Idioglossia

Volume 2, 2017

ADIPOSIS. f. *Med.* Obesidad.—ACAD.

ADITIAS. *Mit.* Divinidades supremas indias en número de ocho.

ADIURETINA. f. *Endoc.* Vasopresina.

*** ADJEMI (Ana o Eudia).** *Biog.* Religiosa maronita condenada como heresiarca por Pío VI en 1778. Fundó cuatro conventos bajo la advocación de Jesús. Murió impenitente en

*** ADJUNTAR.** v. tr. —ACAD.

ADLERFELD (Gustavo). *Biog.* Historiador sueco, cr los XII, al que acompañó Pultawa, en la que encon (1671-1709).

ADMAXILAR. adj. Jun

*** ADMETA.** *Astr.* Asteroide... Período, 1.893 días.

AD METALLA. *Hist.* Fórmula con la que se designaba uno de los peores tormentos que se aplicaban a los cristianos durante las persecuciones, consistente en la explotación de minas b un régimen inhumano.

*** ADMINISTRAR.** v. Realizar el esfuerzo mínimo able a fin de no agotar 'l pudieran faltar después

*** ADMI** para Platón y Aristóteles con la admiración y ella el comienz todos los saberes. Para la admi un temple de ánimo, tal alaje, una tud existencial. Para de las pa el alma alma que impulsa considerar atención objeto admiración designar el pas la Teresa, inquisitivo n la bondad mezcla de amor *.

ADN. *Biomol.* Ácido deoxi co. (Véase **Deoxirribonucleico**).

*** ADOBES.** *Geog.* Muni de Guadalajara.

*** ADOLECER.** cosa, tener algún defecto

*** ADOLFO.** *Biog.* Sevilla, conocido tam rió en Córdoba el año 8 bra su fiesta el 27 de sept **rico (duque de Holstei** Rey de Suecia (1710-1771) pero se le obligó a cont hasta su muerte. Durant Dietas se adueñaron prác el poder.

ADOLORAR. (de *a* y tristecer, afligir, aquejar.—

*** ADÓNIDE...** *Bot.*

ADONNER. m. *Náut.* empleada en el deporte de a vela para indicar que sop favorablemente para la emba

*** ADOR.** *Geog.* Munic. de la Valencia... Pobl., 1.321 h.

ADORBITAL. adj. *Med.* órbita.

*** ADORNO...** *Mús.* decoración melódica que em aplicaban en el canto y en la trumental, desde 1650 hasta fines glo XVIII. Consistía en la adición de sonido vecino (superior o inferior a la nota escrita) o en la modificación del sonido escrito por trémolo, vibrato, etc., o en la intercalación de grupos de notas rápidas entre dos sonidos escritos. Se representaban por signos convencionales y su abuso, principalmente en la música vocal, los hizo pasar de moda. || *Taur.* Primor, desplante o gallardía que, sin ser preciso para la ejecución correcta de una suerte, se realiza por el torero en vista a su mayor lucimiento o belleza de la suerte.

ADOULA (Cyrille). *Biog.* Véase **Adula (Cirilo)** en este SUPLEMENTO.

*** ADRA.** *Geog.* Munic. de la prov. de Almería... Pobl., 15.669 h.

*** ADRADA (La).** *Geog.* Munic. de la prov. de Ávila... Pobl., 1.692 h.

*** ADRADA DE HAZA.** *Geog.* Munic. de la prov. de Burgos... Pobl., 624 h.

*** ADRADA DE PIRÓN.** *Geog.* Munic. de la prov. de Segovia... Pobl., 238 h.

*** ADRADAS.** *Geog.* Munic. de la prov. de Soria... Pobl., 256 h.

*** ADRADOS.** *Geog.* Munic. de la prov. de Segovia... Pobl., 812 h.

ADRALGINA. f. *Quím.* Anestésico local, compuesto de adrenalina, cocaína y timol.

ADRENALINURIA. f. *Med.* Presencia de adrenalina en la orina.

corticoesteroides, corticotrofina, o ACTH. Actúa hipertrofiando la corteza suprarrenal y favoreciendo la secreción de hidrocortisona. Se usa en la como antiflogística, antirreumática, antialérgica, antitóxica y antiálgica.

ADRENOGENITAL o relativo a las

Véase **Adrenalopa**

VA adj. Privado de

RONA.

OPICO *adrenal* *d.* Que tiene

DRE

septicemia

ADRE

*** ADUL** do, nombrado

*** ADULTERO** sentido metafórico se incrédulos contemporáneos de plean esta denominación los evangelistas Mateo y Lucas. Santiago usa esta voz para designar a los amigos del mundo y en el Apocalipsis se refiere a los herejes *.

*** ADUNA.** *Geog.* Munic. de la prov. de Guipúzcoa... Pobl., 468 h.

ADVANTAGE IN. *Dep.* Expresión inglesa utilizada en tenis y otros deportes para indicar ventaja del jugador que realiza el saque.

ADVANTAGE OUT. *Dep.* Expresión inglesa utilizada en tenis y otros deportes para indicar ventaja del jugador que recibe el saque.

ADVENTICIA. f. *Med.* Túnica o capa externa de las arterias.

*** ADVERSARIO...** *Dep.* Oponente en una confrontación deportiva *.

*** ADVERTIDO, DA...** *Hip.* Dícese del caballo avisado, listo para realizar los ejercicios de doma.

ADYE (Sir John Miller). *Biog.* General inglés que en 1882, durante la campaña de Egipto, fue jefe del Estado Mayor y después gobernador de Gibraltar. (1819-1900).

Geog. Munic. de la Pobl., 2.513 h. || de la prov. de Va- h.

Médico de la corte Fue autor de una re- *etrabiblion.*

eroide. Véase **Egle** en

Enfermedad del sistema nervioso.

A. E. L. C. *Pol.* y *Econ.* Siglas con que se conoce la **Asociación Europea de Libre Comercio.** Véase este artículo en este SUPLEMENTO.

ÁLFRIC EL GRAMÁTICO. *Biog.* Es- inglés de fines del Fue abad de m y escribió gramática inglesa y latina.

ELUROPSIS. f. os oblicuos caracde la raza mongólica.

STENIA. f. Psicastenia con de la confia en sí mismo y arenoicos. en los

AERO m. *Parasit.* Miaero y anaerobio a la

AERO OMÓVIL. m. Automóvil de dos asientos, no las ruedas por una anterior. Su invento se debe al francés fat. h 1913 y ofrece de

Parasit. ero de cuyas especies se mal en el conducto

Astron. Cometa norte- exploraciones fabricado 475 y Caracte- as: etapa 1 y longi- m.; diám 36 y 38 cm.; kg., al 120 y 160 ambos 1.2 Mach; pros. En 1962 se llevaban 250 con un 10 % de

