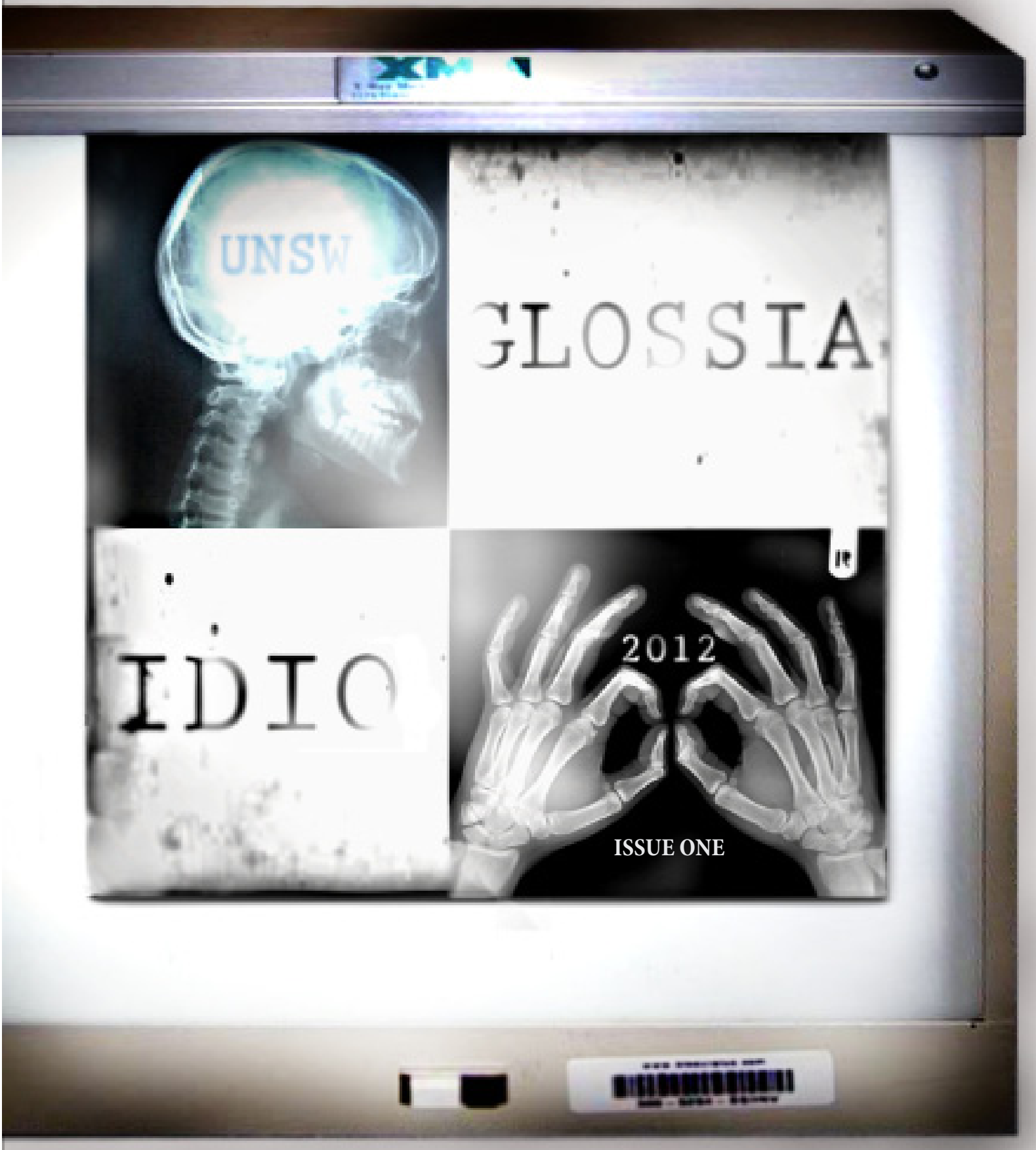

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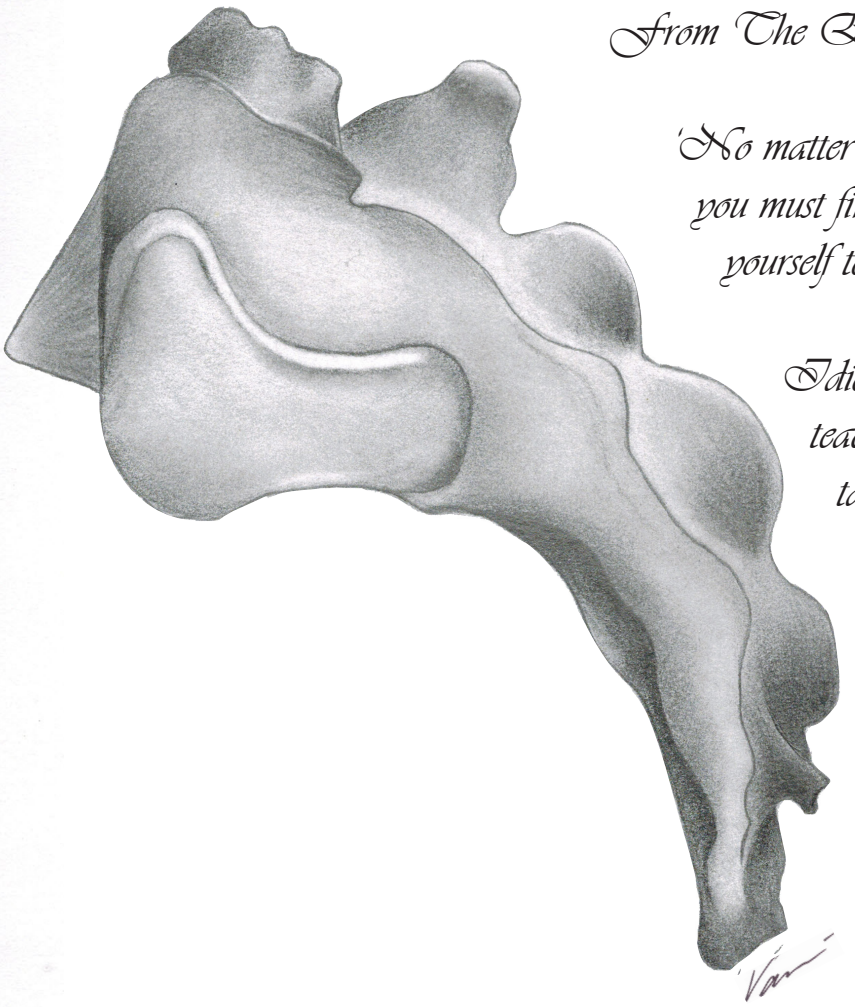

From The Editor

'No matter how busy you may think you are, you must find time for reading, or surrender yourself to self-chosen ignorance' 'Confucius

Idioglossia speaks for students. It teaches, it informs, it jokes and it entertains. Take some time to read what other students have offered and you might find yourself just that little bit less ignorant.

VANNESSA LEUNG (Med III)
UNSW MedSoc Publications Officer

Feature Articles

UNSW Medical Society Reports

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Edited by: Vannessa Leung | Designed by: Vannessa Leung & Daniel Yeo

PRESIDENT'S HALF YEARLY REPORT

Engage. Advocate. Enrich.

Engage. Advocate. Enrich. This was the vision set for MedSoc in 2012, and the Executive and Council have made it their mandate to achieve these objectives through each portfolio. I am very pleased to report that the events and initiatives outlined in this report, and the subsequent portfolio reports, have realised these objectives through excellent planning, new and fresh ideas that attract and involve even more members, and by making some noise over old and new issues facing medical students at UNSW.

-

Engagement.

The year has started off with the welcoming of our newest members to MedSoc. The cohort of first years has taken with great fervour to the many orientation events planned for their benefit, including a spirited attendance at the First Year MedCamp (thanks to Danielle Christmas and Anthony O'Rourke plus the second year leaders for their superb organisation) as well as Orientation BBQs, Umbilical Publication and First-Year Mentoring. We hope that the 'Class of 2017' have enjoyed their first taste of med school life!

-

MedSoc hasn't forgotten returning students either, with a range of successful events, including Amazing Raise, PubCrawl, College Cup Touch Footy, Classical Quest and many more, designed to engage and promote interaction between students of all years, but also to break up the monotony of constant studying. If you haven't been to a MedSoc event, I invite you to come along and meet some fellow medical students – it's a chance to meet other like-minded students and make friends outside of the classroom. There are many more exciting events in store for the rest of the year, but you'll just have to wait to find out what they are!

-

Advocacy.

The most immediate advocacy issue to have arisen in the last six months has been the advent of the Student Services and Amenities Fee, and MedSoc has taken up a strong position against the university in the application of this fee to medical students on clinical placement. This new fee is designed to pay for non-academic facilities and services, however these are in the majority inaccessible or inappropriate for medical students studying at metropolitan teaching hospitals or at rural clinical schools. We sought feedback from our members about their opinions of the fee, and the resulting feedback has guided our approach with an emphasis on improving particular clinical school facilities. MedSoc is continuing to lobby the university through several channels to obtain either a reduction or exemption in the fee for off-campus students (as occurs at other universities who have implemented the fee), and to prioritise fee revenue from medical students back to non-academic clinical school facilities. The progress on this front is still ongoing, and I hope by my next report we will have good news to relay.

