PACEMAKER

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# ARVs Are Not Enough

## *A story from the Bangkok slums*

**By Benedicte Sjøflot**

During my gap year, I worked in the slums of Bangkok with an organisation called the Human Development Foundation (HDF). The organisation works to support and educate residents in the slum areas of Bangkok in many ways, one of the main focuses being to help people living with HIV.

Although I was aware of the severity of the HIV/AIDS pandemic, I hadn't realised how the reality of living with HIV has changed over the last decade.

At the end of 2013, 35 million people were living with HIV globally (UNAIDS), and 440,000 of those were Thai. The increased availability of Anti-retroviral drugs (ARVs) means that HIV/AIDS is "no longer a death sentence, but a manageable, chronic condition" (UNAIDS, 2013).

In Thailand, ARVs are provided for free by the government. Still, there are important barriers to treatment and management, especially for people in slum communities. For example, to be admitted to the free ARV programme, the hospitals require a Thai registration card, which many undocumented slum dwellers do not have.

When I arrived, the HDF had just closed down their free AIDS hospice, which cared for people in the final stages of their lives. Because of the accessibility of ARVs, this hospice had become redundant. Now the HDF works in people's homes, and I was allowed on a few of their visits. This is the story of Mr B, a 46 year old man whom I met in Aril 2013, who was living with HIV in the Bangkok slum.

After an hour on a bus through Bangkok traffic, the HDF crew of nurses, councillors, and volunteers arrived in a slum neighbourhood by the canal in the north of Bangkok. Mr B came to greet us, smiling. He was tall and thin, and used a assistive cane as he was blind. He welcomed us into his home, a shack the size of a Stopford Building PBL room, where he lived with his wife and son. He told us that after moving away from an abusive father aged 17, he worked as a bartender in a central Bangkok slum area. He had multiple sexual partners and abused alcohol and drugs. There was talk of HIV, he said, but he didn't think much about it and didn't know how it was transmitted.

Image by Benedicte Sjøflot

*A slum neighbourhood in northern Bangkok, Thailand.*

He thought he became infected at around the age of 20. A few years later, he married his long term girlfriend and built a home, settling down to a calmer lifestyle. They later had a son. Still working at the bar, he started noticing noticed frequent illness and infections. He had recurrent lung infections, fevers and headaches, and noticed rashes and lesions on his skin. Being ill wasn't too bad, he said, until he started to lose his eyesight. (The nurse explained that this was due to Cytomegalovirus retinitis). By the end of the 1990s he was severely visually impaired.

As a result of his disability, fatigue, and frequent illness, Mr B had to leave his job. His wife, also HIV positive but asymptomatic, had to work two jobs to feed the family.

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## *Problems for Whistleblowers Continue*

**By Cressie Moxey**

In light of the upcoming annual Doubleday lecture, to be given this year by Sir Robert Francis QC, Manchester Medical School continues to keep abreast of current affairs in the NHS.

Sir Robert Francis chaired inquiries into the failings of care at Mid Staffordshire NHS Foundation Trust, where an estimated 400-1200 patients died as a result of poor care between January 2005 and March 2009.

The Francis report, published in February 2013, made a series of recommendations to encourage whistleblowing and promote a culture of openness within the NHS.

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## Small Decline in UK Incidence of Tuberculosis

**By Cressie Moxey**

We all had our vaccination status against tuberculosis (TB) reviewed when we started at Manchester Medical School; and, as the next year of new arrivals to MMS go through the same occupational health proceedings, Public Health England (PHE) have published the annual figures for TB cases in the UK last year.

The UK has seen a fall in the number of new cases of TB from 8729 cases in 2012 to 7892 last year. Nonetheless, this only represents a small decline, and incidence remains high compared with most other western European countries.

With a rise in incidence since the 1980s, and only recent years reflecting a high but relatively stable trend, Paul Cosford, director for health protection and medical director at PHE, comments, "it is too early to tell whether this is the beginning of a downward trend and certainly no time for complacency". However, he described the small decrease in cases and incidence over the past two years as "encouraging".

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Also in this issue...

# *Cover Story:* ARVs Are Not Enough

**By Benedicte Sjøflot**

CONTINUED FROM COVER - I asked about the treatment; didn't the government provide it for free? He said it was difficult getting to hospital (only hospitals provide ARVs), because of the cost of transport. If he did get there he would often be escorted out because of how he looked. "Hospitals don't like slum people, especially not the blind ones."