Astronáu. Es el Aero- ligeramente mayor. Lon- ocidad, 1.8 Mach y alcan-

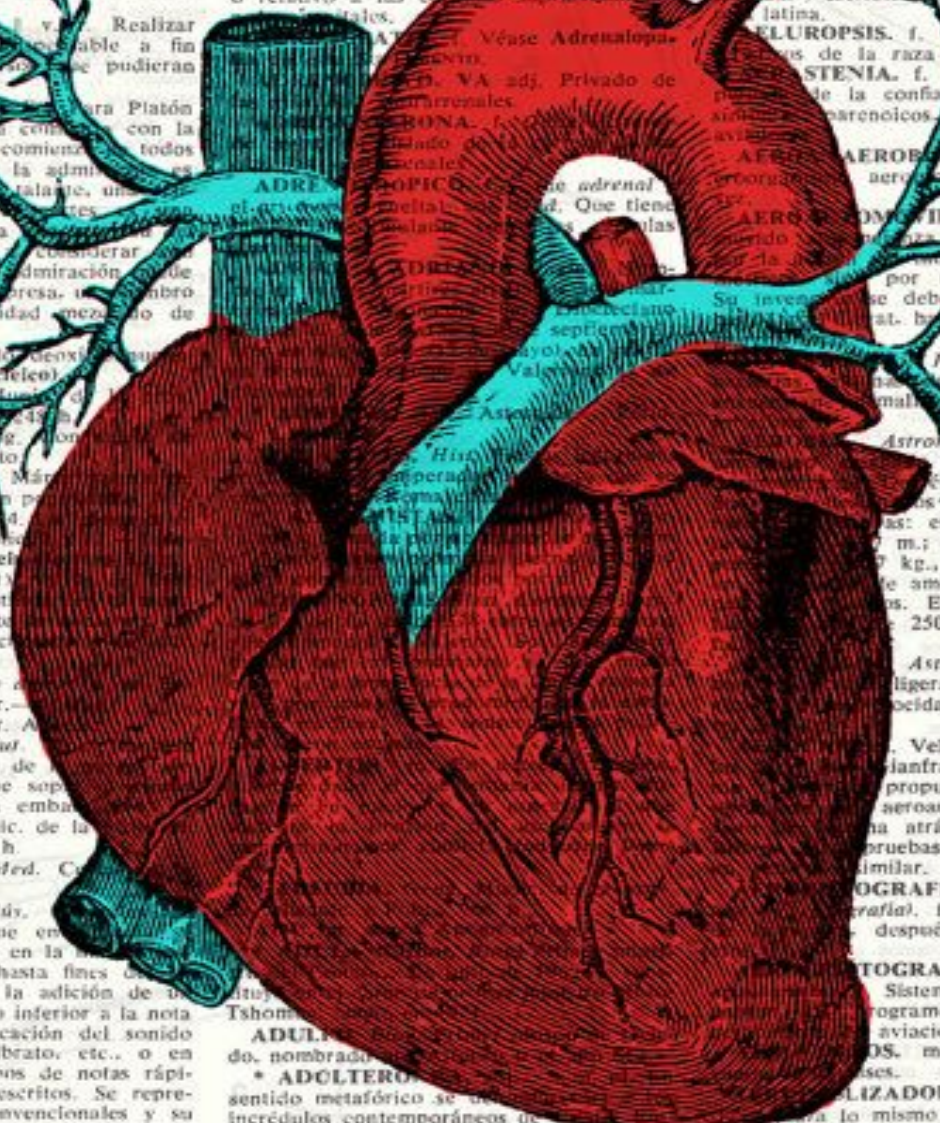
. Vehículo inventado por ianfranco Bricci y Euge- propulsado por hélice. aeroautomóvil, pero pro- a atrás. Más tarde, John ruebas en Inglaterra con imilar.

OGRAFÍA. (del gr. *aer,* *rafía*). f. *Med.* Radiografía después de insuflada con

TOGRAFÍA. (de *aero* y Sistema de escritura para rogramas de exhibiciones aviación.

OS. m. Distensión de la ses.

LIZADOR. m. Vehículo que lo mismo por agua que sobre tierra, por el sistema llamado de *colchón de aire.* Estos aparatos no son propiamente buques, ya que al mantenerse elevados gracias a los chorros de aire comprimido producido por grandes turbinas, pueden igualmente ser empleados en tierra firme. Pero ante la necesidad de tener que desplazarse en superficies preferentemente lisas, su utilización más racional es a través del medio marítico, en el que ofrecen innumerables ventajas. En agosto de 1968 los ingleses pusieron en servicio al "Hovercraft" más grande del mundo, dad para 250 pasajeros y 30 Su peso total es de 170 ton capaz de alcanzar los 140 kil deslizándose a dos metros sob ficie.



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Dear Reader,

It has been a wonderful year for UNSW Medical Society Publications, where we have successfully released Umbilical, Humerus 1 and 2 as well as Idioglossia 1 and 2. These are available on the UNSW Medical Society website. We thank Medsoc Public Relations and our fantastic subcommittee for their support, where we congratulate our subcommittee members Jumaana and Marisse for being elected to fulfil the role in 2018. Furthermore, we are proud of how well our 'Humans of UNSW Medicine' Facebook Page has taken off, where we hoped to capture and share the essence of the medical student experience through photos and student anecdotes. We have focused on evolving Medsoc's tools of engagement in response to feedback from our social media audience and readers. We hope that you have enjoyed, engaged with, been inspired by or even just reacted to content shared and published throughout 2017. It has been an absolute privilege. We celebrate what has been achieved and were impressed by the high quality of articles received from UNSW medical students. As he hand over the role, we are excited to witness Medsoc Publications become even bigger and better in the future!

Thank you UNSW Medicine fam and we hope you enjoy Idioglossia 2, 2017 which is our last Medsoc Publication for the year. It has been a pleasure!

Yours Sincerely,

Ellie and Kai

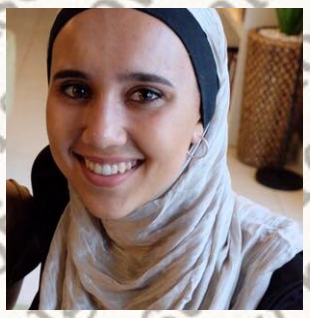
(UNSW Medical Society Publications Offers 2017)

Elizabeth Lun (Ellie)

Kai Lun

Our Publications Subcommittee 2017

Jessica Luo



Jumaana Abdu

Marisse Sonido

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Publications Subcommittee: Humans of UNSW Medicine Facebook Page Managers

Dinuli Kamaladasa

Marissa Rahardja

Medsoc Public Relations Director:

Naomi Sirmai

UNSW MEDICAL SOCIETY PRESIDENT AND VICE-PRESIDENT'S REPORT

President: Eric Xu (right)
Vice President: Nadine Kauley (left)

It fills us with bittersweet joy that we're reaching the end of the year! We were very fortunate and privileged to have been able to serve you all this year, and we are open to feedback - we really hope we were able to be there for you at all times.

To sum up 2017, our main goals this year were:

President:

1. Streamlining subcommittee applications
2. Communication/transparency
3. Sponsorship assistance + Executive assistance and increased bonding within the team

Vice President:

4. Improve MedSoc's appearance externally and also improve the functionality of our website
5. Address some students' concerns about how the society was run, particularly in terms of our finances and what we do with them
6. Further providing support to our exec members

1. Subcommittee Centralisation into Waves 1 and 2

Subcommittee centralisation improved the previous structure of having individual applications for each portfolio, and we also decided to split subcommittees into waves 1 and 2. This allowed portfolios to obtain subcom members from wave 1 for the summer holidays, whereas wave 2 was really aimed at engaging first years, to allow our young meddies to engage at a grassroots level. It meant that a lot of preparation was required, which was really wonderful with executive's help during our first executive meeting.

In the end, Wave 1 was released in October 2016 and Wave 2 in March 2017. Both waves were ran successfully, with all Council and Exec portfolios submitting their questions and choosing their applicants. Feedback was received from both waves and will be incorporated into future subcommittee applications.

2. Communication/Transparency

Since our AGM last year, the executive team really wanted to make sure we had good communication from the beginning. A common communication tool was probably hard to institute, but through our desire for effective communication, we were able to really implement **Ryver** as a tool for all of us. We really want to thank EVERYONE for really trying it and using it to the best of our abilities. We also achieved transparency by allowing exec members to know whether they were looked after by P or VP this year. This helped us to be accountable when we needed to be. We recommend to the incoming executive team to also consider and evaluate
whether another communication medium is better.

3. Sponsorship Assistance + Executive Assistance and increased bonding within the team

There was a period of time from October to March where MedSoc unfortunately did not have a sponsorship director. Subsequently, I (Eric) essentially handled the majority of the sponsorship during the timeframe before Oliver was elected as our incoming sponsorship director. I was able to prepare the prospectus with the help of Chris and send it to sponsors. I also organised the sponsors for Orientation Day and Medcamp, which brought in a significant amount of sponsorship. Since our EGM at the beginning of this year, Oliver has done a fantastic job of everything with little help from me, and is still helping out with MedSoc as our interim sponsorship director.

As president this year, I established a one-on-one system within executive team, which is essentially an informal-style meeting with our exec members to discuss key ideas/goals and issues. Together with Nadine, we were able to spend usually hour-blocks with each executive member individually, and discussed their completed personal development plans, happy moments in MedSoc so far, breaking points, and more. This way we were able to truly figure out what goals and allow our exec members to grow and feel supported.

