idioglossia

issue 2, 2013

your unsw med student magazine

Welcome to the second issue of Idioglossia for this year (2 down, 1 to go!) Once again, many, many, thanks to the numerous contributors who have filled this issue with fantastic articles that range from the evocative (see: Ananya's illuminating piece about her time spent in Tibet), to informative (check out Shohini's Movember article and Bridget's piece on rural specialisation); the fascinating (Qi's reflection on the differences in Singaporean healthcare) and the downright hilarious.

In this issue, we've continued to try and include the things YOU want to hear about. We know exams are coming up soon, so make sure you check out our amazing clinical skills guide written by our wonderful present and past Academics Coordinators. We've also got the lowdown on all the rural clinical schools, so if you're heading over to one next year or are considering going rural, make sure you have a read. And of course, we can't forget our Med Confessions - they said WHAT?! But seriously, Idioglossia is all about serving you, whether it's through giving you some fun procrastination material, helping you get through exams or showcasing the opportunities available to you - so if there's something you'd like to see in coming issues, let us know!

Finally, congratulations to the newly elected Publications Officer for 2014, Jane Guan (who's beautiful design skills can be seen in many pages of this issue). Jane has been an incredible help throughout my time as Publications Officer, and I can't wait to see where she takes Idioglossia next year.

Enjoy the read!

Nadia Perera

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regulars

Got something to share? If you have any ideas or comments about *Idioglossia*, or any articles, artworks or photography you'd like to submit for the next issue, make sure you drop us an email at **publications@medsoc.org.au.** We'd love to hear from you!

UNSW MEDSOC
THE UNIVERSITY OF NEW SOUTH WALES
MEDICAL SOCIETY

president's report

As election season for the new MedSoc year comes around, we reflect on the year that was. One of the things that has come back recurrently from students in feedback regarding what characterized MedSoc this year has been unity.

Unity, of course, is not possible without the co-ordinated efforts of the entire team. But I would like to take this opportunity to thank the students who have been particularly notable in bringing unity to MedSoc 2013, with the different sectors that make up our student body.

john coombs - unity with rural schools

Video-conferencing into many meetings and events all the way from Albury, John ensured that rural school interests were represented and was a driving force in establishing MedSoc Event video conferencing in rural campuses. Along with Hanna Grimson (Coffs Harbour), Alex Preddy (Port Macquarie) and Robert Dickson (Wagga Wagga), these students ensured MedSoc events (such as welfare week) as well as their own initiatives enriched student lives in their respective campuses.

soon lau, kavita ravendran - unity with sigs

Through many discussions to settle agreements regarding finances, logistics, relations and publicity of MedSoc SIGs, Soon (who leads Surgsoc, one of the largest MedSoc SIGs) and Kavita (Groups Liaison Officer) helped ensure SIGs were sustainable, innovative, and could keep benefiting the larger student body.

danielle christmas, lucy ping - unity with alumni

The Student Development Officers' Inaugural Meet the Medics event invited numerous alumni from the faculty and hospitals across NSW to share their experiences and tips with current students. It was an opportunity for student old and new to learn from each other and we believe that these steps to connect with alumni will engender a deep UNSW Medicine Spirit and collegiality in years to come.

dinuksha de silva - unity within medsoc council & exec

With diplomacy and tact, and with many phone calls, DK has sifted through the range of internal issues that have arisen within MedSoc to keep the team united.

These are all steps that have been taken toward building a stronger society that serves the diverse student body at UNSW Medicine. My prayer is that MedSoc will continue to strive to unite the student body, acknowledging the strength that comes in unity. We are bound with a spirit, a pride in UNSW Medicine, which believes in New South Supermen and Superwomen, to be destined for higher things.

Peace out,

Jenny Namkoong

president@medsoc.org.au

medsoc awards

In late August, Luna Park played host to the biggest Medball in recent history. Amidst the frivolities, the MedSoc Awards were awarded at the event, recognising med students who have gone above and beyond with extra-curricular endeavours to benefit the student body as a whole.

The winners of the 2013 MedSoc Awards are:

student life award:

Winner: Navid Ahmadi

Runners up: Alex Preddy, Emily Jansen

peer teaching award:

Winner: Wenjie (Went) Zhong

Runner Up: Henry Lin

best sig event:

Winner: Definitions of Death (by BEAM)

Runners Up: "Organ Donation: Why and Why Not?" (by BEAM), Teddy Bear Hospital (by PaedSoc), Essential Surgical Skills Workshop (by SurgSoc)

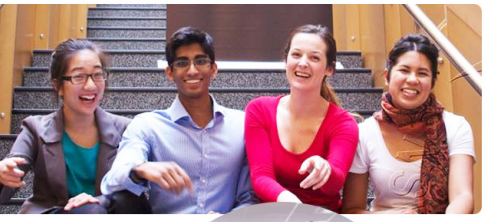
president's award:

Joseph Xavier

The faculty extends their congratulations to the deserving winners, as well as commendations to the nominees, who were all of extremely high calibre.

Dinuksha De Silva,
Vice President

a lot has happened in med during the past couple of months, including the opening of our shiny new wallace wurth building, and the night of all nights - medball: defying gravity. in case you werent there to hear them yourself, here are some words by our president, jenny namkoong. spoken at these events.



Alright everyone, so we've gathered here to celebrate the opening of this spunky new building we have to claim as our own. The new Wallace Wurth building.

You've put up with years of construction, months of sharing your bathroom with builders, weeks of seeing random facebook photos of this funky new space, and a few days of not knowing which door to enter through to get in here. We have a building that makes the Law Building look like....Well, a bit of a shack.

But before Wallace Wurth the new, there was Wallace Wurth the old. Did you know: that the original Wallace Wurth building was officially opened in 1963 by Queen Elizabeth and her husband the Duke of Edinburgh, to over 300 000 people?!

Did you know that Wallace Wurth is actually the name of UNSW's first Chancellor? The man who founded this thing we now know as a university.

And actually, a lot of the buildings around the university (like Clancy, Webster, Samuels) are named after past Chancellors, but I feel its something quite special about having claimed the first Chancellors name – for Medicine.

So, I'm no Queen Elizabeth, nor the Duke of Edinburgh, and there's maybe a tad less than 300 000 people here today. But we are here today, exactly 18357 days since the opening of the old Wallace Wurth building, to open our new Wallace Wurth Building.

And we, like them, will make history!

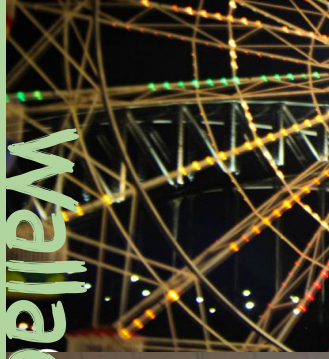
So are you ready for this everyone?!

With three loud cheers we will open this to be yours....

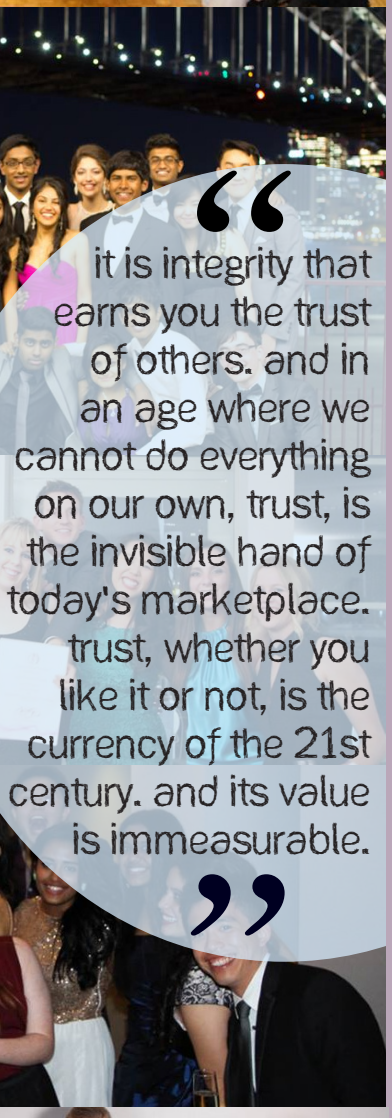
So are you ready?

Three cheers for Wallace Wurth!

Hip hip Hooray! Hip hip Hooray! Hip hip Hooray!



Wallace Wurth Grand Opening Ball '13



“it is integrity that earns you the trust of others. and in an age where we cannot do everything on our own, trust, is the invisible hand of today's marketplace. trust, whether you like it or not, is the currency of the 21st century. and its value is immeasurable.”

Have you ever had a dream about flying? There's a lot of psychoanalysis done on this topic, but generally they say that dreams about flying indicate a sense of freedom, or desire to soar and feelings of being invincible, whereas dreams about falling indicate a life out of control.

