IDIOGLOSSIA

THE UNSW MEDSOC MAGAZINE

2014 ISSUE 1









ATC UNSW MEDSOC

Welcome to Issue 1 of Idioglossia 2014, the official publication of UNSW Medical Society. As usual, we're showcasing highlights of the medical student experience, from plots hatched in lower ground Wallace Wurth to elective terms in rural Tanzania. The bumpy road in between, with its emotional highs and lows (like seeing a cadaver for the first time and the battle for ~~King's Landing~~ wellbeing), hasn't been forgotten either. A big thank you to all our contributors for making this issue possible.

For submissions to Issue 2 of Idioglossia or any other enquiries, please feel free to email publications@medsoc.org.au - we'd love to hear your suggestions.

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PRESIDENT'S REPORT

SEMESTER 1, 2014

Hello everyone,

We are pleased to report that Medsoc has experienced a strong start to the year with successes in all aspects our Society. From the outset, our team had the very clear and united goal of upholding our traditional strengths in running excellent events whilst redoubling our efforts to focus on student advocacy issues.

This is a particularly exciting year as it has heralded a level of engagement between students and Faculty that has not been achieved previously. By actively seeking out long-standing student issues and posing them to Faculty, our Student Representative team has worked relentlessly to bring constructive change. To see the great progress, one only needs to look to the: creation of an ILP/Hons Database, the introduction of a Phase 2 Anatomy workbook, the introduction of student Phase 1 CCS tutors and the plethora of curriculum changes that Faculty is undertaking to address the student concerns raised in the Australian Medical Council Accreditation Review. However this is only the beginning, with many more negotiations still in the works, including the reinstatement of cadaveric anatomy teaching for rural students, review of the distribution of content in Coursework, total review of the ICE assessment bank and the creation of focus groups for feedback on each course.

On the events front, we have been very passionate about continually improving annual staples (e.g. Amazing Raise, End of Course tutorials, Meet the Medics) and realising innovative ideas such as Sh'OutBack, a Doctors vs Students Debate, the creation of example OSCE videos which demonstrate the standard from P+ to F as well as an online Forum and Student Run Clinic. We have also strengthened our peer mentoring measures, continuing the first year mentoring program, strengthening our one-on-one program as well as implementing hospital mentoring between Phase 2 and 3 students, which has been well received by students.

Internally, one of the main focuses has been on public relations. The spam generated from repetitive promotional posts across multiple year groups was identified to be a significant issue for students and thus the UNSW Medicine Noticeboard was introduced to centralise all posts that were not relevant to a particular year group. We have also witnessed the introduction of empowering policies, such as "Pitch your Project", which allows any Medical Student to create their own event or project, with material support from Medsoc. Working with our SIGs has also been at the centre of Medsoc's attention with new measures brought in to foster their professionalism, training them in essential skills and maximise the learning experience provided for students.

It has been a promising year so far and Medsoc is set in an excellent position to advance in exciting, new directions.

Kindest Regards,

HENRY LIN
UNSW MEDICAL SOCIETY
PRESIDENT

JACQUELINE HO
UNSW MEDICAL SOCIETY
VICE-PRESIDENT

YARRABAH: PARADISE BY THE SEA

ANANYA CHAKRAVORTY (III)

If you're lucky enough to be on an 11am flight out of Cairns heading south, late enough that the ground-hugging morning cloud has lifted but not so late for it to have disappeared altogether, make sure you look out the window. As the aircraft makes its initial east-west ascent across the Trinity Inlet, you'll see a sprawling township speckling the tip of the skinny peninsula that looks back at Cairns.

Yarrabah, surrounded on three sides by the lapping waters of the Coral Sea, separated from Cairns on the fourth by the Murray River Ranges, disappears as suddenly as it appears.
Then you'll break through the ever-present cloud-line heading due-south, the southern stretches of the Great Barrier Reef somewhere below you, and Far North Queensland's "Paradise by the Sea" will be long gone.

*

Yarrabah lies 12 kilometeres east of Cairns, across the Trinity Inlet of the Coral Sea, but is separated from the city centre by 90 kilometres of road that winds through fields of sugar cane and spirals around the Murray River Ranges (traveled at breakneck speeds) in the shadow of Mount Yarrabah itself. It is home to Australia's largest mainland Indigenous community, with a township that fluctuates between 3000 and 4000, depending on the time of year.

In February of this year, I spent the last couple of weeks of the summer break on my first John Flynn placement in this very paradise, where every day of the monsoon is green and lush and the daily minimum barely scrapes 29 degrees. The entire community, approximately a third aged between 10 and 24 years, is serviced by the Gurriny Yealamucka Health Service, a half-way-house between Queensland Health and the Aboriginal Medical Service.

Like any place, it is impossible to separate the sociocultural and political state of the present from the past. Yarrabah's history is compellingly unique. Post-colonially, Yarrabah was originally an Anglican Church mission, however the deeds to the land were handed back to the people in 1985, and it is now a self-managed community under the Yarrabah Aboriginal Shire Council, a "Deed of Grant in Trust Community".

While the traditional owners of the land are the Gunggandji people, who finally won native title in 2011 after a 17-year-long battle, approximately 85% of the community are so-called "historical residents" – not traditional owners of the land, but descendents of displaced people who came from all over Australia, forcibly removed from their own land and homes. And so, though many people no longer remember where their ancestors came from, Yarrabah is far from homogenous – it is incredibly culturally diverse, an attribute which seems to be severely underappreciated by the relatively disinterested

mainstream on the other side of the Trinity Inlet.

One great-grandmother told me during her GP consultation – "the fact that we have so many languages says something, I reckon. I've got Sri Lankan, Scottish, Irish, and five different Aboriginal tribes' blood running through my veins, but no one knows or remembers anymore."

*

To dichotomise the Yarrabah experience, it is beautiful and frustrating in equal parts.

Fresh out of second year, I felt as though I learned more in the two weeks of GP clinic, the odd ED procedure and community home visits than I did in the last two years put together. I added rheumatic fever, rheumatic heart disease (with triple valve replacement!), hepatitis B, pilonidal abscess, an expanding keloid scar and chronic tophaceous gout of the most debilitating kind to my limited base of urban Sydney clinical experience.

I saw more young children receive the excruciatingly painful Bicillin injection by the wincingly sympathetic hand of the Irish nurse, Mark, than I ever care to again. I looked over the shoulder of a renowned gastroenterologist-cum-general physician with a side-interest in cardiology as he ran 25 echocardiograms in a row on his monthly travelling cardiology clinic. I spent time with incredibly skilled GPs from Kenya, Adelaide, Scotland, Sydney and rural Western Australia, who, by some baffling twist of globalisation, all call Yarrabah home now.

The beauty of Yarrabah is this. It is an extraordinarily close-knit community where all 3000-odd members know exactly where every other person is at any given time, where they live, what car they drive. It is land that the locals take incredible pride in, and it is beautiful. The people are friendly, welcoming and open. On a drive from Hospital Road down to the Mission you'll see kids running around by the watering hole, a couple of semi-wild horses, more than few dogs napping in the middle of the road, and if you're with a local, every face along the way will be familiar.

All it takes is for me to say "Hi, I'm up from Sydney" and I'm met with a "Gee! You've come a long way", and there is another friendly face.

And yet, as I sit with one of the GPs and see probably the tenth kid under five with abscess-ridden, rotting teeth, I ask the doctor why kids so young have so many dental problems. Surely, even if the kids aren't brushing their teeth, it can't be normal for teeth to degenerate so quickly with fluoride-treated water. He responds with a wry smile.

"You haven't been drinking Yarrabah water, have you?" he asks.

"I had a cup yesterday – why?"

"It's not drinking water!" he laughs.

If you stand on the western coast of Yarrabah, you can almost see Cairns, about 12 km across the other side, and where most people from Yarrabah do their weekly groceries. Yet, in a community this large, there is no safely drinkable tap-water. To stay hydrated, people drink soft drink, fruit juice and cordial. Considering that on the other end of the spectrum are extraordinarily high rates of diabetes, obesity and heart disease, the fundamental problem here is nothing short of ludicrous. How is it possible that the barrier to preventative healthcare in 21st century Australia, an hour's drive from Cairns, is fluoride-treated, drinkable tap-water? I am floored.