4. Improve MedSoc's appearance externally and also improve the functionality of our website

I (Nadine) really wanted to tackle the website as the primary point of engagement for not only people outside of the society, but our entire student cohort – rather than relying on Facebook for almost everything as currently it is used for event promo, feedback and as a general student forum. Facebook may not always be the best platform, and my aim was to achieve this on the website! Right now if you've seen it, it looks quite different, and includes such things as all recent editions of Umbilicial, Idioglossia and Humerus, as well as information on each phase written by our student reps for anyone interested! A big thank you goes to Ashley, our IT Officer this year who worked so diligently on this revamp and put up with my little nitpicky comments on how things were presented :)

We also changed our logo with the help of an external designer (as a competition was held at the end of last year which unfortunately lacked engagement) and updated it to be a little more modern and added some colour! Another aim of mine this year however was to introduce some society-specific merchandise other than our jerseys and hoodies that can be available on our online store, and used as prizes for various competitions, which is still to be developed though I am currently looking into this.

5. Address some students' concerns about how the society was run, particularly in terms of our finances and what we do with them

Last year, the 2016 team worked well to garner where students felt they could be "reimbursed" by MedSoc, and where we could really give back to our students with the money we have. We increased the budgets this year for all portfolios considerably – particularly as we wanted to allow you the chance to do what you wanted with your events and ultimately hold better quality events for students - for instance by buying/more better food.

Furthermore, culling the number of Council/SIG events alongside encouragement of joint events was a strategy we employed this year to target event fatigue. Unfortunately, this strategy did not seem to work as well as we thought it would, and overall it did affect things such as hindering effective promo on FB and attendance being lower than expected at some events. This was unfortunately unfair on event organisers who put so much time and effort into these events.

6. Further Providing Support to our Exec Members

We have been happy to be involved in many of your events (much more so with Nadine as she was at most events!) - either helping out on the day or just attending them because they were fantastic. There were so many new initiatives from council and exec this year which were fantastic and allowed more student engagement - everyone dreamt big! Recognition through official certificates for students for volunteering/being part of subcommittees for portfolios.

I have been grateful to be part of other changes this year, including the inclusion of the AIDA Rep onto council as a permanent member and the induction of Indigenous Health Society. Though of course there are initiatives which I (Nadine) did bring to Council that I have not seen through to their end and I apologise for that - Mental Health Days and asking Ute for assistance being one of those which was discussed two councils ago. I will be continuing to look into this and to get some advice from faculty on this in the remaining three months of my term.

We would like to thank execs - we had the privilege of seeing how much support you gave your council members, was great to be a part of; thank you for supporting us and being there for us when we needed help as well throughout the year. We would like to thank our Council members for dreaming big, and achieving even bigger!

We really hope you've enjoyed your time in MedSoc this year; we have had a great time getting to know you all – best of luck to any of you who will be in the 2018 team.

Much love,

Eric (President) and Nadine

Farewelling Professor Rajesh Kumar

Special Interest Group (SIG) Reports

Medical Student's Aid Project (MSAP)

Medical Student's Aid Project is the global health group for UNSW. We've grown from a medical shipment project to development countries in 2001, to an organisation that runs a midday meals nutrition project in rural India (Food for Thought) as well as several educational events during the calendar year. This year, global health has been bigger and better than ever! Our biggest event of the year, Global Health Short Course had around 300 registrations and featured the likes of Professor David Cooper from the Kirby Institute, Dr Greg Fox, found of ASAP and Alanna Maycock, advocate for refugee health. MSAP also funded the construction of new toilet and handwashing facilities at a rurual girls' school in India, a project completed this year. UNSW delegates were inspired, educated and empowered at this year's AMSA Global Health Conference held in Adelaide. Other highlights of the year included Launch Night, Code Green Treevia Night, Crossing Borders Panel Session, Red Party, raising over $2700 for Medical Action Myanmar. It's been a year of new growth and we look forward to new ideas and energy from the 2018 team.

UNSW Psychiatry Society

2017 was a great year for the UNSW Psychiatry Society, with the introduction of many new events and speakers. Psychiatry Grand Rounds with Dr Julia Lappin and Dr Andrew Ellis was our most successful event, where cases such as psychosis and forensic psychiatry were presented. Other highlights included our collaboration with BEAMsoc for a Mock ICE workshop; our counselling stations were very well-received, and we anticipate to continue holding this in future years. Finally, in order to raise our engagement with the UNSW medical cohort, Psychisoc took a more proactive role on social media this year, with various executive members sharing articles about prevalent mental health issues in the community. Topics covered included the coexistence of mental and physical illness, and the experience of being a medical student with a mental health disorder.

Planning for next year is already underway, with the aim of increased collaboration with other societies, as well as events targeted towards specific years and phases within the medical cohort. Mental Health Trivia Night next March is hoped to be our kickstarter for the year, so keep your eyes peeled. We're all looking forward to 2018, and hope it will be as successful as 2017 has been!

UNSW Rheumatology Society

This year we received 2 sponsorships from Autoimmune Resource & Research Centre (ARRC) and Four Frogs creperie. With their sponsorship we held 5 events this year followed by AGM. We began with 'Introduction to rheumatology' by Dr Arvin Damodaran. He was an eloquent speaker who provided an excellent overview of Rheumatology training and specialising pathways. This was followed by MSK imaging night. This was based on many cases discussed by Dr Sebastian Fung. The cases were quite relevant to medical students and was of a wide range. This was followed by our successful event MSK clinical SOCE/ICE evening. Dr Maxine Szramka was our speaker for the evening and was an excellent speaker with a great approach to teaching. It was quite interactive and was attended by students of all phases. As most years we held a Mock OSCE, this was done this year as well. This was done as a joint event with CardioSoc and Radoncsoc. This had a good turnout as it was quite directly helpful for OSCE. The year was ended with Biomed evening where important questions and high yield exam questions were covered by 6th years Lucy Hanlon and Jamie Pate.

UNSW Pathology Society

This has been a fantastic year for PathSoc, with a lot of great events with great turnouts and new shiny exec T-Shirts. Our events catered for all year groups and much was learnt – by our guests AND our exec. The whole thing has been a blast and we can't wait to see where next year's exec is able to take the society.

UNSW Medical Music Society

The UNSW Medical Music Society has had another amazing year, with our groups continuing to allow an opportunity to continue their passion for music, perform, and to serve the community through music.

The MMS Orchestra, conducted by the talented Nicky Gluch, have had another successful year. Our orchestra held 2 concerts this year to raise funds for the Spinal Network: The Winter Concert in Semester 1 and Mozart & Saint-Saens in Semester 2 featuring soloists Austin Lee (6th year) and Isabella Pak (2nd year). The MMS Choir underwent restructuring this year, becoming a group that was formed based on performance opportunities. As such, our Choir got involved with the community. Performing at Sydney Children's Hospital and with Arc Phil'. Our community focused program, Community, Classical-Contemporary or CCC for short, continued to allow students to form small groups and give back to the community through performances in Sydney Children's Hospital and Brigidine House.

Overall, MMS has had a successful year with facilitating musical opportunities for students and giving back to the community. We hope to see the successes MMS has had this year to continue in 2018.

UNSW Sports Medicine Society

What another fantastic year it has been for the UNSW Sports Medicine Society. Throughout the year, we hosted 4 educational events in total which featured some of Australia's leading sports physicians as speakers. We opened the year at Medcamp, conducting SCAT concussion testing on some 200 (hungover) 1st years. For our first event, *Introduction to Sports Medicine*, we were lucky enough to have Dr Carolyn Broderick share the daily life of a sports physician: spanning clinical practice, team coverage (including the Olympics!), research, teaching and more. Her registrar also outlined the ACSEP training pathway, with her own journey and tips into the program. One of our most popular events, *Daily Life Nutrition and Sports Diet Management*, had Dr Sharron Flahive (SEM physician) and Peta Carige (sports dietician) share their individual nutrition advice for elite and community level athlete. This certainly attracted some extensive Q&A from our students!

We also teamed with AICEsoc and SEMSA (national student body for Sports Medicine) in hosting some hands-on workshops on fracture management (including plastering) and upper limb OSCE examination, each taught by an Orthopaedic fellow and 2 Sports Physicians respectively. We also ran a discounted First Aid course with St John Ambulance, and looked towards hosting an accredited Sports Trainer course with Sports Medicine Australia.

