2016 Edition 1 April

The Pulse

Surgery: A Cutting Edge Career

Deakin Medical Student's Association

Welcome to The Pulse 2016. The Pulse is MeDUSA's quarterly student newsletter written by students, staff and medical professionals alike. It aims to engage minds, provoke discussion and stimulate interest in all things medical.

We will be kicking off the year with Surgery: A Cutting Edge Career. Surgery has a long and rich history, filled with both extraordinary advances and devastating complications, making the field one of great interest and discussion. In this edition, we have a range of articles based on experience, insight and opinion. We also have feature articles, including an interview with Dr. Elysia Robb of the Victorian Medical Women's Society, and an elective report from Corey Thompson (Class of 2015) outlining his experience at The Victorian Institute of Forensic Medicine.

Thanks is given to all those that have contributed to this first edition, with particular thanks to 2nd year student Kate Thimbleby who illustrated the front cover. Now sit back and enjoy reading The Pulse.

Benjamin Paul
Editor (3rd Year)

MeDUSA

A Student's Guide to Surgery

10 tips for surviving theatre

By Pippin Freeth (4th Year)

1. Be a wall

2. If you can't be a wall, be very close to the wall.

Unless there is something important on that wall and then you should find a new patch of wall. Alternatively, hide behind a large machine. If they ask you if you are having trouble seeing, lie and say you have perfect visibility!

3. Scrub longer than anyone else (by about 10 secs).

They will think it's because you care so much about sterility. In reality, it will enable you to mimic everything that the Surg Reg does. Follow at about 2 metres. Repeat everything they do, including saying the same glove size. If you are quick enough they may be there to help you do your little gowning swirl; and it will always be the wrong piece of string that you offer. Then stand in the most obvious 'I'm not touching anything' position and wait to be directed.

4. Gloving.

The hardest thing you will ever do. Do it facing a wall if the judging eyes of experienced theatre staff put you off. Going so very slow? Don't worry, on average it does in fact take longer than your standard D&C and that's fine, you wouldn't be doing anything anyway.

5. Sterility.

Don't touch anything.

If you want to touch something, maintain nervous eye contact with the local theatre nurse and move your hand very slowly towards the desired object, you will be informed if you are about to break sterility.

6. Breaking sterility.

You will do it. You will break gloves, break gowns, touch lights, touch your face and brush your arm too close to someone's back. This is fine, look startled like a rabbit and don't move until someone explicitly tells you what to do or physically moves your body. Try some apologetic eyes, it may diffuse some of the red hot rage currently directed at you.

7. Eat food.

There is food in the staff room, eat as much as you like! If you feel guilty about it or are up to your 17th sandwich, mention loudly that your blood sugar must be a little low. They won't want you passing out into someone's abdomen, you are just being sensible.

8. Passing out.

If you feel like passing out, stand close to your beloved friend the wall, and casually slide down it as if you were just feeling like a nap. Not near a wall? Try and aim

your slumping body away from the patient, sterility IS more important that your wellbeing!

9. Be helpful.

You are useless at the actual surgery and your presence is a burden to everyone. So be helpful in other ways. Is the Reg's phone ringing? Don't feel awkward, put your hand in their pocket, answer it and gently cradle it against their cheek. Take messages for them with your best grown up voice. Be their lackey; if they ask you turn up their music? Do it. If the anaesthetist asks you to turn it down, don't. The Surg Reg can fill out miniCEX forms and you don't have anaesthetics till 4th year. I can guarantee you the anaesthetist will not remember you at all (thanks theatre masks!)

10. Anatomy knowledge.

Not as important as you think! As an ambiguous masked student, you can usually just take a stab and act interested in the right answer. In Ortho, you should know the four X-ray signs for osteoarthritis and you're golden! In O&G, know what a ureter is/looks like and don't act disgusted when your shoes get soaked in blood and amniotic fluid. In Gen Surg, mention Calot's triangle and nod interestingly as different noodle-like structures are pointed out to you.

And finally, if someone asks you if you are interested in surgery, lie and say of course you are!

The second edition of The Pulse is just around the corner and we want you to get involved!

Our next edition will be titled **Medicine: Art vs Science**. We are looking for article submissions on this hotly debated topic. to be sent to publications@medusa.org.au

Articles on current research, personal experiences, opinion pieces or anything else related to the core theme are encouraged. If you have anything else that you wish to be published in The Pulse feel free to send it through as well.

The Pulse relies on student contributions to stay alive and stay relevant so get typing and send in your submissions.

Get involved, inspire others and write something to make a difference!

