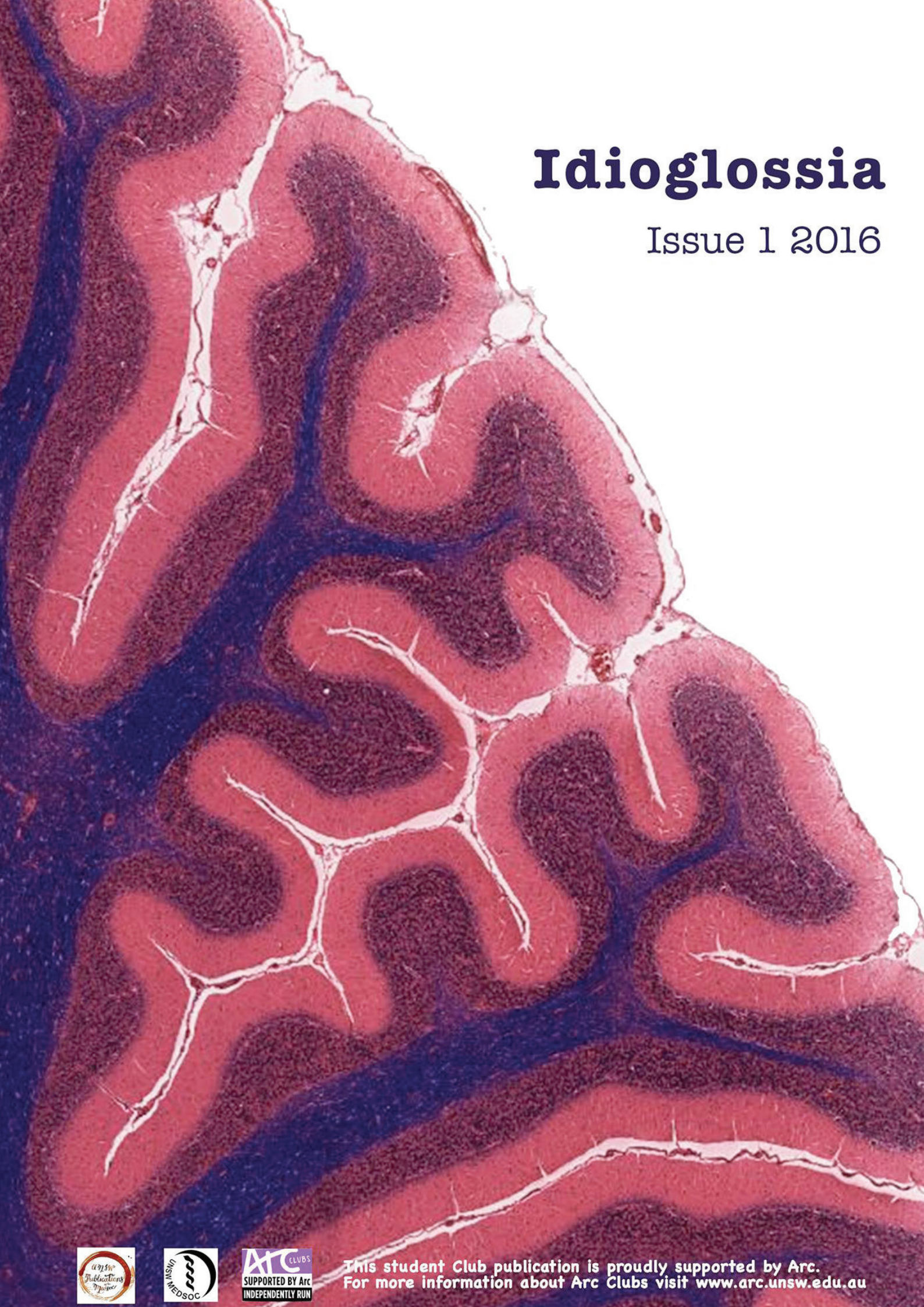

Idioglossia

Issue 1 2016

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Front cover histology image is courtesy of UNSW Virtual Slides.

Welcome to the first issue of *Idioglossia 2016*, the official publication of the UNSW Medical Society.

This is a very special issue, as for the first time in Medsoc history, Idioglossia has been printed in full colour! We hope you enjoy the new look as you browse through some recent highlights of our medical student experience: from placements in regional Tanzania to internship stories from one of our former Medsoc Vice Presidents to advocating for divestment, we are sure that you will find plenty of interesting reads.

We would like to give a huge thank you to all our contributors - without you this issue would not have been possible.

For submissions for the next issue of Idioglossia, feedback or questions, please email publications@medsoc.org.au or message our Facebook page, UNSW Medsoc Publications.

So without further ado, it's time to grab a warm drink, sit back, relax and let the idioglossia begin!

With love,

Helen and Lucy

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EDITING
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Sakeenah Wahab
Esther Wang

CONTENTS

PRESIDENTS' ADDRESS

74 Unami Rd, Randwick 21...

Oops! Not that kind of address?
Let's be honest... who reads the Presidents' Address anyway? Why would you, when so much more talent and coherence and laughs lie behind the folds of Medsoc's **inaugural colour edition** of ***Idioglossia 2016*** you are holding in your very hands!!!

Idioglossia is like another snapchat story to celebrate the vibrance and talent of our medicine cohort. Thank you to our amazing Publications team and their many contributors. Enjoy reading the stories, initiatives, and opinion pieces of some of our very own.

It has been a privilege serving your student body. Every single initiative has been the hardwork of every single one of your elected volunteer reps - THANK YOU to every council portfolio, subcommittee, SIG, and the great support from our affiliates MSAP, RAHMS, GPSN. We'd like to recap the **highlights** of the year so far!

Generally great things - our **Medsoc Membership Sticker Deals and Discounts** is a grass-roots benefits campaign to link you, our 1,700 students, to local businesses - giving cheaper meals, easier sign-ups and a pretty stellar to-do list when you're looking for a catch-up with a friend. We've become more transparent in the way we fund you (YES YOU!) in our **Conference Funding** review to celebrate and support your achievements. We're making **safer elections processes**, have specifically stated our **Community Standards for Online MedSoc Pages** and look forward to testing out a **centralised subcommittees** application process. We've been energised by **new events** e.g. paediatrics OSCE VIVA evening with special guest UK Paediatrician, author, and global health activist Dr Zeshan Qureshi.

To improve student wellbeing, we were proud to create the **MedSoc Women's Officer** position, which aims to make gender equity and the empowerment of women a central mission of Medsoc, and is already organising numerous education, networking, and workshop events. Furthermore, we're also in the process of creating a **UNSW Medical Students Bullying & Harassment Guide**! We've also released the inaugural **'Going Rural Guide'** with student testimonials of each rural clinical school, looking at academic advantage, cost of living and the lifestyle benefits of leaving the big city.

In Medicine Advocacy with Faculty, we've been hearing your concerns and have already been successful in improving: **Phase 1 & 2 OSCE feedback** release and grades breakdown, **Coursework Formative Mini-CeXs**, case report **assignment modifications** with more in-class presentations, and a working group to develop **short-quizzes.** We also split **ILP/Hons portfolios** into 2 specific positions to ensure focused representative for research year, and have negotiated release of **lit review assessment** grades and assessments. We initiated a faculty review to improve **Rural Campus Anatomy** and a big **Coursework Curriculum Re-design** proposal to advocate for better teaching of essentials in general surgery and medicine, and improved public health.