Later, I ask why I never have reception in Yarrabah, even though there is a huge Telstra tower that looms near the mountains.

"Ah yes. Ages ago Telstra managed to rent land from Yarrabah to build a tower that services all of Cairns, without servicing Yarrabah itself. There isn't really mobile reception here…" another doctor tells me. Without functional mobile reception, it is almost impossible to follow-up patients who might not (unsurprisingly) be glued to a landline at home.

***Photos** (previous page): The road from Yarrabah back to Cairns; The GP consult rooms, overlooked by the Murray River Ranges (this page, right): The Gurriny entrance on Hospital Road (next page): Lunch break at Back Beach, on the south-side of Yarrabah*

These are Yarrabah's frustrations – that the barriers to access and a standard of living most Australians would take for granted are ridiculously basic, barely a stone's throw away from the fourth most popular tourism destination in Australia.

*

Of all the experiences I had in those two weeks, this is one that moved me most.

It's a Thursday afternoon, my second last day of placement. A grandmother has come in with her 8-year-old grandson and prefers not to have me in the room during the consultation. I'm sitting outside the door which opens every 5 minutes as her peripatetic grandson wanders in and out of the consult room, disconsolately carrying a finger-marked iPad. He looks at me with neutral regard, ignoring my smiling "Hey!"and hands me the iPad.

"The volume isn't working," he informs me.

"How come?"

"There's probably something wrong with it," he replies, drolly. (Yep, I walked into that one). He kneels on the other chair as I fiddle with the mute and volume level. "You're not very good at using iPads, are you?" he muses.

" Nope." I agree. He laughs. We give up on the iPad and I get out my phone instead. "Do you want to listen to my music?" I ask.

"What's your favourite band?" he asks.

"At the moment, it's The National. Have you heard of them?" He hasn't, but he listens to I Need My Girl and Apartment Story anyway.

"Not bad. Not as good as Timberland though."

I chuckle, and our tentative friendship rolls on. He scrolls through Bob Dylan, Talking Heads, Lilly Allen ("she sings funny") and Beyonce ("why do you only have old songs?") and we sit looking onto the little garden that glows an almost fluorescent green in the afternoon sun.

The door finally opens and his grandmother emerges slightly teary. "Thanks for keeping him busy," the doctor smiles at me. As they leave, the boy winks a "seeya!" at me, and I wink back.

Later, on the daily drive across the Murray River Ranges back to Cairns, the GP tells me about the case. The boy's grandmother had come in about her grandson, stressed to the point of absolute distress about her inability to curb his unruliness, his unwillingness toward self-preservation, and his continual determination to put himself in dangerous situations.

She says he has something called "Oppositional Defiance Disorder".

"Unfortunately, almost a hundred per cent of these kids end up in jail," she adds. "Usually on a background of some kind of trauma or difficulty in their early childhood."

She tells me he is living with his grandmother because his father is out of the picture, and his early life with his mother was dominated by violence and abuse at the hands of various people.

"His grandmother just can't cope. He's such a handful that she's at the point of breaking down."

I think about a little boy who was friendly, inquisitive, engaged and respectful toward me, someone who bore no significance to him. A boy who probably suffered from undiagnosed Post Traumatic Stress Disorder, whose mental health was unsupported, who was surrounded by people perhaps themselves unsupported. I can't help thinking that there were so many points in this boy's life where a little more support, someone caring, experienced and trustworthy to talk to, could have made a lot of difference. And I can't help but question the therapeutic value of a diagnosis that seems destined to condemn an 8-year-old boy to hopelessness.

*

I am lucky enough to be returning to Yarrabah in only a couple of month's time for the second of four two-week placements. While I take with me barely 4 months' more clinical experience, it serves as a reminder that a medical education is as much a lesson in life as it is in science. ▪

SEEING FROM A DIFFERENT POINT OF VIEW

CARRIE LEE (I)

As someone who has been afflicted with the title of “four-eyes” for a good five years of my life, I understand just how important glasses are to my everyday life.

But do I really? Despite wearing glasses every day, I have rarely (if ever) spared a moment to consider how lucky I am to own one of the fruits of modern medicine to correct my oh-so-dodgy vision. To be honest, I spend more time whingeing about looking like a nerd, than simply being grateful for having access to affordable, readily available health services at all (though with Tony Abbot’s recent budget, that might be about to change).

When I travelled to Papua New Guinea (PNG) in January at the beginning of this year with the charity Hepatitis B Free, for the first time in my life I had a small glimpse into what it might be like to live without hope of access to affordable health care, or health care at all. Hepatitis B Free is a non-profit charity co-founded by my mum and a small but passionate group of volunteer doctors and nurses over the last 12 months. The community we worked together with, known as the Barai tribe, are a warm and generous-spirited people who work hard every day to survive in some of the most challenging conditions in the world: humid tropical rainforest amongst the remote hills and valleys of the Oro province.

No roads for miles and the nearest hospital about a five-day hike away, the Barai people live in a series of villages joined by walking tracks which take even the fittest and healthiest at least a few hours to travel. The villages consist of small wooden huts built on dirt foundations, many no bigger than the size of an average Australian bedroom. No running water, no electricity, and at peak times, only one or two health care workers to assist a population of over 3000, most of whom are children.

In both July and January, Hepatitis B Free ran free community health clinics in a few villages, with the primary purpose to provide vaccinations including Hepatitis B, as well as Pentavalent vaccine for children (containing Diptheria, Tetanus, Pertussis, Hepatitis B and Haemophilus influenza Type B). In addition, the teams worked closely with community health care workers to test for Hepatitis B prevalence, and treat

Photos *(this page, left): Young children waiting patiently at clinics in the village Tahama (this page, below): Young boy with his family after receiving a walking crutch for his limp; Young girl poses for a photo in Tahama*

as many presenting ailments as possible. Malnutrition, skin ulcers and malaria were amongst some of the conditions that we saw, and I am still lost for words at how so many live with such basic needs left untreated.

So how do glasses fit into this picture? During their first trip to PNG in July 2013, the team noticed people with vision difficulties, but with limited access to even basic first aid, they had no hope to reaching optometry services. After returning to Australia, the team hypothesised that they could collect used glasses from anyone they knew which could be distributed next time at the community clinics. I piloted the project at my high school, along with a friend who expanded the initiative to her church, a volunteer optometrist sorted through and measured the refractive error for about 100 pairs, and thus the Glasses Project was born. At the January clinics this year in PNG, we were able to estimate and distribute these glasses to the community. It was incredible to see the faces of the people light up, the faces of the elderly cracking into a smile as they saw the world again in clearer view.

Imagine the difference that an old pair of glasses lying dormant around your house could make to someone overseas! The Glasses Project has been so successful in expanding to other high schools around Sydney that we are bringing it to UNSW. This is your opportunity to do something that will bring about positive change to the lives of individuals and communities.

Everyone knows someone who wears glasses, and many of us wear glasses ourselves (especially in the era of technologically-induced eye degeneration). We were lucky enough to be born into a country where medical services are free and accessible. And yet, health care and vision shouldn't have to be a luxury. The question is: will you do something about it?

Bring in your used prescription glasses to support communities like the Barai tribe. There will be a collection box at MESO available until the end of this teaching period. Share the vision! For more information about Hepatitis B Free, visit http://www.facebook.com/bfreebawarebwell or contact pnghepatitisbfree@gmail.com. ▪

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CODE GREEN WEEK

AMANDA ZHOU (IV)

Climate change has been an international concern for quite some time now. Over the decades, the polar bear cemented itself as poster girl/boy/bear for the movement, while flumes of smoke erupting from the chimneys of factories (and Gina Rhinehart) became the face of the bad guy. Climate change has been painted as an environmental issue, an economic issue, a VERY political issue. But as politicians um and ah about whether climate change is real (PS. it is), as they remove carbon taxes, and as they twiddle their thumbs considering the best option to not lose electoral votes, they feed a climate of inertia, and as the situation worsens, climate change is being increasingly recognised as a major health issue.

