2006)

Why do these medical professionals kill? Some say it is because medicine attracts a certain type of personality lured by the power over life and death. Indeed, many clinicidal physicians have narcissistic personalities with overly grandiose views of their own abilities. They develop a God complex, obtaining an adrenaline-fueled, psychopathic thrill out of determining whether a patient should live or die. (Kaplan, 2007)

Other motives include secondary gain of excitement, not dissimilar to Munchausen Syndrome. Benjamin Green, a nurse working in England, injected patients with respiratory paralytic agents for the excitement of reviving them. Others would murder out of pure sadistic whims. Colleagues of Orville Lynn Majors, a nurse from Indiana, reported that they could predict which patients would die



under his care. Often, the victims were whiny, demanding or heavily adding to his workload. Some murdered for profit; the prosecution of two nurses and six physicians revealed that they murdered patients for payment from funeral parlours or organ transplant markets. (Yorker, et al., 2006)

Kaplan, et al. (2007) categorised the physicians who killed into three types – the medical serial killer, the treatment killer and the mass murderers.

Medical Serial Killers

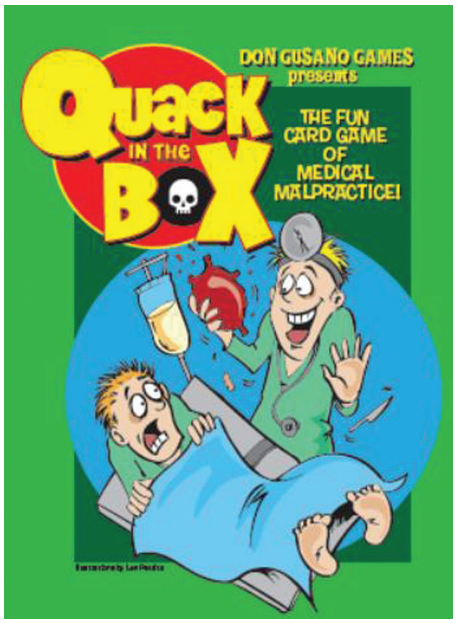
While some medical serial killers are merely murderers who happened to be doctors as well, others like Dr. Harold Shipman and Dr. Michael Swango used their medical skills to kill their own patients. Although the medical serial killers are not as common as your run-of-mill psychopaths, they can be very prolific murderers when unleashed into the society. Between Swango and Shipman, they are credited with at least 313 deaths that far exceed what an average serial could ever hope to attain. (Kaplan, 2007)

Shipman, a general practitioner practicing in Manchester, UK, was found guilty of killing 15 of his patients in 2000 with lethal injections of heroin. After the trial, it was estimated that he may be responsible for the deaths of 260 patients. He began killing his patients from the time he went into medical practice in 1974 to 1998 when he was arrested, taking only a year's break in this period for his narcotic addiction. Out of all the doctors who killed, he was the most dangerous, responsible for high death counts and targeting vulnerable elderly women who trusted him as a family physician. In

fact, Shipman ensured he kept up with standard practice requirements, even receiving positive comments from auditors such as "it is great to see a single-handed enthusiastic GP with a rolling programme of audit – keep up the good work!" just nine months before his arrest. (Kaplan, 2007)

Treatment killers

Treatment killers are used to describe doctors associated with multiple deaths but there is no apparent motivation. While on some level, they are conscious of their actions but they refuse to acknowledge the consequences and desist from further action. However, when the death count reaches beyond a certain number, it is no longer possible to ignore death as the likely treatment outcome and thus these killers are exposed.



Often the public reacts with shock and horror, but most do regard this as the consequence of incompetence without apparent motives. (Kaplan, 2007)

The most notorious example is Dr. Harry Bailey who treated many of his patients right here in Australia with deep sleep therapy. Without much consideration of indications for such a treatment, patients were put into deep coma with high doses of drug under minimum supervision. Using this dubious treatment modality, he was found responsible for at least 87 deaths and several hundreds of causalities. (Kaplan, 2007)

"...the archetypal doctor has always been the role model of compassion, empathy and humanitarianism...so it is most surprising and discomforting that there lurks some amongst us who would gladly give the patient that extra push towards the end of life."

Included in this group is Dr. Ferdinand Sauerbruch who was one of the most famous surgeons in the twentieth century. Having suffered from vascular dementia leading to severe loss of judgement and impulsive disinhibition, his surgical operations became crude butchery. The communist authorities of post-war East Berlin were willing to turn a blind eye because of the prestige of having a renowned surgeon in it midst. Eventually forced to retire, he became responsible for many deaths after continuing to perform operations without anaesthetics on his kitchen table and suturing with his wife's sewing kit. (Kaplan, 2007)

Political Mass Murderers

During times of violent social upheaval, doctors have often been called upon to violate their principle of "thou shalt not harm." They have often been accomplices in government brutality and genocide, performing inhuman experiments and participating in torture. While most doctors involved are no more than self-serving opportunists making the best of a situation, some enjoyed the power of controlling the life and death of millions of people. (Kaplan, 2007)

The Armenian genocide in Turkey in 1915 involved medical personnels who were pivotal in establishing extermination squads made up of violent criminals. Among them, Dr. Mehmett Nazim remained unrepentant even to the end of his life over causing millions of death. Dr. Mehmed Resid's brutality in the "deportation" of 120, 000 Armenians was extraordinary, with accounts reporting the nailing of burning hot horseshoes on the victim's chest and crucifying prisoners on crosses. (Kaplan, 2007)