We're looking forward to continuing to represent you to our faculty and host amazing initiatives and events to improve your time seeing friends, learn about niche subjects and improve leadership skills.

While we do what we can to improve student welfare, **there's always more we can do to improve the lives of those around us.** Coping with the demands of being a medical student, a demanding course, juggling a million other busy co-curriculars, living with financial stress, feeling isolated from peers... sometimes life isn't easy and it's important to ask for help. We are, after all, family.
So share your study notes, shout your friend a coffee and never, ever be too afraid to ask someone if they're doing OK or just say 'hello'.

It's been a pleasure serving you on Medsoc. We hope we have been representing you as promised, and we look forward to the 2nd half of 2016!

Love,
Beryl and Ev

THE HUNT FOR DOCTORS

Bringing light to the NHS crisis, and why junior doctors in the UK are going on strike

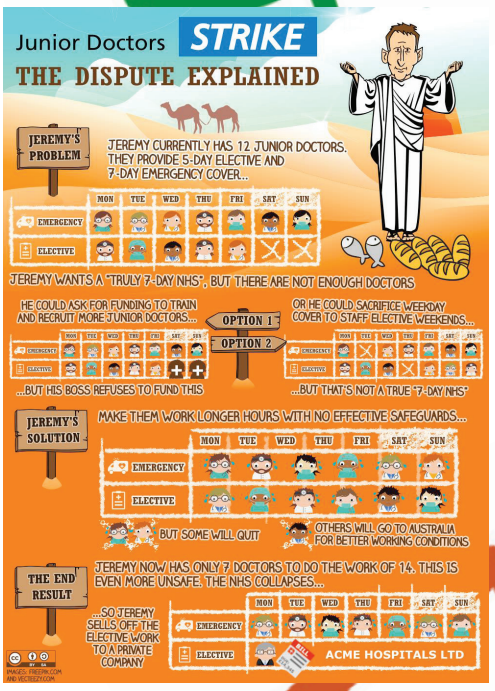
BY **CHRIS CHIU (III)**

The United Kingdom's National Healthcare Service (NHS) takes pride in its quality, efficiency, and accessibility, and was revered as the 'best medical system in the world' by multiple studies. Yet, just a little bit over a month ago, junior doctors in the UK went on a 48-hour full-scale strike for the first time in 40 years. On April 26th and 27th, all junior doctors pledged to walk out, and the subsequent gap in the provision of care was covered by off-duty consultants.

So what happened?

The center of the conflict lies in the new proposed contract for junior doctors (all those below consultancy) employed under the NHS. Currently, the NHS provides 7-day emergency service and 5-day elective (non-emergency) service. As part of the incumbent party's election promises, the NHS aims to provide a 'full 7-day service' under the new contract, attempting to provide both emergency and elective services everyday of the week. The proposed contract will also raise the average base pay for doctors by 13.5%. Sounds great, right? Here's the catch – there are significant changes in the rates and coverage of the unsocial hours payments (UK's version of Australia's penalty rates and overtime bonuses). Under the current contract, base pay for healthcare workers covers hours that are defined as 'social hours', i.e. Monday to Friday, 7am – 7pm. Shifts outside of these hours are compensated with an extra 20-100% of their base pay, depending on the banding for different pay rates and how 'unsocial' a doctor's week is, e.g. night shifts, back-to-back shifts, and 16+ hour shifts. However, under the new proposed contract, not only is the definition of what is deemed 'social' changed to encompass 7am-9pm, Monday to Saturday, the multiplier in banding unsocial hours also decreased significantly. This causes multiple issues:

1) The current system of unsocial hours payments act as a safeguard system against the overworking of doctors at unreasonable hours. This additional cost incentivizes the NHS to either arrange more reasonable rotations for NHS-employed doctors (rotas), or hire additional locum doctors to fill in gaps in rotas. The removal of this safeguard system will mean that junior doctors are now more likely to be rostered in unsafe and sporadic hours, which significantly impacts doctors' quality of life and potentially



creates negative clinical outcome secondary to factors including fatigue, chronic sleep deprivation, and shift work syndrome by overworked doctors.

2) The base pay for an intern in England is £22000 (~$45000 AUD), while the average pay is £37000. This difference in income is accounted for by the compensation through the multiplier from working unsocial hours. While the base pay sees an increase of 13.5%, the multiplier under the new contract is so significantly stunted that the average junior doctor will be expected to see a 30% effective pay cut.

3) The new contract is indirectly discriminatory against women, single parents, doctors with disabilities, and any other doctors who had to take time off work due to various reasons The proposed pay scale demands increased and intensive hours for any progression within banding system, and any time off work for doctors will not only put them on a lower pay scale than their peers, but their progression will also be hindered significantly. This potentially creates a statistical pay gap between male and female doctors that did not exist under the current contract, as reflected by WHO's Health Workforce Director and the government's own equality impact assessment.

As such, there is significant backlash within the medical community in the UK. After multiple attempts in negotiation between the British Medical Association (BMA) and the department of health, lead by Jeremy Hunt, a strike ballot was held in November 2015 with 98% voting for full strike action. Just a week ago on May 19th, a deal was finally agreed between the BMA and the department of health, and a revised version of the new contract will be voted on by members of the BMA.

Why does this bother us?

The UK's NHS and our Medicare system are both publicly funded, and they are both strongly susceptible to any cuts in government budget. What happens to the doctors in the UK can potentially happen to us in the future, and it is vital that we are aware of the situation happening to our colleagues in the UK. In fact, there is already significant political pressure in cutting the medicare budget. While the newly proposed GP copayment has been cancelled due to huge backlash, an independent review by the Grattan Institute has discovered that general practitioners are still receiving a effective 6% rebate cut through a 3-year rate freeze. As such, it is paramount that we remain vigilant in defending our rights, in order to ensure safe, responsible, and sustainable provision of care.

FOSSIL FUEL DIVESTMENT: WHY AUSTRALIA'S UNI STUDENTS ARE TURNING THE OTHER CHEEK

BY DAMIAN GILL (IV)

Students across Australia are staging bold actions at their universities to demand divestment from fossil fuels. Why do the issues of climate change and fossil fuel investment resonate so strongly with university students? It's about equality and justice, explains Damian Gill.

Student activism has never been so racy. Last Tuesday*, nine Melbourne University students stood atop one of their campus' grand buildings completely and unashamedly naked. Their stunt earned them national and international media coverage. Soon after, the group of students was making headlines again, risking arrest for trespassing by blockading every entrance to their university's chancellery.

A wave of similarly bold actions flooded several of the other nation's university campus' this week: at the University of NSW, 11 students occupied the Chancellery building for one and a half days, filling their time with a quasi-slumber party, meanwhile a giant banner was unfurled from the Chancellery building at the University of Queensland, and students at Monash University set up a mock oil drill on the university lawns. Each of these student groups were sending the same message to their University leaders: 'Divest from fossil fuels now', or as the Melbourne University students cheekily wrote on their exposed backs and bottoms, 'Drop Your Assets.'

The continual investment in fossil fuels is mind-bogglingly puzzling; we know that climate change is likely to be the greatest threat to public health in the future. If people and organisations do not invest in the tobacco industry due to its heath effects, then why do we invest in fossil fuels?