Not stopping there - we also established an informal partnership with our local Sports Medicine clinic (Orthosports), where students are able to sit-in on clinics with SEM physicians. Some students also acted as mock patients for their GP education workshops and practice fellowship clinical exams for the final year SEM registrars – which all made for good learning.

To keep up-to-date with our society, check our (brand new) website, Facebook or Twitter pages below.
W: www.unswsportsmedsoc.weebly.com/
F: www.facebook.com/UNSWSportsMedsoc/
T: www.twitter.com/UNSWSportMedsoc/

UNSW Ophthalmology Society

Our events catered for all year groups and much was learnt It's been a brill-eye-ant year for Oculus Soc in 2017! With improving Ophthalmology education as our biggest vision this year, we have continued coordinating our popular Ophthalmology Clinical Skills Nights at Prince of Wales Hospital and the Coursework Ophthalmology teleconference tutorials, and successfully advocated for these tutorials to become on-campus skills workshops from 2018 onwards. We also introduced several new events such as the High Yield Ophthalmolgy Night and the Welcome Back BBQ, and donated all our profits this year to the Fred Hollows Foundation. We hope you've enjoyed our initiatives this year, and having recently held our handover to our new exec team, are sure that Oculus Soc 2018 will bring back many ore awesome, eye-catching events!

UNSW Paediatrics Society

Overall, MMS has had a successful year with facilitating musical opportunities for students and giving back to the community. 2017 has been an amazing year for Paedsoc! This year we've run such academic events such as Embryology Night, BGD-B End of Course tutorial and 6th year Vivas, as well as a Paediatric ICE night with O&Gsoc and a Paediatrics research cup with WSU and USYD. Our volunteering team has run an amazing 5 Teddy Bear Hospitals across Sydney in concert with SPARK. Fundraising has occurred via a bake sale and funding from Dr Ju-Lee Oei. We thank everyone who participated in our events and look forward to the society's achievements next year.

Me, myself, and my WAM

Jana Valle

What does success look like to you?

When someone asks you what success looks like, what image comes to mind? Some people might picture wealth, fame, accomplishments, or loved ones. Depending on the person and the culture, success can be defined as something externally recognised like status, or an internal experience such as self-esteem. But hopefully, for all of you, it involves personal happiness.

A witty expression that you probably heard before is this silly brain teaser: *If you succeed at failing, have you still succeeded*?

My answer is yes.

And the reason being is that success is not about achieving socially recognised milestones. Success to me is about achieving goals that you've set yourself and that have meaning to you. Unfortunately, it took me a much longer time to realise this than it should have, and the journey to that realisation was a hard and challenging one. In fact, I would rather say that the realisation hit me like a rock hitting the back of a head of a climber after they've slipped and fallen down a cliff, because the epiphany only came upon me as a jarring realisation after a long downhill mental slide.

Medicine, by nature, attracts high achievers. We are all intelligent, motivated, and conscientious people that have put in a lot of effort over the years to get to where we are right now. What inevitably comes with this path in life is perfectionism and an enormous pressure placed on oneself to "succeed". When we get to university, this is compounded by being suddenly surrounded by hundreds of peers just as smart as – or smarter – than we are, and suddenly we don't feel as good about ourselves as before. Yet the expectations of our performance just continue to rise as the years go on.

I chose Medicine not only because I loved the science and I loved being able to help people, but also because I decided to challenge myself. In my interview I naively boasted that I wanted to do a career that involved a lifetime of learning. In all honesty, at the time I didn't quite grasp just how intimidating it would be.

No matter what your WAM is or how many P+'s you get in this course, you cannot escape experiencing frequent disappointment and failure in life. For me, this meant that for the first few years in Medicine I felt inadequate, inferior, and mediocre, and I began to question whether I wanted to do this anymore. What was the point when I felt constantly overwhelmed by the expectations I felt I wasn't meeting, and when it started to destroy my self-esteem and even erode into my personal life?

It sounds dramatic when worded like that, but Medicine *can* be quite pervasive. The pervasiveness is fine, to an extent, because it reflects passion and commitment to the career.

Unfortunately, when it goes beyond feelings of passion and commitment and spills into the territory of obsessional and all-consuming, it becomes a problem. A problem that was snowballing into a critical issue for me.

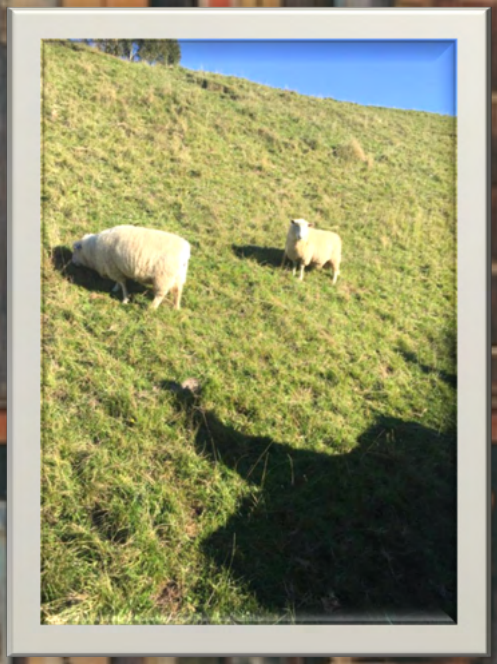
But then, somewhere over the years, I reached a turning point.

I changed the way I thought about my grades and my achievements. Looking back on things, my performance may not have been as good as I thought it could or should have been, but before I knew it I was here, nearing the end of the course. I don't feel like I know less than my peers or less than I should at this stage. I have confidence when at hospital, and with patients. And while I still struggle with the breadth and depth of knowledge we are expected to know, I feel comfortable with the understanding that the knowledge will come with time and experience, and that everyone around me is at the same stage.

The conference I presented at this year helped me realise that. I didn't do honours, and yet the work I had done had been deemed important enough to share with medical professionals from all over the country. My research was respected and people were interested in my findings.

It blew my mind because before that, I'd never felt like I was good enough to get that far. It was surreal but eye-opening to realise how close these amazing opportunities were to me. I was not beneath these things and there was no wall or mountain between these opportunities and myself. I simply needed to reach out and touch them.

It's easy to feel overwhelmed when you stack everything you need to do in life and in medicine on top of each other. It feels like a massive weight on your shoulders. But if you put it down for a moment and take a step back, you realise it's less like a mountain to climb up and more like a gentle river you wade through. Yes, you have to learn a lot, and your career path is a long one. But you grow with the career and your abilities grow with it too. The knowledge and skills you learn come with you and add to your strength. Instead of feeling like this course or your training is against you, an enemy trying to bring you down, this course is in fact working with you, buoying you up as you go along and equipping you with what you need to progress.



After I started to change my perspective on these things, I also realised that my goals, my views of "success", weren't the ones I wanted. Could I have better grades if I studied more every day, and could I max out my learning opportunities by staying at hospital until the sun went down? Yes, probably. But I wouldn't be happy.

So I decided that I wouldn't do that. And while it might sound lazy or unmotivated when put that way, it's not. I adjusted my goals. I learned to accept that the kind of studying I wanted to do was not about quantity or overworking myself. I wasn't happy with it because it didn't suit me, and that doesn't make me inferior to someone else.

Feeling success to me was reaching a healthy balance of achievement and happiness. I am happy to maintain a good level of studying while also enjoying my life and not driving myself into the ground with higher expectations. I learned to let myself relax and have days off without being wracked with guilt and stress.

A teaching session I went to recently really nailed this home to me. The doctor was giving a talk on specialist exams, and said this:

"From my experience, you need three things to pass your exams: (1) Intelligence – and not a single doctor I have met in my career is not intelligent, (2) Time – which, while difficult to make while working, is not unmanageable, and (3) A good headspace – this is the biggest reason most people fail their exams. You simply cannot do well if you're not in a good headspace. ***Stop comparing yourself to others. The only person you're competing with is yourself.***"

The last part was important to me and something I needed to hear. It said to me that you are your biggest enemy in all of this, but also your biggest ally. All throughout my struggles I had a lot of help and support from those around me, but a paradigm shift in the way I evaluated myself only happened after a lot of deep thought and introspection. Positive changes come from within; you have to learn to support yourself.