Surgery in Africa: A First Hand Experience

By Madison Phung (1st Year)

Lying on a wooden plank in an under-staffed and poorly funded hospital, the doctors have just cut open her abdomen and uterus and delivered her two beautiful babies. Suddenly, there is a complication – her placenta had detached from her uterine wall and she's bleeding excessively. Her blood pressure drops and heart beat slows almost reaching a halt. The doctors are pushing on her chest in an attempt to revive her. My immediate thoughts were "Please live, for your children." After some time, her heart beat manages to creep back up to normal, she has been resuscitated. There is a sigh of relief. What I have just described to you is the very first surgery that I saw during my time in Tanzania.

I spent 2 weeks in Tanzania during my gap year and could probably say that it was one of the best experiences of my life. I was given the opportunity to shadow the doctors over there and spent most of my time on ward rounds or scrubbing in on surgeries. My experience in Tanzania allowed me to truly understand the large disparities between surgery and just health care in general, in developing countries and the Western world. The surgical beds were essentially wooden planks almost the same width as the patient. I could only imagine how uncomfortable it would be for the larger patients that we encounter in Australia. They did not have elaborate machinery or technology - they had the bare minimum that would allow a surgery to be performed. At times, the unreliability of power in the hospitals meant many individuals relying on life support would die because of a power outage. And these were only a few of the shortfalls that were presented in the infrastructure and physical structure required to provide basic surgical

Tanzania, Africa

Open reduction and internal fixation of femur

care. Nonetheless, the medical staff over there do such an incredible job with what they are provided.

Of the other many surgeries that I saw, there was one that truly resonated with me. I had scrubbed into an orthopaedic surgery of a man who had fractured his femur. Due to lack of education and the difficulty and cost of transportation, he had waited an entire year before he managed to get his femur repaired and as a result, the two broken bones had fused together side-by-side leaving him with a shortened limb. This had impacted gravely on his overall quality of life and its almost hard to believe that he had endured that for a year without any medical attention as this is an unlikely

X-ray of the fractured femur

scenario for someone living in Australia. He underwent an Open Reduction and Internal Fixation of the femur which involved the surgeons hammering in steel rods and screws in order to realign the two bones and then suturing everything back together to allow it to heal.

I have always had a strong interest in surgery ever since wanting to do medicine and look forward to learning more about it as I progress through the course. We are very fortunate to be able to study and train in such a medically advanced and well-developed country like Australia. I would encourage us medical students to increase our awareness on issues such as the unmet surgical need in countries like Tanzania so we able to promote global change as future doctors. Ultimately, we can help prevent a situation like what I have described above from occurring.

Surgery: Quick Statistics – Australia

2.4 million - Number of hospitalisations requiring surgery per year

26% - Percentage of hospitalisations that included a surgery (59% private, 41% pubic)

12% - Percentage of surgeries that were emergencies (83% elective, 4% child-birth related)

55% - Percentage of emergency surgeries performed on males

Acute appendicitis - Most common reason for emergency surgery (followed by hip fracture and myocardial infarction)

Cataracts - Most common reason for elective surgery (followed by skin cancer and knee disorders)

36 days - waiting time for 50% of patients on public hospital elective surgery waiting lists (90% admitted within 252 days)

$350,383 - The average taxable income of a surgeon per annum

5-6 years - Time to complete the surgical training program (following completion of a medical degree)

53 hours - The average time worked by a surgeon per week

Opinion Piece

Bullying in Surgery: My Experience

By Pooja Krishnaswamy (3rd Year)

There is no doubt that bullying in medicine is rife, particularly towards students and trainee physicians. Albeit hidden from the public eye most of the time, the recent inflammatory reports of bullying and sexism described by the media last year highlights just how prominent an issue it is for all doctors, regardless of their seniority. Not only is this psychologically taxing on doctors, it poses a major impact on patient safety and quality of treatment for patients.

As medical students, our role in the clinical setting is unclear in how we can help advocate for bullied doctors. I was curious to find out whether we have the right to step in and what boundaries we could cross. As someone who surreptitiously wants to pursue a career in surgery, I thought I would share my own opinion of the current perplexing situation that is bullying.

From a personal perspective as a medical student currently in a surgical rotation, I have heard of the difficulties doctors had to endure before they reached where they are today. Many had to work long gruelling hours, while others were forced to tolerate constant demoralisation from their predecessors. ELPD teaches us that there should be a no tolerance policy towards bullying. I also agree that there is a trend for the better, where junior doctors are establishing a less hierarchical system and in retrospect more of a working-teaching relationship. The problem with a no tolerance policy is that they are increasingly difficult to implement when bullying is so subtle and elusive.

Bluntly, there are cases that can be effortlessly distinguished as bullying. However, the difficulty lies in the situations where the bullying is not as black and white but instead endemically constrained to a grey area. There will always be a fine line tread between a sarcastic comment that could be taken as a joke, or instead interpreted as something far more sinister. The interplay of people's individualised perceptions and reaction towards these very situations and remarks makes it even more problematic to judge and interpret.