"If people and organisations do not invest in the tobacco industry due to its heath effects, then why do we invest in fossil fuels?"

Furthermore, the investment in fossil fuels is becoming not just a 'health hazard', but also a 'wealth hazard'. This was one of the reasons cited by Professor Ian Young, the Vice-Chancellor of the Australian National University, as a justification for their decision to divest approximately $16 million from the fossil fuel industry. In an opinion piece published by Fairfax Media, Professor Young questioned the future survival of the fossil fuel industry, predicting that in 20 to 30 years, the main industries in Australia "...will not be in producing fossil fuels." Amongst Australia's universities, this is rarely-seen foresight by a Vice-Chancellor on this issue. Indeed, it is ironic that most of the nation's universities pride themselves in their ability for forward thinking, yet inconceivably continue to invest in fossil fuels.

However, the message to divest is one that resonates nationally and worldwide.

To date, Australia has seen a number of local councils, as well as religious groups and superannuation funds divest from fossil fuels. Globally, whole cities, tertiary institutions and charitable organisations such as the Rockefeller Brothers Fund have done the same. The divesting campaign has been so enormous that an estimated $3.4 trillion has been divested from fossil fuels. This figure will only continue to grow as more organizations choose to divest. For instance, a fortnight ago a joint report by the Doctors for the Environment Australia (DEA) and the Climate and Health Alliance was released, which strongly encouraged the divestment from fossil fuels in the health industry.

Young people are increasingly backing campaigns and movements that espouse justice and reject inequality. This is evident in the current US Democrats' presidential nomination race, where Bernie Sanders is seeking election on the platform of economic and environmental equality. While he may not be leading the race between him and Hilary Clinton, Sanders is amassing a huge following of young people. According to exit polls from the recent New York primary election, Sanders had the support of 72% of voters under the age of 30 versus Clinton's 28%. It is reasonable to suggest that young people have a vision for the future – a positive future that progresses from dialogue to action, from inequality to equality.

Put simply, climate change and the unethical investment in fossil fuels is an issue of equality and justice. This was a point made astonishingly clear by Naomi Klein's 2014 film and book of the same title, 'This Changes Everything'(if you haven't seen the film yet, stop reading this immediately and go watch it). Throughout her film, Klein documents instances around the globe where a preference for the fossil fuel industry has led to the unforgiving destruction of sacred land and people's homes and livelihoods. This striking inequality is a reality for Australia's Pacific Island neighbours, who are under the greatest threat from climate change, with rising sea waters, despite those nations contributing very little to global emissions.

It is for this reason that students, impatient with the lack of action from their university leaders, have taken up the issue of fossil fuel divestment with such ferocity; their impact has been real. For instance, Yale University recently partially divested from fossil fuels after years of sustained pressure from staff and students. Other universities around Australia have also divested after similar actions from their university community.

However, the fight must continue. As the impact from such bold student actions are realised, and as more and more tertiary institutions divest, it will become harder and harder for universities such as UNSW to resist the wave of momentum.

I have been fortunate to be able to participate in these actions in my capacity as a member of DEA at the University of NSW. DEA supports actions which do not break the law. So far we've participated in a climate parade on campus that called on the university council to divest, and we protested outside the Chancellery building to elicit a statement from the university on the matter.

This issue is of particular importance to medical students; the personal impacts of climate change, if it's not controlled, will be devastating on our generation, but the effect of climate change on the health of others and of future generations is why we fight for a healthy environment.

"the effect of climate change on the health of others and of future generations is why we fight for a healthy environment"

The effort will be worth it, for as Naomi Klein concluded in 'This Changes Everything': 'What if global warming isn't just a crisis? What if it's the best chance we are ever going to get to build a better world?'

**This article was published on May 2, 2016, in the News Opinion & Commentary section of the Doctor's for the Environment Australia website*

Doctors for the Environment Australia

Doctors for the Environment Australia is a voluntary organisation of medical doctors in all states and territories. We work to address the diseases – local, national and global – caused by damage to the earth's environment. For example, climate change will bring to Australia an increased burden of heat stroke, injury from fire and storm, infectious diseases and social disruption and mental illness, whilst in the developing world it will bring famine and water shortage.

The medical profession has a proud record of service to the community. This record not only includes personal clinical care, but also involvement in global issues that threaten the future of humanity. We aim to use our scientific and medical skills to educate governments and industry, the public and our colleagues by developing educational materials such as Policies and Posters and by direct contact, in the endeavour to highlight the medical importance of our natural environment. To our patients we try to provide a role model in the care of the environment for this is part of a preventative health ethos.

For more information or enquires, please visit dea.org.au or fnd us on Facebook.

BACK TO THE FUTURE: LIFE AFTER MED SCHOOL

BY DR JACQUELINE HO (UNSW MEDICINE ALUMNUS)

Hi, my name is Jacqueline. I'll be one of the doctors looking after you.

Patient: "You're too young to be a doctor!"
Me: "Why, thank you." (Why do people keep saying this.)
Patient: "How long have you been working?"
Me: "A few weeks..."
Patient: "..."
Me: "But don't worry, I'm really good at cannulas!"

After 6 years of medical school, MD in hand, I am now an intern in a Sydney hospital. Not surprisingly, being a doctor is very different to being a medical student- and whilst I have learnt a bit from university and a lot more from self-directed learning, there's a lot that the degree doesn't prepare you for.

THE FIRST SHIFT

I was thrown into the deep end of being a doctor - starting on a relief term meant that the majority of my first term would be on after hours shifts. After hours involves looking after 2 wards of patients whom I did not know besides what had been written in the notes. I would be responsible for all the clinical reviews, prescribing medications and fluids, and doing cannulas for the patients, with a medical registrar on hand to help with very sick patients.

After a week of orientation and a week of buddying/shadowing, I was on my first shift as an intern. It was 8pm, and I received 3 referrals in a short space of time to see 3 different febrile patients in the midst of other clinical reviews. Now, I knew what I was supposed to do (according to my management vivas), but in reality, it wasn't as simple- I needed to prioritise who was the most unwell. I was overwhelmed, and whilst I was dealing with these patients, my list of jobs started building up. Come handover time, I had to apologise for not getting around to the other jobs on the list.

But a wise medical registrar reminded us that our role on afterhours was to keep patients alive until the next day. It sounds obvious, but re-charting med charts wasn't going to save a patient; reviewing hypotension, decreased sats, fevers or organising blood transfusions would. You learn fast on the job. By the end of my first term, I felt more confident in dealing with sick patients and knowing when to call for help but still cautious about my own limitations.

BEING A JUNIOR DOCTOR (THE WARD JOB)

When I started phase 2, I remember feeling more like a doctor, seeing patients every second day. And then Phase 3 came around and I was an 'almost-doctor', seeing patients every day, registrars playfully calling you 'doctor', but still with the safety of being able to say, "Oh, I'm just the medical student."

As the intern, you're an essential part of the team - you're holding down the fort- there from the morning to the end of the day. The consultant values your presence. The patient sees you the most of anyone on the team. You don't need to have your notes counter-signed. You buy coffee for the medical student. For most of us, this will be our first full time job, and with that comes exciting things... Like not being dependent on Centrelink.

Internship is all about learning on the job, understanding why certain management decisions are made and helping to put them in place. It's where you gain that core instinct of a well vs. unwell patient, where you explore and learn under the helpful guidance of your registrar and consultant.