For those of us who are itching to fly, gravity is not our friend, and John Mayer says in best in his song "Gravity" when he goes: *"Gravity is working against me/ And gravity wants to bring me down / Oh twice as much ain't twice as good ...its gonna send me to my knees, Oh gravity, stay the hell away from me..."*

Some of us today might be feeling like John Mayer – you know, dashingly good looking with a charm that gets the ladies swooning, but ultimately feeling like you're 'slow dancing in a burning room'...

So what is it that pulls us further? Gets us higher, to beyond the grasps of gravity? Is it knowledge, riches, beauty?

Perhaps, in the 19th century. But life is not that simple in today's age of technology where anything can be learnt online, riches go in an instant with a crash of the stock-market and beauty can be carefully constructed under the knife.

I mean, even Socrates, one of the most knowledgeable amongst us knew that he could not achieve greatness by himself, admitting "I know one thing, and that is that I know nothing."

The richest amongst us, Bill Gates, knew his riches weren't achieved by himself, acknowledges the strong team that stood behind him, and even Rihanna couldn't create her beauty by herself, without the help of her parents' DNA.

Barack Obama himself once said "the only reason I'm standing here today is because somebody, somewhere stood up for me when it was risky. Stood up when it was hard. Stood up when it wasn't popular. And because that somebody stood up, a few more stood up. And then a few thousand stood up. And then a few million stood up." And... he became the President of the United States.

So, if it is not our individual knowledge, riches or beauty, what is it that pulls us further? In a society where individualism is so highly valued, yet testimony after testimony it is clear that greatness is never a solitary effort?

Integrity.

I believe the answer lies within the realm of integrity.

Because it is integrity that earns you the trust of others. And in an age where we cannot do everything on our own, trust, is the invisible hand of today's marketplace. Trust, whether you like it or not, is the currency of the 21st century. And its value is immeasurable.

Like everything, word of trust spreads.

As a student, it means that fellow students are willing to have their grade dependent on your work. That seniors trust you to take leadership roles in organizations that they care about, which also build your character and opens up more opportunities.

As an intern, it means your bosses trust you with their own reputation when recommending you to fellow consultants, which opens you opportunities.

As a businessman, it means investors trust you with their money, as a doctor patients trust you with their life.

Ultimately, it is your integrity that builds around you an army of people willing to vouch for you, to trust you, which will pull and push you to defy the clutching forces of gravity, by opening up limitless opportunities and endless possibilities.

And whereas knowledge, riches, and charm is recognized by those around you, trust is earned from those around you.

So, how does one build integrity? How does one earn that trust?

I'll leave that one with you intelligent folk. But do grapple with it, build integrity, earn trust, and see how it carries you beyond the grasp of gravity.

And I will end with the words from another good friend of mine, by the name of Drake, who perhaps encapsulates what it feels like to have defied gravity when he goes:

'I'm still fly, I'm sky high, and I dare anybody to try and cut my wings

I'm still pulling out the phantom and these haters can't stand me nigga I'm still doing my thing

I'm still fly, I'm sky high, and I dare anybody to cut my wings. '

Stay fly everybody, have a good night!

from kensington to bharatpur:

A Lesson in Nepal

By Ananya Chakravorty, Med II

I woke up one morning in the summer of 2012/13 trying to recover from a sense of deep dissatisfaction with my first year of medical school. A kind of dissatisfaction which had nothing to do with the quality of teaching from the UNSW Faculty of Medicine, and everything to do with the fact that for a year that opened the world of healthcare to me, I spent a lot of time studying out of a lot of textbooks, yet the world of healthcare seemed just as elusive as ever.

So, one morning in the summer of 2012/13, I decided to go to Nepal alone.

Six months later and with first semester of Med II under my belt, I left my boyfriend behind at Departures and stepped on a plane bound for Kathmandu, stricken with the knowledge that I literally had no idea what was waiting for me at the other end.

And so it began.

* * *

Eighteen hours pass and after a brief sojourn in hyperalert, hypersecure Guangzhou (China), I touch down in mythical Kathmandu. As the plane makes its final descent, it's difficult to see the city in the dark. Patches of lit city amid speckled inkiness create a higgledy-piggledy image in my mind, and not at all the Kathmandu I imagined. I put my Lonely Planet back in my carry-on, respectably worn after eighteen hours of highlighting and corner-folding, and check my arrival instructions once more:

"A man holding an A4 Projects Abroad sign will meet you outside the airport and take you to Hotel Excelsior where you will be greeted by Projects Abroad staff in the morning."

My Australian passport firmly in-hand, coat-of-arms facing out (strangely, at this moment identity becomes the biggest issue for me), I step off the plane. Warned about Nepali conservatism re knees and shoulders, I'm wearing skinny jeans and a loose T-shirt. It's 11.30 pm and 32 degrees.

Tribhuvan International Airport (KTM) is an incredible building. Built entirely out of brick, the interior is lined with terracotta tiles. It feels a little bit like the inside of a modern Hindu temple and is both very cute and somewhat baffling. Sleep deprived, I'm a bit shell-shocked and searching for a stack of English disembarkation cards, but everything is in Nepali. Then I see an Asian boy who looks about my age holding a Canadian passport and we look at each other and smile with relief as each nods in response to that faintly desperate question – "English?"

Fifteen minutes later it's midnight and I'm sitting in a van alone with two Nepali men having just rescued my suitcase from a host of haggling taxi drivers. Kathmandu is wonderfully, terrifyingly surreal.

* * *

Suffice to say I survived (against what seemed like unlikely odds at the time) and made it to Hotel Excelsior, tucked away in an alley of Thamel district (the tourist hub), in one piece. That crucial operation a success, things started to fall together.

I travelled to Nepal as a volunteer for a company called Projects Abroad who organized a placement for me at Chitwan Medical College Teaching Hospital, the largest teaching hospital in Chitwan District, which lies south west of Kathmandu and includes the low-lying (malarial) jungles bordering India.

After spending a day in Kathmandu acclimatizing (hot – very hot, tiny crowded streets, dust, street-dogs, temples, hagglers, incense, scooters and motorbikes galore) I took a little mini-bus on the six-hour drive down the mountain-side from Kathmandu to Chitwan to meet my host family in Bharatpur (the capital and largest city in

Chitwan) and the other Projects Abroad volunteers at my placement (fondly referred to as CMC). With every kilometre of descent it got noticeably hotter, reaching a scorching 43 degrees by the flatlands of Bharatpur, which remained the consistent temperature for the two weeks I was there.

The structure of the program was such that on the weekdays, we worked at the hospital from 9 till 3 with a break for lunch, where our role was mainly observation, shadowing doctors on ward rounds and sitting in on consultations. On weekends, we were free to travel with other volunteers, and the remainder of the time was divided amongst spending time with my host family at home and exploring Bharatpur which is beautiful in its own right – a lush, green suburban town living at a lazy pace, much more comfortable than the humdrum of Kathmandu.

* * *

My first day of hospital is, for want of a better word, intense. CMC is a private hospital with a lot of stakeholders, and at the time I'm there, only semi-built, meaning it's a working hospital which doubles as construction site – this is much less of a focal point than I initially expect. It is the best and cheapest hospital in the region, but as I am soon to find out, nothing is free in the Nepali healthcare system – a regularly devastating fact. Four storeys are built and functional.

There is no air-conditioning in the hospital except for in the operating theatre and the haemodialysis unit. The smell inside the hospital is overpowering in the heat – bleach, blood, urine, sweat. Even after two weeks, that was something I couldn't get used to.

I'm placed in the female internal medicine ward initially, and join a crowd of nurses, medical students and young doctors who follow Dr Barun as he does the 9 am ward round. The heat is almost unbearable. Dr Barun moves from bed to bed rapidly, palpating groggy patients (often without waking them up properly). Now and then, he gets a few medical students to have a listen with a steth – at which point, six or seven students swarm and begin auscultating simultaneously. I exchange alarmed glances with an American volunteer, but Nepali patients tend to expect paternalistic healthcare and this is pretty normal.

A couple of minutes later we come to an elderly lady coughing up mucoid sputum who then begins vomiting. Dr Barun thrusts a chest X-ray in my direction. It is very similar to a slide in Professor Kumar's tuberculosis lecture in Society & Health. Approximately two-thirds of this lady's lungs are fibrosed. Doctor Barun says she's got TB. I look at another volunteer in horror. She asks if we should be wearing tuberculosis masks and Dr Barun chuckles and moves on.

Something striking about CMC is the number of people who inhabit the corridors of the hospital at all times. It's not until a week or so later that I find out that because the hospital does not feed its patients, families of the patients must bring them their meals, meaning the halls are constantly filled with relatives waiting on patients to ensure they are fed and watered in hospital.

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→ *cont.*

> "the head of radiology turns to me and says: some days i wish i was overseas doing research. i dont cure anyone as a doctor. i stabilize them and then send them home to die."

Top: *Chitwan Medical College Teaching Hospital (CMC);* ***bottom:*** *Female Internal Medicine Ward;* ***opposite page:*** *Kathmandu*

Left: *Outside CMC in our white coats*

> "there is no poetry in poverty. there is no glory in corruption, no sense in needless dysfunction."