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Enrich.

The idea that MedSoc is just a 'party society' is far from true,

however, and many events and initiatives have been run or tweaked to 'enrich' students, through upskilling students in both medical education and general life skills. From the very popular 'Mock ICE' evenings, Faculty Info Nights, to 'Writing Research' and 'USMLE Info Nights', a variety of portfolios have been involved in this facet of MedSoc and run some of our most well-attended events. It is very encouraging to see a culture of peer-teaching and mentoring develop amongst students, and I must say thank you to those many exceptional students who have volunteered their time to make the above events occur.

-

A huge recognition must also be made to MedSoc's Special Interest Groups (UNSW SurgSoc, PathSoc, RadOnc Soc, CardioSoc, PaedSoc, Student's Neurological Society and GastroSoc to name a few who have already run events at the time of writing), who contribute to both Grand Round evenings as well as their own autonomously-planned events. SIGs only further MedSoc's aim of enriching students through their events, and furthermore engage many more students in leadership positions and in attending interest or specialty-specific activities. It is for these reasons the Executive have been heavily invested in overhauling the support mechanisms which help SIGs run successful activities, and we look forward to the massive events from both pre-existing and new SIGs that are coming up in the next few months!

-

Other initiatives.

Some of the more exciting changes to MedSoc have been occurring behind the scenes, with a concerted effort to promote the long-term sustainability of the society. With the assistance of the Long Term Planning Committee (Navid Ahmadi, Chris Mulligan and Evy Panos) as well as IPP Michael Chan, the Executive has already set out a plan to consolidate MedSoc's finances and set up a trust fund, which will hopefully provide financial security into the future and provide a new source of funds. The long-term future of MedSoc is critical to ensure the numerous events and initiatives detailed in this report can continue year-after-year. More information will be provided to general members as discussion continues and specifics are finalised with our professional partners. Thanks must go to previous individuals who have contributed to the formation of a MedSoc trust, including Dr Cam Khorb-Wells, Dr Vekram Sambasivam and Dr Sam Hwang.

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It has been a very busy half-year for MedSoc, and with so many events and initiatives on the near horizon, we're looking forward to another six months of engaging, advocating for and enriching medical students. Remember, it's your MedSoc!

My New Bodia Buddies

Jessica Murray (Med III)

Last holidays I had the trip of a lifetime when I went to Cambodia to volunteer in a school and a clinic situated in a small town just outside Siem Reap.

When I first arrived I didn't quite know what I was in for but my team leader, Amy, made it pretty clear we were in for some very hard work. We were to build a wall, 100m long, down one side of the school to stop unwanted visitors from getting in and also to keep the children's' bicycles safe.

Soon after meeting Amy, I met my other team members: Colleen, Ellie and Sophie. It was pretty daunting expecting 5 young women to make this massive brick wall, but to my relief we had contractors from the area who came to help us. We soon got to work making this massive structure. We moved bricks, dug the foundations, mixed cement, bent the wire fixtures and generally did hard work for 5 weeks. The fact that we had no electricity or machinery to help us made it very difficult and everything was done by hand! Occasionally we had help from the kids who were very keen to have turns in the wheelbarrow. I still have the pictures that one of the girls drew of me. It was difficult and, at times, we didn't think we would get it done but, at the end of 5 weeks, we finished a beautiful wall!

> "My advice to you: get out there and get as much experience as you can, whether it's medical or life experience as both make you a better human being and a better doctor."

Interspersed between all of the hard work, I got to see some of the sites including the amazing temples like ta prohm (famous for its appearance in Tomb raider) and the awe inspiring Angkor watt. We also got countless $1 massages from the market. Once or twice I braved the daunting fish massage which involved putting your feet in a fish tank so that the fish could eat the dead skin off your feet!

Perhaps one of the most eye-opening experiences was visiting the local clinic. I went there twice with a translator as part of my individual and observed the nurses work. On one occasion it was the tuberculosis medication day which is when all of the people in the community with TB came in for their medication. The nurses said they had to give the TB medication out on a weekly basis so that the families did not feel tempted to sell them and also to ensure that they were taken correctly. One case that really stood out for me was a woman who was around 55 years old that came into the clinic. She was so tiny and I noticed her head did not even reach the top of my shoulder. She was very ill looking and

weighed only 23kg. For me it was terrifying to see someone so ill but for the nurses she was just the average patient.

There are many things I will miss about my trip to Cambodia including how cheap everything was at the markets and also needing to ride my bike every morning for an hour to get to the school/worksite. I probably will never be that fit ever again! Some things I will not miss though are the consistent bouts of gastro and the constant nagging of 'lady, lady, you want fish massage?'

However, I will always remember what I did in Cambodia and it will stay with me forever. I hope to go back one day and see how the school/surrounding areas has changed. I wonder if they will ever finish the wall that we started. One thing is for sure, even if my impact on Cambodia was small, it has changed my life forever. My advice to you: get out there and get as much experience as you can, whether it's medical or life experience as both make you a better human being and a better doctor.

UNSW SURGSOC REPORT: Stethoscopes, Sutures and the Future

Soon Lau, UNSW SurgSoc Secretary

Stethoscopes

Have you ever seen a surgeon use a stethoscope? It's commonly held that once graduating through a surgical program, most surgeons hang up their stethoscope, or at the very least, only dust them off once a year when talking to patients' families. Not true! UNSW SurgSoc kicked off an exciting 2012 with the first MedSoc/SurgSoc Grand Rounds for the year: The Acute Abdomen. Students heard about how to approach this classic surgical problem from Prof. Bryan Yeo, and learned that the surgeon does, in fact, use a stethoscope.

Sutures

The first UNSW SurgSoc Suturing workshop for the year was taught by Dr Tim Peltz. Students had the opportunity to practice a variety of suturing techniques on pork trotters. Don't know the difference between the subcuticular and vertical mattress stitches? Keep an eye out for suturing workshops at the various clinical schools throughout the year!

The Future

UNSW SurgSoc is proud to annouce and present the inaugural Asutralasian Students' Surgical Conference. This day will feature a keynote address from the Royal Australasian College of Surgeons about the surgical training pathway, specialty speeches from leading surgeons that will cover the nine surgical specialties, skills workshops, and

student research presentations. It is fully endorsed and supported by UNSW Medicine.

Tribute to a Great Surgeon and a Great Man

It is with great sadness that earlier this year Professor Bryan Yeo passed away. He was a wonderful surgeon at Prince of Wales Hospital and passionate educator at the Clinical Teaching Unit at POWH. For many students past and present, he did not just pass knowledge and information onto medical students, but transformed the way we thought in the often hectic and confusing world of surgery. His contribution to the student learning experience, from regular surgery tutorials, encouraging students to be dummy patients in AMC exams, Medsoc Grand Rounds Speaker, and last but not least, his vision for a "Master Clinician" student experience. Below are some student contributions with their experiences with Prof. Yeo and a glimpse at why he was so highly regarded.

Navid Ahmadi and Michael Chan

To the late A/Prof Bryan Yeo, his family, colleagues, friends, students and his dedicated team...
One surgery, a living memory
It was just another day, in the month of May,
In the bright lights of theatre, where we worked together,

His large hands steady, performing a hemicolectomy,
The twinkle in his eyes, where decades of experience lies,

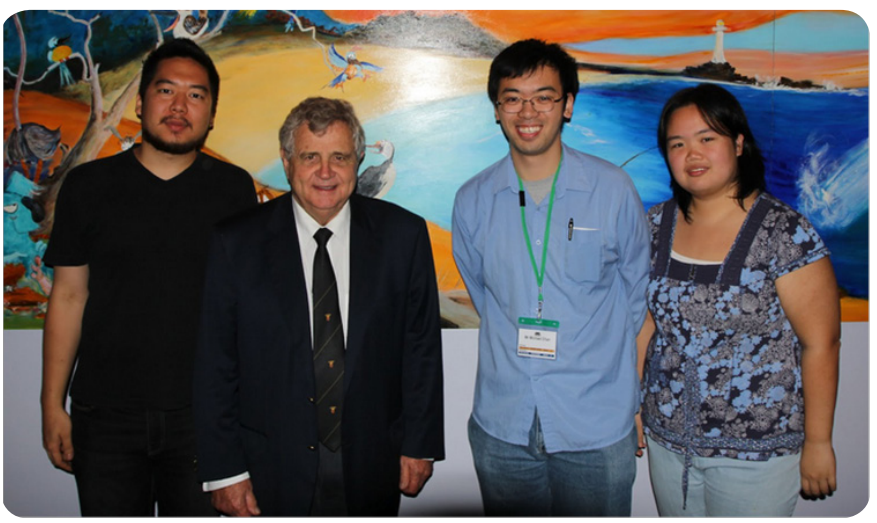
A man of this calibre, brings comfort to the table,
In admiration I looked up high, and breathed a long sigh,

So much yet so little have I known, about a man who has shared many lessons of his own,
Now he has left a shadow, one that I cannot follow,

Though the colours of today, will tomorrow turn to grey,
An experience more valuable than gold, is now mine to hold,

Was that one surgery, now a living memory.....