Not only that, there is an existing perception of some doctors that bullying acts as a test of emotional strength and power. The aim, to weed out and separate the weak from the strong. The result, to select individuals that excel past these difficult and gruelling 'trials.' The added and most concerning difficulty is in proving that these inappropriate experiments occur. The fear implanted into a victims mind of reprisal, impact on career and minimization of the situation only perpetuates

a never ending cycle of silence, anguish and cruelty.

You always hear about surgery-related bullying allegations in the media; scalpel throwing doctors, intellectual humiliation of junior doctors and students during operations, harassment and propositioning for sex, and undermining or belittling of junior doctors. I was recently exposed to the hazing and demoralisation of a junior doctor and I have to admit it was difficult to watch, and even more difficult to stand up and say something about it. It only reminded me that snide and off-hand remarks that you might think nothing of can markedly imprint on another individual's impression of you. You may be competent and reliable at your job, but other health professionals and colleagues are less likely to respect and trust you. As medical students, this is a vivid reminder that we ourselves should not take our own actions and words for granted.

A reminder that the influence that these words bare on a receiving victim can be tortuous and ultimately life-ending.

It should be noted that bullying and harassment is not unique to the surgical profession, but rather to the medical profession as a whole. In fact, we have to accept that bullying is everywhere and in most aspects of our daily life. From a young age, we try and fit into established norms and groups, but there is always someone that we all distinctly remember made our life difficult at one point in time.

Bullying has infiltrated many different work sectors, one of the worst being the health care system. It is an underlying issue that needs to be addressed. Although there is general consensus and acknowledgement that bullying has become rampant in the medical profession, the main challenge is addressing and dealing with these abhorrent situations. Unfortunately, the realm of tackling bullying appears to be challenging as it is not as clearly defined as one might think.

As medical students we have the potential to change the current toxic culture. We have the chance to learn from past situations and prospectively mould our future practise towards changing our approach to these difficult and emotionally charged ordeals. It is only a matter of time before we ourselves are confronted with these situations.

As human beings, I think we have a duty of care to protect our colleagues and friends. No repercussions should be held against those who advocate and speak up for victims of this toxic culture. Mistreatment should be reported and sanctioned, and culprits held accountable. It is our responsibility not only to ourselves, but exceedingly to our future patients to appropriately confront, address and most importantly change and take action against these ugly practises.

Deakin Surgical Interest Group

Who we are:

We are a special interest group consisting of Deakin medical students, democratically elected under MeDUSA, dedicated to catering to the anatomy and surgical interest of students studying a Bachelor of Medicine Bachelor of Surgery at Deakin University.

The team:

DSIG Chair – Morgan Short

DSIG clinical Representative – Andrew Awad

DSIG Preclinical Representative – John Kefalianos

What we do:

DSIG provides opportunities for students to engage with each other, practicing surgeons, and clinical staff in an extra-curricular environment through organised events.

We also liaise with other surgical interest groups inside and outside of Australia to bring you other valuable learning opportunities including national and international conferences.

DSIG plans to host numerous events throughout 2016. These include:

- Weekly anatomy tutorials hosted by surgical trainees from University Hospital Geelong open to any students wishing to strengthen their anatomy

- Seminar evenings where surgeons are invited to share stories about their careers and experiences; aimed to advise, inspire and challenge medical students

- Surgical skill workshops which will provide opportunities for students to learn and practice their skills such suturing, knot tying and removing sutures

Upcoming events:

Anatomy Workshops

When: Every Tuesday at 6:30 pm, starting 12 April 2016

Where: Geelong Clinical School

A Cutting-edge Career: DSIG Surgical careers seminar

When: Tuesday 26 April 2016, 5:30 pm

Where: Geelong Clinical School

DSIG Presents: Women in Surgery

When: August 2016

Where: Geelong Clinical School

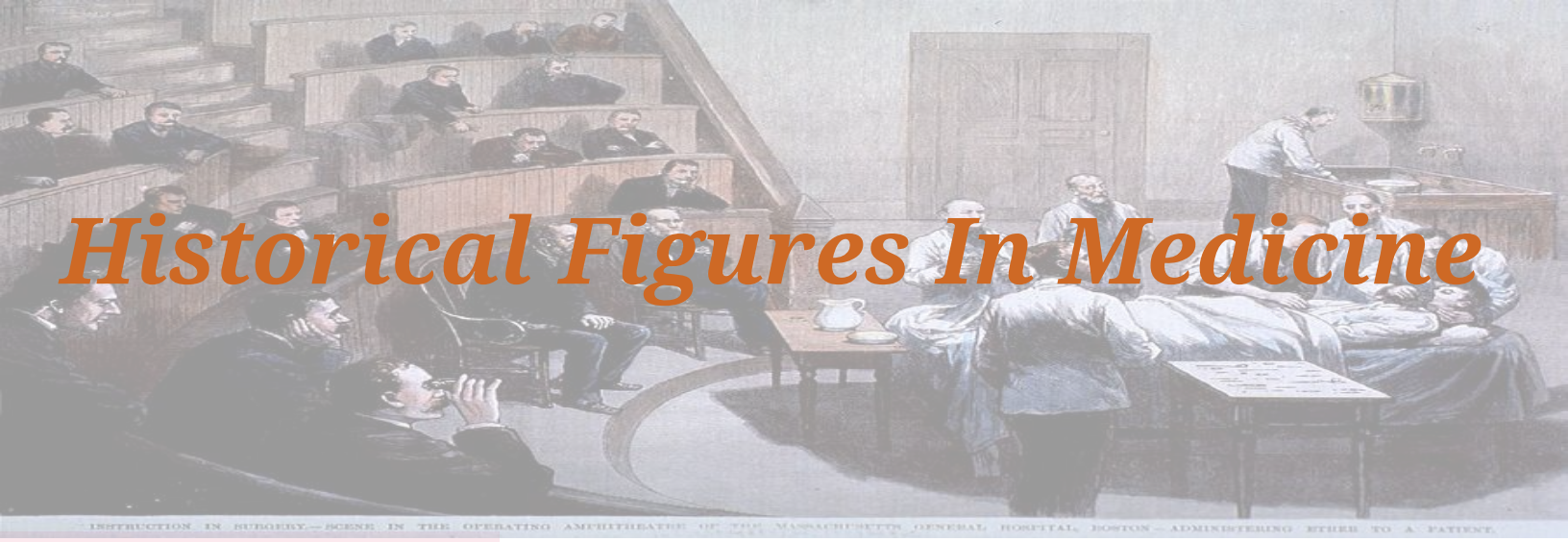
Surgical skills workshop:

When: October 2016

Where: Geelong Clinical School

Keen to know more?

Like us on Facebook to keep up to date with the latest news, events and opportunities. Feel free to post any questions or email us at dsig@medusa.org.au



Historical Figures In Medicine

William Stewart Halsted
1852-1922

Halsted: A surgeon, pioneer and addict

By Benjamin Paul (3rd Year)

William Stewart Halsted was a pioneer of modern surgery in the US. His life was both intriguing and complex, filled with daring surgeries, a meticulous work ethic and hidden addictions. Halsted was born into a wealthy family from New York, and went on to study at Yale where he was the captain of the football team. He furthered his studies at the College of Physicians and Surgeons Medical School in New York City, where he graduated near top of his class in 1877. By all accounts he was an enthusiastic, charismatic young man whose knowledge of anatomy was second to none.

As the House Physician at both Bellevue Hospital and New York Hospital he envisioned and created the very first bedside charts to track and observe vital signs. He then broadened his skills by travelling to Europe to learn from the leaders in academics and the medical profession. This included the likes of Theodor Billroth, Hans Chiari, Richard von Volkmann, Edoardo Bassini and Friedrich von Esmarch, amongst others. Armed with new teachings and a fresh outlook, Halsted returned to the US in 1880 and worked at four different New York hospitals, where he was a bold and original surgeon, as well as a demanding teacher.

During this time he performed two of his more audacious procedures. The first involved his sister who was having a postpartum haemorrhage following the birth of her first child. Unable to control the bleeding, and with his sister approaching a rapid death, Halsted transfused his own blood directly into her, saving her life and in the process probably performing the first transfusion in America. A year after this incident, Halsted again operated on a member of his family, this time on his mother and her infected gallbladder. Under lamplight at 2am on the kitchen table, he drained pus and removed 7 stones from her gallbladder, again performing one of the first gallbladder surgeries in the US.

In 1884, Halsted discovered the use of cocaine as a local anaesthetic from which a story of addiction began to unfold. He and his colleagues experimented with cocaine, using themselves and their medical students as guinea pigs. Unfortunately, this led to the ultimate demise of most involved, and those that were left, including Halsted, were left with severe cocaine addictions. This hampered his ability to adequately perform his duties, and after the submission of an almost incomprehensible journal article, Halsted admitted himself into Butler Hospital, a rehabilitation centre for drug addiction. He spent the best part of the next two years here, finally relieving himself of his cocaine addiction, only to replace it with a lifelong addiction to morphine.

1889 saw the opening of John Hopkins Hospital, one of the most prestigious and influential hospitals in medical history. Halsted was recruited to start up the new hospital as part of the 'Big Four'; four outstanding physicians including pathologist William Henry Welch, physician William Osler, and gynaecologist Howard Atwood Kelly. Here, Halsted was appointed Surgeon in Chief, and eventually, after gaining the trust of the hospital board following his rehabilitation stint, Professor and Chairman of Surgery.

For the next 3 decades, Halsted worked at John Hopkins Hospital, although the audacious surgeon he had once been was now but a vivid memory. During these years, Halsted became more reclusive, started taking extended holidays and began operating in a more delicate and precise manner than other surgeons of the time. His gentle handling of tissue, vigilant reapproximation of tissue planes and meticulous care for organs led to great advances in surgical technique.