In the Lancet itself, climate change was touted as "the biggest global health threat of the 21st century"[1]. Given that in 2003 heatwaves caused 70000 excess deaths in Europe, and the 30-fold increase in global dengue incidence over the past fifty years[2], there is no doubt that it is an enormous public health problem that needs to be urgently addressed to prevent further morbidity and mortality. The predicted consequences of lack of action are many-fold as shown below. They include a further 20-25 million malnourished children under 5-years-of-age, 200 million more displaced migrants

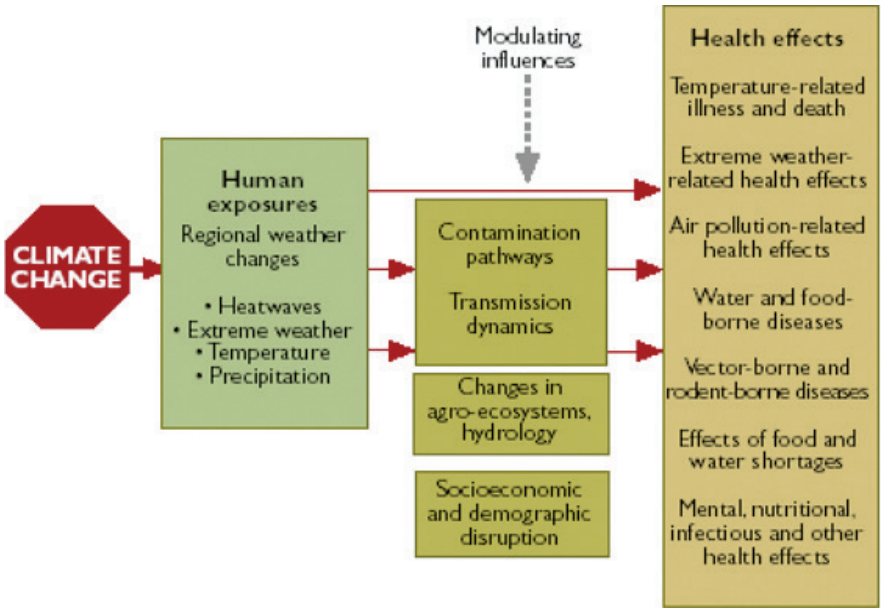


Figure 1- *Pathways by which climate change affects human health[4].*

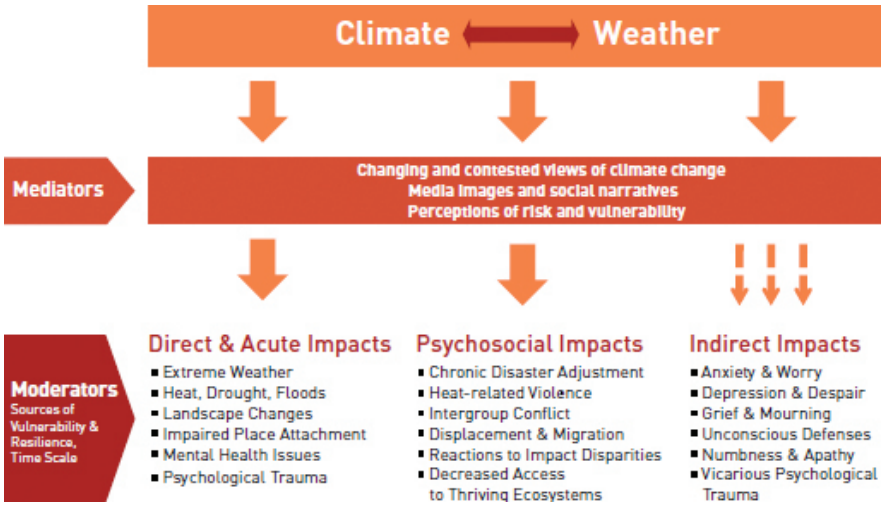


Figure 2 *-The psychological impacts of climate change and extreme weather[5].*



by 2050, violence and conflict[2, 3]. Unfortunately, it is the most vulnerable in society, those without the resources to cope, who will be the hardest hit- that's children, the elderly, coastal communities, rural communities, and developing nations. Self-harm and suicide rates have so far risen by up to 8% as a result of droughts and heat waves[3].

SO... CODE GREEN WEEK?

To reignite the issue, MedSoc and MSAP teamed up with Oxfam, AYCC and the SRC for Code Green Week, 7-11 April. A jam-packed week of events aimed to re-frame, re-introduce and re-empassion! Oh, and recycle, of course!

Thanks to everyone who participated in the week, whether you

- Put your thumb on our Green Thumbs banner (FYI: this got delivered to our local federal MP- yahooo!)
- Popped by for delicious free sustainabili-tea or soup
- Decked yourself in green
- Came to our speakers event and learned about your most important patient: climate change
- Joined us for treevia and/or the recycling party
- Just liked our infographics on facebook!
- All of the above!

A huge thank you to the Code Green Team (Bianca Galgut, Richard Lin, Merry Lin), MSAP exec (Annie Unsworth, Pasan Pannila, Carrie Lee, Regina Hong), MedSoc Socials/Charities (Meydene Ong, Sam Baumgart, Cecile Pham, Evan Browne) and all volunteers for making the week a success!

HOW CAN YOU GET INVOLVED AND DO SOMETHING ABOUT THE PROBLEM?

There are a variety of groups you can join which all fight for the same cause. The most relevant for you as a medical student at UNSW are Doctors for the Environment Australia, the SRC EnviroCollective, AYCC. But simplest thing to do is email me at amanda.zhou@unsw.edu.au with your interest and I'll keep you in the loop! ▪

[1] A. Costello, M. Abbas, A. Allen, S. Ball, S. Bell, R. Bellamy et al., 'Managing the health effects of climate change', The Lancet. vol. 373, 2009, pp.1693-1733

[2] D. McCoy & N. Watts, 'Climate change: Health impacts and opportunities- A summary and discussion of the IPCC working group 2 report', The Global Climate and Health Alliance, 2014

[3] The Climate Institute, A climate of suffering: the real cost of living with inaction on climate change, The Climate Institute, Melbourne & Sydney, 2011.

[4] World Health Organization. 'Climate Change and Human Health Risks and Responses Summary', 2011, <http://www.who.int/globalchange/summary/en/index2.html>, accessed 23 May 2014

[5] T J Doherty & S Clayton, 'The Psychological Impacts of Global Climate Change', American Psychologist, 2011, vol. 66, no.4, pp.265–276.

CONFERENCE REPORT: ASOHNSAM

JACQUELINE HO & TOM PALESY (V)

ASOHNS ASM is the annual scientific meeting of the Australian Society of Otolaryngology, Head and Neck Surgeons, and this year, was being held in Brisbane. We had the lucky opportunity to each be selected for both oral and poster presentations up in Brisbane, reporting the results of our honours research years. We'd submitted the abstracts not long after we had finished our manuscripts - summarising the results of one year's worth of work.

So along with hundreds of other ENT surgeons, we packed our bags and flew up to find out the latest of what was happening in the field - and hopefully teach a few people ourselves. Each person we met was surprised to find that we were in fact medical students attending the conference, and were even more surprised when we told them that we would be giving oral presentations.

Presenting at a conference is much different than presenting to the Honours seminars. Whilst no one is marking you to determine a grade, you are standing there in a room filled with people much more knowledgeable and much more experienced than you. You may be tagged the end of a session with the most renowned consultants speaking before you, or you may be the one to start the session - daunting either way. Not to mention that if you screw up here, you're doomed to never enter the field. Despite all this, in the end, you are the expert and you're the one who knows the most about the project, no matter the questions that they may ask. Our presentations went well, and we were commended by several people afterwards. It's a really nice feeling.

There were some great plenaries and workshop sessions throughout the conference, from 3D imaging, the future of ENT as well as Ian Frazer talking about HPV and Oropharyngeal Cancer. We found that we were now able to critically appraise different research papers and presentations - something we were definitely unable to in first year - and that made it much more interesting.

One of the more interesting parts of the conference was a breakfast session on the use of ultrasounds. Not only did we have hands on experience of using ultrasounds and identifying the different areas of thyroids and vessels (on patient volunteers), but learnt how to do ultrasound guided fine needle biopsies (on models) - something that they'd never teach us in medical school.