Kevin Phang



Professor Yeo. I remember us standing at the nurse's station waiting eagerly for him for ward round at the very start of phase 3. Judging from his name, we mistakenly looked out for any Asian doctor who happened to walk past. It was only in a tutorial later in the week that we got to meet him. Prof. Yeo entered the room, with his usual grin and calming demeanor, and said: " Sorry guys I'm late. So, is the computer set up? I wouldn't know how to otherwise. My daughter helped me prepare these powerpoint slides".

My first impression of Prof. Yeo was nothing like I anticipated. He was kind, loving and humble. In tutorials, he always gave everyone a chance to think and solve clinical questions. " Let him go till he drops", he'd grin. He was always patient and encouraging, never intimidating or condescending. He used real cases and metaphors to teach, and they were what stuck with me till this day. "The slogan on Arnott's biscuits is that there is no substitute for quality". That was how he reminded us to listen carefully for bowel sounds.

In theatre he was precise and meticulous. He showed me that not every surgeon loved to cut and care less for the patients. “When in doubt, always go back to the beginning. Take the history again”.

I feel so lucky to be one of the last students on his team, knowing and working alongside him. If there is only one word to describe Prof. Yeo, to me he was always like a grandfather - ever so caring and full of wisdom. I was trying to recall what he said that was so inspirational, then I realized it was not what he said, but the person he was. Always so full of love and passion for people and his work.

Tran N.

Professor Yeo was the first surgeon I ever met. When pondering a surgical career, I asked my GP for a surgeon I could spend the day with who “won’t yell at me too much”. Needless to say, my initial fears were allayed when I first met Prof down in theatres- with hat askew, a calming voice and a big easy smile. I consider myself extremely blessed to have met such a fine surgeon, an inspirational educator and most importantly, a kind-hearted person. It is a rare surgeon who answers the theatre phone, pauses mid-case for a teaching opportunity and still handwrites his operation reports. A year later, I still find myself down in theatres with an enthusiasm for learning for which I shall forever be indebted to him.

Prof once wrote “A Doctor is a Student until Death. If He/She Ceases to be a Student, He/She Dies”. Despite his passing, Prof is still well and truly teaching. Teaching us to be kind and showing us by example, the importance of patience. He taught me that life’s too short not to do what you love every day. I would like to share with you some “Bryanisms” as they were fondly known every Monday in Theatre A6:

> Never forget, the most overlooked reason for small bowel obstruction is a femoral hernia
> I’ll have some Size 8 gloves thanks. Just the Franklins ones will do
> Surgery is all about moving your feet. Have you seen Roger Federer? He’s got fantastic footwork
> Fat’s not worth a crumpet
> Give it an inch and you can take it a mile

The last time I saw Prof was not in theatres but leading an elderly gentleman down a hospital corridor. Despite just meeting him, Prof had one hand on the man’s shoulder and was chatting amiably. Till the end, Prof always had a kind word and a reassuring sense of direction for those feeling a little lost in the hurly-burly of the hospital.

Goodbye Professor. Your teachings and kindness will never be forgotten. We will miss you dearly.

Name witheld

Report from Phase Three Representatives: *Navid Ahmadi & Michael Chan*

“OMG, How do I study the whole of Medicine and Surgery” or variations thereof are heard from Fifth years across many student common rooms, with the reality of the biomedical exam hitting them.

There are sixth years worried about their final vivas “Hey why aren’t we getting more doctors running more tutes?!” or OMG how did s/he cancel!!”. Such is the reality of the final two years with so much focused at the end of the year. But this is not the whole story, far from it. Whilst many students are happy to be the recipients of knowledge, they ignore an important part. A fundamental pillar of Medicine: that is the need to teach and continue the body of knowledge to our younger peers appears to be ignored by the large majority of senior students.

There are only few students at most urban clinical schools who take the initiative to offer their time to teach younger students. So why do senior students find it so difficult to teach and mentor younger students?

> 1.Poor calendar matching (with phase 2 courses on 6 week rotations) and guidance to classes 2.Lack of student/mentee conscientiousness to organise tutorials with older years 3.Poor training of senior students to teach younger students 4.Belief in senior students to not have enough knowledge in teaching 5.Misconceptions that it is a total waste of time or they are “too busy” 6.“Someone else will do it” 7.Not organised by Medsoc/Faculty 8.Not an assessment, therefore not mandatory, therefore “I don’t care”

None of this teaching/mentoring should replace any teaching at all by the faculty, and unless engaged in a professional capacity, the good-will of students who mentor and teach in their own time should not be taken for granted. Furthermore learning should not just be the regurgitation of lists, but as the whole premise of higher education: regardless of subjects such as medicine, law and engineering, should be about developing critical thinking.

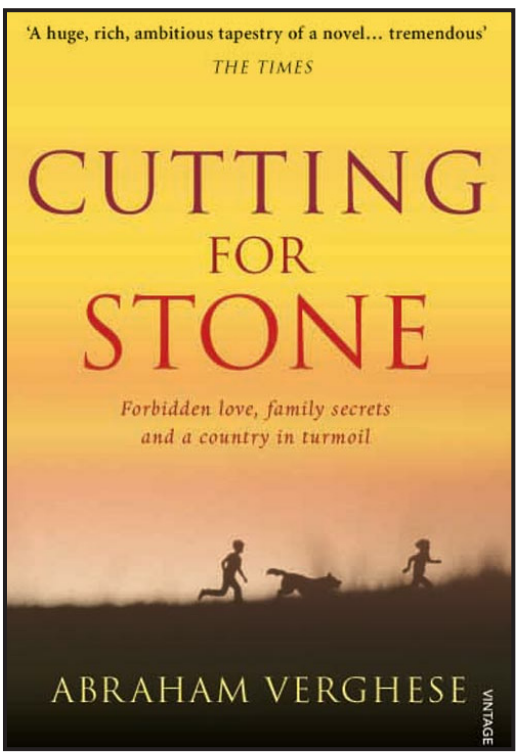
I have great respect for those who take their time to guide students, from one to many, through the many untold rules of medicine, learning from their mistakes and developing their critical thinking. I hope that students who have not thought about teaching and mentoring consider this in their future years, as the vast majority of your medical career will be spent educating the next generation of students/trainees, their peers and last, but not least, future patients.

CUTTING FOR STONE: A Book Review

KAVITA RAVENDRAN (MED III)

Abraham Verghese is a man of Medicine. His weighty descriptions of surgical procedures and clinical signs are a testament to that. He is also a Romantic- weaving in tragedy, magic, love, loss and hope into his dense second novel, Cutting for Stone. It follows the lives of Marion and Shiva Stone, illegitimate twins born to Sister Mary Joseph Praise, an Indian nun who dies on the operating table while their suspected father Thomas Stone disappears.

Raised by doctors Hema and Ghosh, Marion pursues Surgery while Shiva practises Obstetrics, under the individual tutelage of their parents, inspired by their experiences living in 'Missing Hospital,' (Missionary mispronounced). The novel is initially set in Addis Ababa, Ethiopia and spans generations, continents and medical disciplines. It's an epic that requires some commitment. Verghese, proud of the richness of each of his characters is determined to provide a back-story for each and every one (and there are many!).



There's Marion's childhood love Genet and her harrowing experiences that make her the pivotal cause for tragedy and conflict between the brothers. Thomas Stone is given a chapter to explain his resolute detachment and fear of love. Hema and Ghosh have a successful romance spanning a significant portion of the novel (thankfully, the other characters all seem to fail in this department). Political turmoil and betrayal forces Marion to leave Ethiopia for New York where the chasm between the brothers deepens, and he comes to find Thomas Stone.

Verghese's writing is enchanting, neither lengthy nor excessively flowery. He is able to create characters that are unique, loveable and humanly flawed. The stories of each character, themes of political instability and search for identity are all immaculately sutured together. There is a sense of completeness in his novel that feels disconcerting. The magical, mysterious plot concocted from the novel's beginning is treated with too much practicality. While thorough understanding is the desired outcome after a good medical history, there's nothing left to imagine or ponder after the final page.

The title 'Cutting for Stone,' alluding partially to the search for Thomas Stone, is also derived from the Hippocratic Oath, stating 'I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art.' It dates back to a time when the non-sterile removal of bladder stones resulted in many patients dying from infection, perhaps reflective of the difficulty characters faced in providing medical care in desolate circumstances and the personal difficulties they faced.

Verghese describes liver transplantation, bowel surgery and caesareans at length, making references to anatomy and medical practise throughout the novel. Sleep apnoea, premature infant mortality, the progression of leukaemia and post-surgical complications are all topics beautifully explored in his novel, with references to early medical practitioners and their practises. While I gobbled up his medical magic- in case tutorials, on the train, while walking through Uni on Thursday afternoon, his less medically-inclined readers are at risk of feeling lost, squeamish or bored.

Cutting for Stone is a rich piece of writing, particularly enjoyable for any lover of prose and Medicine. It is dramatic, poignant and emotionally enrapturing. Verghese is able to question your understanding of love, sickness and death. Cutting for Stone is an entertaining and relevant way to pretend you're studying, be prepared to lose track of time.