"Watching Halsted operate was the first time I ever saw the upper half of an incision heal before the lower end was closed."

Halsted developed new methods for hernia repair, radical breast cancer surgery, bile duct and thyroid surgery, as well as teaching the future generation of exceptional doctors including Harvey Cushing, Walter Dandy and Hugh Hampton Young. His slow and meticulous approach did however draw some criticism, such as from Charles Mayo, who upon visiting John Hopkins and observing one of Halsted's surgeries noted, "Watching Halsted operate was the first time I ever saw the upper half of an incision heal before the lower end was closed."

Amongst his many achievements, Halsted is also surreptitiously credited with introducing the use of rubber gloves during surgery. Caroline Hampton, head theatre nurse of John Hopkins Hospital and wife of Halsted, developed dermatitis to the mercuric chloride used as disinfectant during surgeries. To avoid this, Halsted wrote to Goodyear Rubber Company and requested a pair of thin rubber gloves for Hampton to wear. These gloves proved popular amongst the other nurses, and eventually the surgeons, though surprisingly, the connection to asepsis was never considered by Halsted.

It was not until some 5 years later that Dr Bloodgood, one of Halsted's residents, suggested that everyone wear them as a

Halsted & Cushing operating at John Hopkins

matter of aseptic technique. The irony was not lost on Halsted who quipped, "Operating in gloves was an evolution rather than an inspiration or happy thought … it is remarkable that … we could have been so blind as not to have perceived the necessity for wearing them invariably at the operating table."

In 1919, Halsted developed obstructive jaundice and cholecystitis, and underwent a cholecystectomy and choledocholithotomy. He recovered well from this, however, three years later in 1922, he once again became severely unwell with marked jaundice. After travelling to John Hopkins, where his residents successfully operated on him to remove stones in his common bile duct, he developed post-operative bronchopneumonia and consequently died on the 7th of September 1922, leaving behind his wife Caroline and their two dachshunds, 'Nip' and 'Tuck'.

William Stewart Halsted's life and career will be forever remembered for shaping the world of surgery. He has been the feature of many biographies and documentaries, as well as the source of inspiration for the current TV show 'The Knick' on Cinemax staring Clive Owen. Through his heroic acts and debilitating addictions, influential teachings and changing personality, Halsted certainly remains one of the most interesting and intriguing individuals to ever grace the field of medicine.

Surgical Complications: A Case Review and Application of the Clavien-Dindo Classification System

By Callum Robinson (4th Year)

During my surgical rotation in third year, I was involved in the auditing of surgical complications that had occurred within my unit. Unfortunately, surgical complications are inevitable. However, we should ensure that we reflect on and understand these complications so that we may minimise the risk of them occurring from them. This principle is not specific to surgery and can be applied to any medical speciality. As part of the audit, I retrospectively analysed a patient's case and attempted to identify complications that might have caused an adverse outcome in this patient. Through this process, I was able to learn about systems for classifying and communication surgical complications.

Clavien-Dindo Classification System:

Grade I - Any departure from the standard post-operative course that did not require any pharmacological, surgical, endoscopic or radiological intervention.

Grade II – A pharmacological intervention was used that would not otherwise be used as part of standard post-operative care is used to rectify a complication.

Grade III – A surgical, endoscopic or radiological intervention was required for a complication.

- *IIIa* - The intervention did not require general anaesthesia.
- *IIIb* - The intervention required general anaesthesia.

Grade IV - A complication occurred that was life-threatening.

- *IVa* - Single-organ dysfunction occurred.
- *IVb* - Multiple-organ dysfunction occurred.

Grade V – The complications resulted in the death of the patient.

The Clavien-Dindo system for classification of surgical complications was born from a lack of consensus on how to categorise and grade surgical complications. In 1992, Clavien-Dindo et al. proposed a new classification system that appeared to be valid and highly reproducible for quality assessment in surgery.1 It is based on the type of therapy that was required to rectify a complication and is the standard for surgical auditing world-wide.2

The Patient

A 70 year old woman presented to the emergency department with nausea, post-prandial vomiting and declining food and fluid intake in the setting of a localised squamous cell carcinoma of the distal oesophagus diagnosed two years ago. Her symptoms had been present over the past year but had worsened to intolerable levels over the past week. She reported regular night sweats but had no fevers, abdominal pain, bowel or urinary changes.

Her past history included chemotherapy and radiotherapy for her oesophageal cancer a year prior and an oesophageal dilatation performed earlier that year. She had a significant and extensive smoking history which had not been quantified at any point during her previous admissions. She also had a long-standing history of depression and anxiety, exacerbated by her cancer.