The conference concluded with a gala dinner (after going on the Wheel of Brisbane, with views of the city) wherein which we shared our table with some NSW based consultants. This included a discussion on current medical student admission into university, why consultants question students (and why do they never ask questions we know the answer to) and much more. The night was capped by some singing waiters, belting out opera classics.

This conference wrapped up a successful research year and it will be interesting to see what happens following from publication of our research. Overall, attending a conference and giving an oral presentation has been a valuable experience, and one that will prepare us for future endeavours in medicine and research.

OUR RESEARCH

Jacqueline Ho

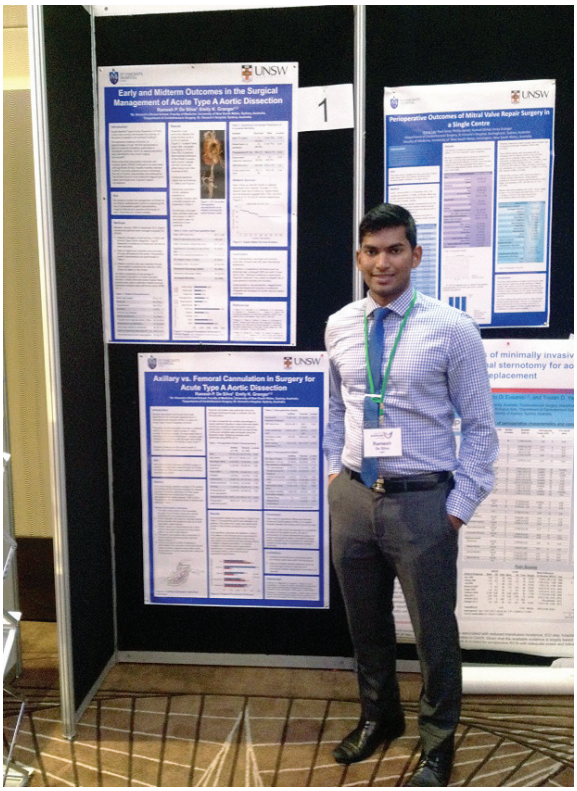
Chronic rhinosinusitis (CRS) is a heterogeneous disease defined by inflammation of the paranasal sinuses, affecting 8.7% of the population, however its pathogenesis remains unknown. This study looked into these newly discovered cells, known as group 2 innate lymphoid cells, which are thought to activate TH2 cells in CRS and other TH2 diseases such as asthma. This study found that these cells were associated with an increase in eosinophils and other markers in the tissue. This has implications for our understanding of CRS and TH2 diseases and may possibly impact future management.

Tom Palesy

External nasal valve dysfunction (EVD) is a common cause of nasal obstruction. There has been very little objective assessment of the changes in the nasal airway following surgery to correct EVD. This study found that functional rhinoplasty for EVD significantly reduced the collapsibility of the nasal airway (alongside significant subjective improvement), but conversely had little impact on the cross sectional area and nasal airway resistance. This has implications for understanding the dynamic changes of the nasal airway following EVD surgery. ▪

CONFERENCE REPORT: HOUSTON AORTIC SYMPOSIUM

RAMESH DE SILVA (V)



The Houston Aortic Symposium is a 3 day conference on the frontiers in cardiovascular disease. Chaired by leading clinicians at the Memorial Hermann Heart and Vascular Institute, Houston, TX, Professors' Safi and McPherson, the academic program covered the breadth of cardiovascular care, from Dissection and Aneurysm to management of complex Peripheral Vascular pathologies. I was privileged to be invited to present a research poster at this conference on the 'Management and Outcomes of acute Type A Aortic Dissection at St. Vincent's Hospital,' a project I completed as part of my B.Sci (Hons.) thesis. During my time at the conference I was able to learn about upcoming incredible advancements in my research field such as the development of minimally invasive vascular interventions for complex aortic catastrophes. My highlight would undoubtedly be the opportunity to meet and lunch with world renowned pioneers in Cardiovascular Medicine such as Prof. Neinaber from Germany. I would like to thank both the St. Vincent's Department of Cardiothoracic Surgery and UNSW Medical Society for supporting my attendance at this highly educational conference. ▪



ELECTIVE: DAR-ES-SALAAM, TANZANIA

NIYATI CHAUKRA (VI)

This placement was challenging and rewarding. The two-week paediatrics placement involved attending paediatric and neonatal ward rounds and daily neonatal and paediatric physical examinations on the ward. During my one-week obstetrics placement, I assessed women in labour and delivered babies, which was incredibly hands-on and eye-opening. The one-week placement in a remote village involved experiencing the village lifestyle in addition to helping in the clinic. We were especially engaged in the antenatal and neonatal clinics.

Despite expecting poor hygiene and lack of resources, the actual experience was more confronting than anticipated. There were insects and spiders on patients' wounds, and on beds and equipment (including "sterile" surgical equipment). Needles would be reused on the same patient after being left on the bed for some time. There were stains from bodily fluids on the floor and beds. Bed shortages often resulted in 2-4 patients per bed. I was able to appreciate the high quality healthcare environments that we have in Australia and the significance of the OH&S and hygiene practices that we have employed.

Furthermore, tests that I was accustomed to calling "simple laboratory and imaging tests" (e.g. haemoglobin levels, ESR, chest x-rays), would take several days to be returned as results. Thus, most patients were diagnosed on clinical findings. This certainly inspired to sharpen my observational and clinical skills, as I realised how dependent I had become on results of investigations. Unfortunately I witnessed countless incorrect diagnoses. For example, a very unwell child was clinically diagnosed with malaria, and then meningitis, but then finally was diagnosed with acute leukaemia when blood films returned 4 days later.

Patients were expected to purchase medical supplies and medication from the pharmacy to receive treatment. In the labour ward, women had to bring in their own sheets, gauze, syringes, needles, Syntocin vials, etc. Patients who were unwell often presented very late due to the high cost of health care to patients (e.g. in septic shock) and many hospitals unfortunately do not have the resources to aggressively treat such conditions successfully.

What I was definitely not prepared for was the way medicine was practiced. Doctors would treat patients as far inferior to them, and there was no respect given to their autonomy or privacy – they were disempowered. Doctors would often perform exposing physical examinations without consent, especially in the antenatal ward. I was very uncomfortable with this, and I became acutely aware of the importance of the practices and legalities in Australia. Through observation of the doctors interactions with the patients, I was aware of my negative reaction to their bedside manner, which compelled to reflect on my own behaviour and attitude to patients.

The most shocking aspect of the medical culture in this placement was attitude to health care. Medical staff often abandoned their responsibility of patient care or constantly sought to pass it on to someone else:

- A young girl was spiking fevers of 40 degrees C and had excruciating arm pain, after 4 days of admission. Incorrect cannula insertion and lack of reporting meant that the IV fluids were draining into her skin and had

caused a massive cellulitis. Furthermore, staff showed no urgency in ordering high-priority laboratory tests and administering immediate antibiotic therapy.

- In the sweltering summer heat, fans over the nurses' station were constantly operating, where as the fans on the ward were "broken", with no plan to repair them.
- Patients would often be lying in their own urine or faeces, and staff refused to help clean them up, casually informing us "that's what the relatives are for". This also applied to patients were who were hungry, thirsty, in pain, or who had fallen out of their bed. This appalled my peers and I so greatly that we cleaned up the patients and their bed ourselves.
- Some patients were even left to die (e.g. a young woman in septic shock) if they were not able to afford their treatment.
- Aggressive delirious patients would have hands and ankles tied to the bed with some thin rope, which would be tied so tight that it would cut into their skin and impair circulation.
- Women in labour were told off (and often slapped) by staff if they cried or screamed loudly, and within minutes of childbirth they were sent on their way (walking) to the post-labour ward. Pain relief was not an option. Anaesthetic was poorly administered during suturing and women were often in immense pain.

This was a huge moral issue for me – how could staff claim to be providing health care, when they were not even showing any care or respect for the basic needs of a person? This really made me contemplate on the responsibility that doctors have, and also the motives behind wanting to become a doctor; I realised that a crucial and essential element must be the desire to help people and end suffering.