CHIMMY's COMICS

Daniel Chim (Med IV)

REFLECTIONS OF THE JFPP

Huffing and puffing with my massive backpack, trolley luggage, sleeping bag and hand bag, I was more than ready for two weeks at Ulladulla, a sleepy seaside town on the South Coast. My eventful journey there – including a dash to the station toilet seconds before my 2 hour train ride to Nowra and nearly missing my stop after snoozing on the one hour bus trip – certainly set the trend for my very first John Flynn placement.

Despite being told by friends what their experiences were like, I was still quite apprehensive as I was unsure of what to expect at the practice and of my medical skills (especially after a whole year of ILP) and I even started wondering whether my mentor and host family would like me or not! Yet there was also an element of excitement as I would be independent to explore the community and learn more about rural medicine.

During my placement at Ulladulla Endoscopy, I shadowed my mentor Dr Le, his wife Dr Hoang and the nurses there. Mondays and Friday mornings were dedicated to GP consultations were I was able to revise my histories, examinations and learn about a wide range of conditions from AF to endometriosis. Tuesdays to Thursdays involved me observing and helping in theatre during the endoscopies performed by Dr Le. This was where I learnt and performed my first cannulation on a patient! Friday afternoons consisted of minor surgeries in which I was able to assist in. I was also able to experience a snapshot of the Allied health professions from spending time at the local podiatrist to participating in community home visitations. However one of the most amazing experiences I had was observing and assisting in on the once a month cataract surgery days at the practice – it was certainly eye opening (pardon the pun)!

There were also several social activities which made my stay at Ulladulla less lonely and all the more memorable. I enjoyed a lovely Melbourne Cup lunch with some ladies from work (my horse won the sweep!), toured the Harbourfest (the local food and wine festival), travelled down to Bateman's Bay for the Caravan and Camping Expo and got to know Dr Lee, Dr Hoang and their son Adrian over a home-cooked dinner. Looking back, I definitely enjoyed my stay with my host family despite opting for my own accommodation initially. We were able to share our experiences and cultures over our many car rides and meals and even watched Australia's Got Talent together!

Indeed, over the span of two weeks, I came to realise that all my initial fears were unnecessarily based. I have learnt so much from my mentors and have enjoyed interacting with a

Not what most people would think 'rural' looks like!

community so different to my home town. The John Flynn Program is certainly one I would recommend anyone to participate so as to challenge themselves in more ways than one.

Deborah Zhou (Med IV)

Having always thought of myself as a city chick because I love its fast-pace, excitement and bright lights, I wanted to take myself out of my comfort zone and explore the potential of practicing rural medicine. John Flynn was an excel lent opportunity, and took me to a peaceful town called Cootamundra, which just over four hours from Sydney, with around 7000 people. I thought I'd share three of my myths that I busted in my time there.

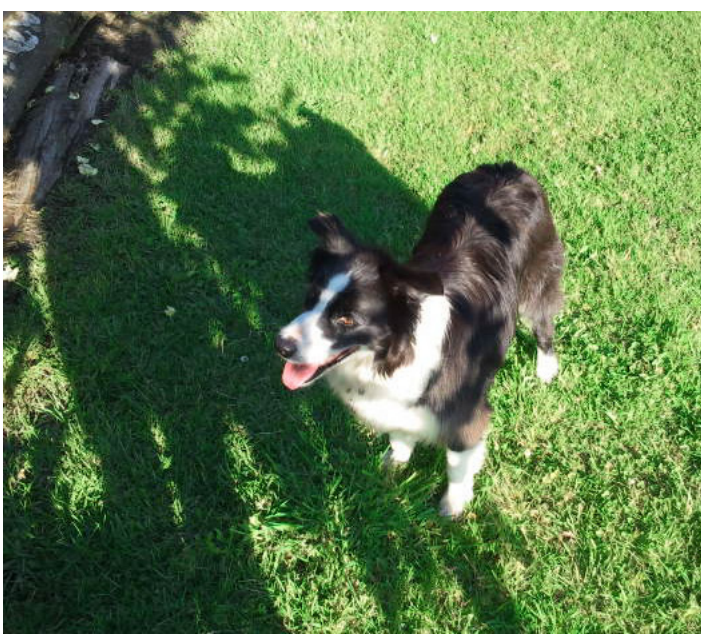
Myth 1. If I practiced in the country I'd become isolated, and my career would fall by the wayside.
I had a great mentor, Dr Tony Hobbs, whose life experiences quickly "K.O.-ed" this misconception. His name preceded
him, and indeed you can hear a lot about him from our friend Google (and YouTube, incidentally). He is well known and highly regarded, having worked closely with the government on numerous fronts. His country practice is quite revolutionary, and was probably one of the ancestors of the 'super clinics' idea for the future. In the time I was there, he was taking flights weekly, presenting at numerous conferences. Quite glamorous in a slightly nerdy way, don't you think? His passion to make a difference was key in inspiring me to get involved, for example in Medsoc last year and producing Medshow this year.

Myth 2. The program could be boring at times and would just involve observation.
Medically there were many opportunities. Being in third year, I was given my own clinic room and saw my own patients, which was exciting! This involved taking histories, performing relevant examinations and then reporting back to my mentor. One of my favourite experiences was suturing numerous patients, and also assisting in minor surgeries. Socially, there are good opportunities too. Going to parties held by the doctors at the clinic complete with background classical music, becoming good friends with a doctor's son, who as it turned out also went to UNSW, and making friends with a girl my age (hard to find) at the local church.

Myth 3. I would be struck down by a mystical tropical disease.
No, not really. But I did see yet more patients with the dreaded Christmas eye, the pain of which is apparently on par with child birth. My tip: don't leave your windows down when driving at higher speeds in the country! Some of the other rural-associated inconveniences included falling sick and being unable to buy meds since the pharmacies were closed on the weekend, and overpriced limited stock (for example in the three stores stocking clothing). On a more serious and sad note I also met a lot of farmers who shared how heavy rain had destroyed their whole harvest on occasions. It was sobering to see the impact that the weather can have on one's livelihood.

Other than that the town has a curious surplus of coffee shops, nice bushwalking trails and lots of fascinating people. My time at Coota definitely provided me with an excellent dose of the country lifestyle. Finally a tip for bonding with patients (at Coota at least): learn how to ride a motorbike; it's an excellent talking point!

Grace Lu (Med IV)



What JFPP is about?

The John Flynn Placement Program (JFPP) was established in 1997. The JFPP, funded by the Department of Health and Ageing, is an important part of the Australian Government's strategy to attract more doctors to rural and remote areas to address areas of workforce shortage & improve the quality of healthcare for local communities.

Accepted students are placed with a rural doctor and a local contact person for a minimum of two full weeks per year, over a four year period. The program enables students to form a long-term relationship with a rural community and gain a better understanding of rural medical practice and health care services.
The JFPP covers the cost of travel and accommodation for students to go on placement and ACRRM provides assistance with these arrangements. In addition to this students are paid $500 per week to cover food and living expenses during the placement.

Handy Book Recommendations and Tips for Surviving Med School*

PHASE 1

Oriented Anatomy $105.60 ($132) by Moore, Snell's **Clinical Anatomy by Systems** $79.20 (RRP $99) and **Last's Anatomy** $184.67 (RRP $230.84) by McMinn are all great Anatomy textbooks, but have different thing to offer. The first two relate the anatomy to function and clinical relevance while Last's is directed towards the more ambitious amongst you. **Color Atlas of Anatomy** $88 (RRP $110) is the next best thing to having a tutor and a cadaver in front of you, with a labelled photographic atlas. This is great in preparation for anatomy spot tests.

Larsen's Human Embryology $88 (RRP$110) by Schoenwolf: A must read if you find embryology a struggle. Contains succinct summaries on the development of each system, and for the interested, detailed explanations, diagrams and clinical cases.

Guyton and Hall's **Textbook of Medical Physiology** $119.20 (RRP $149) is the go-to book for physiology. Provides more detail than a lecture, but won't fry your brain. Makes everything clear!

Robbin's Basic Pathology $114.40 (RRP $143) is fantastic for a good understanding of various conditions and diseases, and will save you from coming off as a bumbling fool in Prof. Kumar's lectures. You'll be able to sit at the front/near the aisles without fear of humiliation!

PHASE 2

Clinical Examination $107.96 (RRP $134.95) by Talley and O'Connor: If you are only going to buy one book in phase 2, you must buy this book! Your best friend for OSCE preparation.

Oxford Handbook of Clinical Medicine $43.16 ($53.95) is the best thing to take around hospital besides your stethoscope. Provides a quick guide to common diseases including signs, symptoms, diagnosis and treatment.

Davidson's Principles and Practice of Medicine $76 ($95) for the ambitious who want more detail behind the diseases and conditions they come across at the hospital.

ECG Made Easy $34.40 (RRP $43): Confused about leads, axis, waves and complexes? This little book provides clear explanations on how to read and interpret an ECG with examples.

Check out the **Clinical Book Pack 2012,** designed for Phase 2 students containing the books mentioned here for $210 (RRP $322.95).

PHASE 3

Murtagh's General Practice $140 (RRP $175)**:** As the title suggests, is great for the GP rotation and a good overall guide to medicine and common conditions for students.