When I asked about support from his family or friends, he said "I didn't want to ask for help from my neighbours, I didn't want them to know. They would not respect me anymore."

Losing face is a big deal in Thailand, and admitting weakness to your peers is difficult. He kept it a secret for as long as he could. His shack started to fall apart, and the roof was leaking.

In 2004, B's wife heard about the HDFs programme. They helped him in many ways, with transport, registration at the hospital, advice on treatment, and talking to the doctors. Taking the cheapest ARVs is difficult as they must be taken three times a day with a meal, and Mr B only ate once a day.

The family received food donations and help rebuilding the house, and from then on HDF staff visited monthly to check up on them.

Mr B said that the best thing about the home visits was talking about his condition. A lot of the HDF personnel are HIV positive themselves, making it easier to share fears and worries.

Simling, Mr B added, "I accept it now. It makes me weaker, but I am still me."

Nine years after beginning treatment with ARV and receiving help from HDF, Mr B has a stable CD4 count of 342. He is now almost completely blind, and has multiple skin lesions due to Herpes simplex and oral mucosal infections thought to be due to Candida. He has a place to live with his wife and son, and enough food to survive. He seems motivated to continue treatment, although he sees no way of returning to work.

HIV/AIDS is becoming a chronic condition with the global spread of ARV treatment. In the case of Mr B, extra support was crucial for access and adherence to treatment, and therefore the preservation of his quality of life.

Limited by funding, the HDF helps around 350 patients and their families in the Bangkok community, and with the current HIV prevalence in Thailand, such help is in great demand. According to the World Health Organization, the prevalence of HIV positive patients that are visually impaired is expected to rise with access to life-prolonging ARV treatment. Life expectancy for these people is limited.

Breaking ARV patents was a vital step in the fight against HIV/AIDS, but it is not enough. Patients now live longer, many with disability, and a new challenge lies in enabling individuals living with HIV to cope with their secondary conditions.

As it's been over a year since I met Mr B, I called the HDF to see how he's doing. He is happy that his roof held for the whole rainy season and hopes you'll all visit him in Bangkok!

Image by Benedicte Sjøflot

*A HDF staff nurse taking Mr. B's pulse.*
*For more information about the Human Development Foundation, Mercy Centre, please e-mail benedicte.sjoflot@student.manchester.ac.uk or see www.mercycentre.org*

# When Will You Ask? The Big Balloon Launch

**By Helena Sweeney**

The sky above Owens Park campus was filled with colour on Friday afternoon thanks to the When Will You Ask? Campaign's balloon launch event. Aiming to de-stigmatise mental health issues within the student community and encourage open discussion about emotional wellbeing, the campaign is run in association with Greater Manchester Nightline- the listening-ear service that serves Manchester's four universities- and Storm Skills Training.

More information can be found at the campaign website www.when-will-you-ask.com.

Image by Elyssa Liu Jiawen

# The Manchester Wilderness Medicine Society

**By MWMS**

The Manchester Wilderness Medicine Society (MWMS) is a longstanding student organisation with a variety of interests, ranging from first aid and pre-hospital care to global health and disaster medicine (and everything in-between!).

We kick off the year with our annual freshers' weekend adventure trip into the wild, initiating new medschool recruits into the epinephrine-fuelled realms of emergency care (what better way to spend a Sunday afternoon than being radioed to a helicopter crash!).

For the geeks in our midst, there will be a series of upcoming lectures on the above mentioned topics given by the best in the field.

Previous speakers have included a doctor who skied the Antarctic in a t-shirt (and had the lowest ever blood glucose reading at the pole – Sir Mike Stroud), doctors who work on helicopters, and Manchester's very own Tony Redmond, always first (British professor) on scene in response to any international humanitarian crisis.

For those interested in cutting up cars with heavy machinery, we have (and will again because it was awesome) taught students how to extricate patients from car crashes in partnership with local fire departments. Other events have involved us hosting the 2012 National Student Wilderness Medicine Conference (which was a pretty big deal), indoor and outdoor skills days and race days at Oulton Park.

Watch this space for our student-run expeditions, as well as a promising multidisciplinary event to be organised by our president, Chris Wheeler, where a huge simulation involving paramedics, nurses and doctors will follow a casualty scenario from roadside to bedside (good luck organising that one, CW!).