Unit 731 of the Japanese Imperial Army carried out cruel and bizarre experiments on thousands of people from Manchuria. Freezing of limbs of prisoners, performing live vivisections infecting hundreds of villages with anthrax and cholera were not uncommon sightings. In these experiments, the victims were depersonalized and referred to as the "logs", implying that killing a few prisoners were no different from cutting down some trees. (Kaplan, 2007)

Throughout the history of medicine, the archetypal doctor has always been the role model of compassion, empathy and humanitarianism. Most of us came into medicine because we wanted to fight against disease and death, so it is most surprising and discomforting that there lurks some amongst us who would gladly give the patient that extra push towards the end of life. While it is unlikely that the likes of Shipman and Sauerbruch are swarming our medical systems, the fact that there are major police investigations in the past year all over the world leading to arrests of healthcare professionals are worrying. As medical students, perhaps the only way we can help is to keep a vigilant eye. After all, history does tend to repeat itself.

Cindy Wang | UNSW IV

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DECRIMINALISING DRUGS

Grace Lu & Andrew Tse | UNSW III

Historically, Australia has been a champion of harm minimisation, for example modelling to the world leading Needle Syringe Programs that have significantly limited transmission of HIV and HCV. Harm minimisation is the well-known national framework based on the premise that we can aim to reduce harm to users and communities without necessarily reducing uptake. Australia must keep up its innovation in drug policy development from 1985 to 2010. The triple alliance includes supply reduction, demand reduction, and harm reduction. We propose that in our generation, the tenure of law enforcement must be revised, as it is currently counter-productive to the principles of harm minimisation. We simply cannot blindly cling onto traditional mores in the face of mounting evidence for drug decriminalisation. We must be forward thinking and make evidence-based and progressive decisions. The war on drugs has failed, and we will show you how current law enforcement tactics contradict harm minimisation through increasing harm.

First let's just clarify – this article isn't written for the blazed med potheads craving their next hit this second. It's written from the desire to improve health in our world that runs in the veins of fellow med students. For the purposes of this article, the illicit drugs we are referring to are cannabis, heroin, cocaine, amphetamines, ecstasy, hallucinogens and 'designer' drugs, and not the illegal use of legal drugs such as tobacco, alcohol, pharmaceuticals and performance enhancing drugs.

War on Drugs

The "war on drugs" may sound appealing for all its romantic undertones – think a battle of good vs. evil of epic proportions, with Clint Eastwood doppelganger police cleaning up the streets. However law enforcement agencies have not succeeded in preventing the supply of illicit drugs, and it is unrealistic to expect them to do so. The central issue of law enforcement is the lack of research into effectiveness, impact, and unintended consequences. However the majority of the Australian direct drug intervention budget continues to be spent on law enforcement (55% or $740 million/year) compared with $44.8 million in harm reduction, which is far more cost effective. [1]

Law enforcement is missing the major target of minimizing harm, since illicit drugs are only responsible for 9.32% of drug related deaths while tobacco is responsible for a staggering 84.76%. [2] Globally, the trend has been increasing drug supply and falling prices, despite increasing drug-law expenditure. Countries with stricter drug prohibition did not have lower levels of drug use than those with more evidence-based approaches [3]. For example in Portugal, where drugs were decriminalised since 2001, use among young people has fallen. [4]

AUSTRALIA'S PRESENT DRUG CLIMATE

- 38% of the Australian population aged 14 years and over had used any illicit drug at least once in their lifetime, and 15% had used any illicit drug at least once in the previous 12 months. [2]
- Illicit drug use was responsible for 2% of the total burden of disease in Australia in 2003. There were 1,705 deaths and almost 51,500 DALYs attributable to illicit drug use. [2]
- Hepatitis C was the major condition for deaths attributable to illicit drug use in 2003 (759 deaths), followed by hepatitis B (329 deaths). [2]
- Cannabis use has declined to 26.0% amongst young people in Australia, however this is one of the highest rates of use in the world and the harms have increased [1]. Cannabis-related hospitalisations and drug-induced psychosis have increased. [6]
- Amphetamine use is stable or declining, heroin use is declining, there is a stable pattern for cocaine use, and ecstasy use has increased in the general population to 3.5% in 2007. [1]

Decriminalisation vs. Legalisation

DECRIMINALISATION is the removal of an activity from criminal law, usually talking about abolishing sanctions for drug consumption and regulating it through noncriminal laws.

LEGALISATION is the removal of all drug-related offences from criminal law, including use, possession, cultivation, production, and trading. Regulation would involve a strictly controlled legal market regulated by administrative law (taxation, availability, access, production, distribution) using models based on current licit drugs.

In the Netherlands, although cannabis is available from licensed premises, the levels of use are not significantly different from its prohibitionist neighbours. [5]

Reducing Demand & Harm

Law enforcement is expensive, which has led to scant allocations to demand reduction in the form of drug education and treatment. The most effective form of demand reduction is currently drug treatment. If a substantial proportion of drug users can be attracted and retained in effective drug treatment for long enough, the demand in the community decreases. The best example is

the treatment of heroin addiction using substitution drugs such as methadone or buprenorphine plus psychosocial assistance, with benefits including reduced deaths, HIV infection, crime and drug use, and improved physical and mental health. [7] Increased funding could allow development of further treatments including those for stimulant users such as dexamphetamine substitution.