To learn through cases use ***250 Cases in Clinical Medicine*** $48 (RRP $60) or ***Clinical Problems in Medicine and Surgery*** $46.40 (RRP $58)

* along with some cheeky self-promotions

What you need in hospital

- ✓ Stethoscope: An absolute must for medical students, and one of the few things that will last you into doctor-hood. We stock a range of Littman stethoscopes including the Classic II from $90 and the Master Cardiology at $250. A range of colours available!
- ✓ A pen torch for looking into your patients' souls, for only $9 (cheaper than dinner).
- ✓ A tendon hammer: choose between the classic white plastic handled Babinski hammer for $12, or a snazzy telescopic one for $31.

Thinking about sitting the USMLE because you aspire to be the next *House*?

- ✓ **First Aid for the USMLE 2012**: now in colour! Only $47.96 (RRP $59.95)
- ✓ **First Aid for the USMLE Step 2 CS**: only $56 (RRP $70)
- ✓ **First Aid for the USMLE Step 2 CK**: only $48 (RRP $60)

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SOCIAL MEDIA, TECHNOLOGY + MEDICINE

VANNESSA LEUNG (MED III)

The undeniable domination of the internet in recent times has not only expanded, but largely reshaped, the nature of communication. The potential of such systems remains systematically unharnessed in respect to healthcare however exploding populations, technological reliance and information thirst has demanded integration .

The phenomena, e-heath, proposes utilisation of information-communication technology to advance health services . Three distinct applications are apparent; firstly as a tool for medical education, secondly, as a mechanism to aid governance efficiency and, thirdly, as an instrument for public access to health education. Whilst the former two are undoubtedly crucial, particularly for public health, this report concentrates on the latter. Conceptually, it is in the mediatory role, between health providers and patients, where communication technology surpasses traditional means. In harnessing telecommunications one must evaluate the modes of application and limitations.

Modes of Application

Social technologies defy tech nical, geographical and logistical barriers thus facilitating interaction, rapid access and transparency . Three discrete categories for use exist; information, online support and patient-practitioner interaction. Through an interplay of these uses, health will be improved.

A major consumer demand is access to online health information . It is ideal that medical literacy is promoted, encouraging active participation and autonomy. Reliable material regarding disease, treatments, prevention, hospital performance, insurance and support services should be endorsed. The mediums to deliver these services are mainly wikis, information web-pages and podcasts which offer user participation, thorough detail and interactive video-audio. Additionally these platforms may be utilised for public health interests via dynamic tailoring.

A clear advantage in harnessing technology is online support groups which connect widespread disease sufferers. Users have highly rated such services due to 24-hour availability, anonymity, convenience, emotional support and cost-effectiveness . Online support groups facilitate improved health in the comfort of one's environment at a controlled pace. The third field in which technology may be utilised is patient-doctor interactions outside the bounds of traditional consultations. Temporal, geographical and logistical constraints may be overcome through email . Not only may patients have 'access' to a greater spread of physicians, the arrangement simplifies appointment-making, opinion seeking and follow-ups .

Mechanisms of Improved Health + Barriers

Harnessing technology will improve health via several mechanisms namely; reducing costs, convenience, accessing isolated populations and autonomy . However several barriers must be addressed as benefits of adopting telecommunication hinges on four unrealistic assumptions; availability of physical infrastructure for provision, development and access, obtainability of access for all, adequate education is instilled for services to be appropriately utilised and information provided is tightly regulated to ensure reliability. Consequently a threat of 'digital divide' has developed, both nationally and internationally

Conclusion

The rapid development of the internet undoubtedly possess a large potential for remodelling health. The provision of quality information, support groups and novel patient-practitioner interactions are key in the revolution but the formation of a 'digital divide' must be hindered.

LATERAL ENTRY SCHEME

Joseph Xavier (Med IV Lateral Entry)

I'm sure a number of phase two students were wondering why the middle row of their first lecture for 2012, was taken up by fifteen completely unfamiliar faces. No, we were not auditing the class; this was in fact our first year as medical students. We entered medicine through the lateral entry scheme – having only completed our bachelor of medical science the year preceding.

Quizzical looks are the norm when I tell people that we are 'lateral entry students,' so I thought I would shed some light on our program, and the nature of our entrance into medicine.

The program essentially takes the top thirty second year medical science students (based on their weighted average mark and UMAT score from that year), and subjects them to an interview – similar to that experienced by undergraduate medicine applicants. The interview process whittles down the number of students to fifteen, all of whom are granted a "provisional entrance to the medicine program." I was one of these fifteen.

Apart from one email a month after the interview, informing us that we had been granted a place; we received almost no notifications or information for the following year. Therefore our introduction to medicine only began during the first semester of our honour's year – with a riveting series of weekly public health seminars. During the second semester we attended a number of 'clinical skills tutorials' that covered basic clinical skills, history taking and system examinations. We had not yet set foot in a hospital and consequently practiced/honed our clinical skills on each other – which I am told was akin to the way students in phase one learnt. During each of these sessions a 'lucky' few were asked to interview a mock patient whilst being videotaped, and be critiqued shortly after. While daunting at first, everyone eventually got videotaped; ensuring our initial ineptitude was equally showcased.

It was a general consensus among the fifteen of us that our honour's year was the most tedious and stressful year of our medical science degree; cementing in my mind at least, that a career in research is definitely not for me – enjoy your ILP guys… :)

Following the completion of our honour's year, we were told that we had to enroll in a course for the summer teaching period, during which time we would undergo eight weeks of "intensive bridging" and then be catapulted directly into phase two with the rest of the cohort. While I was not thrilled at the idea of cutting my holidays short, I was nonetheless excited about undertaking the first phase of what would ultimately become my lifelong career. I must admit that I was quite skeptical at the thought that we could cover two years worth of medicine coursework in eight weeks however it soon occurred to me that we had covered much of the anatomy, physiology, pathology and pharmacology we would need, in our previous degree. The structure of the bridging course closely mirrored that of the phase two course, with two hospital days a week and two to three days of coursework that covered: ethics, how to behave in the hospital, further clinical skills tutorials, and a class that closely resembled our weekly case method tutorials.

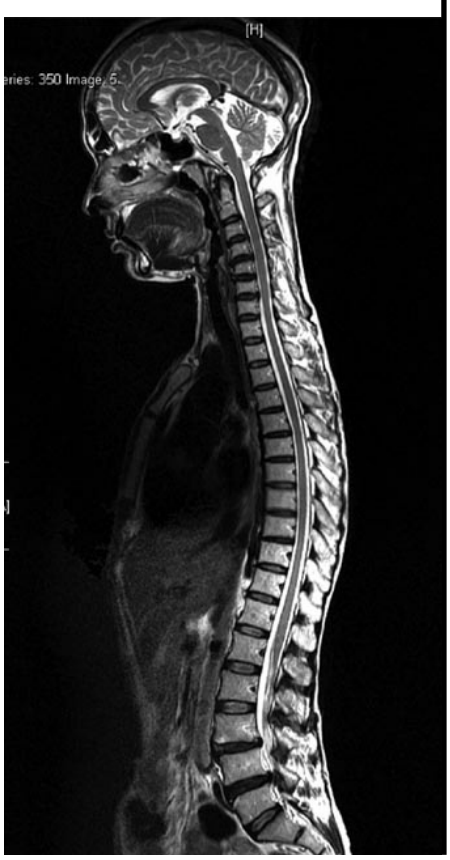
Walking into the hospital for the first time as a student, with a stethoscope around my neck and the scrubs theme song in my head (lame, yes I know) was quite an exhilarating yet also nerve- racking experience. Not only did I attempt to take a shortcut through the hospital – which got me horribly lost and resulted in me being thirty minutes late for class, but I am fairly certain that I put my stethoscope plugs in the wrong way and failed to even ask the patient their name. Whilst this was quite a poor first showing for a future doctor – these initial jitters passed fairly quickly, and I have since come to cherish and thoroughly enjoy every chance I get to examine patients in the hospital.

I was genuinely surprised by the number of patients that didn't mind being interviewed, poked and prodded by students – a willingness that prompted me to interview as many as I could during my bridging course. I had a number of memorable patient experiences – ranging from being given dating/marital advice from an 80 year old Greek lady; to being yelled at and almost having a slipper thrown at me for having cold hands.

Sharing an almost identical expe-

rience for the past year has made us a rather tight knit group. As a course of one hundred and fifty people was condensed down to only fifteen – I got to truly know people that previously, I may have only seen from time to time in lectures during that past three years, but never really talked to.

Despite its brevity I was quite satisfied with the structure and content of the bridging course, and apart from still griping with the intricacies of the complete neurological examination, it has been a fairly smooth transition for me from medical science to medicine. A transition which, has been greatly eased by the general helpfulness and acceptance of the rest of the students in the sequence (in fact I even had a few students claim they remembered me from first and second year medicine). And Even though it has only been a few months, I really feel like a medical student – eagerly awaiting the next pub crawl and dreading the day where I have to perform my first PR exam.



So you've come to a period of great transition – from the theoretical juggernaut that is Phase I or from the break from clinical studies that is the ILP. Or you are a lateral entry student from medical sciences, where structured and thorough learning are paramount. Entering coursework is rarely a smooth process for anyone, least of all those thrust into the deep end in the new Adult Health 1 and 2 courses. Complicating this is the fact that there is an expansive curriculum with a "syllabus" which gives you free reign to bite off more than you can chew. Here is some advice to help you through the year.