I am now able to recognise that simply providing resources and funding will not fix the situation there. In fact, I have seen the staff at the hospital sell supplies provided by foreign students and staff, such as boxes of gloves and neonatal masks. Re-training and re-education of medical staff is crucial for improving health care and providing sustainability. Current successful initiatives (e.g. eonatal and paediatric vaccination and provision of anti-retroviral treatment for HIV in urban and remote areas) need to be expanded and integrated into the medical culture.

The harsh reality of the patients' experiences there in Tanzania really allowed me to appreciate the patient care here in Australia. I query whether the enormity of the burden of disease and disadvantage in Tanzania has made the health system "immune" to it. The disparity in health care also deeply troubled me and motivated me to help bring better care to disadvantaged populations, both in Australia and abroad. ▪

PRACTICAL ASPECTS OF AN ELECTIVE IN RURAL TANZANIA

GRACE LU (VI)

Some things I would recommend after my elective in Teule Hospital, Muheza, Tanzania (Dec 2013). If you are travelling to a rural area, I hope these tips help to smooth the process of adapting to a different world, especially if you are not going with an organisation. I hope you enjoy the experience as much as I did. Some of the tips below will make a lot more sense in retrospect, once you have gone through it.

- "Pole pole" (slowly, slowly) is basically the national motto. Try to relax, and expect low productivity in hospital. Prepare yourself and go with the flow, otherwise you will go crazy. Excuses that people use: "tomorrow", or "no money", or "I will ask someone else".
- Put more music onto your phone/iPod before you leave (there are many long bus trips, weekends away with friends, lounging around).
- Bring muesli bars and snacks and tuna cans if you wish (there is a lack of meat, lack of non-perishable food).
- Girls BYO makeup, it is rare to buy.
- Bring your own scrubs (due to lack of sanitation don't wear your own clothes to hospital). Our hospital had no electricity or running water.
- Buy your own Swahili phrasebook (e.g. lonely planet guide) and a separate learn Swahili book.
- Learn the language and the numbers especially so that you can haggle.
- When haggling say in Swahili that you are students, not tourists. You may want to carry around an official document from your hospital stating that you are a student, and show this to the shopkeepers. This can help in getting local rates as opposed to "Mzungu" rates.
- Travel wipes are a MUST. There may be many days without showering
- Bushman's repellent is a MUST (or anything with DEET).
- Download currency exchange and language apps on your phone before you leave.
- If you like reading, bring lots of books on your kindle/iPad; there is a lot of free time. Things (including hospital work) tend to happen in a brief window in the morning when the sun is not so hot. From about 12pm onwards it is too hot to do anything, until about 5.30pm.
- For hospital theatre bring your own googles, cap and mask. At my hospital they reused disposable ones.
- There is not much you can book from Australia (in terms of trips, safaris etc.). In general it is much cheaper and easier to find contacts when you are there. Everything is found out through people and word of mouth, including bus timetables etc.
- Make friends with reliable taxi drivers who offer fair rates and make sure you get their mobile numbers.
- Mobile phone carrier: airtel is reliable and cheap, buy from the airport as soon as you come out. Top up with vouchers that are widely available.
- When bringing medical supplies through MSAP, it might be better to give the supplies directly to individual workers as opposed to being sieved through the hospital hierarchy. At my hospital they tended to get dumped in a storeroom because no one knew how to use them and in general people could not be bothered to sort the equipment. ▪

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AVADA CADAVER: MY FIRST EXPERIENCE WITH THE DEAD

WORDS **HELEN ZHANG (I)**
ILLUSTRATION **CATHY CUI (IV)**

’That’s right guys, you will be seeing cadavers on your first week!’ exclaimed Evan, the first year rep, beamingly on our first day of uni. Immediately, animated murmuring began to fill the lecture theatre. I turned to the friend beside me,

‘What organ is a cadaver?’ I whispered. She shrugged.

‘I dunno,’ she whispered back,

‘Someone always faints every year,’ Evan continued, ‘and it’s usually one of those tall, gangly guys.’

This cadaver organ was really beginning to mystify me. Soon, Evan moved on to other news for us first year medical students and my little conundrum was dropped for the time being.

A few days later…

‘A cadaver is a dead body, you idiot,’ snapped my other friend, ‘do you have NO general knowledge at all?’

‘W-WHAT?!’ I stammered.

A dead body on our first week? In no way was I ready for this. However, not wanting my friends to question my Med-liness, I immediately followed up with,

‘That’s… so cool!’

I had seen plenty of corpses before… in the form of rat dissections in Year 11 biology, images on the news and in movies. Seeing one in real life wouldn’t be too far from that. I hoped.

When the day finally arrived, I had managed to somewhat come to terms with the thought of seeing, perhaps even dissecting, a cadaver. Although I did not have much of an idea of what to expect, I was pretty sure I would be able to cope. After all, I wasn't the 'tall, gangly guy' who was fated to faint. (In fact, quite the opposite.)

Yet, when I strolled into the cold anatomy room, heavily fused with the acrid odour of formaldehyde, and saw the long, grey towels draped over the contours of a body, suddenly the breath caught in my chest and my legs froze mid-stride.

If confidence was a muscle that one could exercise, then at that moment I was experiencing severe and extremely rapid confidence dystrophy.

'Are you alright?' asked my friend,

'Yes… yes, I'm fine.' I laughed shakily, forcing myself to walk again as we took our seats towards the back of the classroom before the lesson commenced.

Soon, the words 'glenoid humerus joint, greater omentum, peritoneal cavity, proximal and distal phalanges...' began pouring out from our tutor's lips with incredible speed and ease. As I struggled to note them all down, I felt my attention continually being drawn towards the body on the metal bench. It seemed almost like another presence in the classroom.

At last, it was time to unveil the body. Cautiously, I drew closer to the bench. We stood as a small, tentative huddle around the cadaver. The sound of the ventilation suddenly became deafening. Our tutor scanned our faces before he slowly, gently pulled away the towel. The smell of formaldehyde intensified as a yellowy-brown, preserved male torso met our eyes, starkly lit by the stale lights. I felt a wave of vertigo pass through me.

Don't faint, I thought, don't faint.

A silence ensued as we let the sight sink in. When no one passed out, everyone seemed to let out a breath which they had not realised they were holding. Our tutor moved along the bench and began lifting away the next grey towels, revealing a leg, followed by an arm. Yet the more I looked on, the more absurd it felt for me to be afraid.

Before, I had only considered my own fears- perhaps of seeing a reflection of my own mortality laid out before my eyes. Probably because I have lived in such a protected, insular world, where my exposure to the concept of death was fairly limited to movies (a side effect of Voldemort yelling 'AVADA KEDAVRA!'), to confronting images relayed daily on the news until I had become relatively desensitised, to a distant, teleologic notion about my life. In short, nothing this real.

I realised too, that my lack of familiarity with, and the almost dehumanising effect of the term 'cadaver' had cushioned me from realising that 'it' was really 'him' or 'her'. 'Cadaver' was really 'human being'. Once living. Once breathing. Once seeing. Once feeling. Once, just like you and me.

It was a shell of full consciousness.

How much courage it must have taken for these people to consent to donate their bodies to the poking and prodding and inquisitive eyes of medical students. To give their bodies, despite the plethora of religious and sociocultural extrapolations about the unknown realms beyond death. To give away the one thing which they have possessed for their entire life. To give - literally - their all, to the future of medicine. To us.

As our tutor began to point to the various structures on the cadaver, which just a few minutes ago were only convoluted words to me, I felt my shoulders loosen a little as I stood a little taller and really began to listen.

This was never meant to be a fear-inciting experience. This was, and always will be, an immense privilege. A gift of a lifetime. ▪

GAME OF BONES

WORDS **EM JANSEN**
ILLUSTRATIONS **ELAINE NG**

Amidst a war that has been raging for centuries is the struggle for valour and wellbeing.

SYNOPSIS
Noble lords put themselves on the line in a ferociously nerdy battle of responsibility and suffering.