On examination, the patient appeared unwell, dehydrated and cachectic. Vital signs were within normal ranges and she was afebrile. There was no evidence of lymphadenopathy, masses nor any

other remarkable findings. The unit's impression was of a patient who was dehydrated and malnourished as a result of an obstructive distal oesophageal SCC.

Management, Complications and Outcome

Shortly following admission under the surgical team, a gastroscopy was performed with a stent inserted in the oesophagus to relieve obstruction. However, an X-ray showed that this stent had migrated distal to the gastro-oesophageal junction. This rendered it ineffective and a threat to the distal gastrointestinal tract. Two days later, another gastroscopy was performed to rescue the stent but failed.

Three days later, a laparoscopic gastrotomy was performed to remove the rogue stent. The next day, the patient was found be febrile and tachycardia. She had developed new-onset atrial fibrillation. It was believed that this may have been caused by an underlying infection. Tazocin and metoprolol were prescribed. However, the patient remained in asymptomatic atrial fibrillation.

Four days following her gastrotomy, the surgeons made another attempt at gastroscopic insertion of an oesophageal stent. However, once again, an X-ray found that this stent had slipped out of place. Another gastroscopy was performed the next day to reposition the stent and hold it in place with resolution clips.

Eleven days after her presentation, the patient was discharged the next day following three gastroscopies, two oesophageal stents, a laparoscopic gastrotomy and persistent atrial fibrillation.

Application of the Clavien-Dindo System to this case

We can apply this system to the complications encountered along the patient's pathway of care introduced earlier. Firstly, gastroscopy was performed, but failed to retrieve the slipped oesophageal stent. This represents a grade IIIa complication (general anaesthesia was not used).

The gastrotomy was performed to remove the same stent. This demonstrates a more invasive grade IIIb intervention under general anaesthetic. The atrial fibrillation and medical intervention for this was a deviation from the standard post-operative course and is thus a grade I complication. The final two gastroscopies performed to reinsert, reposition and fasten the stent represent two more examples of grade IIIa complications.

Discussion

Communication is essential to all aspects of medicine. Universally used systems are often devised to ensure information is communicated in a clearly understood and reproducible way. The Clavien-Dindo system one such example of these.

Complications and adverse events are an unfortunate reality. When they do occur it is imperative that we reflect on these incidents. This allows us to better understand why they have occurred and develop methods to prevent them from happening. We should use these events as opportunities for improving patient care and providing teaching and assistance those that need it. For example, in this instance, I presented these findings to a surgical unit. After some discussion it was agreed that resolution clips to hold the stent in place should have been used earlier in the patient's care, after the first stent slipped out of place (side note: these stents are also exceptionally expensive!).

Conclusion

In terms of direct relevance to the Deakin medical student, in their surgical rotation, 3rd years are expected to submit an assessment on a patient who has encountered post-operative issues. The Clavien-Dindo system might be a good framework to reference when reflecting on how complications unfolded.

Victorian Medical Women's Society (VMWS) Profiles: Dr. Elysia Robb

Interview by Sylvia Ye (4th Year)

in my opinion

Breastfeeding on the run

Please join me on my breastfeeding journey as I ask the question: What is it that makes breastfeeding in public in Australia offensive to many?

Dr Elysia Robb

Sometimes I start to feel sorry for my neighbours and passers-by ... then I regain full consciousness and realise that breastfeeding is one of the most beautiful and special experiences in the world. So what if they cop a view of a nipple or a breast as I switch sides or 'pack up' or express? Or as I express and feed at the same time? Or — this is a good one — as I coat my nipples in breastmilk and air-dry them.

I breastfeed everywhere. And I mean it. On my first day home from hospital with my 3-day-old firstborn, when I knew not what I was doing, I breastfed while pushing the pram back to hospital for a physiotherapy session, as I was running late! These days I breastfeed while I walk down the street, at the museum, at weddings and other parties, and at the park. Sometimes I walk around the playground while feeding. This is particularly difficult and even somewhat dangerous but is sometimes a necessity when the elder sibling is exploring.

Recently, I was very impressed by a friend who breastfed her baby while standing and crawersing at a party. She did it using a baby-carrier on her front and she did it with ease — well at least that was how it seemed. Of course I have copied this method since, which has enabled me to breastfeed in many more situations and locations. I must say though that, while it definitely facilitates a whole new level of breastfeeding, it is not as easy as it looks. It is awkward. Getting your breast and nipple into the right position, getting your baby into the right position...

I remember the first time I tried it. I was shopping at the Queen Victoria Market. My two babies in the monster double pram. 'Baby-baby' needed a feed, and 'toddler-baby' was getting bored while I attempted to pick fruit and, to make matters worse, I was being fussy about it. So I put 'baby-baby' in the carrier and onto the breast and I continued to choose fruit. 'Toddler-baby' decided to start climbing out of the pram. He was standing up before I knew it, which meant I had to hold the pram in counterbalance it, while still choosing fruit, delicately now, in an attempt to not ruin the feeding attachment. The shop lady could see I was in trouble, so she offered him some grapes. Thankfully, this placated him and he sat down and ate.