Going to New Zealand and attending the conference put me well out of my comfort zone and admittedly was stressful. I also did other things on the holiday I wouldn't normally do, like clay shooting and quad bike riding. But you know what? It was also exhilarating and fun, and I'm glad I decided to do them otherwise I would never have known I was capable of those things.

I wasn't shutting myself into a box with limitations, and the happiness and sense of achievement I got from that is success to me. However small, I was able to grow more as a person and add new experiences to my life.

For a long time, I was confusing social ideas of success with my own goals of succeeding, and it was pretty damaging to me. Now I know better. I may not be sitting on a HD, but that does not make me a failure. I know that I am competent and I have confidence in my abilities. And because of that, I have no doubt that I will become a good doctor.

World Glaucoma Congress 2017

Sascha Spencer (Year V)

In June this year I was lucky enough to have both my ILP and another research project accepted as posters to the World Glaucoma Congress in Helsinki, Finland. I had kind of assumed that an international conference for subspecialists would go way over my head, but I'm happy to say that I was only mostly right. While the conference had a lot of information about surgeries that I had never heard of, there was still some great teaching for our level. The moderator for one of the poster-walks that I presented for turned out to be one of the authors of several papers that I'd used in my ILP literature review, which was weirdly exciting and kind of like meeting a celebrity, only much nerdier. If I had any advice for people doing something similar, it would be firstly: try and go with your supervisor- thanks to mine, I got to meet some really interesting Ophthalmologists from all over the world. Secondly, look ahead at the schedule- there were so many things happening at once sometimes it was hard to pick and choose. Having a schedule of where to go and when made it much easier. I would like to say a big thank you to Medsoc in helping to cover the cost, it was a really fantastic experience and I would recommend to anyone and everyone.

OFFSHORE DETENTION HEALTH CRISIS:

‘ GRINDING MEN TO DUST ’

JUMAANA ABDU

Imagine dying from a cut on your foot. Imagine living under the Australian government and knowing your brother or son is no longer with you because he went for a walk and hurt himself.

For the family of Hamid Khazaei, imagination is unnecessary. The 24-year-old’s story is one us mainlanders have all but happily forgotten. From war and persecution to imprisonment on Manus Island to dying of sepsis due to onshore treatment that was delayed over *two weeks* because he ‘[hadn’t] obtained a visa’. Hamid’s story would have only compounded the suffocating atmosphere of desolation and insignificance felt by the almost 2000 asylum seekers being held in offshore camps. It seems in accordance with the ‘tragedy-of-the-day’ culture that has possessed the privileged world. We struggle to deal with the overwhelming plethora of health crises that are being dealt with every day, long after the newspaper headlines have moved on.

Meanwhile, just offshore, families wait with dwindling hope. Indefinitely. A prison sentence which is, in many ways, more punishing than the life-long certainty we afford even to murderers. Just offshore, Australia manufactures its own health crisis, intentionally fostering an environment where, according to a 2003 study, suicidal behaviours among men and women are approximately 41 and 26 times the national Australian average, respectively.

Yes, intentionally. The aim of the camps is to push asylum seekers to the point where returning to a home that no longer exists is preferable to staying. It’s evident in the $25,000 our government offers to any asylum seekers who choose to ‘return home’. And it’s poignantly clear in the first-hand retellings of Mark Isaacs, a Salvo volunteer on Nauru turned whistle-blower (for which the government took him to court); “The camp was built around destroying men…grind[ing] them into dust.” The accounts of frequent suicide attempts and barely existent health facilities Isaacs writes of in his non-fiction book, *The Undesirables,* are horrific, tragic, and most importantly, shameful.

However, the current government seems incapable of either acknowledging or comprehending this shame. But that is not an excuse for the rest of us to use density of the government as a scapegoat. As future health professionals, it is well within our capabilities to, if not change inhumane policies, at least improve the humanity of the health facilities in those camps. If something is not done, then any asylum seekers that do achieve that oh-so-elusive refugee status may indeed prove to be the very disturbed and unsociable health burdens that uninformed Australians paint them to be.

NO ALTERNATIVE FACTS HERE

When it comes to mental health, the statistics are staggering. Most of the men women and children in those camps are already deeply affected by experiences of torture or war faced before arriving

in Australia. A friend of mine worked with a refugee boy who, while attempting to migrate to a safer town, had seen his pregnant sister's belly cut open by rebel militia while she was still conscious.

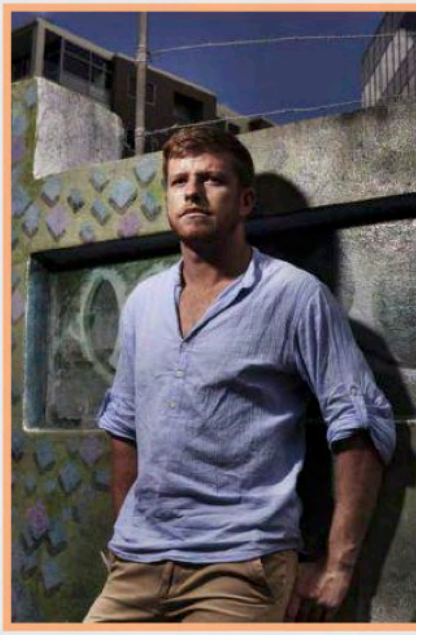
Instead of being met by much needed comfort and counselling upon their arrival, asylum seekers are placed in detention, faced with deep uncertainty, hopelessness and a fear for their future they thought they had left behind. For many adults who were skilled workers back home, months are forced to be spent wasting away the day with meaningless activities. And I will not even delve into the psychological damage done to children in those camps, some of whom were born into war or detention.

Prolonged detention in itself is a recipe for psychological distress. It groups together already traumatised communities for long and uncertain periods of time, often creating a mass psychology of frustration, despair and mental illness. The statistics speak for themselves.

Studies show that 95% of children detained on Nauru for between 3 - 17 months were at risk of PTSD. Compared to 2% of the general Australian population, 34% of children had moderately severe to very severe mental health problems. And 60-80% of detainees reportedly had some form of mental illness; anxiety, depression, PTSD, self-harm and suicidal thoughts.

Physical healthcare, as tragically proven by Hazim Khazaei's death, is no better. The detainees live in overcrowded conditions of poor water safety, sanitation and nutrition with little or no provision of health care despite the obviously high risk of communicable disease. In the past, detainees have suffered from gastroenteritis outbreaks due to extremely poor toileting facilities, as well as high risk of diseases such as malaria, which is common in the area. Moreover, the harsh physical conditions which a UNHCR Regional Representative described the conditions as "harsh, hot humid, damp and cramped," foster the mental health issues addressed earlier.

Health services at Christmas Island, Nauru and Manus Island are, at best, limited, at worst, non-existent. This is reflected by the numerous health professionals and human rights watchdogs such as Amnesty International which voice deep criticism of how the conditions in offshore detentions seem to consciously cause deterioration of its inhabitants mental and physical well-being. Medical treatment is almost always delayed and usually insufficient; Mark Isaacs' (pictured right) *The Undesirables* confirms the utter lack of health facilities on Nauru, painfully remembering the suicide attempts that occurred every other day and instances of men with broken bones being prescribed Band-Aids and Panadol.



All this only makes the possibility of full recovery from past trauma upon admission into the general public as refugees much slimmer. With the length of time in detention being shown to strongly correlate with the psychological detriments suffered by individuals, it is no surprise that many asylum seekers which are eventually settled in Australia after many months or years, often struggle to assimilate. The people responsible for offshore detention policies, those so afraid of foreigners 'coming into their country', are making it harder for the men, women and children who suffer under their ignorance to prove them wrong. It's a cruel self-fulfilling prophecy.

BE THE CHANGE YOU WANT TO SEE

The 'Stop the Boats' policy is naïve. Wilfully ignorant. Nowhere else is this captured with such despicable irony than in the image below:

The image shows September 3, 2011, Quetta – a suicide bombing kills 42 and injures 80.

Afterwards, men remove the bodies of those killed, against the backdrop of an Australian Government poster, warning people not to come to Australia "the illegal way".