You see generic presentations where you need to work out the differentials. You see different presentations of the same disease. And by actually managing these conditions, you learn so much more than you would from a textbook. You feel more confident dealing with situations, running your decisions by your registrar rather than asking them simply what to do.

You inevitably make mistakes and learn from them (like not making consults on a Friday afternoon... oops!). You may feel incompetent at times and not know how to deal with certain situations, but remember you've only just started working. And then there are days when your consultant praises what an awesome intern you are - this is the best feeling!

WHAT UNIVERSITY DOES NOT TEACH YOU

As a medical student, you might not appreciate how much teamwork goes into caring for a patient. Every day I'm talking to other doctors, nurses, care coordinators, social workers, physiotherapists, occupational therapists and pharmacists, trying to ensure the best care for the patient and getting them home.

But whilst we see patients get well and discharged home, there are always patients who don't get better. I had a patient who had made remarkable progress and just waiting to be transferred to rehab on the Monday. My discharge

summary was up to the date and the patient was looking forward to getting out of hospital. However, come Monday, they had deteriorated and suddenly had a very poor prognosis - they ended up being palliated. The rest of the team seemed so nonchalant about the situation (I guess they had seen their fair share of these patients over their careers) and my registrar noted quite rightly that this probably was the first time I'd cared for someone who was going to die. We can't cure everyone and there will always be patients who despite our best efforts won't make it through.

Remember that you should always look after yourself first - make your own health a priority, and this especially means your mental health. Get a GP. Talk to others when you have a difficult experience or just want to vent. Have lunch in the sun every once in a while (I'm sure I have low vitamin D). At the end of the day, remember to turn off your pager and forget about work until the next day.

"Remember that you should always look after yourself first - make your own health a priority, and this especially means your mental health."

You'll make great friends with your fellow interns, residents, registrars. I work at a great hospital, very well supported, it's so much fun going into work each day and seeing others in the corridor or elevator. You help others when they're busy and they'll repay the favour when you've got a massive list of patients. And when the week is done, you can sit and chill with each other at Friday Night Drinks.

And despite being in different hospitals, your uni friends are still there and you're all experiencing internship together. Our *Whatsapp* chat is continuously active, where we ask questions when we don't know what to do, or just recount funny, awkward or annoying stories and make an effort to catch up for coffee or dinner every once in a while- except for the depressing situation when someone's working a weekend. Oh, how I value my weekends now.

THE FUTURE

There's still a lot I have to work out - like when should I stop letting the registrar shouting my coffees, was that my consultant who just called with "No Caller ID" or am I just being paranoid (I'm pretty sure it was though), should I climb the 6 flights of stairs today and lots more.

I think that I'm doing a good job as a doctor. And I'm always striving to be better. You'll learn a lot from other doctors aside from actual medicine. I've worked with some amazing doctors so far and seen so many things that I hope to adopt into my own practice. They put the patient first - the consultant spending 20 minutes convincing a patient to take their medications despite running late for clinic, or the registrar taking an hour just to be by an anxious patient's side and reassure them during an awake procedure. I'm so fascinated about how much we learn and progress just working day to day. Every day, I feel more confident making different decisions. To think that in a few short years, I'll be a registrar and then eventually a consultant, making the big decisions.

Overall, being a doctor is amazing - you guys are going to love it. I love going into work each day. People used to tell me that interns were just glorified secretaries but I feel nothing of the sort. I'm helping people (like many say in their med school interviews) and making a difference. Seeing patients being discharged despite being so unwell when they were first admitted. There'll be days where you make mistakes and days where you have personal wins. But at the end of the day, hopefully you leave hospital knowing that you've achieved something.

TIPS FOR MEDICAL STUDENTS

- For our Phase 1/2ers, the medical hierarchy (from bottom to top): intern/junior medical officer (JMO), resident medical officer (RMO), senior resident medical officer (SRMO), medical/surgical registrar, consultant.
- Help out your intern when you can - I cannot say how much we appreciate it when we have a long list of jobs and have an extra pair of hands to take bloods. And you might get rewarded with a bit of teaching.
- Don't be afraid to ask questions - it shows that you're engaging with the term and we'll try to answer it if we can - or if we don't know, we'll ask you to look it up and present so that we can both learn
- You may have your heart set on a specialty in med school but that experience may be very different as a doctor - and you may even find that you love something that you never considered before! (I'm currently having this dilemma...) So keep an open mind!
- Know your limitations - don't be afraid to ask for help!
- Be keen!

LESSONS LEARNT IN THE IRINGA REGIONAL HOSPITAL, TANZANIA

BY GABRIELLE LEVY (IV)

The names and some details in this article have been modified to protect patient confidentiality. However, every effort has been made to maintain the integrity of their stories.

The Iringa Regional Hospital in Tanzania provides health care services to a population of over 1.5 million individuals. The three weeks I spent volunteering as an undergraduate medical student at the hospital was the most eye opening, beautiful and shocking experience of my life.

I encountered patients suffering from stage four AIDS, Tuberculosis, Typhoid, severe malaria and extremely rare forms of pneumonia. There were many times where I remembered learning about certain diseases or infections in lectures at UNSW, with the lecturer introducing the disease with, "This is so rare that you will never see it in your life." But then there I was, staring eye-to-eye with a patient suffering from a disease that in Australia, doctors would only know how to treat through textbooks.

Having returned from Tanzania, I now struggle with the challenge of articulating the horrific health inequalities that I witnessed through words that cannot do justice to the power of what my eyes have seen. The following three patient cases are my attempts in conveying both the sadness and beauty that I witnessed and underscore three powerful lessons that have shaped my newfound understanding of medicine.

ELIA

I first saw Elia, aged 25, when he was admitted to the Internal Medicine ward with astonishing oedema on his lower limbs and massive blisters enveloping his feet. A bucket lay under his bed with more than a litre of thick blood that he had vomited up. I remember the Tanzanian medical students crowding around his bed in awe, each competing for a diagnosis that would best fit the patients' presenting complaint. The next day my supervising doctor, Sazu, diagnosed him with leukaemia. With only one doctor responsible for up to 50 patients, specifically paying special attention to any single patient is a rarity. Accordingly, when I saw Doctor Sazu pause, her face crumbling with despair, instead of just writing her notes and moving on to the next bed, I knew that his case was dire. She informed us that Elia was in urgent need of a blood transfusion and took us to the hospitals' blood bank. The mere fact that she personally went to get the blood herself amazed me, amplifying the motto 'if you want to get something done, do it yourself,' of which she personified. When we arrived to collect the blood, we were told that there was no blood available. In the entire Iringa Regional Hospital, there wasn't a single blood bag available. My heart sank.

"A bucket lay under his bed with more than a litre of thick blood that he had vomited up."

"What happens if he doesn't get any blood?" I naively asked. Dr. Sazu reluctantly responded,

"There's nothing much I can do for him now."

Determined to find Elia blood, my colleague and I went from ward to ward, asking medical students and doctors with appropriate blood groups to donate to this dying 25 year old patient. Most of them responded with the same reaction, laughing,

"Do you know how many patients I have right now who are also in urgent need of blood?"