What else can reduce demand? You could be thinking: educating children from a young age to empower them make healthy lifestyle choices, which is cost-effective and has potential. However, in a context of drug law enforcement drug education is rarely based on evidence and emphasises unrealistic achievement of abstinence. Primary prevention techniques including school-based and mass education campaigns have had disappointing and transient results. Benefits tend to be less positive attitudes to taking illicit drugs rather than reducing consumption or harms. [7]

Supply Reduction

The criminalisation of something that is in demand creates a lucrative business venture and as expected, gives oxygen to organised crime. This was evident when the increased demand of cannabis, heroin and cocaine in Western society during the 1970s and 80s allowed illicit drug trafficking to expand into a multi-billion dollar business under criminal control. [8] Internationally, Turkey supplied the illicit opium markets in Europe and the United States until opium production was banned in the 1970s. To meet this void, Mexico emerged as the major source of heroin for the United States market and became the initial target of President Nixon's "war on drugs". Later, supplies shifted to Pakistan, Burma, Iran and especially Afghanistan in 2004 where opium production rapidly increased and now grows 90% of opiates. [8] Aggressive eradication of opium in Afghanistan would only serve to increase the vulnerability of Afghan farmers to the Taliban while alternative sources of income are unavailable. [8]

Currently in Australia it is estimated that the average price of cannabis is $10-20/6 cones, for heroin it is $50/cap, methamphetamine $50/point and ecstasy is $30/pill. [1] Nationally, drugs considered 'very easy' or 'easy' to obtain in the last six months, include heroin, all forms methamphetamines, cannabis, methadone, buprenorphine and cocaine, most commonly from a friend or known dealer. [9]

The negative implications of drug prohibition for supply and demand are inevitably linked with increased harm. The unintended negative consequences arising from prohibition of drugs are numerous.

Crime and Violence

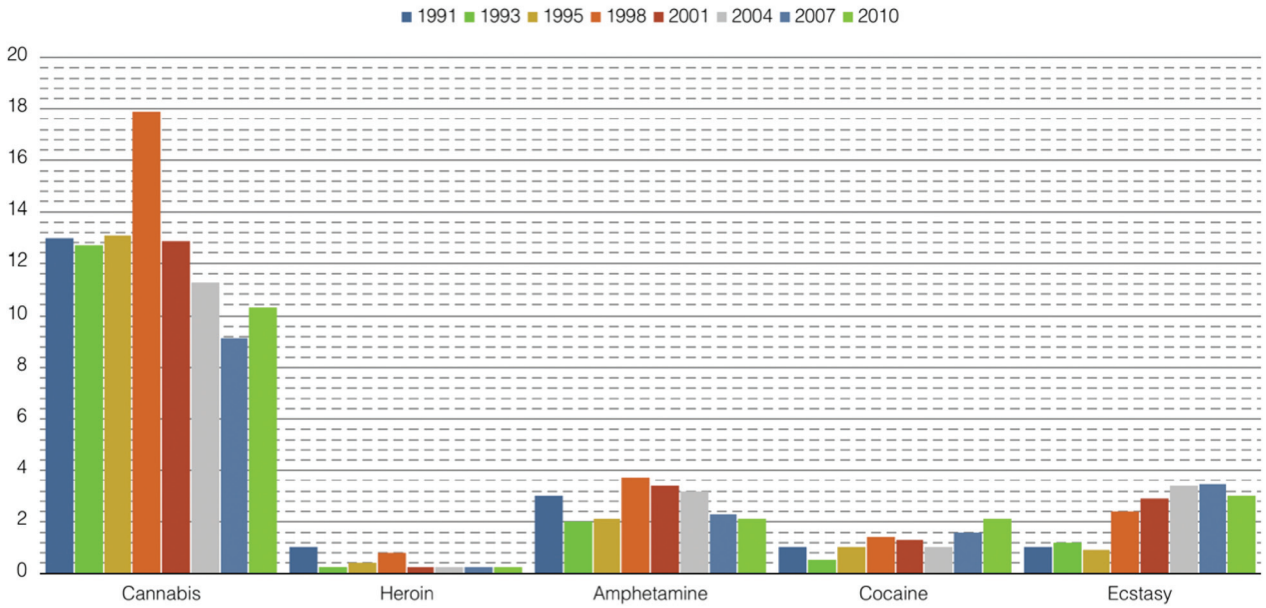
As mentioned above, an unregulated black market has flourished despite the declaration of "a drug free world, we can do it!" by the United Nations Office on Drugs and Crime. The vast networks of organised crime have driven violence, corruption of law enforcement and governments, military crop eradications, and provided funding for terrorism. [10] Despite increasing arrests of dealers and drug users [1], illicit drugs remain easily accessible. Instead intensive law enforcement has served to exacerbate violence and the overcrowding of prisons while using up police resources. In Australia in 2005, one in ten prisoners were imprisoned for drug-related offences. [2] Otherwise law-abiding citizens are pushed into the world of organised crime through their dealers.