No poster will stop a parent trying to save their child from a slaughter like the one above. People will go anywhere in the hopes of survival. If the government refuses to change its ways in the meantime, we must look to other methods of helping those suffering offshore.

The simplest thing you can do is donate to NGO's which support asylum seekers and refugee. Some of the primary asylum seeker aid organisations in Australia are, The Asylum Seeker Resource Centre, The Australian Refugee Association, United Nations High Commissioner for Refugees (UNHCR) Australia and The Refugee Council of Australia.

A much more comprehensive list or organisations can be found in the Solutions Module on AMSA's online Crossing Border's Education Portal, where you will find truly excellent and comprehensive fact sheets detailing the history, health issues, cultural issues and possible solutions surrounding asylum seekers. (http://crossingborders.amsa.org.au/educate/)

Additionally, you can support asylum seeker asylum seeker advocates like author Mark Isaacs, whose non-fiction works *The Undesirables* and *Nauru Burning*, will not only rock you to your core, but help you better understand the situation and how you can help.

For a more involved approach, you can join UNSW's Medical Students' Aid Project's (MSAP) Crossing Borders subcommittee, or volunteer at any of their events. You can also volunteer with Doctors for Refugees, which organises many stands against current asylum seeker policy on the basis that it violates the Hippocratic oath – they appreciate help from medical students, and can be found @Doctors4refugees on Facebook.

The list goes on. Opportunities to make a difference are only a Google search away. If not now, then remember those suffering offshore when you graduate. Remember them when you take an oath to 'do no harm'. Because by doing nothing, we are allowing harm to be done. When will we tire of only caring about asylum seekers when one of them dies for no reason?

amsa advocates
refugee and asylum seeker mental health

msap

CROSSING BORDERS FOR HEALTH AUSTRALIA

(Credit to Patrick Song and AMSA Crossing Borders for invaluable resources.)

Combined Otolaryngology Spring Meeting in San Diego

Sophia Ma (Year V)

In April this year I had the privilege of attending the Combined Otolaryngology Spring Meeting in San Diego to speak about my ILP work on vitamin D in sinonasal epithelium. Spring was an amazing time of year to visit California, and I highly recommend a visit, especially for those trying to avoid the inevitable seasonal change in the southern hemisphere. The meeting was an opportunity for those interested in the fields of otorhinolaryngology from around the world to come together, collaborate and hear the latest happenings in academia. I remember I was really excited to finally put some faces to academics that I'd only been able to appreciate via the mysterious inner workings (very often not-workings) of EndNote!

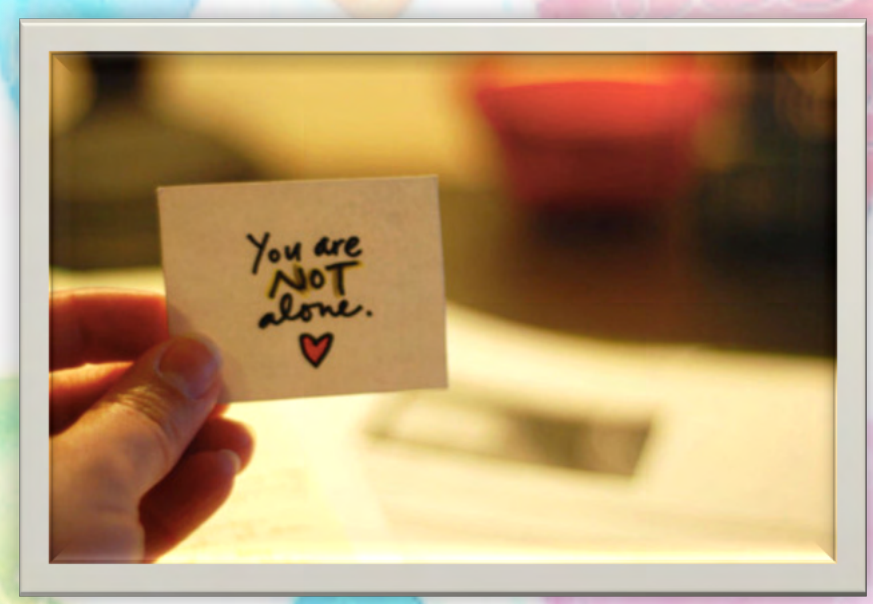
There was an interesting mix of basic science and clinical projects presented. The collegium had also organised several well-attended panel talks on topics pertinent to the workforce. The Women in Rhinology talk was particularly involved, and with input from residency directors, trainees, and professors, evolved into a productive discussion on how to tackle barriers to inclusivity of minority groups. It was really encouraging to see the issues being addressed in such a high-profile forum and I think everyone who was there left inspired and more aware, and perhaps with a few ideas to apply at their institutions.

The Transplantation Society of Australia and New Zealand had their annual scientific meeting in sunny Brisbane this year. I presented work on paediatric kidney transplant complications. The weather in Brisbane was also amazing, perfect for the launch of Fit for Life – a fun-run initiative to encourage physical activity in transplant recipients. Keeping physically active has been shown to help allograft organs last longer.

The talks were, again, an interesting mix of basic science and clinical research. A particular highlight was hearing infectious diseases/public health rockstar Prof M Lindsay Grayson speak about multi-resistant bacteria in hospitals. Prof Grayson is the director of Hand Hygiene Australia, and had recently returned from the WHO where he'd been working with a team to develop guidelines for antibiotic use and infection control in hospitals. He was an impassioned speaker, with an important reminder message of the socioeconomic burden of hospital acquired infections at both the patient and hospital level.

I had a whole lot of fun, and loved having a valid reason to be away. I am so incredibly thankful to the researchers I've met for their support, encouragement and mentorship. As scary as it is, I really encourage each of you to get involved in research projects that you can really get behind (it does wonders for motivation) and whenever the opportunity arises, to go out and let people know what you've found! Don't be afraid to ask your supervisors about conferences that are happening – it's impressive, it shows your interest and motivation, and they will likely have a few hints and tips about writing up a successful abstract.

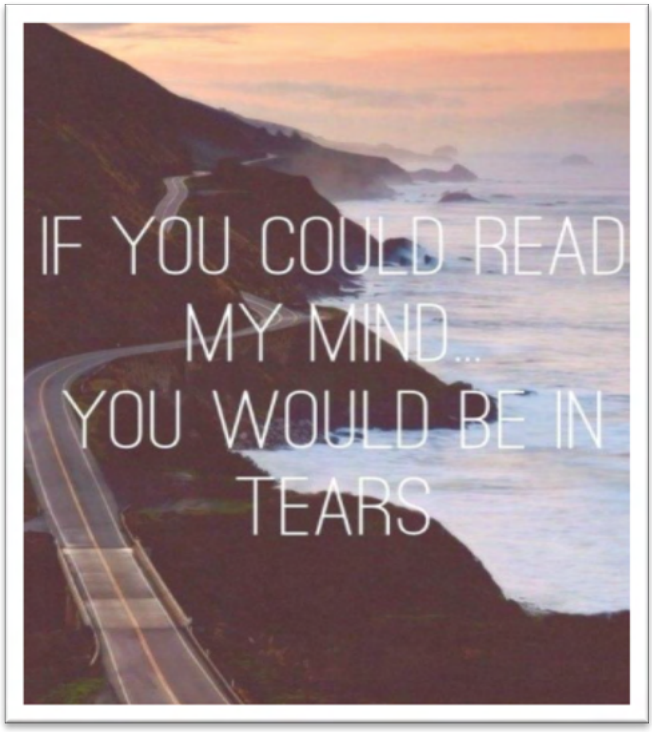
The 7.5%



Marisse Sonido (Medicine II)

In the beginning of first year (a time that seems simultaneously long past and just like yesterday), I first heard a statistic that I would become intimately familiar with in the next two and a half years: around 7.5% of medical students are currently diagnosed with depression. I kept this statistic tucked away in my mental box of interesting facts as an unfortunate, but distant aspect of this new community of people I found myself in. Wistfully, I hoped the situation would improve someday.

Fast forward to months later, when I find out one of the people closest to me in my year was suffering from depression. A few months later, another good friend. Then, a year and a half later, I am answering the K10 questionnaire in front of a nurse. I take a peek her notes and read 'minimal eye contact' and 'persistent low mood' and it hits me like a brick. I have joined the 7.5%.