My heart sank even further. Here we were in a hospital, a sick patient and an accomplished doctor with a correct diagnosis and a manageable treatment plan, yet we didn't have any of the necessary resources to save his life- because this was a third world hospital, where surgeries can be canceled due to a lack of gloves, and cannulas were often inserted without any antiseptic. I saw at least one case like this every single day of my placement - literally watching people die in front of my eyes to preventable diseases, infections and injuries.

FLORENCE

During ward rounds in the Paediatrics ward, we encountered Florence, an extremely sick 9-year-old girl who presented with a highly inflamed swelling that protruded from her right cheek. The cause of this swelling, and the multitude of other symptoms she presented with, was idiopathic. The paediatric doctor, Brian, ordered a full blood count immediately. The medical student in charge of Florence expressed that this would be impossible. Like the majority of the patients in Iringa, the girl came from a family that was poverty-stricken, and her parents could not afford the price of the investigation. The doctor shook his head and insisted on the urgency of the investigation,

but the family still could not afford it. The team accepted this, being accustomed to most of the patients not being able to afford the required investigations, even when it was the only gateway to saving their life. The team prepared to move onto the next patient, yet I stood still, in shock and confusion. How could we move on from this patient knowing that without ordering the full blood count this girl would probably die from an idiopathic disease? I asked the doctor how much the full blood count cost.
"Eighteen thousand shillings," he replied.
Eighteen thousand shillings was $12. And this family could not afford it.

One week earlier, we had taken the doctors out to the most expensive restaurant in Iringa as a thank you for their mentorship. At the time, the doctors stared at the prices in disbelief, refusing to order any food. However, after much insistence, we convinced them that while the prices were very expensive in comparison to any other restaurant in Iringa, in comparison to Australian prices, this restaurant was relatively cheap. Finally, they agreed to sit down and order. One of the doctors ordered a pork schnitzel. It cost 18,000 shillings. How carelessly we had paid for the piece of pork schnitzel. And here was a patient, amongst so many others in the same position, whose family couldn't even afford 18,000 shillings on a full blood count for their own child. All the meaningless junk I had bought for the equivalence of 18,000 shillings flooded my head: a string bracelet, a stuffed toy from the market, a snack, an accessory for my hair. One pork schnitzel.

I whispered to the same doctor that we took out for lunch if it would be okay to pay for the investigation for the sick child lying before us. I was fortunate enough to be with the doctor when he later gave the money directly to Florence's mother. She received the 18,000 shillings with disbelief, unsure of how to respond. Her eyes shone with gratitude and my heart sang. And all I did was pay the equivalence of one pork schnitzel.

JOY

Joy was a twelve-year-old girl suffering from stage four AIDS, severe malnutrition and a plethora of other health complications that were seemingly benign in comparison to the first two. She was 15kg, which was more than 30kg underweight. Joy was also an orphan, both of her parents having died from AIDS. She was left under the care of changing faces, a new carer with her every day.

I will never forget walking to her bed at the end of the ward. Her tiny face with big black eyes peaking out from under the covers as she watched us approach her bed. She lay cocooned in blankets, her bulging eyes staring blankly at the strangers surrounding her – blank, yet with a wealth of suffering well beyond her 12 years of life. Her skin was wasted, with purple lesions splashed across her limbs. Her prognosis was poor; it was clear that I was witnessing a patient who was on the brink of death.

The last time I saw Joy, she had been improving slightly from her medication. She was able to eat a tiny amount without a feeding tube, yet she still wasn't able to sit unaided. She was crying, begging the doctors to discharge her and let her go home. I couldn't help but wonder who or what she would be going home to, and it left me with an unnerving sense of hopelessness.

Doctor Brian told me that Happy was discharged after I left had Iringa. I wish I could have seen the smile on her face when she left. I asked what finally made them discharge her, and he told me that the reason she wanted to leave so badly was because she just wanted to go back to school. All she wanted was to go learn. How amazing is it that a 12 year old girl, with no parents, no more than a 5-year prognosis, and so much misfortune in her life, had the will and strength to carry on due to her passion to learn? And it was that will to learn that gave her the will to live.

"And it was that will to learn that gave her the will to live."

Despite the abundance of health inequalities plaguing the Iringa hospital, the compassion, determination and resilience of both the medical staff and the patients was beyond comprehension. During my placement I would incessantly ask for the prognosis of the patients that we encountered, with the doctor responding dismissively each time. Towards the end of my placement I questioned the doctor why he always shrugged off my questions regarding patient prognosis. His response transformed my outlook of patient management and care.
"The prognosis of the majority of these patients are dire and if we choose to focus on it then we will lose the determination and drive to save them. Here, in this hospital, we choose to focus on saving the patient's life right now."

My placement in Iringa has reminded me of my purpose in life and why I chose to become a doctor: to save lives and improve the quality of life of those in need. This task stands as the backbone of medicine, a goal that should be, as I have learnt from the Iringa medical staff, understood as both a sacred privilege and responsibility.

TURN DOWN FOR WHAT?

BY JEFF WANG (IV)

I am just like many of you: I never spent much time doing things that I didn't have to do.
I have not conquered any student societies, I have not changed the world through advocacy, and I have not cured cancer in my spare time. In fact, spent the majority of the first half of my degree brushing off events with,
"Why should I bother?"
However, because I am someone who is familiar with the appeal of apathy, perhaps that my insight into work-life balance could actually help out those who are like me.

To date, I still haven't attended any Medballs; I've failed to participate in many useful Medsoc events such as Meet the Medics, or SB Dowton Leadership, and I've missed a whole range of socials such as Integration Party. I was on the fence about attending these, and I usually ended up tending towards the side of the fence that is closest to my bedroom. In hindsight, it really would have been good to go. As much as I'd like to pretend otherwise, I really did have all the time in the world, particularly in Phase 1 and 2. However, once you miss your window to attend these events, you can't go back and do them afterwards.

"I was on the fence about attending these, and I usually ended up tending towards the side of the fence that is closest to my bedroom."

Some time around mid-third year, I decided I would start attending events that I was on the fence about, just to see how it goes. I spent some time catching up on socials I'd missed in Phase 1, so I attended my first Medcrawl in fourth year. I always thought that I wouldn't enjoy it... but I did. I also thought I wouldn't enjoy AMSA Convention, but I went in third year... and I did. I was also thought applying for an extracurricular research project advertised in the Medsoc Mailout would take too much time, and I wouldn't enjoy it, but guess what... I did.

So far, trying things that I was on the fence about has turned out to be good experiences. Even if it turns out to be something you didn't enjoy, I'd argue that it is a more valuable experience than staying at home on YouTube. (Yes, even more valuable than that.)

I know I previously mentioned that it may feel like you don't have any time, but over the years, I've found that the amount of time you have somehow stretches to fit all that you have to do. For example, if you're given 2 months to do an assignment, you might be thinking,
"You want me to do background reading, a literature search, AND synthesise that information into a report? That's going to take all of 8 weeks, thanks."
But let's be real - if you had to do 3 assignments in the same time, somehow they would all get done too.

My take home message is this: if you are ever undecided about giving something a go, make it so that your default decision is to go. You'll get more out of your time in uni that way!

A NEW WAY OF TELLING TIME

BY ZI YING SU (IV)

THE timeline of my life, like the timeline of the world, is predominantly divided into two big chunks of time. Sure, there are smaller chunks; periods of discovery, rebellion, learning. But the simplest (read: crudest) way to split this timeline is to choose the defining point of my life, a moment shared by many in my community, and to wrap our shared personal history around this arbitrary point. And so, just like we have BC/BCE and AD/CE in world history, we have BMS and AMS – Before Medical School, and After Medical School.