Poorer health outcomes

Prohibition of drugs also absolves the government of responsibility to control the quality of drugs. Governments *cannot monitor production, toxicity, and purity*, and for consumers there is no in-

Illicit drug use

2010 National Drug Household Survey: Changes in 'recent use' (%) over time



formation on how strong the drugs are, no warning labels or advice on where to seek treatment, and no restriction of sales to young people or pregnant women. Drug-overdose deaths are of concern, with elevated rates of drug-related mortality more likely in settings emphasising drug-law enforcement. [11] Policies enabling people to safely admit to drug addiction problems are more effective at managing drug addiction. [12]

Further inadvertent harms of criminalisation include placing barriers to rehabilitation. There is increased difficulty in accessing drug treatment and health education, and provision of primary health care of prevention, treatment and care for HIV. [7] The marginalisation and stigmatisation of people who use drugs makes it more difficult to assist them and integrate them into community. Mass media campaigns must be careful not to increase stigmatisation, since those who use drugs are always someone's son or daughter, sister or brother, or father or mother.

Globally, the overcrowding of prisons in the last three decades has been largely due to dramatic increases in incarceration of drug offenders. [12] This intervention has limited impact in reducing drug dependency and cannot address spread of Hepatitis C and HIV. Punitive policies may aggravate chronic unemployment, family destabilisation and increase the risk of recidivism. [12] Often drug law enforcement is discriminatory, as it tends to target low-income communities that have little political power to resist aggressive policing. This questions its legitimacy, since drug use appears to be driven by underlying social inequality. Prevalence of drug use increases in countries with greater levels of inequality such as the USA. [13]

Alternative Model

The discussion around drug policy is steeped in complex political waters, and change will be slow and must be acceptable to the community. Although drug prohibition is a lofty ideal with good intentions, it has inadvertently led to numerous harms by creating such a lucrative business opportunity. Although we support legalisation of drugs to overcome the black market and starve criminal incentives, we definitely do not think drug use should be normalised or in any way encouraged. Legalisation will not eliminate all drug related problems, however the failures of drug prohibition undoubtedly augur the need for alternative solutions.

Decriminalisation or legalisation would help to cultivate an environment conducive to honest discussion of drugs, reduce hypocrisy, and reduce barriers to seeking help. Governments would be in control of the market and could carefully regulate availability and quality. There should be clear consumer information including warnings and treatment services, and tax revenues directed into primary prevention and harm minimisation clinics. Advertising and donation to political parties must be banned. Positive impacts would be seen in reduction of prison overcrowding, and expansion of harm minimisation.

In many countries including Switzerland, Belgium, Luxembourg, Spain, Portugal, Ireland, the Czech Republic, and some states of the United States and Australia, the law has changed to decriminalise the possession of small amounts of cannabis for personal use. The models that move beyond this are the Dutch, California and Spanish models. [8] The scope of this article limits our discussion of their impact, however it is clear that decriminalisation does not necessarily lead to increased use, but increases access to treatment.

Ultimately harm reduction is still limited by international drug conventions that affect national legislation. Many key superpowers including USA and China are in favour of prohibitive policies. [14] Just as a small group of countries gave birth to the current international drug control system over a century ago, another group of countries could initiate this reform based on the evidence that has emerged since. As newer and more effective drug treatments for drug addiction develop, the 21st century demands a paradigm shift to greater emphasis on access to health care and respect for human rights and dignity. Watch this space.

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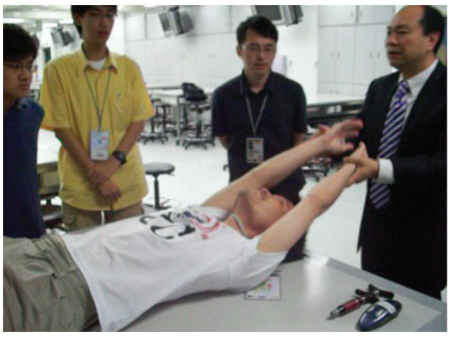
2011 AMSA & IFMSA JOINT CONFERENCE

HELD IN HONG KONG, SPECIAL ADMINISTRATIVE REGION OF THE PEOPLE'S REPUBLIC OF CHINA

The first Joint conference held between the Asian Medical Students Association (AMSA) and the International Federation of Medical Students Association (IFMSA) was held in Hong Kong from the 25th of June to 2nd of July. 30 Australian delegates attended the conference with 5 students from UNSW – Samuel Vo, Rachel Ng, Frances Chen, Harshita Rajasekariah and Aaron Tan. The theme for the conference was - Integrative Medicine: Evidence-based, traditional, complementary and alternative medicine in modern medical practice. The combination of academic, social and cultural activities allowed the 550 delegates from 32 countries to explore the theme and learn new skills through workshops and training sessions.

Academic Program

The academic program was focussed around two keynote lectures, delivered by Dr Vivian Taam Wong and Professor Jin Ling Tang, two prominent academics in the field of traditional and complementary medicine in Hong Kong. Their lectures detailed the growing importance and developing interest in traditional medicines, using traditional Chinese medicine as a particular example. Countries around the world are increasingly integrating traditional medicines into the Western medical model and knowledge of complementary and alternative practices are crucial for any future medical professional. The conference also consisted of several sessions on the UN Millennium Development Goals (MDGs). The eight MDGs range from halting the spread of HIV/AIDS, to reducing child mortality and improving maternal health. An inspirational lecture from Dr Sandro Calvani, Director of the ASEAN Centre of Excellence on UN MDGs, implored all future doctors to consider and empower the needs of the vulnerable and underprivileged portions of the global population. Other aspects of the academic program included sessions on the various standing committees of IFMSA. These include various programs and initiatives promoting public health, reproductive health, medical education and professional and research exchanges.