Depression. It is talked about so often in the news and in our lectures that many of us simply accept it as a normal facet of life. And that's a good thing. With mental illness taking centre stage, there is a push to improve the situation on an institutional scale—increased resources, awareness and prevention that represent a significant step forward in making mental health a priority. I have found, however, that no amount of education and awareness was ever an adequate preparation for confronting depression in day-to-day life. It is impossible for any Headspace pamphlet to describe the exact nuances and difficulties that come with supporting someone with mental illness, or how it is to live with one yourself.

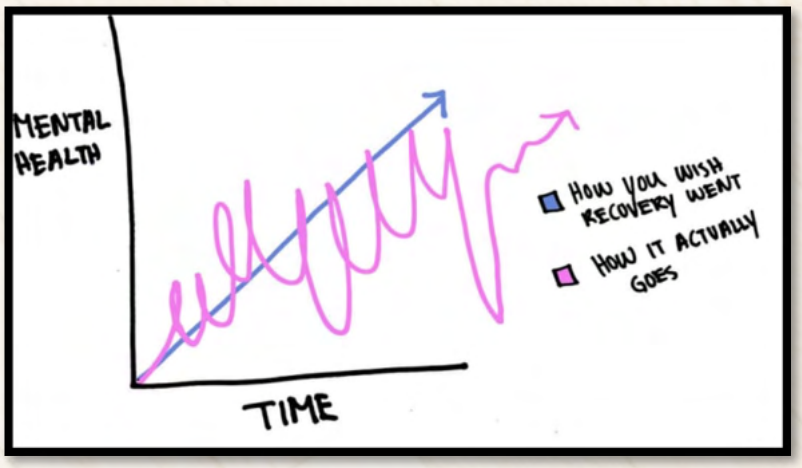
With the benefit of the experiences I have now, here are some things that I wish I had known before I had to learn things first-hand:

#1: Patience is a virtue (AKA Dory was right. Just keep swimming.)

Depression has a tendency make everything feel like an endless cycle comprised of a combination of steps:

1. Feel empty/sad/worthless/guilty or all the above
2. Find yourself too drained or unmotivated to fulfil your responsibilities, enjoy your hobbies and feel like a functional human being.
3. Find some healthy or unhealthy way to cope with the gnawing pit in your stomach. Options include (but are not limited to) exercise, binge watching Netflix and/or eating a whole tub of Ben and Jerry's.
4. Sometimes, you feel like you're getting better. Sometimes, you feel like you're getting worse. Sometimes, you feel like you're going nowhere at all.

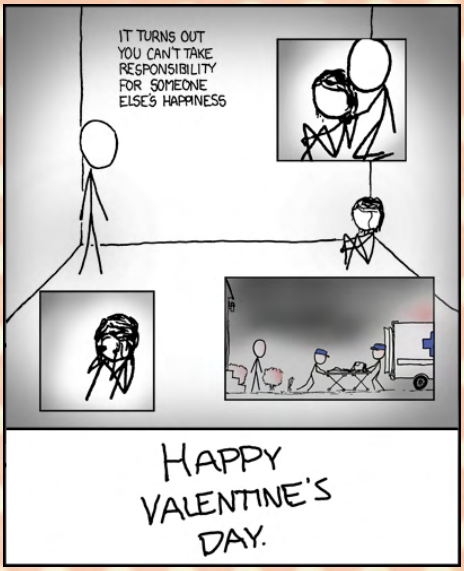
It can be frustrating seeing someone you love, or watching yourself, going through this cycle for what seems like the nth time. It is tempting to see a drastic life change as the solution out of the rut. I cannot count the times I have pushed myself into one new life philosophy or a major lifestyle change, trying to find a one-stop solution to a chronic problem—or suggested a friend do the same. Maybe it works like that in movies, but reality rarely cooperates with the script.



Source: Anna Borges, Buzzfeed Life

Hence, why being patient matters. While it does inevitably 'get better', it takes small steps to get there—and, sometimes, you accidentally go backwards. Some days, you'll feel like finishing your assignment, volunteering and writing a novel all at once; other days, you'll feel too drained to do anything as soon as you wake up. That doesn't mean it is hopeless. Every high and low is merely another step in the slow climb up.

#2: Love may be a drug, but it's not an anti-depressant.



Source: xkcd

Whenever I've been a confidant to a friend in need, I've felt a natural sense of responsibility to make a positive difference in whatever situation they're in. It is the same sense of altruism that pushes me to be a doctor one day, heightened several times over by my loyalty to these people I love. Because I know them well, I see myself as being in a position to 'reach' them when the typical cookie-cutter advice fails. It has always been tempting, especially in dire situations, to consider myself as part of my loved ones' 'last line of defence'—one of the people with the greatest ability and responsibility to help.

We live in a world that likes to believe that love is powerful enough to fix everything. As an idealist (and a bit of a hopeless romantic), it was always difficult to admit to myself that that notion could be utterly wrong. It hit hardest when I had to explain to my dad why I needed professional help.

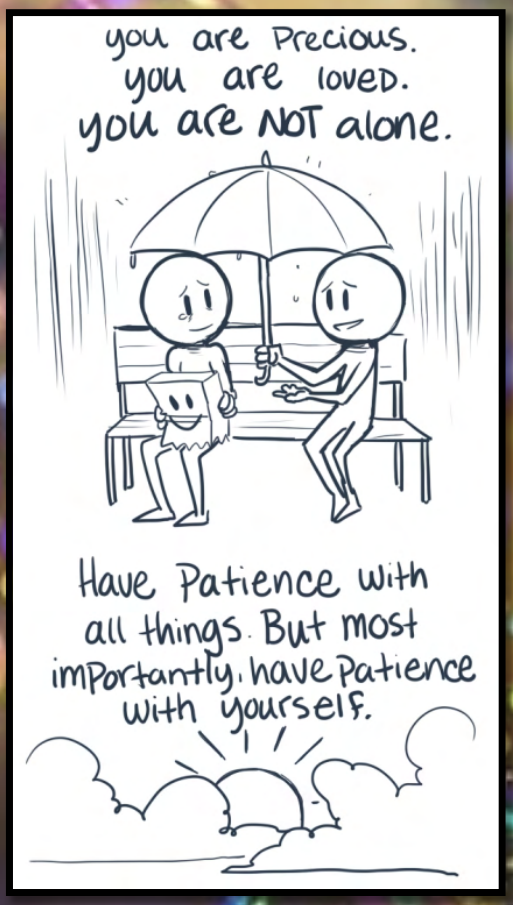
Coming from a culture that put family above everything and had quite old-fashioned views on mental health, he saw my mental illness as a sign of his failure as a father. 'Why aren't we enough to help?', I remember him asking. 'Why couldn't we protect you from this?' I saw, in him, my own desire to 'love' others into being well, and my own belief that I had the obligation to be the lifeline my loved ones needed.

I'll be the first to admit that this is a dangerous mindset to have. In my own experience as others' moral support, disappointment followed whenever I could offer no help; guilt and helplessness came when the situation appeared to get worse despite my reassurance—and, as I've mentioned, steps backward are not rare on the road to recovery. While feeling loved and supported can make a world of a difference to someone who is depressed, it will never be the sole cure. Unhealthy thought patterns and coping mechanisms often override even the strongest sense of reassurance and support, and addressing these should be a priority in managing depression. Very often, this means needing professional help. In many cases, medication may be necessary as well. Need for these things does not mean someone's social support has failed but, rather, it is an indication of how complicated mental illness is, and how multiple kinds of tools are needed to affectively address it on all fronts.

#3: You are going to feel like you 'need' to do it all alone. You don't.
Yes, I know everyone knows this. 'Get help' is literally the first thing anyone is told when the words 'mental illness' come up. As medical students, we can all probably name at least ten websites, helplines, organisations and Ute-equivalent health professionals that would offer some sort of support or advice.