"Wait!" I hear you protest, "my life is not defined by the moment I got accepted into medical school!"
Well, maybe not obviously, but we all know that when you accepted UNSW Med, you closed off all other doors to possible careers at that point – and so, life is defined by this, like it or not. Maybe in 199X BMS, your mother would never have dreamed of having a medical student in the room as she laboured to expel you into this world. Maybe now in 201X AMS, she might consider this – if she were to give birth again, and could – because "my son/daughter is a medical student too." Maybe in 200X BMS you were a bookworm, a nerd. Maybe now in 201X AMS you are 'clever, smart, noble – a future doctor'.

Now, in 2016 AMS you routinely introduce yourself as,
"So-and-so, an X-year medical student, can I ask you some questions about why you're in hospital…", and you make sure prospective employers are aware of your line of study, subtly but desperately signalling: "Hire me, I'm smart!" As dinner conversations and small talk turn towards medicine yet again (from the mundane "How was your day?" "Saw another surgery today…" to the more exotic "What do you think cancer tastes like?"), you start to sink into this identity more and more, until it envelopes and engulfs you – and that is who you are. A Medical Student.

At Kings Cross station one dark evening, a dishevelled man yelled at me for wearing my 'slave tag', the hospital ID I used to wear with pride (and self-consciousness. But now it's just part of the uniform). I wanted to yell back that as a Medical Student (fourth year, 2016 AMS), I am slave to no man, and slave to no system. But in the end, aren't we all just a slave to our identity?

Twenty-thirteen, first year AMS, the junior doctors I bumped into at the hospital chided me for looking too much like a student, as though looking like a student when I am in fact, a student, is a gross oversight on my part. Twenty-thirteen, first year AMS, when a patient called me 'nurse' and I reflexively answered,

"Oh, I'm just a medical student."

Just a medical student.

I'm sure most of us learnt to say that in our sleep in the early AMS years, rewiring ourselves to be doctor-butterflies as we sit in our own cocoon of med textbooks and unfamiliar jargon.

Here's the thing: we can make a difference outside of our capacity as 'just medical students'. We wander the hospital hallways, granted entry because the tags on our clothes read 'medical student'. But when you help that woman put on her socks because she can't reach her feet, stay and chat for longer with the man who reminds you of your grandfather, hold the hand of a grieving relative, we are doing all these things in our capacity as human beings.

"But when you… hold the hand of a grieving relative, we are doing all these things in our capacity as human beings."

So I am urging every one of us to abolish this ridiculous and arbitrary temporal divide in our lives, and to incorporate the identity of 'medical student, future MD' into your identity as "[your first name], human being with interests, quirks, and dislikes". I challenge myself and everyone to explore empathy outside of the stilted lines we practice in clinical skills. I challenge all of us to see our worth as human beings to be separate to our clinical and academic performance as medical students.

And lastly, I beg all of you, don't make BMS and AMS a thing, because that's just so wanky yo.

WOMEN IN MEDICINE

BY GABRIELLE GEORGIOU (V)

After attending the first UNSW Women in Medicine event for this year, which featured presentations from three extraordinary female physicians discussing their experiences of life in medicine, it got me to thinking... Do women in medicine still truly face a gender-based struggle ahead? The media, the literature, supervisors and colleagues around me have warned about some of the issues which may occur. So, where are we now? And what can we possibly do as a medical community to prevent or allay these challenges from occurring in the future?

BACKGROUND

Medicine has traditionally been a male-dominated profession.[1] And yet, the newest trend in discussion is what has been coined the 'feminisation of medicine', where there are now more female medical students graduating than male medical students globally.[2] However, women still on average earn less than their male counterparts, and are under-represented in the upper echelons of the medical field, with a significant lack of females in departmental leadership roles, fewer female than male consultants across the board, and in academia, less females than males reaching the rank of full professor.[2] Indeed, despite increasing numbers of women entering medicine, there is still widespread horizontal and vertical segregation in the medical field.[3,4]

"The newest trend in discussion is what has been coined the 'feminisation of medicine', where there are now more female medical students graduating than male medical students globally."

WHERE ARE WE NOW?

Women are, in general, disproportionately located in areas of medical practice, where they will have less impact than their male colleagues on the changing overall conditions of medical work.[5] A number of possible obstacles stand in the way, including domestic responsibilities, rigidity in career structures, and potential discrimination.[6]

Findings suggest that even female physicians with high career achievement motivation, exceptional skills, and all necessary qualifications, interrupted their career for a period approximately three times longer than their male counterparts, and that couples still divide their responsibilities according to traditional gender roles, which expect women to interrupt their career for family reasons.[7] We also know that the so-called 'superwoman', someone who identifies as both a dedicated professional and a mother in equal parts, is every bit as career-motivated as the next woman, who might focus solely on their career.[8]

Furthermore, current data suggests that the reason behind a lack of women in specialties like surgery and internal medicine stems from the fact that women are not completing their specialist training. Heavy work loads, with increased duties and nights-on-call, make it particularly difficult if a woman must then combine childcare with full-time work.[9]

Overall, the culture and practices of medicine are intertwined within the social context in which healthcare is delivered, so approaches aimed at isolating these factors are likely to fail to identify or explain the complexities of the context involved.[3] Gender equality in the workplace remains a difficult aim to fully achieve in the medical profession in particular, as it is intimately connected to other constructs and traditions of professional work.[4]

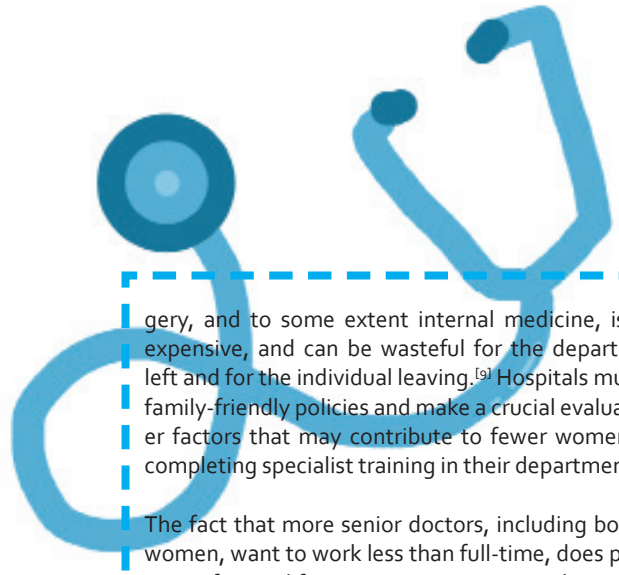
In most Western countries, a doctor's choice of specialty has been strongly gendered. Female physicians have tended both to specialise to a lesser degree, and to enter other specialties to male colleagues.[9] This being said, there is change occurring. However, there is still a tendency towards an increasing concentration of women in some disciplines, such as Obstetrics and Gynaecology and Paediatrics. It has also been described that female physicians work mainly in niches of the healthcare system, or in branches of medicine potentially characterised by lower earnings or prestige.[5]

In academic medicine, there is similar gender gap amongst authors of original articles in academic medical journals, and women still comprise a minority of the authors of original research and guest editorials in major journals around the world.[10]

IMPACT OF GENDER IN MEDICINE

The role of women in medicine is pertinent, not only as a significant social and culture issue, but also because of underlying impacts on the facilitation and provision of medical services worldwide. Female doctors provide more preventative services and psychosocial counseling, and patients of female doctors report being more satisfied with their therapeutic experience, even after adjusting for patient characteristics and physical practice style.[11] Knowledge and strategies to facilitate a gender-balanced approach is thus crucial for the delivery of high-quality gender-sensitive healthcare delivery.[11]

We know that the loss of women from specialties such as sur



gery, and to some extent internal medicine, is extremely expensive, and can be wasteful for the department being left and for the individual leaving.[9] Hospitals must promote family-friendly policies and make a crucial evaluation of other factors that may contribute to fewer women than men completing specialist training in their departments.