Nepal is a nation of misplaced oxymoron. With a United Nations Human Development Index rank of 157, it is poor – much poorer than it should be considering the amount of tourism revenue poured into the nation every year. The problem – as my host father tells me, as the Head of Radiology tells me, as the security guy at Hotel Excelsior in Kathmandu tells me – is corruption. Poverty, I am told, breeds corruption in high office – if government officials can feather their nests a little more with public money, then they will jump at the chance because it's the best bet they've got.

It's my second last day and we're in the CCU. A 72 year old woman has Acute Respiratory Distress Syndrome (another condition I've only seen in lecture slides). Life support costs 20 000 rupees per day in Nepal. A nurse earns 10 000 rupees a month. It's this lady's third day in hospital and her family has run out of money. If she goes home, she will die – she is effectively drowning. She must be discharged – nothing is free in Nepal. The Head of Radiology turns to me and says – "some days I wish I was overseas doing research. I don't cure anyone as a doctor. I stabilize them and then send them home to die."

Later on, I'm having tea and mo-mos (kind of a Tibetan-influenced Nepali dumpling) with a couple of the other doctors. They ask me about the Australian health system. I tell them about Medicare, about the PBS. They shake their heads ruefully. Then they ask me if every house in Australia has "A/C". I laugh and shake my head – I don't have air-conditioning, I say. They laugh in disbelief. Then one quips that 95% of his graduating class no longer practice medicine in Nepal but have moved overseas to countries like Australia. I ask him how much a plane ticket out of Kathmandu costs in rupees. That's 100 000 rupees, the equivalent of three month's salary for a senior doctor.

This seems inescapable.

* * *

If I had to sum up the Nepalese healthcare system in a sentence, this is it – it is as though two competing paradigms of medical care have collided and remain at loggerheads; one is of the paternalistic mid-twentieth century, pre-sanitary practice, the other of modern medicine with cutting edge technology – the operating theatre is well fitted and I watched a standard endoscopic surgery. And bizarrely, neither paradigm has won.

I left Nepal with a lot of mixed feelings. There is no poetry in poverty. There is no glory in corruption, no sense in needless dysfunction.

I went to Nepal expecting poverty, yet equally expecting to see a healthcare system that put everything it had into trying to make the best of its lot. Instead, I was shocked by the fact that while there are bottles of hand sanitiser on the walls, face-masks costs 10 rupees, and there are spare empty wards, no-one uses hand sanitiser, surgeons don't cover their noses in the OT and tuberculosis patients are not isolated. I found a place where nurses and doctors who know better – who demonstrated personally that they know better – were essentially complicit in a culture of lazy, and ultimately fatal, healthcare. Basic hygienic practices were not in any sense beyond the means of the hospital. Yet, I stood in front of a woman vomiting tuberculosis aerosol into the air, next to a girl with an idiopathic fever.

* * *

Nepal is a strange, beautiful country. I was only there for three weeks in total, but I came back feeling like a different person. Despite the language barrier, I learned a lot of useful things for future medical practice.

There are two lessons I will keep with me always, however. First – the absolute glory and humanity of the Australian healthcare system; never in my life have I felt more thankful to be Australian. Second – the fact that no matter where you come from or where you studied, medicine is a profession that unites the world. I learnt from Nepali doctors and nurses alongside medical students from America, England, Ireland, Denmark, Belgium, Poland, France and Germany. Together, we spoke ten different kinds of English, yet it never stopped feeling like I wasn't home.

■

MOVEMBER

By Shohini Mukerji, Med II

they say the moustache is the catalyst for conversation. with the coming of the movember season comes the return of what is arguably one of the most effective ways to show your support for a cause and even raise some funds without needing to say a word.

The growing of a supportive stache is near-equivalent to having the cause you want to raise awareness for written on your face – but in a non-confrontational way that will get the people on your daily commute sparing it a thought and you friends and family digging into their pockets.

You may know of Movember as a campaign to raise awareness for prostate and testicular cancer, but it has evolved into much more than this. What started as a small initiative in Melbourne has now spread to over 21 countries to support a range of causes, including men's mental health funding programs such as Beyondblue's National Depression and Anxiety Initiative. Kudos to the Mo Brothers and Mo Sistas out there who have already been hard at work to get people thinking about men's health issues which are not the easiest to bring up.

Willing to take up the challenge? Registrations online at **http://au.movember.com/** open in September. Mo Bros start with a clean shaven face on the 1st of November, embracing their Mo's for the rest of the month. If you have a little too much oestrogen to sprout a stache but happen to be a keen bean who likes to get behind a good cause, I have learnt from a female colleague who road-tested abstaining from removing leg hair for the Movember month, that this decision yields great fundraising outcomes. Do not despair if it seems too great a sacrifice - Mo Sistas can still register online and support their Mo Bros without any complementary hair growth.

To mo or not to mo? To help with your predicament, it seemed fitting to do some undercover investigations to identify evidence-based reasons that could make it easier for you to justify the plunge to go mo:

1. There seems to be an association between upper-hair growth and the capacity to effectively accumulate anatomy and pathology knowledge – this moustache could be the turning point where you say goodbye to pass grades, begin to shine in the dissecting room and even start to drop wondrous puns of the side-splitting sort.

2. Your style of stache may one day be limited by your specialisation – Only now as a medical student do you have the freedom to grow any irresponsible mo that is truly you without creating controversy or frightening patients. Sources have reported of a Gynaecologist in a Sydney hospital (which shall remain unnamed), who has been harbouring a handlebar stache that was previously only a signature to the upper lip real-estate of 70s porn stars (and the enthusiastic owners of 70's porn stores). Perhaps it's time for a change of Gynaecologist?

Of course, as well as taboo staches, there are also all-or-nothing staches. Starting out as a psychiatry registrar and wanting to treat yo self to a mo? ...You may have to submit to the pressure of Freud-or-nothing facial hair (the go-to style for psychiatrists).

3. You didn't place in the City to Surf this year and need another means to satiate your thirst for glory – luckily there is still the World Beard and Moustache Championships (believe it or not, it be true).

Here is a fine contender from a previous year of finalists, who would have surely shamed all the competition had there been a section for medical practitioners. Benefits: a pair of functional twirls; a Stethoscope may be threaded through loopholes for an aesthetically pleasing effect and lower wisps can be twirled meaningfully with the fingers whilst deliberating over a diagnosis. ■

Nadia Perera, Med III

MEDFAC SURVEY: THE **MEDICINE STUDENT EXPERIENCE** QUESTIONNAIRE

Every 2 years from 2006 to 2012 MedFac has surveyed students about their experiences of the medicine program. The results have finally been released - check out the key **POSITIVES** and **NEGATIVES** we've expressed about the program below:

RESOURCES

- ✓ Resources are readily available for us
- ✓ We have effective IT and related support
- ✓ We have good learning environments

STUDENT SUPPORT

- ✓ Teaching clinicians are helpful and care about our academic problems and circumstances
- ✗ Support mechanisms are **not** readily available and effective

LEARNING, TEACHING & ASSESSMENT

- ✓ Good understanding of the professional practice of medicine provided to us
- ✗ Poor constructive feedback
- ✗ Our feedback to faculty is **not** taken seriously

ORGANISATION

- ✗ MedFac policies & processes (e.g. allocations) are **not** well understood
- ✗ Special circumstances pathways and procedures **aren't** clear
- ✗ Clear info to assist with transitions is **not** provided

COMMUNITY INTERACTION & VALUE

- ✓ Clinical activities are valuable for our learning
- ✓ Tutors, supervisors etc support us in clinical settings
- ✓ Relationships and collaboration with other students are valuable for our learning

QUESTIONS? COMMENTS?

We want to hear what **YOU** think the Faculty can do to improve the negatives, and how we, as MedSoc and students can work with them to improve.

Email any thoughts to **vp@medsoc.org.au.** To read the rest of the study findings, head over to http://med.unsw.edu.au/reports-and-publications

Brain Foundation Student Placement Scholarship

By Elizabeth Chong (Med III)

As much as I love studying medicine (over say, engineering), there is one thing that forever eats away at my restful hours: the ever impending anxiety over starting a new placement. Whilst the average uni student is only required to start a new job twice over their education career (the first when their parents axe their allowance for drinking too much and the second when they get fired for drinking too much), to me, medicine has been a cycle of sleepless nights anxiously counting the minutes of sleep I am losing in concern over making a fool of myself in front of a new team. Winning the neurosoc scholarship was a new spin on this, as after filling out a form about why Neurology is pretty damn cool and what I've done about this (research, marks, and cv), I had volunteered myself the additional stress of being judged in all my ineptitude by the POWH head of neurology, Prof. Colebatch.