Logically, getting help for depression is clearly a necessity, and not an option. In reality, it isn't always easy to confide in others when you are at your most vulnerable. Depression is a clever illness. Along with all the other insidious ways it changes someone's thinking, it is also very good at influencing individuals to keep its existence a closely guarded secret. For evidence, I submit the internal debate that goes on in my brain on a fairly regular basis:

Me: I really wish I could tell someone about what I'm going through.
Depression: Yeah, I guess you could do that. But knowing you, you won't, because then people will get worried. You hate getting people worried.
M: Yes, I do. If they notice I'm acting differently, though, won't they also get worried?
D: So don't act differently. Just play it cool, and no one can tell. Whatever it is, it'll probably go away on its own. And you don't want to bother them all with your problems *again*, do you?
M: But it's getting bad. Maybe I could just talk to a stranger about it, like Lifeline or a GP.
D: And waste their time? Come on! This is probably not even *that* big of a deal. You're just making it seem bigger in your head. Once you talk about it out loud, you'll realise it's just your usual old complaining. And even if they take you seriously, what makes you think they can help you? It'll probably take all the time you have to even explain to them what's going on and it won't even be enough!



Source: Colleen Butters, Tumblr

While perhaps this fictionalised conversation risks over-simplifying the issue, it is easy to see how it can seem reasonable for someone who is depressed to keep functioning in isolation. The feelings which come with the package—low self-esteem, emptiness, worthlessness, hopelessness—can easily colour what is usually straight logic, creating all sorts of irrational consequences for opening up to others. The worst consequence to most people, including myself, is that others will begin to see them as weaker or more fragile, and begin to treat them differently. I have found that this fear rarely reflects how others objectively are, but is more often a projection of how those with depression view themselves negatively for the emotional and mental difficulties that they face.

Does knowing this make me immune to closing myself off from others? Definitely not. However, acknowledging that I won't always be objective about needing help prevents me from dismissing that possibility entirely—no matter how 'wrong' it feels to seek support. Personally, I follow this formula: the more forcefully I insist to myself I that I don't need help, the more I probably need it.

Talking candidly about mental illness, is something we are beginning to do more often as a medical student community. It helps make an issue that once seemed comfortably distant, become a close—if sometimes uncomfortable—reality. These difficult discussions need to continually take place to ensure that we never stagnate in our efforts to improve an aspect of life so critical to our collective well-being as individuals and as future heath care practitioners. That 7.5% statistic is, and never has been, set in stone. It's up to us to make sure it continues change, and that it changes for the better.

Conference Report: ANZICS/ACCCN ASM & APELSO

David Zhang (Medicine V)

In October of this year, I went to the Gold Coast and attended a couple conferences. In all honesty, if you'd asked me earlier this year about whether I would go to a medical conference to present research from 4th year, I would have shrugged and said "probs not". I thought conferences would be highly specialised and technical discussions, and it would all just go over my head. And the thought of presenting research and getting grilled by people who knew a hundred times more about the subject matter didn't seem appealing. However when my supervisor asked me a few months ago about attending, I thought "why not", and took the opportunity to miss a few days of university.

The theme for this year's conferences on intensive care and ECMO was "thinking outside the flags". At face value, this seems to be against what intensive care is all about- making things as safe and stable as possible. But after hearing various speakers throughout the conference, it is clear that the ICU is a place of innovation, where there is huge scope to further develop practices and technology to support our sickest patients. One of the talks discussed the future of extracorporeal life support, and envisioned techniques such as ex-vivo organ regeneration, and ECMO at home; things that might become reality in our careers. As a medical student, it sometimes seems like we spend all our time focusing on what is already known in medicine, and forget that there is a lot more to be learnt. Going to a conference certainly helped encourage me to look forwards, not just backwards.

Presenting research at these conferences felt meaningful. When I first presented my project, I got some questions about methodology, stats, and so on, from the panel of judges; it didn't seem like any of the projects presented really mattered. It was only after the session that various people, from all areas of medicine, came to discuss specific treatment choices, parameters and findings from the research project. It was a good reminder that while research might be enticing for that extra line on the CV, it should be done to help improve our collective understanding of medicine. One of the talks from a senior researcher at the conference discussed how there is increasing pressure for junior doctors, and now even medical students, to publish research. He pointed out how much of the research had minimal/no impact, or had pretty big flaws, and served to muddy the waters. While students should be encouraged to take an interest, and perhaps a part, in research, there should be more emphasis on the type and quality of research.

Even though the conference was just a national conference, I was surprised to see people from all over the world attend the conference. Some of the many people I talked to included a perfusionist from the States, medical students from Asia and the Europe, and a paramedic from the UK. It was a great way to find out what medicine was like in other places around the world, and how different healthcare systems, education models, and local issues affected patients and doctors.

Overall, I got way more out of the conferences than I had expected. At first I thought I would spend most of my time exploring the beaches and attractions of the Gold Coast, instead of sitting in seminar rooms listening to presentations on things I wouldn't understand. But there were many talks that were useful and relatable to a medical student; things such as futility and when to stop treatment, and balancing hope and realism when talking to relatives of patients in the ICU.

If you have the opportunity to go to a conference, whether to present your ILP project or just out of general interest, definitely consider going- there's a lot you can get out of it!

Walama Muru

Erica Longhurst (Medicine III)*
*Article was written during Medicine II

During our stay, we had the opportunity to gain a deeper insight into the workings of the health care system in such a remote environment. A lot of our time was spent chatting to people we met on the island, who soon became our friends. One particular conversation was really powerful for me - a former social worker on the island was kind enough to share with us her thoughts on what matters to patients when they go to see a doctor. It is *trust*. The patient needs to feel comfortable going to see a doctor, so that they can share what is troubling them with the utmost ease and sense of safety. This is definitely something that occurs over a long time though, and it could potentially take years for such a relationship to form. Now all that focus on good communication really makes sense! There are always so many small signs that can really give you a better understanding of how to best serve anyone who comes to seek your advice.

The lovely chats and adventures that we had with the community of Palm Island were also accompanied by experiences that made us quite upset with the inequity and unfairness that continues to occur in Indigenous communities across Australia. Simple things like the extremely overpriced nature of the supermarket on Palm Island. There was only one supermarket on the island, and this was *owned by the government*. Despite this, the average price of a loaf of bread was $4.30. We met many families who have to take the two hour boat trip to Townsville every two weeks to do their shopping. Factoring in the cost of transportation and accommodation, this is still a cheaper option than shopping on Palm Island. How is this fair? How can anyone be expected to eat a varied and healthy diet when it is so expensive to purchase basics? This is just one example of the various things that we were shocked about, and thought needed to be changed.

Each year, Arc runs an Indigenous cultural immersion and volunteering project known as Walama Muru. Walama Muru is an opportunity for university students of all faculties to get a better grasp on what Indigenous communities are really like, and in doing so, contribute to the process of reconciliation. Throughout this year, the Walama Muru group fundraised to go to Palm Island, an island off the coast of Townsville in Queensland. In the mid semester break, myself and 17 other university students had an incredible experience living and working in the community.

Palm Island is home to the Bwgcolman people. The Australian Government originally used Palm Island as a settlement for Indigenous people, which essentially was an example of extreme and brutal discrimination. Originally, the island was set up as a jail and mission, and the treatment of people on the island was anything but just. People from many different Indigenous communities on the mainland were sent here. Despite their diverse cultures and languages, they formed the collective identity 'Bwgcolman', which actually means something along the lines of "all one". This definition really does encompass the essence of this vibrant community.

Time and time again, we are told as medical students that we have to be culturally aware and respectful when we approach every patient that we meet. This is so true. However, how can we actually achieve this if we don't have a good grasp on the complexity of a culture that is the essence of Australia's history?

Something that has often crossed my mind is how little I know about Indigenous Australian cultures. By going to Palm Island, I was hoping to change that. I saw that there are rich traditions and customs in every facet of life on Palm Island. Before the trip, there were many thoughts in my mind about how *different* my culture was to the one that I was going to be learning about. However, at the end of our stay, I could list more similarities than differences. For example, there is nothing more that the families like to do on the island than just relax and spend quality time with each other either at the beach or at a family get together and barbecue. There is a real urgency amongst the parents regarding providing their children with the best opportunities in terms of education and health care as well. There is an incredible attitude of selflessness that we saw on Palm Island, which meant putting your community and family before yourself in almost every instance.