Academic Competitions

The academic competitions enabled an appreciation of how extensively integrative medicine is practiced in other cultures. Additionally, they provided insight into medical practitioners and students attitudes towards the use of TCAMs in clinical practice. Through the poster, paper and video competitions, the wide use of alternative therapies globally was evident – from Thai massage (not the seedy, erotic kind) to relieve pain, Korean hand therapy in alleviating post-operative nausea and vomiting to the widespread use of Filipino herbs in clinical practice. Our brains were challenged beyond that Phase 1 Ross Grant pharmacology lecture criticising alternative medicines when original student led research was also presented and alternative therapies had proven to work - Indonesian delegates demonstrated that mangosteen, a tropical fruit extract could lower lipid levels and help contribute to reducing atherosclerosis.

Australia participated in all elements of the academic competitions, but Australia's video entry was produced by our very own UNSW medical students. Our video followed Anna Ma, a stressed medical student suffering from insomnia who sought various alternative therapies - from Aboriginal medicine, vitamin supplements, meditation and a healthy dose of chocolate before finally being cured with hypnotherapy. Although there were an impressive range of informative videos presented, we still managed to come second in the competition!

Community Service

The theme for the community service program was "Fall Prevention" targeting the elderly population. As part of the program, delegates were split into 2 groups with one group carrying out a home visit while the other participated in a training workshop. As part of the home visit, delegates were invited to the homes of elders, majority of whom were living alone. A detailed home assessment was carried out to assess fall and trip hazards and delegates were then able to interact with their elder via a translator and social worker from the Salvation Army, teaching them simple exercises to strengthen their muscles and educating them on fall prevention. The training workshop was carried out in the community hall with elders and delegates participating in a variety of presentations, games and activities, all with the aim of increasing awareness of the importance of fall prevention. Through these 2 programs, delegates were able to not only gain a better understanding of Hong Kong culture and other social aspects through direct interaction with Hong Kong locals, they were also able to help the elderly through simple activities.

Site Visit

An afternoon was dedicated to visiting various sites including the Hong Kong University Chinese Medicine Faculty and clinic, chiropractic, acupuncture and moxibustion workshop, in relation to the theme of traditional, complementary and alternative medicine. This gave delegates an opportunity to see and personally experience some of the traditional therapies that they had been introduced to over the week in lectures and workshops, in order to gain a better understanding of how they work. Brief introductions and demonstrations of the various therapies were given and discussions on how they are currently integrated into the conventional health system were also conducted.

Cultural Program

Throughout the Joint Conference, delegates were exposed to different aspects of Chinese culture. The conference was officially opened with a traditional lion dance performance accompanied with music of the beating of drums, cymbals and gongs. On Day 5 of the conference, a Dinner and International Food and Drink party was held, where the Australian delegation set up a food stall which allowed delegates from other countries to sample food and snacks from Australia. While the Sao biscuits with Vegemite received mixed responses from those sampling them (being the first time for many), the definite favourite food item were the Tim Tams, which attracted plenty of delegates to the stall. Australian delegates were also given the opportunity to sample food from other countries' stalls, which added to the experience of sharing cultures of not only Hong Kong, but also from all around the world.

On the final day of the conference, the Organising Committee arranged a cultural bazaar, in which delegates participated in small workshops that were aimed to share the culture of Hong Kong. These workshops included traditional knot-tying, paper cutting, calligraphy, learning traditional chinese games and lessons in cooking Cantonese food, as well as a small workshop on basic kung-fu techniques. The Cultural Night was planned for the last day of the conference, where each country participating in the conference went on stage with a cultural themed performance, such as traditional dancing and singing. The Australian delegation began their performance with a game of famous Australian icons/animals charades with the audience participating, which was followed by the delegates singing 'I Still Call Australia Home' and was finished with the Hawaii Five-0.

Social Events

As to be expected in a vibrant city like Hong Kong, there was a great deal of social events and fun injected into the conference proceedings. Day One saw delegates allocated to small groups with a mix of students from different countries. Icebreakers like card games saw delegates forming fast and steady friendships, which were important as for the rest of the week group members would be fellow eating partners, shopping stylists and city explorers.

Through private buses, the highly efficient Mass Transit Railway (MTR), buses, trams, the Peak Tram, ferries and substantial leg muscle movement, delegates delved into the crowded and happening streets and sights of Hong Kong. Highlights included the stunning views of a shining city amidst rolling hills, which were seen from Victoria Harbour and its nightly lights show as well as from top of the highest mountain on Hong Kong Island, The Peak. So the Peak Tram, ferries and substantial leg muscle movement, delegates delved into the crowded streets and sights of Hong Kong. Highlights included the stunning views of a shining city amidst rolling hills, which were seen from Victoria Harbour and its nightly lights show as well as from top of the highest mountain on Hong Kong Island, The Peak. Some serious food sights were also seen and tasted at Yum Cha. Mountains of dim sims stacked in bamboo steamers were devoured. The challenge was so rewarding that many groups revisited this sight several times (or more) during the Conference. Finally it would not have been an all-inclusive visit to Hong Kong without shopping. Shopping malls take on a whole new meaning and size in Hong Kong, and price in some places (such as the IFC mall - strictly window shopping unless you are blessed with heavy pockets). Shopping proved to be a tiring exercise, from the very get go for some delegates, and after a good couple of hours for others. Thankfully there was always a ready respite available - in the form of Yum Cha or just any available seat to watch busy Hong Kong life power on.