Nonetheless, I stopped fussing. I have learnt over and over that fussy and mothering don't go well together. I know I only had a minute before the grapes would be devoured, so I finished my shopping. We made it home without further issue. Thank goodness for the kind lady and the grapes and, of course, the baby-carrier. Sometimes my life is a circus!! Sometimes there is just not enough time to not breastfeed while doing something else. When there is an opportunity and baby is hungry, I take it.

Is this too much? Should I be more choose about where I breastfeed? Should I worry about my company or exposing some flesh to strangers? Is this article even a little too confronting? After all, I have used the word breast a lot!

Well, I personally don't think so, and here is why.

Breastfeeding is one of the most beautiful and natural practices there is. It is not without difficulties — pain because of poor attachment, not to mention the self-doubt and the unrelenting, time-consuming and draining nature of it. For those who manage to get over these humps, excuse the pun, it can be an incredible experience and has many benefits that I'm sure I don't need to list in this forum. The importance of breastfeeding is reason enough to encourage breastfeeding in all domains.

The primary biological function of the breast is to produce milk to feed and nourish a child. Well at least so I thought till I did some research.

In Mali, West Africa, women breastfeed everywhere. Malian women place significant value on the 'kinship' relationship between mother and child and between two children who have fed from the same breast, such that to not breastfeed renders the child unrelated to the mother in this patrilineal society and nursing from the same woman creates bonds of kinship between otherwise unrelated individuals. In Mali, breasts hold no sexual connotations for either women or men and the people of Mali

Dr. Elysia Robb is a mother of two, partner of one, daughter and sister of many and part-time intern. She completed her MBBS, graduate-entry at Melbourne in 2014. She grew up in the country and before medicine had been busy – including a yearlong exchange in Panama, a BBiomedSci degree and Honours and a career in Alzheimer's Disease research. She has a keen interest in public health and was previously involved in Teach the Teacher, a program aimed at bettering sexual education in schools and hence sexual health in our community. She is currently an active member of the Victorian Medical Women's Society, as a general committee member and plays a role in coordinating the VMWS student representatives.

Elysia is a proud feminist and equalist and is grateful for the ability we have in Australia to choose to work or to stay-at-home. Elysia had her two beautiful kids while at med school and since becoming a mother, Elysia has become even more passionate about equality for women *and* men. Elysia has faced many challenges juggling babies, breastfeeding and medicine.

In her spare time - for the most part, her past-life - she loves listening to music, playing the guitar, dancing and teaching salsa and dancing flamenco.

What does VMWS mean to you and why do you believe it is important to have a medical society dedicated to women?

I became involved in VMWS as a student; I attended some events that included presentations about disempowered groups such as women, refugees and asylum seekers. Then I became a student representative and started attending committee meetings and most VMWS events, where I interacted

with and was supported by a large group of established medical women.

VMWS means support for me personally and professionally. It means supporting minority groups who need it, which applies to me both personally and professionally as well. I find many women-only events to have a personal vibe, very different to open events. Although it may seem exclusive, I really appreciate the opportunity to experience such women-only events, whereby I feel safe to express myself honestly and others seem to also. I like hearing factual and evidence-based information, but I really enjoy hearing personal and anecdotal stories at VMWS events and feeling the emotional atmosphere. Women admit and discuss things in our spaces that they perhaps wouldn't otherwise. As a part-time intern, the first and only one at my hospital and only one of eight ever in Victoria, I really benefit from debriefing in the VMWS.

'Part-time internship is an excellent, and very rare, opportunity'

How has intern year treated you so far? Can you tell us a little bit about the part-time internship and how have you juggled two children and a busy job?

I am very grateful for and lucky to have the opportunity to do my internship part-time. There are many positive aspects of this. First and foremost, having plenty of time with my family – making for a very manageable and happy home life. Yet it has been quite a difficult year so far for many reasons, especially since I am the only part-timer. In particular it is difficult to *not* be totally immersed in medicine in my first year out and it is an extremely difficult way to attempt to establish a career. I.e. I imagine going back to an established/specialist job part-time would be far easier. Progressively, these difficulties have lessened with time and I predict that when I have finished my internship at the end of the year, I will feel like I have had an excellent experience.

Part-time internship is an excellent, and very rare, opportunity. Although it has disadvantages, mostly because it is very new, I believe there are many ways to improve the program and that it can only get better from here. I hope part-time junior doctor positions, for both women and men, increase in numbers in the coming years, and I think this will positively and greatly influence the nature of part-time junior medicine. In an ideal world I would like to have as much time with my family as I currently do, *and* to work full-time at the same time!

Is there a particular specialty or area that you would like to go into and why?