The fact that more senior doctors, including both men and women, want to work less than full-time, does pose specific issues for workforce capacity. However, there needs to be a working culture which ensures that part-time consultant posts are welcomed, for both men and women, if they so choose.[12]

FUTURE CHALLENGES

For true change to occur, there must be alteration in gender representation, changes in workplace structures, style of organisation, as well as questioning the assumptions of identity which have traditionally shaped medical institutions.[4] Policies alone cannot achieve gender equality and equity. Instead, addressing stereotype-based gender bias through practical interventions for both men and women will be critical to promote a culture allowing full participation of women at any career stage.[13] There should be expansion of support networks in hospitals and training facilities for child-rearing care during extended work hours, promotion of more flexible work schedules for male and female trainees and consultants, and changes to the underlying conventional ideas about gender roles within educational and professional environments, through improved leadership and learning strategies.

"Policies alone cannot achieve gender equality and equity. Instead, addressing stereotype-based gender bias through practical interventions for both men and women will be critical."

CONCLUSIONS

Ultimately, there are few, if any, enduring differences between women and men in medicine in terms of academic performance, competency and motivations.[3] Medicine as a whole will benefit from closing the current gender gap, and supporting both females and males as they train and work in the Australian medical system and globally. Greater female participation will also provide increased opportunities for female mentorship of younger generations, which may work to improve learning and training outcomes for female students and facilitate transformation of previously stereotypical gender roles within our healthcare system.[14]

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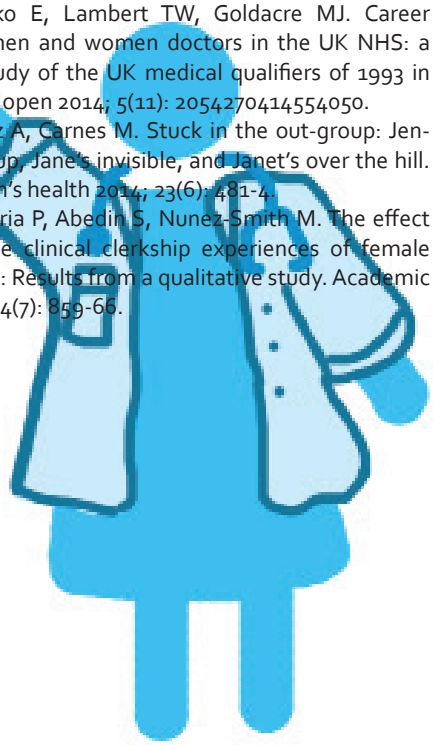

MUSIC AND MALADIES

BY BIANCA SO (III)

The close link between medicine and music has been evident from as early as 1908 [1]. Music therapy has been shown to have positive effects, particularly for medical, neurological, and psychiatric conditions.

There is a physiological effect of relaxation and relief of symptoms such as pain, dyspnoea, hypertension, pulse rate, and respiratory rate; this is useful for patients with coronary heart disease or COPD [2]. Music also exercises both the analytical left hemisphere and the creative right hemisphere of the brain, potentially improving cognitive function. Studies have shown that social interactions and motor skills are improved after compounding music therapy with traditional treatment. For those with dementia or other neurodegenerative disorders, music may also serve as a form of expression, providing a vessel through which to interact with others without requiring much cognitive load. Music therapy has been shown to improve global and social functioning in mental disorders such as schizophrenia, gait and related activities in Parkinson's disease, depressive symptoms, and sleep quality. Most importantly, there are no negative side-effects [3].

"Doctors infamously suffer from high levels of depression, anxiety, and suicide, but anecdotal evidence shows that keeping an outside interest such as music improves work-life balance and overall well-being."

Music is also an effective way to improve one's mood. Five randomised trials found that those with depression generally accepted music therapy and had greater improvements in mood when compared to standard therapy [4]. Another study found that these patients were better able to express their emotional states, as music overcomes verbal barriers [5]. Music has also been shown to significantly reduce levels of the stress hormone cortisol [6].

Aside from benefiting the patient, music may well benefit the practitioner. Both music and medicine emphasise the need for good communication, analytical skills, and empathy. Music has been shown to enlarge the areas of the brain processing sound, language and movement, and seems to improve academic performance overall [6]. Music is also a creative outlet that may help with stress relief. Doctors infamously suffer from high levels of depression, anxiety, and suicide, but anecdotal evidence shows that keeping an outside interest such as music improves work-life balance and overall well-being [7].

For these reasons, UNSW Medical Music Society (MMS) exists as a student society aiming to promote music amongst medical students and the wider community. Founded in mid-2015 by a group of musically inclined medical students, MMS holds two principles at its heart; to provide medical students with music opportunities amidst busy schedules, and to benefit the community with music. The Community, Classical-Contemporary group have presented musical items to the residents at Brigidine House and children and families at Sydney Children's Hospital.

Perhaps in the years to come, more doctors will appreciate the several benefits of music. Perhaps alternative therapies such as music will be compounded with traditional medicine to provide holistic health care that benefits both the patient and the doctor in terms of physical, emotional, and spiritual health.

MMS had its first concert on 3rd June 2016. Follow MMS on Facebook or online.

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CONFERENCE REPORT: OTOLARYNGOLOGY + HEAD AND NECK SURGERY

BY JESSE ENDE (V) & ERIKA STRAZDINS (V)

The ASOHNS Annual Scientific Meeting is the annual conference of the Australian ENT and head and neck surgery society, bringing together academic surgeons from all over Australia and overseas. Held this year in the Melbourne CBD, attendance was something we were both looking forward to. With the huge diversity of attendees, the conference was split into streams, each catering to combinations of ENT, oncology, head and neck, paediatrics, endocrinology, and sleep disorders.

We were both fortunate enough to be selected to give oral presentations at the conference, which was such an exciting adventure. After working so hard on our projects last year it felt great to finally be able to share our findings with practicing doctors and surgeons. It really puts the final piece in the puzzle when you see how at conferences like this, research findings are translated into clinical practice as the audience probes with questions and discusses the implications. The doctors were very impressed with our presentations as students, and this is really a testament to the UNSW research program, and how it enables students to become active in the academic medical community. The networking opportunities were also incredibly useful for setting up potential future research or elective projects in specialities we would like to get more of a taste of.

For anyone doing their research now or in the coming years, the best thing we could recommend is think of the big picture - what are you trying to show, and why, and how? Putting your work in a greater context will help motivate and guide you along your journey, which is something we have been able to now see first hand. Finally, think about the absolute best way to communicate these findings - without a clear message and delivery, your hard work won't change anything.