EPISODE 1: PREPARING FOR BATTLE
Banners in full flight, essential equipment in hand[1], I looked with wondrous eyes upon the fort in which I prepared to conquer; I speaketh of St Vincent's Hospital, in the quaint shire of Darlinghurst.

My road there was long and laborious; a one-hour commute from Campbelltown upon a wearisome cityrail stallion[2] would put any warrior on edge. Not to mention that my eyes had not closed last evening[3], for I had been tormented by thoughts of the upcoming battle[4]. It had also been many moons since I had sunk my teeth into sufficient nourishment[5]: Instant coffee and Migoreng are not adequate food to sustain a warrior[6]. Though I was fatigued, I shouldered my bag, put foot before foot[7], and made my way up t'wards yonder gate, prepared to lay siege.

EPISODE 2: THE SIEGE
The limp forms of casualties were already scattered before me. I nodded reassuringly to those who made eye-contact[8]. A warrior is always a warrior, and I choose to lead by example.

A messenger brings word of some administrative matters that I must address[9]. A new assignment?![10] Will this battle ever end?[11]

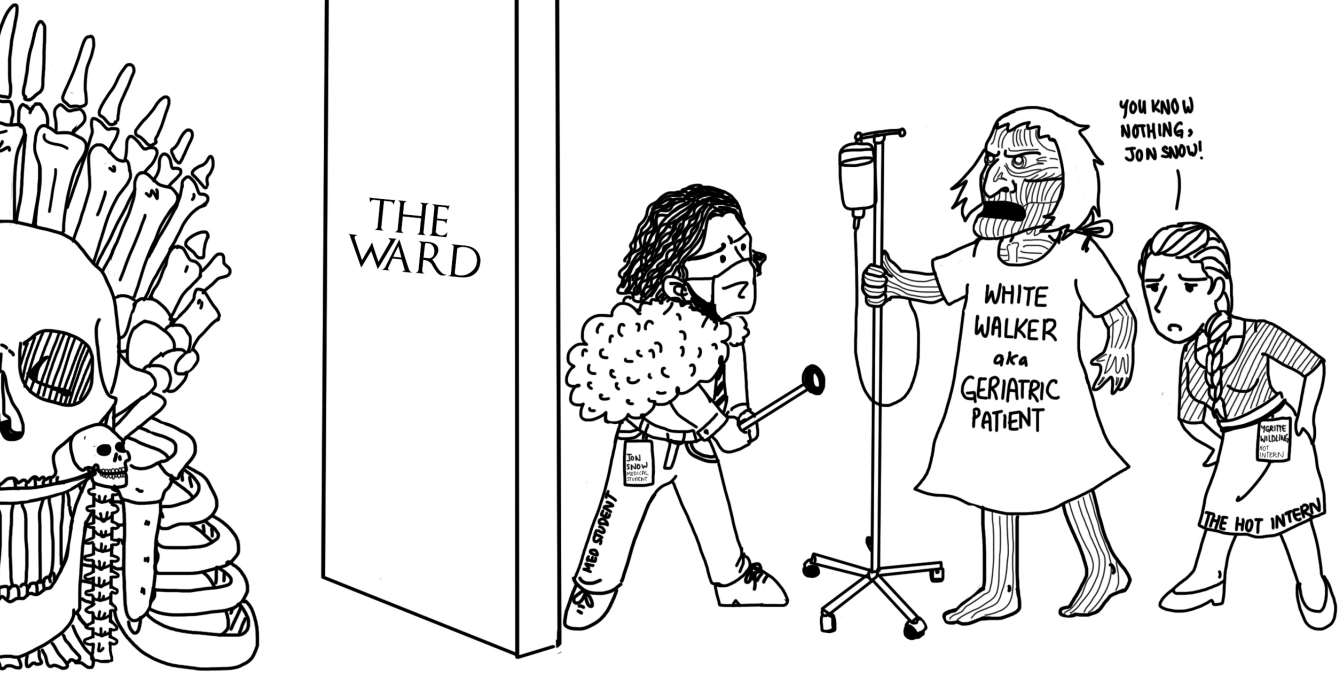
Word comes from Medfac (the throne and capital). Hospital allocations?[12] Another siege?! I preference, knowing that the stronghold of Medfac is far and impenetrable, and that their carrier pigeons will not return me an answer for many weeks to come[13].

My commander comes forth. 'Consultant', we call him[14]. He hands me my orders and reminds me of my duties. 'Now get it done'[15], he says, reminding me of my charge. I tell myself that I am a soldier, and I fly under the banners of greatness. I grit my teeth and get on with it.

EPISODE 3: THE OATH
I line up on the frontier, peers beside me[16]. All of them fine soldiers of esteem and valour, and I feel honoured to be serving with them[17].

We advance, united under a common banner. But what is it?! What cause could be so wor-

1. Pack your bag the night before.
2. Prepare for delays in your commute.
3. Get your 8 hours.
4. Don't ignore anxiety.
5. Eat.
6. Don't cut corners.
7. Attend as much class as you can.
8. Always remember the patient.
9. Try to be diligent in checking your uni email.
10. Start your assignments as early as possible.
11. Prepare for the fact that there are more to come- Be prospective.
12. Familiarise yourself with the clinical allocation policy, learn how to stack them. Start thinking about where you want to go in advance.
13. Medfac takes their time. Accept it.
14. Use correct titles for doctors.
15. Try to get as much done at hospital/uni as you can to save the extra work later.
16. Remember your friends, see them whenever you can.
17. Remember that you are NOT your friends; don't compare. Everyone has their own struggles.



thy? Who do we serve? Our Medsoc[18]? Our institution[19]? Some even clad in the orange of a veteran AMSA ranger[20]?

No, we stand proudly under the flags of medicine worldwide, founded on our loyalty to the Hippocratic Oath[21] and the Realm of Medicine. We are leading the fight against disease, and we are martyrs for the struggle of health[22].

I feel inspired, and wave my stethoscope in pride.

EPISODE 4: THE ART OF WAR

So much suffering, so many casualties[23]. I wonder how much one (wo)man can be expected to do, and if it will ever end[24].

The battle rages on and on, and part of me wished to collapse and be done with it[25].

Moreover, I check my phone (carrier pigeon/raven/messenger boy/smoke signals/whatever) and my beloved[26] hasn't yet replied to my plea for comfort and mother[27] asked me to collect milk on my way home.

So much stress! It affects me acutely![28]

'What are we even fighting for?!' I ask my comrades, the carnage of our plight making me churn in my insides. 'We are commanders on the frontier of the battle, and we are waging a war on disease', they reply. I muster at their words.

I am a warrior, and I should be leading the charge[29].

EPISODE 5: THE BATTLE DONE

How does one maintain hope in the midst of an endless battle? How does one earn glory when each small victory appears fruitless?

I look at my comrades, unwavering in dedication. I look at my casualties, I look at those recovered from their maladies, and I recall with a warm feeling in my belly the Oath under which I serve.

"…If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all humanity and in all times; but if I swerve from it or violate it, may the reverse be my life."

I clock off for the day, inspired by my work. I look back upon he small ground in which I have advanced[30]. I climb aboard my cityrail stallion and zone out to the sound of minstrels in the twilight[31], the battle done for today, looking forward to a nice glass of mead[32] when I get home.

Then I remember. Damn I forgot the milk[33]… ▪

18. Get involved with Medsoc.
19. Get involved on campus.
20. Get involved with AMSA. Definitely go to convention.
21. Read the Hippocratic Oath if you haven't, else find something that inspires you to push on when it gets rough.
22. If you find yourself affected by things you see at hospital, seek help.
23. Medicine is a long path, but it's not straight- you have MANY options.
24. Be aware of burnout and compassion fatigue. Use your time off and holidays wisely.
25. Practice safe sex.
26. Don't neglect your family.
27. Be aware of the signs of depression and other mental health concerns. Don't put off seeking help.
28. Know your responsibilities, but don't be too hard on yourself.
29. Don't be a martyr for the sake of other's health- you come first.
30. Acknowledge your achievements.
31. Get some downtime.
32. Keep alcohol to a minimum.
33. Know that stress is going to come and go, but battles aren't won by a single sword. Take it a day at a time.