Conclusion

Needless to say Hong Kong was a wonderful and memorable experience for all those that attended. Apart from expanding our knowledge in the field of Traditional, Complementary and Alternative Medicines, we managed to forge new friendships from all across the globe, explore a whole new country and experience a new and exciting culture. This was an invaluable experience for all of us and we would strongly encourage more UNSW students to come along and participate in AMSA-international/IFMSA conferences in the future.

UNSW MedSoc Council Reports

International Students' Report
What have they been doing?

Calvin Park and Ria Ko

Facebook group: In the beginning of 2011, we've created the Facebook group *'NSW International Medical students'* Forum' to facilitate communication among international students in NSW. In this group we've been posting useful up-to-date information on the internship shortage issue as well as alternative options for postgraduate training should international students do not get a training position in NSW.

International Students' info night - Internship: In May, we held an information evening to inform international students about status quo of the internship issue. Professor Simon Willcock and a couple of his colleagues from Clinical Education and Teaching Institute (CETI) kindly made their way to UNSW to give us a talk on the happenings of the internship issue, why it is happening and what international students should do in the meantime. CETI has promised to keep us informed & return to give us similar talk in coming years. At the same night, we also had 3 final year international students, Jai Nathani, Fred Lui and Tim Yang, share their own 'Plan Bs' – inter-state, New Zealand, Hong Kong and Singapore.

At this point of time, September 2011, it is anticipated that all international students graduating in NSW (Category 3.1 in the NSW Internship Priority List) who applied for an internship in NSW will get an offer for 2012. The first offers made to Category 3.1 were in Round 4, on August 19th. Offers to students in Category 3.1 are still going (Round 7 on September 9th) and most of the positions offered so far are in *Wollongong* (Network 11, aka Oceans 11), *Newcastle* (Network 12, the Hunter New England) and *Blacktown* (Network 15, newly formed this year). Unfortunately, this doesn't mean we can now sit back and relax – there will be another increase of some 200 in the number of graduates in 2012. To meet this challenge, the NSW government, in collaboration with other stakeholders, is looking into overseas rotations, such as in Hong Kong and New Zealand, as well as placements in the private sector and GP practices.

International Students' Dinner: In August, we had our annual international students' dinner at the Belgian Bier Café in the Rocks. It was great to see both international and local students, ranging from first through to fifth year, mingle with each other. And of course, the mussels were amazing.

Plan B Night: In the mid-October there will be another information session on overseas internship, including Singapore and the United States. This is not to encourage students to leave Australia but to inform both local and international students of different options available for their postgraduate training. Details to be confirmed shortly, so keep an eye out for the Medsoc mail-out!

Advocating international students: Internally, we've been communicating with many international students in person and via emails to assist them with resolving their concerns at our best – whether it be providing information, connecting them to the right person to talk to, or just listening.

Externally, we've been attending the NSW MSC meetings to advocate international students and keep ourselves up to date with what's going on in regards to the internship allocation in NSW. The Australian Medical Students' Association also recently formed the International Students' Network, in which international students' reps from each university in Australia are having regular online meetings to discuss on issues regarding international medical students in Australia.

10-year moratorium: Lastly, we'd like to finish on a new topic. Most UNSW students may not have even heard of 10-year moratorium, thanks to you-know-who. It is a federal government regulation, which states that international medical graduates and Australian medical graduates who were not Australian or New Zealand permanent resident at the point of entry into the medicine program, will have to work either in the 'area of need' or without Medicare provider number for 10 years, should they choose to apply for permanent residency in Australia. It is actually not as bad as it sounds, as there are abundant 'areas of need' in both metropolitan and rural regions, depending on the specialty. You also don't need your own Medicare provider number to claim Medicare benefits as long as you work in a hospital (you can use the hospital's provider number), and as you may already know, postgraduate training easily takes ten years. Yay. This was recently waived for New Zealand permanent residents and we're hoping to see it disappear completely in the near future. The initiatives for this regulation was to meet the shortage of doctors in the areas of need, especially in the rural Australia, however, it is criticised by many professionals that this is not the most efficient nor effective way of improving rural health in Australia. For more information, google '10 year moratorium.'

Assistant Secretary Report

Daniel Yong Tze Yeo

Aside from assisting the secretary (surprise, surprise), some of my roles this year have included updating the MedSoc website with new events (especially from the mailout), calendar event management, and providing a monthly summary of MedSoc's activities for readers of the mailout.

The publishing of the monthly summary was done with the aim of increasing students' awareness of MedSoc activities. It is only a small part of a move to not only increase participation in MedSoc events, but also to encourage involvement with the running of the student body itself. With approximately 270 of us in each year, making sure that everyone feels like they can contribute and be part of something bigger is an issue that MedSoc is tackling head on.

Being only a first year, it is a privilege to be given the opportunity to work alongside senior medical students. It's a good chance to learn how MedSoc works, and I encourage other first years to take the opportunity to be involved with MedSoc as much as possible. You're going to be here for 6 years after all!

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Charities Report

Lorraine Cheung & Kelly Chen

Hands up if you have tried balancing a book on your head whilst walking down the wind-swept Northern Coogee cliff. Or running around a busy Sydney museum in search of a hidden Chinese chair? How about dressing up as babies and characters from the Wizard of Oz? Or better yet, trying to move a cookie from your forehead to your mouth (and eat it) using thy facial muscles, with no hands? (encouraged to try at home).