So there I was: Monday morning, standing in front of a mirror trying to work out if my outfit was too feminine, too unattractive, or too unprofessional. The next thing I knew, I was in the middle of an EEG meeting with the presenting neurophysiology registrar actually explaining to me personally how to interpret the scans. I went into clinics the average clueless 3rd year and came out able to instantly pick a diagnosis of everything from acoustic neuritis to NMO. Prof. Colebatch was both lovely and a great teacher, completely engaging and friendly; happy for me to pop in and out of his office whenever I was a bit confused. The team was friendly, welcoming and by the afternoon of the first day I felt like one of them: the useful people in the hospital who actually knew what was going on and who could help out with things like electrophysiology and a muscle biopsy. It was fantastic and if ever needed to work out the week in medicine that I have 1) enjoyed the most and 2) learnt the most from, I'd point to that week.

Being part of a team, in a specialty you love is, as it turns out, the reason we endeavour through the long hard slog and getting the opportunity to remember this and experience what it might be like at the other end was something I can't help but recommend to anyone even vaguely interested in neurology.

Tl;dr: If you like brains, then this is definitely for you.

Dos and Donts of Med

Emily Jansen, Social Coordinator

Do put your steth on the right way around. **Do** jovially laugh at the new freshers when they do it wrong. **Don't** wear it around your neck on the way to hospital, you're not a doctor yet. Again, **do** laugh at the freshers when they do this.

Do attend your lectures. Definitely **do** attend the lectures of the following attractive academics: Anne Galea, Rebecca LeBard and, if you share my tastes, Ken Ashwell. Though you've attended all your lectures, **do** leave your revision till study week. We all do it- don't pretend you don't.

Do go to medcamp. **Do** party hard. **Don't** get drunk on the bus ride there. If you were there this year, for future reference: **don't** bring a bucket.

At uni, **do** flirt with the boys at coffee cart- they're attractive. Also, **do** flirt with the man at Gradueat. He's not attractive, but will discount your coffee.

Do partake in medcest. Be it whatever way, shape or ethnic form you please. **Don't** be afraid of meeting conservative ethnic parents. **Do** tell them you're a medical student. **Do** tell them you intend to be highly specialised. **Don't** tell them that you met their son at pubcrawl. **Don't** tell them that Australia's refugee policy is too lenient.

Don't be afraid to run in the opposite direction if you're not ready for commitment- we're in our early twenties, people!

Do meet people outside of med. If you're a guy, **do** tell women you meet that you're a medical student. They will swoon. If you're a girl, **don't** tell men you're a medical student; they will either expect you to be the girl of their dreams or run in the opposite direction. Both of which are equally daunting outcomes.

Do attend AMSA Convention. Everyone says it, but you need to at least once. **Do** attend uni parties. **Don't** go to the same boring nightclub every week. When you go out, **do** hit the dance floor. Every time.

Do Medshow at least once. **Do** Amazing Raise. **Do** Talent Quest. **Do** engage with your Medsoc. **Don't** be afraid to run for a Medsoc position.

Do make the most of the lucky chance we've been given (though do take a little credit for that yourself). **Don't** hesitate to go rural for a year. If you're not local, **do** go home as often as you can afford. **Do** keep in touch with your family and friends.

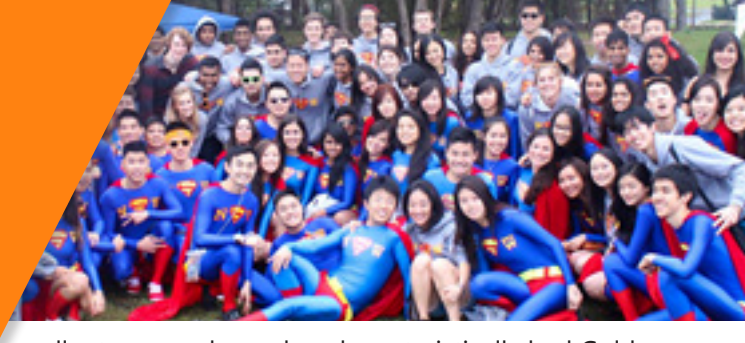
Do keep friends in all year groups. **Do** keep in touch in your older years. **Don't** ever forget where you started.

Do know your boundaries. **Don't** be afraid to push them sometimes. **Do** be nice to people. **Do** be extra nice to yourself.

And lastly, don't stand on the toilet seat or bowl. The bowl may break and you may hurt yourself. ■

AMSA CONVENTION 2013

by Beckie Singer, Junior AMSA Representative



spot test: a patient comes in with pale, green and orange streaked skin, a relentless cough, hoarse voice, tourette's consisting of profanities and "i wish that all the ladies" and anhedonia regarding real life.

What is your likely diagnosis? What key question in the history do you need to ask?

If you said Post Convention Depression and "Did this ranger attend the 54th AMSA National Convention in the Gold Coast?" then four for you Glen Coco.

Sandy beaches, inspiring academic speakers, breaking world records, litres upon litres of body paint and over 100 UNSW med kids in Superman suits – what better way to spend mid-year break?

Over a hundred of our very own UNSW Rangers made up the third largest delegation out of roughly 1200 medical students from all over the country (with one or two Kiwis thrown in from across the ditch).

(Most of our) Rangers heard from awe-inspiring speakers such as Simon O'Connor (as in Talley and O'Connor), Michael Bonning and Phan Thi Kim Phuc and took away many motivational and I am sure life-changing messages.

On the Wednesday, six brave UNSW medicine students powered through declining BACs and sleep deprivation to get up at the crack of dawn and deliver babies, battle burn wounds and fend their way through combat zones in the annual Emergency Medical Challenge. The rest of our gallant rangers braved uncharacteristically bad Gold Coast weather to support them in Superman costumes which flew above every else's sports day costumes.

To let off some steam after traversing the path less travelled and being taken off the grid, Rangers donned body paint and wild, outrageous and imaginative costumes and boarded buses amongst some good old Yogi Bearing and AMSA Rangering to be transported to social venues beyond their wildest dreams. What happens at convention stays at convention, but our rangers certainly bought home stories they should be proud (and possibly ashamed) of.

Not only did UNSW Rangers FSU(r), GAI and Yogi Bear with the best of them – we actually were the best of them:

Dushyant Iyer (Med III) – Winner of the 2013 Research Presentation Competition

Alexander Murphy (Med VI) – Recipient of the 2013 AMSA National Student Award

Richard Shaw (Med IV) – Tied 3rd place in Australia's Brainiest Medical Student

Dinuksha De Silva (Med IV) – Our vice-pres not only has academic and leadership skills but also runner up for Australia's Brawniest Medical Student

Matt Rubic, Jeremy Knott, Dinuksha De Silva and Em Jansen (all Med IV) – Semi-finalists in the Debating Championships.

There was an unprecedented show of UNSW spirit and pride at Convention this year, despite some hiccups (including Superman suits being lost somewhere between here and China!) I can't wait to see you at rAdelaide 2014 – it will be unCONVENTIONal! ■

RURAL MEDICINE - NOT JUST RUNNY NOSES?

by Bridget Cavanagh, RAHMS Junior NRHSN Representative

One would not be alone in thinking that for those of us who signed the dotted line of a Bonded Medical Place or Medical Rural Bonded Scholarship we were resigning ourselves to a career of runny noses, stomach bugs and the odd case of chickenpox.

But is this a gross misconception? With increasing growth in rural and regional areas and government support to lower the health gap between metropolitan and rural populations could there now be a place for the obstetrician, physician and dermatologist?

It's a scary thought - the prospect of signing a form which will ultimately shape the course of your career many years ahead. Of course no one thinks about this when pen finally comes to paper. You're 18 years old and unimaginably keen to enter medicine. You've worked hard for 12 years to get to here and 6 years in the country seems like nothing at this point. Hell, maybe you'll even enjoy yourself in the countryside out amongst the gum and plum trees with a sheep or two and a clothesline out the back. But now I start to wonder if in doing so, I've eliminated many career paths. What if I want to work in the country, not as a GP but as a physician/surgeon/obstetrician?

First let's just set the cards straight: general practitioners in rural areas deal with a lot more than your everyday cold. You could well be the first port of call for many in isolated areas when a woman goes into labour, when a car crashes or even when someone sticks their hand in the wrong end of a monstrous machine. You may see things some emergency doctors in metropolitan cities will never see. But "hey", you say, "what if I really just want to look at skin all day?"

Well, currently over 80% of specialist doctors work within the immediate proximity of a capital city. However this is changing. There is an ever-increasing demand for rural specialists, particularly in obstetrics, gynaecology, geriatrics, paediatrics and anaesthetics. Some specialities are limited by population size, including cardiology, neurosurgery and radiology. However most specialists are able to at least work in inner regional areas; with the majority working in their own practice alongside the local hospital.

There is a huge discrepancy in the number of specialists working in rural and remote areas as opposed to the larger cities (20 per 100,000 population, as opposed to 130). There is a strong call for the government to determine the critical mass for each speciality (how many specialists are needed for a set population) and for them to fill the gaps - preferably sooner rather than later. To help, many colleges have incentives for working rurally, including the Rural Obstetric and Anaesthetic Locum scheme where you may be offered $1100 per day on top of what you get paid (for up to two weeks) plus additional travel subsidies! In other words, they really do need you!