MEDSOC SIG REPORTS

First event: "The Electrifying ECG"

CARDIOSOC

The University of New South Wales Cardiology Society (CardioSoc) is a student-run, not-for-profit organisation designed to facilitate the development of cardiology-related skills, interest and knowledge within the student community. We are proud to be affiliated with the Cardiac Society of Australia and New Zealand (CSANZ). 2014 will be another exciting year for CardioSoc UNSW with numerous events in store for students interested in cardiology. The ECG tutorial held on the 14th April 2014 was directed at medical students across all years. It aimed to introduce medical students to the ECG, provide an overview of how to interpret basic traces and identify common abnormalities, and apply these skills in different cases. The event was highly successful with an enormous turnout of around 100 students. We'll be continuing the year with popular events coming up including our 'Interventional Cardiology vs CT Surgery Debate Night' and 'Health Maintenance A course revision night'.

Radoncsoc Intro Night: Dr. Melvin Chin, radiation oncologist, speaks about the challenges, lifestyles and rewards of his medical career, and the decisions that led him to his chosen field today

RADONCSOC

Radiology and Oncology Society aims to deliver quality and informative teaching on these two disciplines to the student body. Our society's 2014 schedule began with our introductory night, Pathways into a Specialty, where a paediatric oncologist, radiation oncologist and radiologist discussed the requirements of obtaining a position as a specialist and their experiences with the profession. The audience found their differing perspectives on these challenging fields extremely insightful, and we look forward to providing more of these career-oriented talks next year. Next up is the two part Neuroimaging series joint-run with Neurosoc, which hopefully provides the basic training in radiology interpretation all medical students need to grasp in a clinical setting. We look forward to seeing you all in the second half of the year with further educational teaching sessions- radiological interpretation of fractures, the chest and the abdomen.

Mr Teddy is getting taken care of by the Ambulance Team at Albury.

PAEDSOC

It's been a great start to the year with so many students involved and attending PaedSoc's academic and charity events. Intro night saw great attendance with talks by Professor Adam Jaffe and Dr Adam Fowler. This event was followed up by a packed biomed theatre full of first years keen to demystify the study of embryology. The Teddy Bear Hospital has also seen a significant expansion this year. We'd like to extend special thanks to our rural reps and students who have organising multiple teddy bear hospitals, particularly across the Albury and Wagga campus sites. For metro schools, our volunteer co-ordinator Nadiah and the PaedSoc team have done a stellar job in reviewing over 100 applications for volunteers and visiting Rainbow Street Primary school on May 23rd. The students and children greatly enjoyed the morning fixing Mr Teddy up and learning about doctors.

So what's next? The next 6 months features BGD teaching for Phase 1, more teddy bear hospital sessions, a research skills night, global health night and collaborative events with other SIGS (paediatric surgery, and ethics in paediatric care). Keep in touch via our facebook page [UNSW Paedsoc] and think about getting involved on committee too!

Students in action at the Basic Life Support workshop

AICESOC

AICESoc has well and truly aced 2014! From our humble beginnings last year, our committee has grown; with new event coordinators dedicated to bringing our fellow students exciting and educational lectures, workshops and competitions. Covering three different specialties (Anaesthetics, Intensive care and Emergency medicine) is no mean feat, so it's sure to be an "intense" year to come! We kicked off 2014 with our Basic Life Support workshop, taught by our senior committee members. Aimed at Phase 1 students, the workshop was hugely successful and the participants came away with hands-on experience at managing various emergencies ranging from cardiac arrests to anaphylaxis and choking. Our Acute Obs lecture series was a 2 week-series which focused on ECGs, ABGs, fluid management and diagnostic imaging; topics which are essential in critical care medicine. The lectures were well-attended and ran smoothly thanks to our brilliant events and sponsorship teams. The rest of 2014 is set to be just as exciting with a convention-style Emergency Medicine Challenge in the works, as well as more lectures and workshops to come in semester 2! Check out our Facebook page at http://www.facebook.com/AICESoc for updates on our events – we'd love to see you all there!

IVF ethics night

O&GSOC

The Obstetrics & Gynaecology Society has many events lined up for this year for all medical students, not only those interested in O&G as a specialty. Our first event for the year was a panel of experts discussion on IVF ethics (in conjunction with BEAM). We will also be holding revision nights for BGD EOC to go over key concepts, and Phase 1 OSCE and Phase 2 ICE revision nights to consolidate and practice key clinical skills in obstetrics and gynaecology. We also plan to hold an Epidural Workshop in conjunction with AICESoc , as well as run the annual Women's and Children's Global Health with MSAP and PaedSoc. Our society is currently liaising with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to create a nationwide student society for those interested in O&G – keep your eye out for more details in the future! If you have an idea for an event that you'd like us to hold, please email us at oandgsociety@gmail.com and like us on Facebook (https://www.facebook.com/groups/OGsoc/)

GastroSoc Bake Sale

GASTROSOC

GastroSoc has made a remarkable start in 2014, with our new dedicated executive team. We recruited some fresh blood from all 3 phases. The first event, "Bake Sale", was a great success. All the delicious good-looking cakes created by our enthusiastic bakers helped us raise more than $300 for donation to Hepatitis NSW and supporting future GastroSoc events. The Gastroenterology Grand Rounds, presented by Dr Nicholas Williams from Sydney Children's Hospital and Dr William Bye from Prince Of Wales Hospital, were a perfect blend of paediatric and adult cases, common and rare diseases, as well as acute and chronic conditions. The audiences not only learned about the presentation and management of acute liver failure, gastrointestinal bleeding and inflammatory bowel diseases, but also gained an appreciation of a rewarding career in Gastroenterology. In the second half of the year, we are going to hold a clinical night to cover GIT cases for phase 1 and 2 students in the form of a mock OSCE. Later, we are looking forward to collaborating with RadOncSoc in the event "Abdominal Imaging". Please like our facebook page to keep track of our future events at http://www.facebook.com/#!/pages/UNSW-Gastrosoc/260905030754596.

PATHSOC

PathSoc is a UNSW Medsoc special interest group which aims to help medical students understand pathological concepts and promote pathology as a potential career. Pathsoc has been focusing on organising educational events that help students to understand pathophysiological mechanism of disease and its management principle. We created Basic Pathological Science tutorials for students in all phases to consolidate high-yield pathological concepts that are relevant to exams and future clinical or research applications. We also incorporated contents from the Royal College of Pathologists of Australasia Basic Pathological Sciences(BPS) exam and United States Medical Licensing Examination (USMLE) into these tutorials to further enhance its practicability.

Pathsoc has delivered two Basic Pathological Science tutorials; disorders of immune system and infectious disease. These two sessions covered high-yield concepts relevant to exams and clinic-pathological correlation seen in autoimmune and infectious disease. These concepts were further consolidated with case studies and review MCQs at the end of the session. Both of these tutorials were video conferenced to rural clinical campuses. Links to recording of the tutorial and slides are accessible in Pathsoc UNSW facebook page.

Surgical Instruments Night

Students handling a variety of surgical apparatus commonly used in theatre

UNSW SURGSOC

SurgSoc has had an extremely eventful year so far and has continued to provide many opportunities for surgically inclined students and also prepare everyone else for their surgical rotations. We started off with the deeply inspirational Mercy Ships Film Screening night, featuring the hospital ship which provides thousands in developing countries with free life-saving surgery. We were honoured to have the powerhouse film director herself, Madeleine Hetherton, the ENT surgeon in the film, Dr Neil Thomson, and the Managing Director of Mercy Ships, Alan Burrell, tell us about their rare experiences onboard and how we can get involved. For the aspiring General Surgeons, we have had the hilarious Dr Darren Gold speak on the Acute Abdomen. In a completely new style of event, Dr Francis Chu spoke on Appendectomies and Inguinal Hernias giving students valuable insight into the steps of the procedure and the thoughts processes of a surgeon. We also had a standout Plastic and Reconstructive Surgery double-lecture where Dr Damian Marucci (who always has excellent slides) spoke on Facial Trauma (Common ED presentations) while Dr Pouria Moradi spoke on Breast Surgery and his unconventional route into the specialty. Urology Night saw Prof Richard Millard and Dr David Malouf (immediate past President of Urological Society of Australia and New Zealand) speak on common urological presentations and procedures, and exciting technological advancements in urology such as robotics.