Well you may have been lucky enough to view this phenomenon, & even luckier to have taken part in it on the 28 May 2011. All in the name of the Medical Students Aid Project (MSAP): raising money for medical supplies to be sent overseas with our medical elective students, 200+ UNSW medical students embarked on an "Amazing Raise" around Sydney. It was a chilly day, as teams and volunteers awoke to find themselves in the fairytale land of Sydney. 'Once upon a time' brought princes and princesses from faraway lands, childhood characters and even babies to assemble at the Library Lawn. As the whistle blew, teams sprung into action – trust me when I say that med students are competitive!

The race was tough, arduous and exciting, with numerous challenges and laughs littered along the way. There was one leading

team the whole way through, and finished the race victoriously sweating and puffing. They lived up to their name as 'The Knights' were the first to save their princess. Congratulations to Chris Go, Ronald Ho, Pat Ly and Angelica Tjokrwidjaja.

Honorable mentions to Daniel Chim, Ben Chau, Eva Zhang, Christine Ma, Vincent Tsui who raised the most amount of money for MSAP entertaining Sydney in adult-sized diapers. Best dressed went to Wizard of Oz: DILFS of Oz: Henry Vo, Joseph Firrilo, Tram Nguyen, Xiang Yih Lay, Victor Wong, Jacqueline Ho.

At 4 o'clock, all teams rolled/ crawled/ were carried back to uni, after an exhausting race. Many may have suffered severe post-exercise pain and crippled-ness for the next few days, but hey, in the name of charity! Best of all, we managed to raise a massive $3000 for MSAP! Thanks go to our competitors and volunteers and friends and family who sponsored these brave souls.

As for those who have felt as though you missed out on such exciting adventures... well you did. Make sure you are training for next year's race! Until then, get pumped for the opportunity to shave for a cause- introducing squareSHAVE! Register to shave your hair, eyebrows, moustaches, legs, arms, chests for this year's WORLDS GREATEST SHAVE by emailing charities@medsoc.org.au

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IT Report
Jacqueline Ho

So what's going on from the Medsoc IT?
This year, we've revamped the website, bringing back all the goodies from the old website & bringing new resources for everyone to use. It features the latest news, opportunities, videos & upcoming events for Medsoc members. With 361 users signed up on the Medsoc website, this is great news.

Mednotes is back: a collection of notes contributed by students for students with a vast range of resources for Phase 3 students, especially for Vivas. The Electives Database is also back, featuring students' elective experiences: stories from across the globe. Of course, these features wouldn't exist if people didn't send their notes and experiences in and we're always looking for more!

There's also many other features, just to mention a few: Have you ever been overwhelmed by the numerous events that Medsoc runs? Can't access facebook on the hospital computers? Check out upcoming events on the front page & you'll never miss out on what's happening when. Facebook: Being the person behind the facebook page, we've started up this year at facebook.com/unsw.medical.society where we've been updating people of upcoming events, news & photos from the numerous Medsoc events. If you haven't liked it yet, like it now. We're also on Twitter, so please get on the bandwagon & follow @unswmedsoc!

Interesting Issues: Being the first female IT Officer, it's been a full time job procrastinating on facebook and the website all the time. But it's a lot of fun. I've been involved with lots of other work in Medsoc such as co-ordinating event form and PayPal logistics. As a consequence, IT Officer has been promoted to an executive position due to increased workload. On the side, I've also designed most of MedSoc 2011's apparel this year, including shirts for Medcamp, Amazing Raise, AMSA Convention hoodies & Medsoc business cards.

The future: I am planning to create a Medsoc iPhone app (yes, that's right) and hopefully that'll keep everyone in touch with what Medsoc is doing. We're also looking to develop an online Medsoc archive as well as rural clinical school pages with student opinions on the different campuses, & if successful, expanding this to Sydney clinical schools.

We're always looking for new ideas, so if you want to suggest something, go ahead! Email it@medsoc.org.au

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Academic Report
Vineet Gorolay & Devinda Jeyawardene

2011 has been an exciting year for the Academic Portfolio. Continuing from the excellent work of last year's Coordinator, we have introduced 3 new Medsoc initiatives – Mock ICE/OSCE, and Grand Rounds.

Our year began in our summer holidays with a phone call from El Presidente Mike Chan asking us to run a practice session for the fourth-years' ICE exam. Having never sat an OSCE at that point, let alone coordinated an exam practice session, our apprehension was significant. However, with some firm guidance and plenty of patience from older years, we cobbled together three nights which assisted our third-year colleagues in their preparations.

As the months progressed, we and our colleagues found ourselves facing the gauntlet of the SH, OSCE and End-of-Phase Theory exams. At this point, we called upon every waking hour and every favour imaginable to organise four Mock-OSCE nights, one week out from our first exams. As before, many Phase II and III students were willing to put in their time and efforts on multiple nights, as assessors for our students. Additionally, many students from our own year were willing to assist after they rotated through their session; this was of great assistance to us. Despite many teething problems, we believe this night was beneficial for our cohort as a whole.

Our third major initiative has been weekly Grand Rounds, which has quickly become one of the most successful events on the MedSoc Calendar. Jointly coordinated with a Special Interest Group (SIG), it typically featuring case studies & information about entrance into the specialist Colleges. General practice, global/international medicine, ophthalmology, radiology, radiation oncology, psychiatry, cardiology, orthopaedic surgery & plastic surgery have been represented at some point this year, with plenty more to come. We are grateful to MIPS for their support and the ubiquitous post-event food.