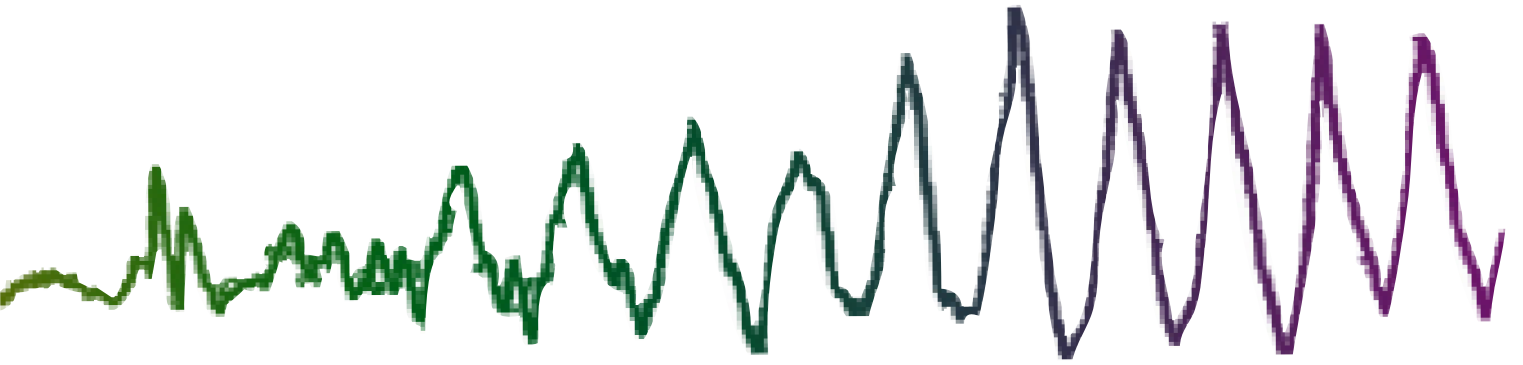
Differential Diagnosis

Firstly, and most importantly, Coursework is about the differential diagnosis. In fact the diagnostic process is all about generating and testing hypotheses, via the history and physical examination. I found a structured list of differential diagnoses was my best friend; and attempted to learn one for each weekly theme encountered. There are a variety of ways to generate these, and you will decide what is most logical for you. For example, diarrhoeas fit into clinical patterns such as secretory, os motic, exudative, steatorrhoea, and dysmotility disorders. Conversely, syncope can be divided into reflex-mediated, cardiac electrical, cardiac mechanical or mimics of syncope. Other methods include anatomical or histopathological classifications, and the catch-all backup mnemonics (VITAMIN-D, IWATCHDEATH and so on). Find a system that works for you, and practice using it to take histories and do your physical examinations.

The history and physical examination

The history and the physical examination remain the cornerstone of good medical practice, so you might as well work hard at them. Your history will be guided by your differential diagnosis list, and you should ensure that you work through it systematically with your patients. Learn to perfect your physical examination from Talley & O'Connor, practice on your friends so that your basic framework is set. Just like symptoms, physical signs have differential diagnoses also. However, do remember that some of the signs listed in Talley & O'Connor are exceedingly rare, and keep that in perspective.

Every clinician emphasises



GUIDE TO COURSEWORK

Vineet Gorolay (Med IV)

one thing – see patients in your free time. Practice taking a history, formulating provisional and differential diagnoses, and putting yourself in your patient's shoes. Don't forget that we are in this business to help our patients. Every encounter can (and should) be therapeutic, and you should take the opportunity to explore patients' concerns as part of the healing process. Equally, practice eliciting signs to support or reconsider diagnoses; and summarising the case and considering further steps. Take another student with you, to keep you on your toes and make sure you don't miss anything. In the words of a fellow student, "practice does not make perfect – perfect practice makes perfect".

The Bedside Tutorial

Bedside tutorials are a rarity in some hospitals, and I can safely say that I had about two in total throughout coursework. This was a terrible shame, because they were incredibly useful. If you can find a clinician who is willing to teach, and has free time, you should make the most of this opportunity. Practicing clinicians generally teach things in a way that makes logical sense to them – and hopefully to you! By the bedside, practice your history and physical examination, be scrutinised, and use the feedback to improve your technique. If you can't find a clinician for a bedside tutorial, find a Phase III student who is keen and interested.

Some things are left unsaid

Many things in coursework are left untaught, and it is up to you to direct your own learning. Interpretation of ECGs and other investigations; many of the physical examinations (e.g. hip, shoulder, thyroid, hernias) and procedural skills are left to the students to learn. Finding a clinician who can teach you these skills is a good move.

Conversely many things in coursework are left over-taught and it is up to you to decide where to stop with details. With Society and Health, I focussed on the high-yield topics of sexual history, drugs and alcohol, domestic violence and tropical and infectious diseases. Exercise your own judgement, and use your time wisely.

Assignments

The structure of assignments is in constant flux as the new Coursework structure is changing. However the basic principles remain. Find patients early, conduct a thorough history and physical examination, and write up your impressions as soon as you can. If you miss any details or are unsure, come back and ask again later. When selecting a case for your assignment, simpler is often better – you must be able to reason through the differential diagnosis, and provide an adequate discussion of both basic sciences and other issues.

Medical cases are often best found in ED, if you can get access. I must emphasise, do not get in the way of the caring teams who are invariably busy. Ideally, find your surgical cases pre-operatively, and follow them up after surgery. In Geriatrics, your home visit is your case study, so take your time, be thorough and be very observant – focus on functional impacts upon the patient, and talk to the carer, often an eye-opening experience. For the Society and Health group project, get organised and finish your interviews as soon as possible; and get writing. The earlier you finish writing, the more free time you will have. Remember that some courses have specific focus capabilities (e.g. Geriatrics asks you to look at Ethics & Legal Responsibilities) so choose wisely when

deciding perspecitives.

Examinations

Much can be said about the examinations, and the approach varies from person to person. At the end of the day you need to be thorough, confident and demonstrate that you are thinking through every step of your history, physical examination, and summary.

The summary is vital – as it tells the examiner what you think are the most important elements of the case. I found the framework provided by Dr Segelov to be quite useful:

"(Full Name) is a (age) year old (occupation/relevant detail), previously well (or significant diagnosis) who presents with (duration) of (symptom 1) and (symptom 2).

On examination, s/he appeared (well/unwell) with normal vital signs (or list if abnormal) (and any significant observations). Further examination revealed (sign 1, sign 2, sign 3). Other systems were (unexamined/ unremarkable/remarkable for ABC).

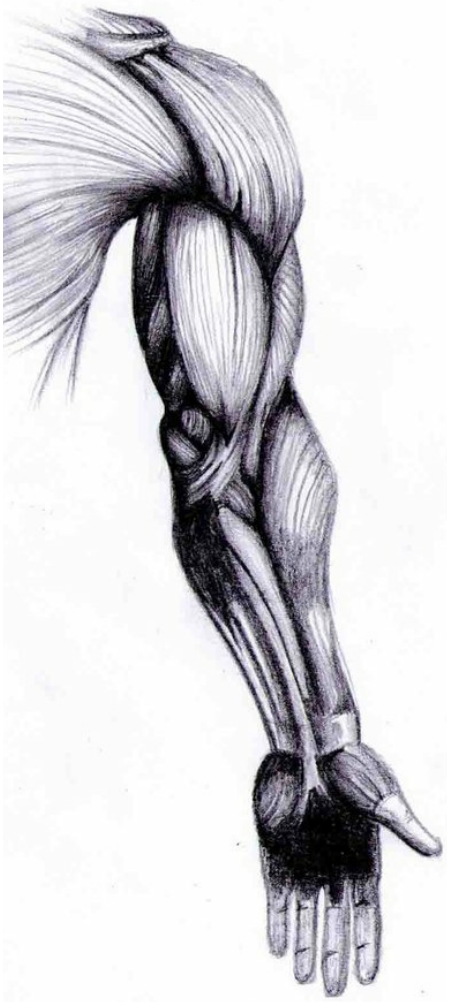
My provisional diagnosis is (X) with differentials (Y; common) and (Z; dangerous).

[My immediate management is ABC if life-threatening or risk of rapid deterioration]

I would follow up with (relevant investigations)."

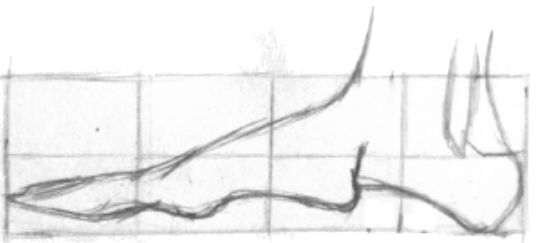
Of course the Integrated Clinical Examination consists of either history or examination (not both), and so more detail including relevant positives and negatives is necessary for assessment purposes. Prepare to answer questions regarding historical details or physical signs, and be as thorough as you can. Also remember to prepare for ethics scenarios which are commonplace in the assessment.