> "you could well be the first port of call for many in isolated areas when a woman goes into labour, when a car crashes... you may see things some emergency doctors in metropolitan cities will never see."

There are many additional benefits to working as a rural specialist including HECS debt relief (reducing your debt by up to 5 years worth of university study), a great breadth of professional experience, attractive lifestyle opportunities and the prospect of being a part of a caring community. Or you could work in Broome, the Athertone or Mt Isa hospitals and they'll even throw in incentive packages including cars, accommodation, additional leave, return airfares and even career support for the spouse and family of specialist doctors.

So I reiterate again, there is a need for specialist doctors in rural areas; so for the quarter of us who have signed on the dotted line, don't stress! You haven't signed your future career away. You've signed on for the experience of a lifetime. ■

RURAL HEALTH MYTHS

myth 1: there are no opportunities to work as a specialist in rural areas.

There is demand for specialist doctors in rural and regional areas, both permanently and on a locum basis.

myth 2: once rural, always rural

This is partially true because in a survey conducted on rural specialists over 60% had lived in the area for over 10 years; but this was their own personal choice, with over half surveyed not intending planning on leaving their workplace within the next 5 years and the majority who did intended on to leavingleave doing so because of retirement.

myth 3: working rurally will limit the career and schooling opportunities for my (future) family

This is hard to answer because not all jobs are easily obtainable in smaller areas, however this shouldn't limit your ability to work rurally. There are many locum job opportunities, from anywhere between 1 day to 6 months, with big pay packages and nice incentives on the side.

myth 4: there s no way i ll be paid as much as my city colleagues.

You are likely to be paid as much as your city counterparts, with the addition of some nice little extra incentives!

[RURAL CAMPUS FACT FILES]

Are you thinking about going rural but aren't too sure where you'd like to go? Are you heading to a rural campus next year? Or have you never really considered going rural and have no idea what the rural campuses are like? Whatever your situation, RAHMS has assembled some fact sheets about UNSW's main rural campuses to give you a glimpse into each of these towns, their hospitals and student life!

[ALBURY - WODONGA]

basic facts about albury

Albury-Wodonga are twin cities on either side of the Murray River in the Riverina.

Population: About 90 000
Hospital Statistics
Beds: 130 in Albury Base Hospital, access to 4 other hospital facilities
Specialties: More than 90 specialists covering wide range of specialties

getting to and from

Car: 3.5hrs to Melbourne, 6hrs to Sydney
Train: $30-$50 one way (Sydney or Melbourne)
Flight: 45min to Melbourne, 70min to Sydney, $80-$110

what to do in albury?

Whether for leisure or sport, there is always something to do! With the Hume Weir only 15kms east, there is a plethora of water sports (sailing, canoeing, water-skiing, kayaking & fishing). The extensive environment from the Murray to the mountains provides cycling & bushwalking trails to explore. In winter, skiing & snow sports at Falls Cree/Mount Hotham (1.5-2hrs away) are always a winner! Local festivals celebrate local wine, food, art, music & theatre. If you're a lover of food, why not try the Farmer's Markets every 2nd weekend?

what is it like?

The Murray River is now a lazy waterway that tempts you take time out under a shady tree. There is a blend of city style and country pace, history and contemporary art and adventure attractions. Think grand old buildings, richly established gardens and broad, tree lined streets.

opportunities for med students

Get involved in sporting, volunteer and cultural activities in the community! The students also regularly hold BBQs, dinners and other social activities for the RCS and the community.

[WAGGA WAGGA]

basic facts about wagga

Wagga Wagga is NSW's largest inland city.

Population: About 50 000
Hospital Statistics
Beds: 200
Specialties: Cardiology, respiratory, gastroenterology, neurology, paeds, O&G, emergency, anaesthetics, rehab, surgery (orthopaedics, trauma, vascular, plastics, gastro)

getting to and from

Car: 450km, takes about 5 hrs to Sydney
Train: About $45 concession, takes about 7hrs
Flight: $100 to $150, takes about an hour

opportunities for med students

Wagga has a great community of doctors who are happy to teach. Students are attached to teams in the hospital, community & private hospital. There are opportunities in Aboriginal health & at nearby Junee prison.

what is it like?

Home to CSU & Air Force/Army bases, Wagga has a young and dynamic population–there are plenty of students to meet, and share houses if you want to branch out. The Phases integrate well, with most social events involving a mix. Notre Dame Uni also places med students in Wagga, adding to the social circle. Everyone else is really friendly–people are used to out of towners & are very welcoming.

what to do in wagga?

In winter: 1.5 hours to Falls Creek Ski Field or 4 hours to the bigger ski fields
In summer: Visit Wagga Beach, or float/kayak down the Murrumbidgee River or waterski on Lake Albert
All year: Go out- Wagga has plenty of cafes, restaurants, a great microbrewery, some classy bars, country bars and Romano's...always full of students on the weekend!
Exercise- The Wagga Effect is a term used by the media to describe the disproportionately large number of elite sportsmen and women that originate from the city. There are recreational and competitive sports teams, 3 large gyms, and a beautiful 5km lake run.
Don't forget the glamour and excitement of race day! There are also botanical gardens, a zoo, cinema, art gallery & library.

[PORT MACQUARIE]

basic facts about port

Port Macquarie is on the Mid-North Coast, 420km north of Sydney.

Population:
- **City & Suburbs:** 41 491
- **Local Government Area:** 72 696

Hospital Statistics
- Beds: 161, with more being built!
- Specialties: All major except neurology & cardiothoracic surgery

getting to and from

Car: Travel to Sydney is 4-5 hours drive (about $60 petrol).
Train: CountryLink train (about $40) stops at nearby Wauchope, with a connecting bus to Port Macquarie.
Flight: QantasLink and Virgin Blue have regular flights to Port Macquarie for about $100.

what is it like?

What is Port Macquarie Like?
In recent years, Port Macquarie has become one of the centres of highest population growth on the coast with the demographic shift out of the cities.
Port Macquarie has a legendary climate & beautiful beaches. Southern Cross and Newcastle Universities also have a presence. The vibe of the town is 'surf-retirement', with the clinical school having a play hard, party hard atmosphere (among the students... AND the staff!)

what to do in port?

Enjoy beautiful beaches, tranquil running tracks, whale watching, sandcastle building, and even a nudist beach! The town has many restaurants & the region is surrounded by some of Australia's finest vineyards. There are cinemas, as well as live shows & art galleries. There are heaps of sports including multisport, touch, basketball, volleyball, netball, futsal, surfing & badminton, as well as outdoor activities such as bushwalking, hang gliding, sailing, canoeing, kay-aking, tennis & golf. Port Medical Society (PMS) holds many events including BBQs, pizza nights, wine trips, trivia and parties.

[COFFS HARBOUR]

basic facts about coffs

The coastal town of Coffs Harbour is roughly between Sydney and Brisbane.

Population: About 68 000, fluctuates with season.
Hospital Statistics
- **Beds:** 226
- **Specialties:** Basically all. Also includes North Coast Cancer Institute, Refugee Health Services, Aboriginal Health Centre, Women's Health, Early Childhood Intervention, Drug & Alcohol, Sexual Health, Fracture Clinic, Grafton Correctional Centre, General Practices

getting to and from

Car: 6.5hrs to Sydney, 4.5hrs to Brisbane
Train: $50 (Sydney), $40 (Brisbane)
Flight: Timeliest/cheapest way to get to Sydney is Tiger Airways (from $29 if catch them early)

what is it like?

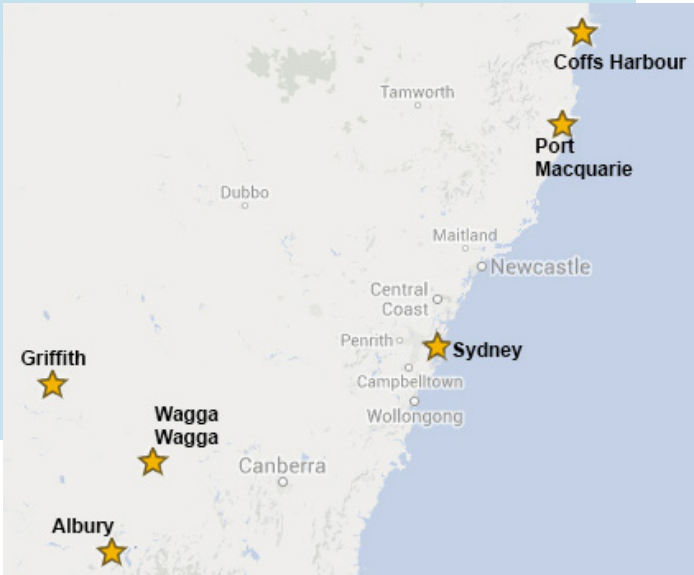
Coffs is home to the Big Banana, Pet Porpoise Pool and the Clog Barn. With amazing, beautiful beaches and more banana plantations that you can poke a stick at, the CSIRO claims it to have the most liveable climate in Australia. When not hitting the wards, surf, work on tan & throw outrageous parties. It's a very relaxed lifestyle!

opportunities for med students

Excellent clinical exposure, scrubbing in and assisting with surgeries, attending private rooms, practicing suturing/cannulas/ABGs/venepunctures. All the 4th years have delivered a baby!

what to do in coffs?