It is to be stressed that our position could not be tenable without great assistance from the student body. We have relied heavily upon older students to assist as mock examiners in our practice exams, younger students as practice patients, the SIGs for making Grand Rounds possible, and the rest of MedSoc for their helpful advice and assistance.

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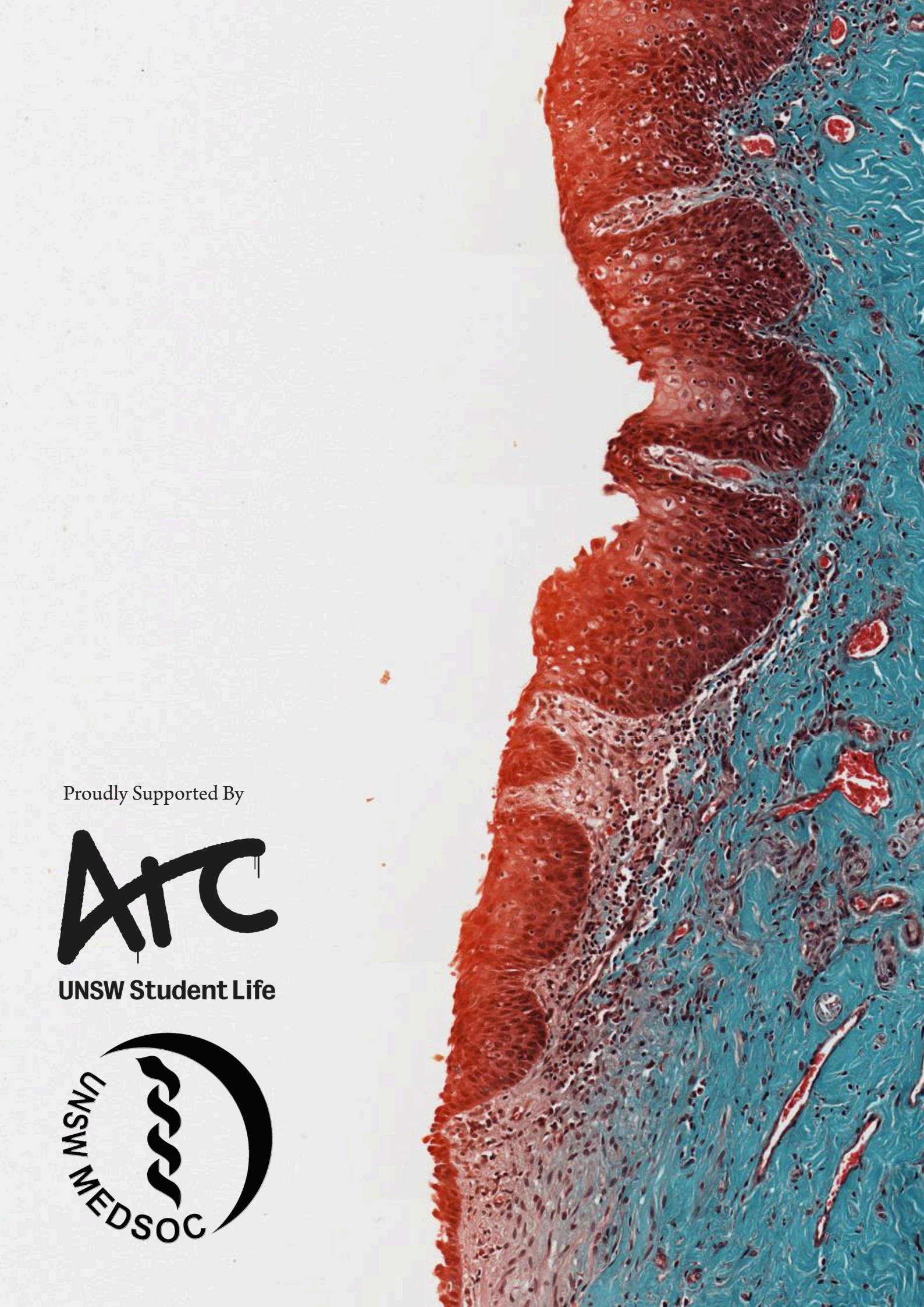
Coffs Harbour Rural Report
Natalie Ammala

At Coffs Harbour RCS campus we have had a busy year. With renovations continuing to upgrade our facilities (which will include a 40-seat teared theatre), we welcomed new students to 4th and 5th year as well as celebrated not one, not two but a total of seven engagements. Needless to say most of the 6th years are funding the wedding boom on the Mid North Coast this year. Students have also enjoyed my commitment to self-directed learning and cant wait for the arrival of my baby due the week of 6th year exams.

In between dodging workmen, studying and spending time on the wards, in 2011 we have enjoyed engaging in community fundraising activities, cook-offs, helping out at Career/ High School information days attracting/coercing students into medicine, the Medsoc/RAHMS Bowling Alley Night and winning (but mostly loosing) at the annual Coffs Harbour Races.

With the end of the year looming, 6th years are preparing for final exams, 5th years are organising electives while preparing for their Biomed exams and 4th years are doing what 4th years do best. All-in-all, 2011 has been very busy for us at Coffs but who can complain with such great weather, staff and friends to do it with.



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