Join our society at 'www.manchesterstudentsunion.com', add our 'ManchesterWMS' facebook page, and for more information contact us on 'manchesterwms@googlemail.com'. Whether you're completely new to the game or a seasoned jungle veteran, we're looking forward to hearing from all you crazy cats!

Image by MWMS

# *Seizing Opportunities: Success for Manchester Student*

Pacemaker talks to fourth year Manchester medical student, **Alicia Pawluk**, who recently won a national prize for a project proposal submitted for the RCGP/SAPC Annual Elective Prize.

**As told to Olivia George:**

**What did you do and why did you do it?**

I was able to undertake my elective period Victoria, Canada, with generous funding provided by the RCGP/SAPC. The clinical portion of this elective focused on providing respirology and tuberculosis care in the community and at a local rural hospital. During this time, the effectiveness and treatment outcomes of patients with Mycobacterium avium complex (MAC) were audited.

Although the initial intention of my elective was to assess the outcomes of patients with Mycobacterium tuberculosis in rural communities, the focus of my project shifted to a similar bacterium that is relatively unknown in contrast to its more infamous cousin. The local Director of Tuberculosis felt that it was more relevant to do my audit on MAC, as cases of MAC on Vancouver Island had never before been formally studied.

This was the first of many lessons that I learnt throughout my elective; although research plans may be decided, it is much more useful to allocate time to projects that the local community needs most.

**What did you learn clinically?**

The clinical study that I undertook alongside my audit research was phenomenal. I was able to participate in assessing respiratory conditions and tuberculosis in the community. Cases included foreign-born labourers who had travelled to Canada to work in the farming industry, as well as indigenous patients who had been living in close quarters with a relative who had been diagnosed with tuberculosis. Late symptom presentation was common, and non-compliance was a challenge by language and cultural barriers. I was also able to assess multiple patients with MAC, the basis of my audit.

I learnt from my data that MAC remains a challenging clinical dilemma. The interpretation of the ATS guidelines, especially in the community, is a difficult decision for clinicians.These results show that symptomatic, rather than radiologic, outcomes may be the most relevant outcome measure for physicians. Furthermore, the continuation of treatment for an extended period of time is a purely clinical decision that must be made in the context of each individual patient and their tolerance for indefinite treatment.

One of the main challenges encountered throughout this audit was the difficulty in obtaining patient information. Hospital electronic records were compiled in one database, and treatment through the tuberculosis clinic was held separately. Furthermore, there were many patients that had incomplete hospital records, or their records were stored in other facility elsewhere on the island. As more data is obtained from these missing records, I am confident that there may be more useful interpretations of the existing data that has been collected.

**What do you feel you gained from undertaking the audit and clinical study?**

I had the incredible opportunity to encounter respirology and tuberculosis patients in the community setting and now have a much broader understanding of the difficulties encountered when treating communicable diseases, especially when cultural and language barriers exist. Conducting a clinical audit on a relatively unexamined condition has no doubt been a valuable experience that will be of great benefit in my career as a general practitioner.

**What is your advice to students wanting to get involved in similar opportunities?**

The best way to get involved is to be proactive. There are many opportunities for competitions on Medlea, but I would suggest also looking online to see if there are any competitions in the speciality area you are interested in. I would encourage all medic al students to apply for these competitions, as a bit of extra work is undoubtedly worth it. Winning competitions and prizes is an excellent way to stand out on core training or speciality training applications, as it shows dedication and early interest in a specialty field. Competitions are announced year round, and an easy way to be prepared is to keep an updated CV at all times –you never know when you'll need it! Overall, by entering competitions you have nothing to lose, and I would strongly suggest it!

# Upcoming Society Events

**Thursday, 16 October**

11:00pm - Medsoc presents 'FULL MOON'

**Saturday, 18 October**

9:00am - Scalpel's 6th Annual Undergraduate Surgical Conference

**Monday, 20 October**

6:00pm - CATS Lecture on diagnosis of cancer in the young

6:30pm - MMOC Choir Rehearsal

8:00pm - MMOC Orchestra Rehearsal

**Tuesday, 21 October**

6:00pm - MUMPS Lecture on diagnosis in paediatric immunology

**Wednesday, 22 October**

2:00pm - Intercalated Degree Fair

**Thursday, 23 October**

Day 1 - Psychiatry Revealed Event

**Friday, 24 October**

Day 2 - Psychiatry Revealed Event

**Wednesday, 29 October**

2:00pm - Doubleday Lecture

Medsoc's Halloween Party

**Saturday, 1 November**

Scalpel's RCS Skills Day

**Wednesday, 5 November**

6:00pm - Bonfire Night!