Our Surgical Education and Training (SET) night featured Prof David Storey giving a great introduction to the surgical training pathways and life in surgery. More hands-on skills workshops have included our first-ever Surgical Instruments Night, where participants rotated through stations where they could learn how to handle basic instruments and understand their applications in theatre. Our very popular Suturing Workshops have returned this year with a greater emphasis on tailoring workshops to different skill levels, with two Basic Suturing workshops in Semester 1 and the Advanced workshops in Semester 2. Our first Bone School of the year, made possible by Synthes DePuy, gave aspiring orthopods a great chance to practice hands-on basics with pins, plates and screws. A portion of the fees from all our workshops this year will go to Mercy Ships, as our chosen charity for 2014.

We have also been proud to support the inaugural Australia and New Zealand Introduction to Plastic Surgery Conference 2014 where a panel of industry leaders in craniofacial, breast, burns and aesthetic surgery spoke at Concord Hospital in May. Look out for more exciting events in Semester 2, including our highly anticipated Students Surgical Skills Competition and Sharpy's Surgical Series!

Careers Night and Launch Party

DERMSOC

DermSoc members are erythematous with excitement at the events we have planned this year! Our Careers Night and Launch Party held in March was the most anticipated event of the year, with four dermatologists sharing their personal journey into dermatology. The speakers came from varied backgrounds and experiences, with one experienced dermatologist, a second year trainee in the College (who was also a UNSW alumni!), and two dermatologists from the Philippines who are completing their fellowships in Australia. The students were amazed at the dynamic presentations, which were chocker-block full of tips for planning their future careers and how to make the most of your medical school years. DermSoc's Grand Rounds was held in May and was presented by a dermatologist who talked about a practical and concise approach to diagnosing common skin problems that are need-to-know for medical students and JMOs. The talk was fantastic in providing an introduction to dermatology, which is often not covered in depth in our current curriculum. Look out for our upcoming events, with our popular suturing workshop held in conjunction with SurgSoc to be held in a few months, and our mock OSCEs held right before exams at the end of the year!

Over 50 interested students attended the event to learn more about elective planning and experiences.

NEUROSOC ELECTIVES NIGHT

Sponsor: Brain Foundation

Speakers: 6th-year and ex- students (Samantha Saling, Patrick Teo, Mirna Hunter, Grace Lu)

This event aimed to guide and advise students on the unique opportunities available for medical electives. Previous medical students who had undergone prestigious or unusual placements across the globe were invited to talk about their experiences and impart some personal advice to younger year students. It was well-received with very interesting elective experiences covered, giving attending students a realistic expectation of the application process and what their medical electives can offer.

The "Bioethics Today" series, featuring rural teleconferencing.

BEAMSOC

The Bioethics and Medicine Society (BEAM) endeavours to make future doctors ethical, moral and philosophy education stimulating and challenging. As well as enhancing ethics' tangibility in student lives, it supports academic excellence through workshops and targeted course presentations. Our 'Bioethics Today' series is run through-out the year and is well-attended by all years of medical students, as well as a growing number of other-faculty and medical school students. Events run this year include, "Introduction to Ethics" which explored ethical principles, and focused on the role of religion in patient care. Our second event, "Design Your Own Baby" was run in conjunction with Obstetrics and Gynaecology Society and focused on the ethics of reproductive technologies. Upcoming events in this series include Resource Allocation in the Over-Populated World (August), Youth Mental Health (September), and End-Of-Life Controversies (October). Semester 2 will also see the introduction of an invigorating monthly lunch-time discussion. Our 'Academic Seminars' are highly sought after by older students, including the 'Mock Viva' (July) for Phase 3's preparing for final exams and the Phase 2 'ICE Workshop' (October). BEAM's success has also seen representatives requested to address the 21st Annual Conference of Professional and Applied Ethics. Please refer to http://bioethics.wix.com/beamunsw for further details.

Introduction to Opthalmology night

OCULUSSOC

During the first half of this year, Oculus Soc has hosted two great events to promote ophthalmology among our student community. In TP1 we held our 'Introduction to Ophthalmology' night. Professor Minas Coroneo and Doctor Ashish Agar spoke on why every intern should know the basics of emergency eye presentations and covering some interesting case studies of emergency eyes gone wrong. Coupled with a few pointers on how interested students could get onto the training scheme, it made for a fascinating and informative night for everyone.

In TP2, we held our Clinical Skills Workshop in conjunction with the Prince of Wales Ophthalmology Department and Designs for Vision. It was a great night with over 40 students coming to learn the basics of ophthalmic examination: direct ophthalmoscope, slit lamp and cranial nerves. For many students, it was their first opportunity to really get a handle on the slit lamp, the bread and butter of the ophthalmologist's work. It was exciting to see the wonders of the eye up close and peer through the lens to see the intricacies of the retina first hand! Following great reviews, we will be looking to host a similar workshop again in July for those who missed out this time round.

Our other events for this year will include: 'The Essential Ophthalmology: What every intern should know,' to be hosted by Doctor Matthew Ball, consultant ophthalmologist at Sydney Eye and St George Hospitals and 'Paediatric Ophthalmology' to be held in conjunction with our friends at PaedSoc. As always, all are welcome to attend!


GPSN Trivia Night

GPSN

GPSN (General Practitioners Students Network) is a student-run group dedicated to promoting awareness and interest in general practice for UNSW medical students. We kicked off 2014 with GPSN Trivia Night with fantastic turnout where students were introduced to upcoming GPSN events and engaged in fun trivia/activities. Our next event was Indigenous Health Night for which we had 2 great speakers increasing knowledge of Indigenous Health, how to tackle common clinical scenarios, and how medical students can become actively involved in supporting indigenous issues. GPSN has also been busy planning our next events such as Clinical Skills Night, Rural Health Night and a Sydney-wide GP Masterclass. We are looking forward to next semester and look out for us on the GPSN Facebook page for more information and updates!

MEDSOC BOOKSHOP

The UNSW MedSoc Bookshop enhances the UNSW medical student experience through the provision of essential learning resources and equipment at affordable prices. Any medical textbooks or items that we do not stock can be ordered in-person, over-the-phone or online, and delivered directly to your door. The returns generated from all sales are funnelled back into MedSoc to enrich your student experience.

This year the bookshop has remained a favourite donor of many MedSoc affiliated events and SIGs. We developed book packages for 1st years- both the Essential and Survivor packs, and promoted the most favoured Phase 2 and 3 textbooks. We have also developed relationships with other health science courses, including the Students of Medical Science Society. MedSoc Bookshop has had continued success with medical schools around the country, with our cost-effective products and delivery prices enabling increased accessibility. Direct sales at GP conferences have also continued to be successful marketing opportunities. Our plans include creating book packages for other health sciences courses, as well as re-introducing book packages for other medical schools. The MedSoc Bookshop Facebook page is updated regularly with interesting articles, as well as give-aways and discounts, so 'Like' us for the latest promotions.

Still figuring out #medlyf? It's now or never - package offers end after June.

SURVIVOR

$625 (RRP $800)

Crossman's Neuroanatomy 4th Ed.
Rang & Dale's Pharmacology 7th Ed.
Talley & O'Connor Clinical Examination 7th Ed.
Guyton & Hall Medical Physiology 12th Ed.
Mims' Medical Microbiology 5th Ed.
Larsen's Human Embryology 4th Ed.
Robbins & Cotran Pathologic Basis of Disease 8th Ed.

or

ESSENTIALS

$389 (RRP $519)

Talley & O'Connor Clinical Examination 7th Ed.
Guyton & Hall Medical Physiology 12th Ed.
Larsen's Human Embryology 4th Ed.
Robbins Basic Pathology 9th Ed.

UNSW MEDSOC BOOKSHOP

Where: Old Morgue Building, Barker St
Prince of Wales Hospital, Randwick NSW 2031

02 9382 2121 bookshop@medsoc.org.au

Open Mon, Wed & Fri
9am - 4pm

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