"Putting your work in a greater context will help motivate and guide you along your journey"

Of course, we didn't neglect the city outside the conference centre. Melbourne has a lot to offer and we made the most of it. Seeing Melbourne from both a fun and academic perspective really was a highlight coming out of the research year.

WHERE THE EQUATOR CROSSES THE INTERNATIONAL DATE LINE

BY ERICA LONGHURST (II)

In February this year, I went on a University funded trip to Kiribati to look at the impacts of climate change and to do some ethnographic research. I have written a little reflection from the perspective of someone living on the island. The persona in this reflection is based on a variety of lovely people I met - but is not really centred around one person. I hope you enjoy what I have to share, and thank you for reading!

For me, dawn was the best time of day. In Kiribati, dawn was spectacular. Sitting in the middle of the equator and the international date line, the experience of dawn in Kiribati was unique, I was sure of that. The clouds parted like the lips of a warm smile as the orb of the sun rose over the Pacific Ocean. I could stand with my feet deep in the sand, watching from the safety of the beach as a new day awakened. The orb of the sun burst forth from the deep, blue sea with confidence, shedding the darkness of the night. The morning was a time of hope, renewal, magic.

I had grown up in Kiribati on the island of Kiebu. My family had grown up here, my children schooled at the local primary school and my wife and I had formed friendships with the three hundred other people on this special island. It was an island that was as delicate as a shard of glass, perched on an ever-changing ocean. But it was paradise. As I watched the sun yawn over the sky, I thought of the many people on the many islands of Kiribati that were witnessing the same beauty that I could see unfolding. From any vantage point, this view was incredible. Standing on the shoreline of the island that I was born into made this spot this spot special for me. But that did not make it any more special for anyone else. Each person on my island, the island of Kiebu, had a particular connection to this place that could not be described in words.

The contours of this islands were etched into my brain like the creases on my palms. Over many years the same movements had created patterns in my brain. This meant that I knew the quickest way from my house to the beach where I now stood, from the beach to the well in the centre of the island, and from the well to the Babai plantations where I spent my late mornings and afternoons.

As time swayed by, the sun spread rose from its bed in the ocean; a symphony of reds, oranges and yellows exploded into the sky.

The ocean. My father was a fisherman. I can still remember the tune that he would whistle each time he went fishing. It was so distinct, the rising and falling of his voice, that I could whistle it to you now without hesitation. But I do not remember much else about the adventures that my father had whilst he was fishing. I suppose that is because he ended his sea voyaging prematurely. I was twelve when he told me that the fish had swum out of the ocean. He said that fish had lost interest in the sea surrounding the islands of Kiribati and instead decided to migrate south to Australia. He told me that the fish were curious animals that were always looking for action, and Kiribati was a very peaceful place. Those were his words. Now I look back, and I realise that what he was really referring to was the fact that overfishing by hungry international companies had drained our oceans of fresh catches. I often thought about trying to explain this to my father, but the look of certainty that he had on his face when he told me that story made me feel very sad.

I decided to sit down and watch the sunrise; my feet were getting tired from standing. I had spent all of yesterday standing in the Babai plantation, making sure that the compost adequately surrounded each plant. Babai are magnificent plants- they are small trees that grow in pits, and each Babai trunk is surrounded by a thick circle of compost that is there to support the plant. Each Babai plant has a complex system of roots, and off each root is the Babai vegetable that is eaten. Nothing beats Babai cooked in a thick coconut sauce...ooh, I am salivating now just thinking about it! The Babai is a staple of my diet. My wife complains that I ask her to cook it too often, but I know that she is just teasing me. When I do the cooking, she will ask me to cook Babai as she loves it as well. The leaves of these trees are useful for thatching roofs and making other useful materials. We actually built our house from the materials of the pandanas and coconut tree, but we have friends who have used the Babai for walls of their houses.

I became a Babai farmer because my uncle was a Babai farmer. I wanted to be a fisherman, but as I told you, the fish dried up. Fishing has become even harder than it was during my father's age, because now we have hotter oceans as well as more crowded oceans. I listen to the radio, I know about climate change. What frustrates me is when people come here and think that I do not know. I do. I am educated; my wife and I met at university in Suva, Fiji studying commerce. We could have stayed in Fiji, but we decided to go back to my island

to raise our family just like we were raised. And we do not regret it. But when our children are old enough, we will give them the same chances that we had. For now though, they are living carefree lives on an island that has given us all so much.

My wife and I, we try to decipher the facts that have led to the changes that my family has observed in our land and our ocean. Pollution from other places in the world has changed our paradise. There is not a 'place' to point the finger at, but I know that we did not cause this change. Having the big fishing companies and hotter average temperatures have both driven the fish from Kiebu, and stopped me from becoming a fisherman. I asked my uncle if I could carry on his tradition, as he was the most successful Babai farmer on our island. He was more than happy to pass on the shovel; he and my father were old now. But things had become hard in the Babai world as well. I looked down at my feet and wriggled my little toes in the sand. I had been standing for ten hours straight yesterday, trying to drain out the salt water from the Babai plantation that was closest to the shoreline. You see, when the salt table rises, salt water seeps into our plantations. The Babai trunks sit within a circle of compost that sits in a pit that is filled with is usually filled with beautiful fresh water. But we have noticed that the pit closest to the shoreline has become salty. How long before that happens to the others as well?

I gazed out at the sea, watching the shore lap against the beach. There was nothing I loved more than watching my children splash and giggle in the sea, their hair wet with water, sand in every nook and cranny. The sea was our beginning, our life, but it could also be our end. How far would the ocean rise? Could it cover my Kiebu? Could it submerge my Babai plantations? My family?

I will tell you something my uncle once told me. One night every week, after dinner, my uncle would leave our house and go and sit on the log that I am sitting on now, and watch the ocean for the night.

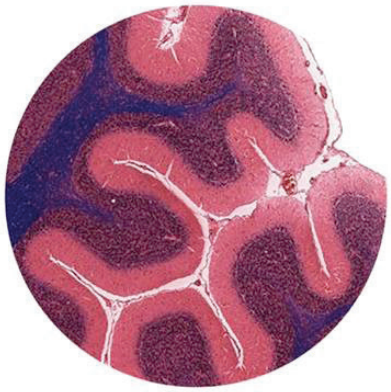
I asked my uncle, "Why do you watch the ocean overnight?:

My uncle was a man of great wisdom. He had large, busy eyebrows, broad shoulders and a broader smile. But he did not smile as he told me this. He looked at me carefully, and said,

"I watch the ocean to make sure that it doesn't sneak up and cover us whilst we are at rest. If I watch it, it won't cover us."

As I think about these words, I look over at the wall of sandbags that we laid down last January to welcome in the new year. We etch in the highest point that the water has reached each month now, and I feel sad to say that every month so far, we have had to raise the line a little higher. It is now July, and my uncle no longer watches the ocean like he did before. He and my father sit in the Maneaba and talk of the old chiefs of the island, smoking, drinking sweet tea and playing Canasta. They don't trust the ocean as they once did. I want to explain to them that it is not the fault of the ocean, there is something else that is happening, something bigger than us.

The sun has fully risen now. It was quite a sight this morning, the hues were brighter and even more cheerful than yesterday. I suppose that this means that they will be even better tomorrow. So I will come again.



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