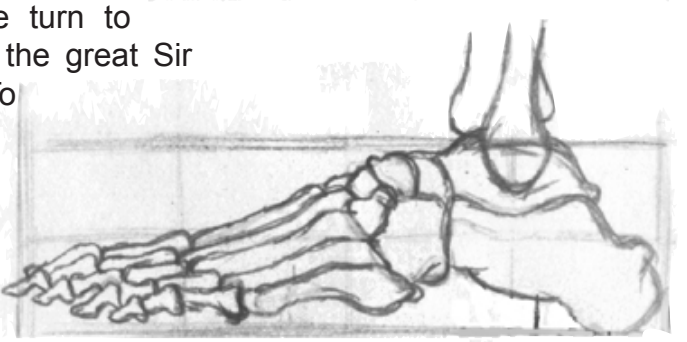
As for the multiple choice examination, all of the questions are derived from the lecture material. The majority of the questions are from the basic sciences (clinical anatomy, histopathology, pharmacology, mechanisms/reliability of clinical signs) with some questions from ethics and public health also. However as mentioned before, Coursework has a poorly defined syllabus and it would be foolish to confine yourself to studying lectures only. Read widely, be conscientious, this is your first taste of clinical medicine and it is fantastic.

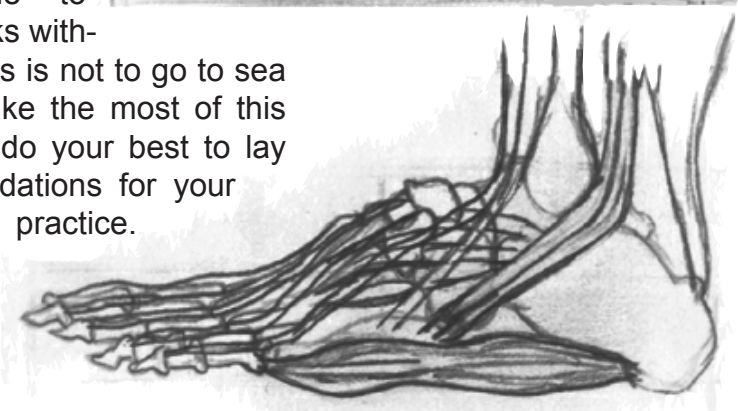


Conclusions

I am a fan of good quotes, and there are a great many in the history of medicine. But to summarise Coursework in one, we turn to none other than the great Sir William Osler. "To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." Make the most of this year, and do your best to lay good foundations for your clinical practice. Good luck!







A few days ago, I attended a talk at my old high school about entry into medicine. Topics ranged from which university was the best (it was unanimously UNSW), to the sorts of interviews you'd encounter, to what sorts of credentials we'd have to flagrantly display in order to convince the interviewer that we were medicine material.

I hope that for most of us, that we haven't forgotten the pain, the struggle, the blood and tears it took to enter one of the most competitive and most coveted courses in the country. I certainly hope that you hadn't forgotten what you had felt at that moment when you waited for your ATAR (or anything else for that matter), or UMAT to pop up on screen. Each of us eagerly balanced on the precipice. Some overjoyed and elated after. Others to carry a silence, to a moment of solitude or sorrow, knowing in that second of uncertainty lost went dreams and hopes too. For some that I know of, this is the moment the experience of which calls into question the validity of one's talents and abilities. All grandeur ground to ash.

And still others shall wait to fail, though they do not know it yet. As it must happen at every interview, the question that must hurtle across the table into your face: Why medicine? Why not nursing? Or physiotherapy? Or social work? Or child care?

To each student in the room, we asked. Job stability. The desire to help others. A love of the human body. Each should be right, but are wrong ultimately.

So commences the hunt for the perfect doctor. One who cares, loves, feels, knows, hears, listens, speaks, thinks and is all things that things should be. Already when postgraduate medicine was introduced, the standard had been clearly set for our doctors to be well-rounded. And not just well-rounded, but "well-rounded." "Well-rounded" to the same extent that a perfect sphere has no visible features on its face, no variations in surface markings and has no other discernible quality other than its "well-roundedness." The expectation is for doctors to cut out our faces and wear a mask of perfection, the Adonis or Aphrodite of mind, soul and body.

Recent talks in certain American universities have raised the point of introducing even more humanity courses into medicine. Aside from the obvious bloat of intellectual masturbation that is ethical perspectives, we are to somehow arise as the next generation of opera aficionados, Shakespearean intellectuals, proletarian dilettantes and appreciators of abstract, fine and contemporary art (all of which are meaningless). So the idea is to suck dry further the medical time drought in the hopes that forced learning makes one well-rounded, rather than giving free reign to exploration.

And now in Australia, the AMSA is introducing further forays into the matter. The current stance being that doctors have "failed" to be taught the skills of the 21st century doctor. No indication as of yet has been given as to "what" these skills are, whatever they may be. Only that we, as the human beings that medical students are, have "failed" to attain the lofty aspirations of some dried up geriatric who doesn't grasp the concept of normal. The word is "failed;" written in black and bold on a piece of paper. It bristles with spittle and polemic. It is unjustified and unjust. It is false, and it is in every single respect, wrong. Rather, I would say that the institution has "failed" to recognize a basic appeal to common sense, and let itself be ruled by ivory tower politics.

So now that you've gotten into medicine, I want you to answer truthfully. Why medicine?
I for one cannot answer it. For nothing that I shall ever say shall ever satisfy it.

MEDSOC

Treasurer: *Calvin Park*

2012 has been a challenging year for Medsoc, with difficulty in getting large sponsorship due to the dire economic situation. However, Medsoc is aiming to run more events for its members with early planning and efficient organisation of events.

The largest expenditure this quarter was the GST, due to Medcamp tickets. Social events had the largest expenditure, due to orientation activities and classical quest. Academic and SIGS were the second and third largest expenditure. This will be a continuing trend due to great increase in academic related events and SIGs.

Medsoc is undergoing major structural change as we attempt to incorporate Medsoc. This will incur some unexpected expenditures. In the longer term, Medsoc still expects to make break even for this financial year.

Secretary: *Sara Ooi*

This year we've seen such a great increase in the amount of activities Medsoc and associated organisations have been involved in. This is such that we have seen the Medsoc calendar booked for almost every night. Certainly, the variety of events available means there is something to interest everyone in our diverse cohort, and as many of our fellow students as possible are involved in the academic, social, sport and charity spheres of UNSW Medicine.

It has been great to see so many more people coming to the Medsoc Council meetings and seeing the workings of Medsoc. We have also brought in speakers for important issues such as Professor O'Sullivan on the new MD proposal, allowing students to be more informed on changes affecting them.

With such developments in the activities of Medsoc, the weekly Mailout is now packed with more information than ever before. Keep an eye out for a Mailout revamp courtesy of our IT officer.

Social Coordinators: *Matt Rubic & David Bui*

It's been a busy year for the Socials portfolio in 2012 with a consolidation of es tablished events and expansion into new territory. Our End of Semester Party for 2011 - held at Soho bar in Kings Cross - was a raging success with numbers breaking records from previous years. Medsoc resident DJs Chris Mulligan and Adam Seruga, combined with attendance of all year groups made it a night to remember.

After the summer break, our first event of the year was Pubcrawl 2012. Over 300 UNSW medical students descended on George Street, with a great selection of budget friendly hotels such as Scary Canary and Scruffy Murphys.

Anticipation continues to build for our biggest event of the year – Medball 2012. On the 17th of August, 2012, we will gather on the steps of the iconic Sydney Opera House and prepare to board the largest and classiest floating ballroom in the southern hemisphere. That's right. Medball 2012 is on a boat. Get pumped boys and girls!

Charities Coordinators: *Katherine Nguyen & Ronald Ho*

Amidst 9am lectures, part-time work, that social event everyone is going to and the requirement to at least make an appearance at home, we med students often forget how good we have it. We forget that not everyone goes to university, not everyone is in good health, not everyone has the same opportunities we do and we forget the simple fact that not everyone lives in a country like Australia. This is what we, as your Charities Coordinators, want to remind you of this year and not just remind you, but challenge you to do something about!

Together we've chosen to support MSAP, Starlight Children's Foundation and Fred Hollows Foundation this year.

Dust off those running shoes with sporting events like the City2Surf and Tough Mudder coming up!

Just up the road from upper campus, the Starlight Room is waiting for you if you want to volunteer. The Starlight Room offers kids a chance to play all their favorite games in a safe and fun environment. Volunteers are needed for 4-6 hours a fortnight - you'll be having a blast too!

MSAP Trivia Night? Open Aid Cinema? Social Charity Event? These are just some of our upcoming events and ideas so stay tuned for more exciting things to come!

Academic coordinators: *Henry Lin & Richard Shaw*

Why hello boys and girls. What a year it's been so far! Our journey began with the Mock ICE for coursework students way back in February this year and since then we have run approximately 10 events! Most of these events such as the Phase 1 EOC exam and OSCE tutorials as well as the Writing Research night have been part of our new initiative to run events targeting the specific requests and needs of the student population - that's you! So keep those vital communications lines open, because what you say really does make a difference to what we do for you.