Students enjoy all kinds of activities in and around Coffs Harbour. From the beautiful Boambee Reserve swimming hole to hikes and camping in mountainous Dorrigo National Park. Every Sunday there are markets down at the jetty, and once a month the famed Bellingen Markets spring up. Of course, you can't turn down a trip to the Pet Porpoise Pool or a night out at one of Coff's hot spots in town such as the Hoey Moey, Plantation Hotel (affectionately known as the Planto), or new hipster magnet Old John's. For a quieter night in, half of the campus works at Sarong in Sawtell – a gorgeous venue that also does Japanese lunch! We also enjoy frequent dinners at each other's houses and birthday celebrations.



Right: *Rural clinical school locations*

Variations in global ENT practice

by Qi Zhang, Med VI

How they do it in Singapore

As increasing numbers of international students return to their home countries after they graduate, many will start to wonder about the differences between the medical practices there and the urban Australian setting. I tried to find the answer by doing a two-month elective in Singapore (Khoo Teck Puat Hospital & National University Hospital). Of course, I had to do it in the specialty that I am most familiar with – Otolaryngology (Ear, Nose and Throat).

Comparing the elective experience to my months of ENT terms in Prince of Wales Hospital and Liverpool Hospital, there are indeed a number of differences in practice due to diverse local factors, such as:

Sets of differentials

If a patient presents with an unexplained cervical lymph node in Sydney, the physician will first search high and low for a possible dermatological primary malignancy. A patient with the same complaint in Singapore on the other hand will have his fossa of Rosenmüller checked within the first five minutes, as nasopharyngeal cancer is the number one condition to be excluded among the predominantly Chinese Singaporean population.

Influence of healthcare costs

While the costs of investigations are not a major consideration factor in Australian medical practice, this can be a life-changing element in Asian countries including Singapore. Here are a few illustrative examples:

- Case 1: A typical 50 year-old patient presented with a sensorineural hearing loss that is more severe on her left side. I explained that there is a small chance that this is due to a tumour of the hearing nerve (acoustic neuroma) and recommended a MRI of the internal acoustic meatus. Half the time, the patient may not be willing to do the test. The main reason – the MRI-IAM will cost her $500 cash, and she only earns about $1500 per month.

- Case 2: A 75 year-old gentleman presents for gradual bilateral hearing loss and difficulty communicating with family members. He was found to have almost equal sensorineural hearing loss on both sides. 'Hearing loss due to aging', I thought to myself. Although this was a clear-cut diagnosis, I felt uncomfortable explaining this to him. This is because he most probably could not take up hearing aids, due to the $1200 out-of-pocket cost. As expected, he left disappointed.

- Case 3: A 70 year-old gentleman came in with his daughter for otalgia (diagnosis: otitis externa). It was also found that he had a family history of nasopharyngeal cancer and I offered to do an opportunistic flexible nasoendoscopy. 'No need, he's smoked all his life', his daughter interrupted 'The $100 charge of the scope can be deducted from your Medisave (a mandatory governmental health insurance scheme)', I tried to reassure with her. I then learnt that she worried not so much about the $100 for the nasoendoscopy – she was more concerned about who will be the one to foot the bill for the subsequent management if I were to find something. I was dumbfounded and began to appreciate the liberty to scope all suspected patients in POWH, thanks to the Australian healthcare system.

Demographics and culture
Because of the high prevalence of skin cancer in Australian, there is a significantly heavier major head and neck surgical case load here in Sydney. While ENT works with the plastic team here on a daily basis, I do not remember scrubbing in for any head and neck surgeries that involved a flap.

On the other hand, there are some frequent cases in Singapore that are seldom seen in Sydney. While I only saw two cases of fish bones stuck in the throat in one month here in POWH, there is almost one fish bone foreign body case per day in Singapore!

Waiting time for patients
Singapore is a fine example of a high-paced Asian metropolis, with everything put on fast-track. While an elective tonsillectomy takes about 12 months of waiting in Sydney Children's Hospital, it just takes at most 3 weeks for a public patient to have his tonsils out in Singapore. While a public clinic appointment in Prince of Wales Hospital takes 4-6 months, it only takes 5-10 days there. Of course, this came at the expense of highly pressured medical stuff. While an ENT registrar in Liverpool considers 10 patients per afternoon a really bad day, the same workload is what a Singaporean registrar expects day in day out. Asian style.

Emphasis on clinical research
Singapore Ministry of Health pours in large amount of capital to encourage clinicians to do research there, and I can understand why. Given the substantial workload, most medical students and doctors struggle to find time to do any research work. In order to get a poster presentation or paper in a local journal, keen medical students actually have to do research in the evenings after class. A local medical student I met went around all hospitals trying to get a ENT-related project. He eventually managed to get one; to investigate how different duration of exposure to vinegar alters the mass of fish bone. Again, Asian style.

Photos previous page: *Khoo Teck Paut Hospital, Singapore; this page: National University Hospital, Singapore / the famous Singapore dish - curry fish head*

While both Australia and Singapore have first-world healthcare environments, there are some distinct differences, even when just focusing on one specialty. When compared with another country, we should be able to appreciate the pros and cons of our Australian healthcare system better. Given the significant Singaporean population within our medical cohort, I hope this report also shines some light onto the importance of learning and adapting to local culture practices for them if they decide to return to the sunny island state. The Singapore government has begun to recognize the importance of better work-life balance, and it continues to take constructive steps towards making medical practice in Singapore a more attractive one. With the construction of new hospitals and increasing population, Singapore will continue to be one of the popular destinations for medical professionals worldwide. ■

clinical exam guide

by Henry Vo and Jasmine Cheng, Academic Coordinators

osce and ice are a few months away and you re all practising your clinical skills (or planning to start soon anyway). here s some general information and tips that hopefully makes your life easier and gives you an idea of what to expect.

Objective Structured Clinical Exam (OSCE)	**Integrated Clinical Exam (ICE)**
6 stations (15mins each)	6 stations (10mins each)
History *and* exam	History *or* exam (not necessarily three each)
Expect a communications station (e.g. take an detailed psychosocial history)	Expect a communications (e.g. counselling) and/or ethics stations (e.g. duty of care)
Examiners want you take a history and perform an exam competently. It's about correct manner and technique.	Examiners want to see you thinking about and adapting to the information you gather. It's about narrowing your list of differentials.
Questions test your understanding of what you're doing. Expect questions like "Describe the Korotkoff sounds" or "what is the difference between upper and lower motor neuron lesions?"	Questions test your ability to interpret the case. Expect questions about differential diagnoses, investigations that you would perform and interpreting any signs you elicit.

Some general pointers

1. Dress to impress and come prepared – Dress appropriately. Stay conservative. First impressions matter. You want to seem like you're professional and taking the exam seriously. Don't forget your stethoscope (preferably separate diaphragm and bell) and pen torch.

2. Wash your hands – A lot. As obviously as possible. They really stress the "5 moments of hand hygiene". There should be alcohol rub provided before you enter the station, as well as inside. Make use of these!

3. Get consent! – A simple "Is it ok if I …" once at the start is enough. Don't keep asking for each part of the exam, because then it sounds repetitive and detracts from the smoothness. Still tell the patient what you're doing, but don't ask for consent repeatedly.

History

1. Have a structure! – The history should be presenting complaint, past medical, medications, allergies, psychosocial, family history. Even if you're asked to focus on a particular aspect (e.g. psychosocial), don't neglect the other parts of the history. Unless instructed, spend most time on presenting complaint.

2. Show off those communication skills – Comms skills are important. Understand when you should use open and closed questioning (yes – closed questions are necessary). Revisit the techniques you learnt from the communications assignment (e.g. signposting, reflecting). If there's time, check your understanding by summarising back to the patient.

3. Should I take notes? – If you decide to take notes, don't let it damage your patient interaction. Limit it to name, numbers (e.g. age, pack years) and lists (e.g. medications, past history) because they're easily confused after a few stations. You should be able to summarise presenting complaint, issues and concerns without needing to refer to notes.

Exam

1. Study everything – Learn all the exams (and procedural skills) in the CCS guide including the obscure ones you weren't taught or didn't know you needed to know. If you're not sure, check with Talley and O'Connor, older students and doctors.