6:00pm - Medsoc Lecture on Confidentiality

**Saturday, 8 November**

9:30am - Sports and Trauma Day by FAST, Scalpel, SEMSoc, ASiT

**Thursday, 20 November**

7:00pm - Medsoc Lecture on Clinical Audit

**Want to feature your society's events in the next issue? Email Yousef at pacemakerdeputyeditor@gmail.com.**

# All Your Eggs in One Basket?

**By Sarah McBrinn**

Egg donation is the process of donating your eggs to couples who are unable to conceive a child themselves for various reasons. It is a compassionate gesture and can give the chance of parenthood to people who no longer thought it was possible.

For many people, having children is seen as a natural and normal part of life; that is, until they discover that it may not be possible for them. There are multiple reasons why a woman may be unable to conceive; increasing numbers of women today delay motherhood until later in life when it's not always possible, in some cases ovaries are damaged by chemotherapy and radiotherapy cancer treatment, others may have a genetic disorder or premature menopause. Despite this, these women have the chance of having a child with the use of a donor egg.

In the UK the demand for donor eggs is unfortunately overtaking supply with a resultant shortage in eggs, meaning that some couples may have to wait for a long time. One way of encouraging people to donate was the introduction of a £750 compensation fee, yet even with this incentive, the shortage continues.

A reason for this reluctance may be the fact that since 2005, although the egg donor's identity remains anonymous to the intended recipients, the child has the right to obtain information about the donor from the age of 18.

This can raise a lot of questions, particularly if you have or want children of your own. However, the Human Fertilisation and Embryology Authority offers lots of support and guidance throughout this process and is the regulating body of all egg donation in the UK.

After considering all the implications, if you decide that egg donation is for you then you have the chance to help families struggling with conception – a truly generous act.

Insider's Perspective – I spoke to a friend (anonymous) who is currently in the process of egg donation.

**Could you briefly describe the process and any concerns you may have?**

After filling in an online application I was given an appointment at a nearby clinic. They explained what they were going to do and gave me a second appointment for a scan and counselling session. The next appointment involved a blood test and in a few weeks I will start the hormone injections. After daily hormone injections for two weeks I will have a minor operation under sedation to remove the eggs. My only concerns are about the risks involved in the operation, and also the potential side effects of the hormone injection.

**What made you decide to donate your eggs?**

We had a lecture talking about organ donation and they mentioned the shortage in egg donors which inspired me to look in to it. My own strong desire to have children made me think that if I was in that situation I would hope that someone would do the same for me.

# Problems for Whistleblowers Continue

**By Cressie Moxey**

Continued from Cover - However, nearly two years on from the public enquiry, the organisation Patients First continues to campaign for better rights for whistleblowers. Patients First has submitted a dossier of 70 cases to an independent review of the reporting culture in the NHS.

The review, Freedom to Speak Up, was established by the Department of Health in England and is being conducted by Sir Robert Francis QC. The call for contributions to the Freedom to Speak Up Review closed on 10th September, and Sir Robert is expected to make recommendations to the Secretary of State for Health by the end of November.

Patients First chairwoman, Dr Kim Holt states, "There has not been any real progress."

Nearly half of the cases in the dossier are still ongoing, but all of the whistleblowers have reported some adverse effects. These include the professional, personal and financial implications of raising concerns. Fifty-five of the cases reported bullying, including being suspended, ignored and removed from cases. In 20% of cases, whistleblowers sought legal advice without success, or had simply run out of funds. Many whistleblowers are referred to professional bodies only to have their concerns dismissed.

Following Francis' report on the public inquiry to Stafford Hospital, measures have been implemented to try to encourage whistleblowing. These measures include an end to gagging orders and a "duty of candour" to promote honest and open reports about mistakes made in the NHS.

According to Health Secretary Jeremy Hunt, "We have come a long way since the tragic events at Mid Staffs but we still hear of cases where staff concerns are being ignored."

# Small Decline in UK Incidence of Tuberculosis

**By Cressie Moxey**

Continued from Cover - TB is concentrated in large urban centres, such as London and Manchester, where the disease disproportionately affects the most deprived communities. Here, rates can be more than triple the national average of 12.3 cases per 100,000 people.