While you can trust that we will keep churning out these academic events, for those of you who haven't made it to one of the Grand Rounds events thus far, there is no need to worry. In the coming weeks we have a number of SIG Grand Rounds coming up so make sure to keep those Wednesday afternoons free! Also, it's still a while away but be sure to keep August 1 free in your diaries for the Inaugural Career Networking Evening!

Social Development Officers

Chris Go & Dinuksha De Silva

So far this semester our main priority has been running the 1st Year mentoring program. We received a great response from students throughout Phase 2 and 3 who volunteered their time to assist groups of first year students entering Medicine. Under the guidance of the VP, the program has run smoothly. Thank you to all the mentors that got involved – we hope you continue to take initiative and follow up on the progress of your mentees.

Currently we are in the planning stage for our SB Dowton Seminar. The annual conference gives students the chance to be exposed to a range of inspirational speakers. This year we have the assistance of our SDO Subcommittee, who are hard at work contacting a some of the biggest names in Australian medicine.

REPORTS

The seminar will be held on August 4th at UNSW – more details to be released soon. Be sure not to miss out on registration!
What else to look forward to: this year we're expanding the SDO role to include student wellbeing and advocacy. As such, we'll be holding a mental health awareness week in August with a
a bunch of events you can get involved in.

Port Macquarie: *David Prince & Matt Irwin*
Greeting from sunny Port Macquarie. Time is flying by – we are already finishing TP1. Again this year we have a record number of students (46).
So far this year we have had several successful social events including barefoot bowls and the annual fun-run/breakfast. Events planned for the rest of this semester include the trivia night and end of semester function.
Work is about to start on extensions to clinical school which we see a 100 seat lecture theatre, additional classrooms and private study rooms added. Hopefully this will be finished by then end of the year.
Port Macquarie is great place to live and study. Both the administrative and academic staff go out of their way to make it a fantastic experience. If anyone would like more information drop us a line.

Bookshop Director: *Joanna Lee*
The bookshop has always aimed to provide books and medical equipment to impoverished medical students at more affordable prices. Any profit goes back to Medsoc so that students can benefit.
We are glad to have been able to broaden our bases this year, and reach out to not only more UNSW students but open our doors to students throughout NSW. The new website has improved the online purchase experience, The bookshop's Facebook page has also been active with monthly giveaways and liking competitions. (Like us if you haven't already!).
Further plans for the year include the inclusion of product reviews on the website, and the addition of alternative payment options online such as PayPal.

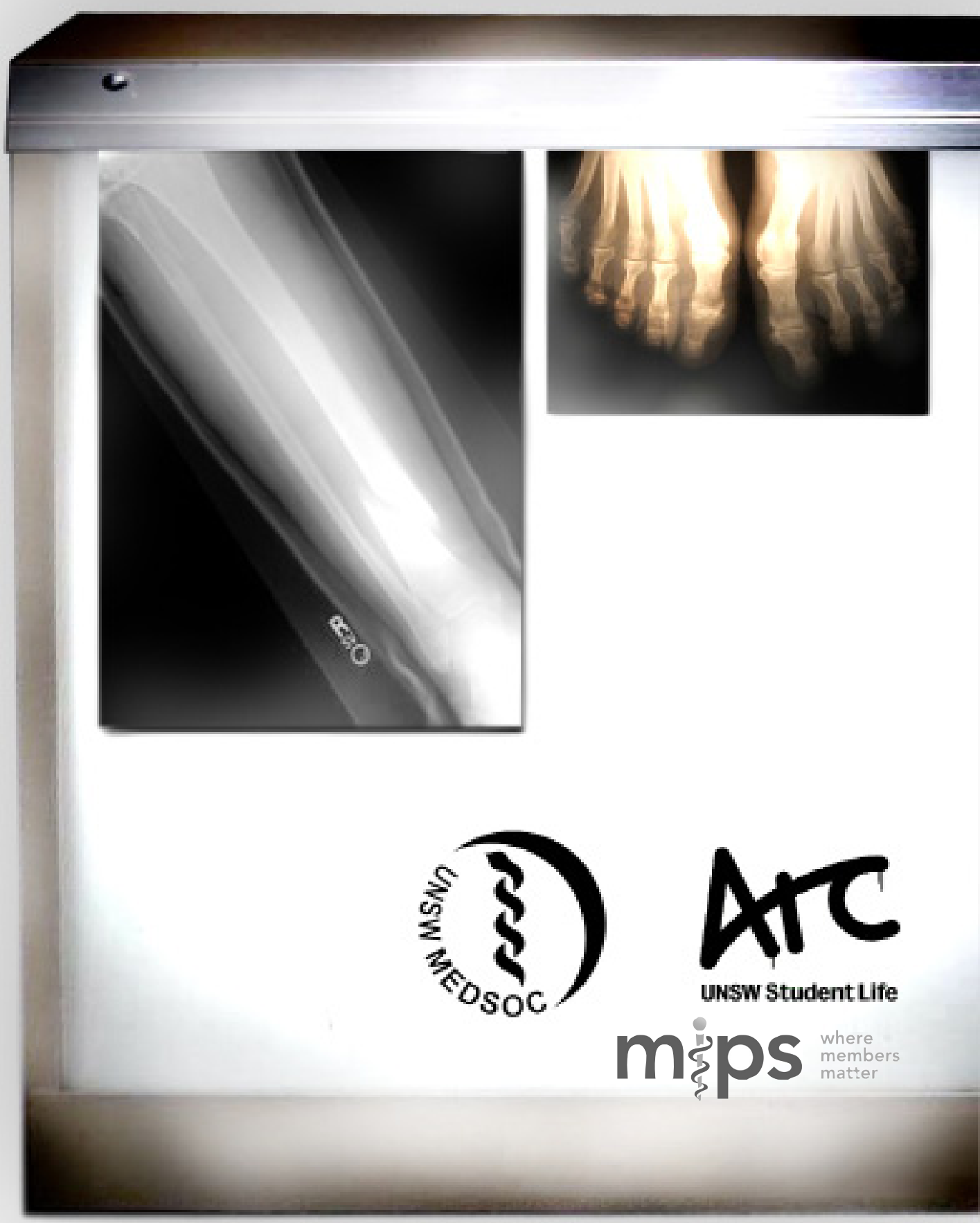
Faculty Liason Officers: *Devinda Jayewardene & Vineet Gorolay*
This year we have been warmly welcomed by faculty members and have been working closely with them. Events such as the information nights for ICE, Phase 2 and Phase 3 have been interactive and informative for the students. We hope to continue assisting students with provision and information and queries for the faculty in the near future with the 6th year exam information night and the Phase 1 Portfolio information night.
We have also been co-ordinating the representatives to the faculty phase committees, where phase specific issues are discussed and resolved with the faculty. We would like to thank our representatives for their hard work and constant feedback to us and MedSoc as a whole. We have been attending the committee that oversees all of these meetings (Curriculum Development Committee) and the open dialogue with the faculty has helped improve the medical program overall.

IT Officer: *Evonne Ong*
Hi there – it's your friendly IT Officer! 2012 will be a fantastic year for the organisation of fantastic resources for all of us. At the moment, there are many avenues of getting news of events and opportunities out there: including lecture shout-outs, the weekly MedSoc MailOut, the UNSW MedSoc Facebook page as well as the UNSW MedSoc Website (www.medsoc.org.au).
Be sure to check the MedSoc Website in the upcoming weeks as it will be going through a review – making its contents more accessible and relevant to everybody! In particular, please find the new Resources tab which is filled with both academic and non-academic links and pages!
A great achievement this year has been a good response for the Students Services and Amendments Fee Consultation Survey which was released on the MedSoc website in April, which was critical in adding weight to our letters to the Vice-Chancellor and ARC student union.

First Year Representatives: *Anna Fernon & Tom Morrison*
The start of 2012 brought with it a new batch of UNSW Medicine First Years. Unperturbed by the frequent reminders of the length of the journey to doctor-hood and the realisation that "the M-bomb" doesn't work, the first years were happy to start Foundations, and even happier to finish it on April 21. Medcamp, held at Castle Mountain on the Hawksbury River and themed 'Medlympics', was a great success and brought the year group together over toga party, a bonfire and merciless naming and shaming. A barbecue at Coogee was organised to celebrate the end of Foundations. Unfortunately, it was rained out. Fortunately, the party was moved to the Regent Hotel and the barbecue was rescheduled for the third week of BGD. Now in teaching period two, the first years are continuing to reach new heights as we don our shining, new stethoscopes and head to our hospital placements. The first years cannot wait the join the second years (and move to Clancy) in semester two.

Second Year Representatives: *Annalise Unsworth & Philip Lo*
Being elected as second year reps is a great honor for the both of us. Our main accomplishments so far have been communicating MedSoc events during lectures and as online social medium posts.
The next half of the year will be a whole new chapter as we get down and dirty, and busily creating events that are both fun and exciting. First up we have the annual sales of the renowned UNSW Medicine jerseys, and 2nd years can also look forward to EOC celebrations right before everyone breaks up on their separate ways to enjoy their well-deserved breaks. But most exciting of all will be the Integration Party during the early days of TP3 that will allow 1st and 2nd years to mingle and get to know each other a bit better before we fight over seats in the lecture halls.

Please see Page 09 for the Phase Three report.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where members matter