2. Structure! (again) – The key to the exam is having a good structure. Before you even touch the patient, remember:
   - Position and exposure – Get the patient in the right position with the correct exposure. If that involves undressing, allow the patient privacy (e.g. sheet over female chest).
   - Wash your hands (again) and never forget to observe. Observations come in two categories: the environment (e.g. sputum cup) and the patient (e.g. laboured breathing). Also observe the part of the body before you start examining it (e.g. chest before percussion or auscultation).
   - Ask about the patient's vitals (except for the ones you're told to measure). Know the normal parameters.
   - Check if patient has any pain and leave painful areas last.

   The actual examining needs to have structure too.
   - Nearly every exam in medicine begins with the hands, moves towards the head and proceeds down the rest of the body.
   - If there's something that should be done, but is too time consuming or not appropriate for a patient volunteer (e.g. per-rectal exam for the abdominal exam), mention that ideally you'd like to do that as well.

3. Practice practice practice! – Practice until everything's

smooth and you know how long each exam takes. Sit a friend, family member or other guinea pig of choice down for an hour and just repeat the exam over and over again until you get it perfect. Try it, it really helps.

Summaries

1. Be nice to your patient – Before summarising, thank the patient, help them dress and make sure they're comfortable.

2. Keep summaries short and to the point – Take a moment to collect your thoughts. A brief pause at the beginning is better than a disorganised summary in which you blurt out whatever comes to mind. You don't need to retell everything to prove yourself (the examiner has been watching throughout the entire station). Using medical terminology makes things concise and exhibits a higher level of thinking (e.g. dull retrosternal chest pain alleviated by rest is stable angina).

3. Organise your summary in your head – Don't regurgitate everything the patient just said in the order that they said it in. Try using a scaffold or script to make it a coherent and succinct summary. For instance, a history summary might sound like:

<name> is a **<age>**-year-old **<occupation>** who presents with a **<length of time>** history of **<presenting complaint>** characterised by **<feature>** and **<feature>** on a background of **<risk factors>**. **<if necessary, further characterise complaint >**. Associated symptoms include **<symptoms>**; however, the patient denies **<symptoms>**. Past history consists of **<diseases and operations>**. **<name>** currently takes **<medications>** and is allergic to **<medications>**. **<name>** smokes and has a **<X-pack year>** history, drinks **<Y standard drinks>** a week and **<frequency>** uses **<drugs>**. **<other relevant psychosocial history, but keep it short>**. Lastly, there is a family history of **<disease groups>**.

OSCE & ICE

LET'S TALK SPECIFICS

by Richard Shaw, Med IV

Let's keep this simple and straight to the point, so sit down my child and let me tell you some of my musings.

OSCE

1. **SWAG!** – I say this every single year and it's with very good reason. OSCE is about checking that you're COMPETENT at taking a history and examining a "patient". Hence, you must PORTRAY COMPETENCE! No matter how nervous you are, it's important to be confident and roll with the punches when you get it wrong. Even if it's the first time you've examined a knee, pretend like it's the 1000th time you've done it. This seems like a stupid point but there's a reason I put it first.

2. **HAVE A STRUCTURE…HAVE A STRUCTURE FOR YOUR STRUCTURE** – If you were like me and genuinely (and foolishly) tried to pay attention during CCS, you may have learned about "patient-centred" interviewing. While that's all very nice and true, don't let it prevent you from structuring your history. There's no point having a nice "chat" when you aren't even 100% clear on what the presenting complaint is! The same is true for exams. In AEA you will learn about "LOOK, FEEL MOVE". So before you put your grubby hands on the patient's knee have a think…have you looked everywhere you are supposed to?

3. **EXAMINATION TECHNIQUE** – It's ESSENTIAL that you don't just "study" by reading about the examinations and then imagining yourself doing them. ACTUALLY DO THEM. Practice in front of your friends, older year students and doctors. Their feedback is going to help you refine your technique. Not only will you learn to examine in the same way real doctors do but it will also remove 90% of the things you read about that just seemed awkward.

4. **GO THE EXTRA STEP** – The CCS guide is a barebones scaffold of what you need to know, the baseline, allowing you to pass the exam. If you're passionate about developing skills that you can actually use later on, it's important that you supplement this with Talley and O'Connor. For example, doing a more comprehensive peripheral inspection will give you an enormous advantage. Also, do you think the random doctors that mark your OSCE stations will be familiar with our little Phase 1 guide or will they be more familiar with the examination textbook that literally every single doctor and older year student has studied from? Having said that, DO NOT neglect the CCS guide, this is where you should start and frame your study…use it as a syllabus, not a textbook.

5. **REPORT THE EXAMINATION AS YOU GO** – If your patient and examiner are ok with it, then reporting the examination as you go is an excellent way to demonstrate to them both that you know what you are doing and what you are looking for.

→ *cont.*

6. **BE THE NICEST PERSON IN THE ROOM** – Patient rapport and communication are an ENORMOUS part of OSCE. If you remember my first tip, listen and be super nice…you will probably pass.

7. **TALK TO OLDER STUDENTS** – There's a good chance that many of the OSCE cases you will see have been used before. Chat to older year students; learn about their OSCE experiences and what questions they were asked.

8. **PRACTICE EXAM CONDITIONS AND PRACTICE IN GROUPS!** – You can't practice unless you have a stopwatch counting down from 15 minutes. Re-create the stress and time pressure of the exam. Learn to deal with, THRIVE in it and the actual exam will seem like a breeze.

9. **LEARN BY DOING AND MAKING MISTAKES** – if you're saying things like "Don't time me! I don't even know the examination yet!" or "I can't take a history now, I need to go over what to ask first" then be careful because I will run from hospital to come and slap you in your silly little face. Can you learn to ride a bike by reading about it? Probably not! You need to go out and FORCE yourself to do it. It sucks and I hated practicing histories too but you will be SO much better off because of it.

ICE

1. **SEE ABOVE!** – Everything for the OSCE still holds true in ICE – have a quick skim and remember the fundamentals!

2. **DIFFERENTIAL DIAGNOSIS** – You need to be thinking about this constantly! Never stop thinking about differentials, never! I want you to all go out and register as being in a de facto relationship with the phrase "differential diagnosis". I cannot possibly overstate the importance of this! It completely shapes your approach to your history and examination. When you read the stem outside a station or when you hear a presenting complaint, you should automatically generate a list! What's common given this patient's demographics? What's a life-threatening or serious differential that I should always rule out? A list of presentations that you should have differentials for can be found in your phase 2 clinical skills guide. LOOK AT IT!

3. **SYSTEMATIC APPROACH** – If you haven't heard the phrase "Surgical Sieve", "VINDICATE" or "VITAMIN D" then you're in desperate need of a quick googling session! If you develop systematic approaches for your differentials you will realise it's not hard to generate a few differentials for anything. Patient has chest pain, ok so myocardial infarction. But what are respiratory causes of chest pain? What about musculoskeletal? (Yes…yes there are).

4. **KNOW YOUR SIGNS** – Know your signs like the back of your hand…know the signs on the back of the patients hand too!! Clubbing! OMG the patient has clubbing! Well that's nice…do you know what that means? Not only do you need to know signs but also DIFFERENTIALS for them too!

5. **DON'T NEGLECT THE FLUFF** – You will all have what I call a "fluff" station. Examples include stations regarding consent, medical certificates, ethical dilemmas and drug and alcohol issues. Don't neglect these stations as it is GUARANTEED to be 1/6th of your exam. While many think you can't prepare for these, I disagree! Talk to older year students, hear their approaches and develop your own!

6. **LEARN TO SUMMARISE** – If your summary takes more than 1 minute, then you're probably doing it wrong! Keep theses succinct. Get out of the Phase 1 habit of reciting what you did. They want to see that you can SYNTHESISE your history and examination findings. For example, with your examinations, report all of your significant positive findings FIRST, then report significant negative findings afterwards. Don't blindly report everything in the order that you performed them. And if you have been thinking about differentials the whole way through, you should be able to volunteer a couple of these at the end of your summary whether you have been prompted to or not!

7. **LEARN TO BE EFFICIENT** – Time is your enemy! If you struggle to complete an exam on a friend in time, then you're DEFINITELY going to run out of time in the actual exam. Remember, your friends don't have a weird visual field defects or a confusing combination of hyperreflexia and areflexia (well most of them anyway), but ICE patients may very well! If you can perform your examinations quickly, it will give you MORE time to slow down when you feel that there might actually be pathology.

8. **REPORT WHAT YOU FIND** – If you think something is abnormal, you're better of describing or identifying it rather than not saying anything at all. It's better to be looking too carefully than to miss the patient's pathology…which is kind of the entire point of that station.

9. **PRACTICE!** - I found the best thing to do was to practice in groups of 2 or 3 students. Take turns performing exam condition histories and exams on each other (if you have a third person, then have one student be the examiner). Even better, find case books in the library or online that might give you inspiration for histories.