Although I am still unsure, currently I am most interested in obstetrics and gynaecology, oncology and palliative care. These interests stem from my interest in women's health, locally and globally, and probably my own wonderful personal experiences in gestating, birthing and parenting.

Due to my previous career in biomedical science, I really enjoy molecular based research and hope to re-enter this field one day. Perhaps this influences my oncology interests. Recently I have also become very interested in general practise. In particular, I like the continuity-of-care and the lifestyle friendly training program and consultancy it offers.

As a junior doctor, what do you believe are some of the biggest issues regarding women's health or women in medicine?

With regard to women in medicine, I think the biggest issue is trying to mix work with family, finding a partner and/or having children. This is probably one of the major reasons that there is a relative lack of women

in senior positions in medicine, and hence can account for some of the sexual harassment and bullying that has recently been a focus in medicine. It is extremely difficult for a woman or man to find a part-time job as a junior doctor. Little paternity leave entitlements for men puts the obligation on women to take time off to look after their children and in the meantime neglect their careers. Also, society often expects women to do the majority of childcare and household tasks, and doesn't expect, encourage and/or allow the same of men.

As a junior and female doctor, are you worried at all about bullying or having your work and achievements acknowledged equally?

As a junior doctor I do worry about the expectations placed on us by our seniors. I do think there is a difference in how men and women are perceived in the medical workforce however I am not aware of having experienced this firsthand. I haven't worried about not being acknowledged equally due to being a woman, but I am very junior in my career so perhaps I haven't got to a point yet where this exists.

I have been in situations where patients have seemed to trust my male colleagues more than me. Once as students, a patient mistakenly asked me where the male doctor was. He was not yet a qualified doctor, but the patient had assumed he was – perhaps because he was male, probably also because of his demeanour.

In addition to this, I am part-time so I worry a lot about not having my work and achievements acknowledged equally. I am the first one and the only one at my hospital, so a bit of a guinea pig and have no one to compare myself to or to be compared to. I have had some difficult encounters at work relating to this, I think this is because some people don't understand that I have other priorities.

Do you have any advice for female doctors to balance work, family, friends and finances?

Choose what is important to you and do not worry about what others are doing or thinking. I realise this is easier said than done. Don't hesitate to ask for things that you need, or to 'rock the boat' as they say, for things like flexible training, maternity leave, breastfeeding rights etc., and don't be afraid to do them. Don't hesitate to ask repeatedly for things you really need. Get help, support and advice the whole way through. VMWS is great for this!

If you're thinking about having children, or thinking about thinking it, there is *no* best or worst time in our medical careers to do so. The only worst time is when it is biologically difficult and in a highly demanding career like medicine, we can easily get side-tracked.

For more information about VMWS, go to: http://afmw.org.au/vic

Elective Report: The Victorian Institute of Forensic Medicine

By Dr. Corey Thompson (Class of 2015)

The elective rotation is one of the most exciting things to look forward to for fourth year. Unfortunately it is something that requires reasonably great preparation with a tiny bit of soul searching. It is important to decide what kind of elective experience you are trying to achieve (observational vs hands on, full time attendance and expectations vs no real expectations, contact and interest building for future career vs exploring unique fields of medicine).

I spent 6 weeks at the Victorian Institute of Forensic Medicine (VIFM) in Melbourne gaining insight into forensic pathology and clinical forensic medicine. Whilst this might seem like an odd choice when many are choosing to pursue electives in tropical locations, pathology is a highly important area of medicine which underpins EVERY medical speciality. You will be better prepared to appear in court, write medical reports, death certificates and documents which are often overlooked in conventional medicine teaching.

9 way teaching microscopy – I bet you haven't seen one of these before!

When most people think of VIFM they think autopsies, of which 8-20 are completed every day. There is ample opportunity for the interested student to be involved in processes such as the weighing of organs, preparing samples for photographs and dissections. Police reports, case files, pathology and radiology meetings are also accessed on site to pull together information and determine cause of death to present to the coroner.

There were also many offsite activities such as courts, clinics and toxicology meetings. Pathologists and clinical medicine physicians are frequently summoned to court to be an expert witness and detail their findings to the court. This may be explaining to a jury how a patient died in a murder trial or a detailing extent of injuries and how they might occur (e.g. bruises) in a domestic violence hearing. It is interesting to see when the defense gives the doctor a hard time and tries to refute their findings or question their knowledge.

I commuted from Geelong throughout this elective, which did have its downfall of very long days. Many aspects are also confronting, however the quality of teaching and supervision was amazing. Motivation is essential to get involved, with all staff very approachable and receptive to the student learning experience. It is recommended you apply early at least one year ahead of your predicted time, as VIFM is a popular choice for students across Victoria. Most of the places are reserved for Monash University selective students as VIFM forms part of the Monash University department of medicine. Be sure to have a read of the elective reports from myself and other students who have been to VIFM.

Thanks for reading!
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