10. **TALK TO OLDER YEAR STUDENTS** – As usual, MedFac have a tendency to repeat stations and it is in your best interest to talk to as many older year students as you can and learn about what types of stations they had. What type of questions were they asked after their histories and examinations? ■

research spotlight

Each issue we'll be featuring a different ILP and Honours project to showcase the kinds of awesome things UNSW medical students get up to during their research years! **If you'd like to share your project or know someone else doing something really cool, drop us an email at publications@medsoc.org.au**

Honours: Jacqueline Ho (Med IV)

About the project: My project looks at a new cell in TH2 immunity (discovered only 3 years ago!) known as a nuocyte that activates TH2 cells and mediates diseases like asthma and chronic rhinosinusitis. It's a mixture of otolaryngology and immunology.

A typical day: It begins waking up at 6am to get ready to head off to hospital for surgeries with my supervisor. During surgeries, we take sinus biopsies and I rush back on the train to St Vincent's to start working on it before my cells die. I usually get back around 2pm. I then work on my sample in the lab – a bit of pipetting, mashing and staining – and it'll be 6pm. I then run my sample through flow cytometry and it's 8pm. I start to remember that I haven't eaten yet at this point. The day is not over yet. I have to analyse my results that night and then I'll probably leave the lab around 10pm. 16 hour day. Fun fun. Rinse and repeat. I'm not too sure my supervisor knows that this is my typical day.

Most interesting thing so far: Escape to Europe (haha jokes). But I really enjoy watching surgeries, anywhere from a typical endoscopic surgery opening up the sinuses to a facial skin flap surgery.

Tips: Don't be afraid of a lab project – it can be a lot of fun, you do a lot more and you don't feel like you're wasting your time. Keep your supervisor updated with everything and don't be afraid to branch from your original project. Your research year is what you make of it, and you can learn a lot of useful skills for the future. Also take the opportunity in your research year to take a holiday, and/or get involved with things outside medicine.

ILP: Varun Bhoopathy (Med IV)

About the project: My project investigates the health status of Kenyan men who have been internally displaced due to the horrific 2007 political violence. My particular focus is on cardiovascular risk factors. The 2007 Kenyan political violence saw the displacement of 660 000 people. Five years on, many are trying their best to reestablish their lives and provide a better future for their children. We based our research at the Shalom City Internally Displaced camp, one of the many camps established by the government for those internally displaced. Mixed methods were used to collect the data, including surveys, physical measures and qualitative interviews.

Where is your project located? All over the place! Uni, home, and Kenya! I'm working closely with an honours student (Kamal Singh) on this project. My supervisor's office is at Samuels, where we work once a week. The rest is either at home, Kamal's house, or at the library. We did spend a cool three weeks in Kenya during the semester break collecting data, alongside our wonderful supervisors (Prof Robyn Richmond, A/Prof Heather Worth and Dr Holly Seale) and three MPH students.

A typical day: It varies! One day, we would be contacting sports clubs throughout Sydney seeking donations of sporting equipment to take to Kenya. Another day, we would be crunching data and reading tutorials to decipher SPSS. And the next day, we'll be writing a report on lighting conditions in Kenya to help persuade philanthropy out of solar light companies. Currently, Kamal and I are gathering and creating resources to help a Kenyan High School Principal start a health promotion campaign on tobacco use, alcohol consumption, and sexual health in his local district.

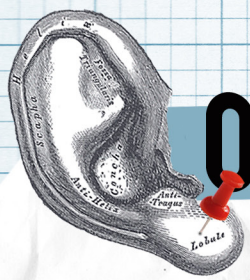
Most interesting thing so far: Over the past 6 months we have became fluent in talking to a copy machine, proficient with starting fires in a fireplace without kerosene, speaking rudimentary Swahili, drawing and labeling all the countries of Africa, spotting chameleons in the wild, and mastering the art of using an automated sphygmomanometer (having measured nearly 750 readings in a week). The most memorable learning experience was facilitated by A/Prof Heather Worth, where she used our daily activities in Kenya, such as the game safari through Nakuru National Park to teach us various research techniques such as participant observation.

Tips: This year has provided an eye-opening experience into the world of research. Although we are taught the importance of research in Phase One, I did not truly appreciate its role until this year. A year of research focusing on one topic alone can and will at times become a bit dry. I've found that involving myself in extracurricular activities and befriending those outside of our faculty, certainly helps add a breath of fresh air and spice to the ILP life when it gets dry. My advice would be to try and finish the literature review and the final report as early as possible, so that you have more time to seize the freedom of this year to partake in all extracurricular activities that you wanted to but never had the time for in Phase One.

By Elaine Ng, Med III

THE NATURAL HISTORY OF TB

WHAT HAPPENS IN OT STAYS IN OT



overheard

I heard a girl in the lounge talking about medball and probably jealous that she couldn't go, she said: "One of my friends is going for medball and there's like 500 people going. Each person has to pay $100, thats like $500,000 and they booked out the entire Luna Park. How ridiculous, think about how many brand new cars I can buy with that!" *Girl, you need to think about how you even passed high school maths.*

During the information session for the final year exams
Dr. Phil Jones: "You will have 3 minutes between stations."
Friend: "That's enough time for six panic attacks!"

Friend: "When I was 9 years old, I thought I was pregnant because I felt a pulse in my abdomen"

During a pathology lab:
Kumar: "How do we digest fats?"
Student: "By eating them"

Student: "How many standards are in a shot?"

Medical student in a QMP practical, unaware that the tutor is right behind him: "GOD DAMMIT, SCREW THIS, I JUST WANT TO PLAY TANKS!"

Student: "What's the difference between mesentery and duodenum?"

In a taxi coming back from Medball:
Taxi driver to 1st year girl: "I think you'd make a great doctor as long as you show as much skin as you are now!"

Need to get something off your chest? Submit your confessions, love letters, and anything overheard at **http://***Ta***/SNxqr**

YOUTUBE VIDEO SPOTLIGHT

"Diagnosis Wenkebach"

Remember Justin Timberlake's hit "SexyBack"? Well, now you can use it to learn about Wenkebach, also known as Type-1 second-degree atrio-ventricular block (which is otherwise known as that condition you may very vaguely remember Karen Gibson talking about once a long time ago). With genius lyrics such as "The QRS gets missed oh what a shame", it's the most engaging ECG revision you can find anywhere!

Liz Huynh, Med II

confessions

"A certain unnamed final year in a certain South West hospital only recently discovered that one should ask a patient to repeat "99" during the vocal resonance part of the respiratory examination. He had spent the last five-and-a-half years asking patients to repeat "69." Who knows what the hospital consultants think the uni teaches us during CCS sessions."

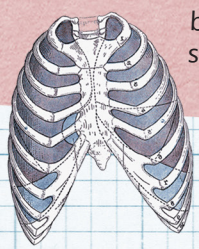
"I'm a virgin but every time my period is late, I get scared that I'm pregnant."

"Every time we learn an examination that requires us to take our shirts off, I train cardio, abs and diet heavily in case I'm in one of the videos."

"On my Facebook status, I like to post verbose stories about how busy medicine is for me because I don't think people had the chance to see my previous 50 similar statuses."

"I don't wash my hands when I leave anatomy pracs. I'm sorry."

"I learnt nothing about kidney disease because I was too distracted by how sexy George Mangos is."



THEY'VE GOT STYLE, THEY'VE GOT (A) CLASS: Fashion tips from your lecturers

Sue Britton
Sue works as a GP at the UNSW Health clinic, cycles to work and is a kickass Scenario Group facilitator. Here, she demonstrates how to brighten up an all-black winter outfit by accessorising with a teal patterned scarf and her own handmade jewellery. In fact, Sue makes all of her own jewellery!

Q: Are those earrings DNA-inspired?
A: They sure are!

Q: How do you make your jewellery?
A: Well it's very easy. I just get some aluminium wire and get a hammer to bash it flat and then bend it into shape by hand. The more you bend it, the better it looks. It's always more interesting if you don't make it too perfect. My friends are always very impressed when I make some for them as presents, but it's really very easy to do!

Gary Velan
Q: Which fashion faux pas do you hate the most in students?
A: Underpants showing above pants – only super heroes are allowed to wear their underwear on the outside!

Q: What is the best accessory a person can have?
A: A stethoscope draped jauntily over the shoulders.

Q: *What item do you think will never go out of style?*
A: On the basis that it is not possible for something to go out of style if it has never been in style, it's hard to beat the combination of sandals and long socks!

Ken Ashwell
Q: Which stethoscope colour is the most stylish?
A: I always prefer basic black. It goes best with beige and light blue.

Q: Which brands do you enjoy shopping from?
A: I am so fashion challenged that my wife just shakes her head when she sees what I pick. So she has pretty much decided to do the clothes shopping for me now. She knows that choosing what to wear in the morning is beyond my abilities, so she keeps it serviceable, uniform and bland.

Q: What is the most important accessory to own?
A: A set of coloured pens to sign any form, or mark any exam paper, whenever one needs to.

jumble

Unscramble the words and then rearrange the circled letters to solve the following clue:
"Protestors of Chinese Politics"

RTINOATMP

LETACIRBA

HTROPPE

HKRSMSII

Liz Huynh, Med II

Answer: MAO Inhibitors