Such statistics highlight the economic determinants of the disease. However, with nearly 75% of all cases occurring in people born abroad, and 85% of cases reported among settled migrants rather than new entrants to country, TB has clear social determinants as well as economic.

The report addresses these factors, attributing the small drop in incidence over the past two years to a decline in the disease among UK people born outside the country: most likely a result of changes in migration patterns and the impact of interventions to control the disease in the UK and abroad.

Dr Lucy Thomas, head of TB Surveillance for PHE, asserts that, "sustained reductions in TB, particularly amongst the most vulnerable groups, will require the social and economic determinants of the disease to be addressed, in addition to the provision of strong and effective public health and clinical services."

Public Health England and NHS England will soon publish their Collaborative TB Strategy for England 2015-2020, establishing plans to help continue the downward trend of tuberculosis incidence in the UK.

# Experience: Global Health Intercalation

**By Josh Walker**

The room, it's fair to say, has got a little heated. "But don't Global Health actors just hide behind neutrality to avoid putting themselves at morale discord (dilemma??). The distribution of Humanitarian Aid, whether we like it or not, has a political 'charge'. Bias is inevitable".

We're amidst our 2nd Seminar of a War, Migration and Health Module, discussing the contrasting stances of 'bearing witness' and 'maintaining neutrality'. The International Committee of the Red Cross (ICRC) have always maintained that by remaining impartial in the administration of Aid, they can transcend political tensions and so rely on being granted access to places of humanitarian crises. Medecins Sans Frontieres on the other hand, want to break free from the shackles of passive complicity and voice its concerns to the world about the atrocities it sees.

I must admit, when I applied to intercalate in Global Health, I didn't really know what the course would entail. I knew I would be able work on my essay writing skills, my public speaking and learn about various public health systems but apart from that I had very little insight. I certainly wasn't expecting to spend my Thursday afternoons locked in passionate debate. Having spent the first two years of medical school caught inside a textbook I cannot tell you how refreshing it is to take a step back and engage with the pertinent issues surrounding global healthcare.

From researching how culture influences the perception of Ebola in Sierra Leone to reading why undertaking IVF might "produce the very 'desperateness' that it is often represented as helping to relieve", the multi-faceted nature of the course not only means continued interest but also universal relevance.

# Pre-Medical Volunteering:
## *A tricky business*

**By Olivia Holtermann Entwistle**

Type into google 'medical volunteering', and a veritable feast of enticing organisations and exotic locations will greet you. But underlying the promises of adventure and lending a helping hand might be something darker altogether. On my gap-year, I went on just such a trip to Tanzania, and left disillusioned with the whole idea. When I went away I didn't have great expectations of making a real difference. I hoped instead to learn something about healthcare in the developing world. What I actually discovered was a far more uncomfortable truth.

To call this type of activity volunteering is a complete misnomer. You wouldn't call a cat a dog, so lets just call this what it is: paying for an 'experience'. But the word volunteering lends a veneer of the charitable to it and has no doubt served the companies that offer the trips well. Volunteering implies working for free, offering your time and skills. Paying to go implies that they need your money, not your time. It isn't goodwill or charity, its business.

The hospital I was based in was overrun with 'volunteers' just like me; untrained, unknowledgeable and unhelpful. It seemed to be creaking under the sheer weight of patients and diseases – malaria, HIV and TB at every turn. With this mountain to climb I have no doubt that our presence was complicating matters. Why would a doctor with tens of patients to see to find it helpful to have a teenage lackey, with no skills and not even the native language to deploy?

And how was our presence affecting the patients? When students visit hospitals in this country every patient is asked if they mind, told they can refuse to speak to them, but here I was a paying customer and I would get my show, like it or not. Never was anyone asked if they wanted me there and never did anyone question the idea of me being told every detail of a patients life, from ingrown toenails to HIV status, confidentiality be damned! What must they have thought, staring up from their hospital bed, to be greeted by a wide-eyed teenager, staring at them like a museum display? But even this might have slipped into the realm of the acceptable if it hadn't been for the constant offer of clinical tasks sent my way. Did I want to insert IVs? Clean wounds? Help deliver a baby?

May I remind you at this point that I wasn't even a medical student, my only qualification was the cheque that I had sent. Yet, this was enough to place me in the position of pseudo-physician. Fear prevented me from saying yes – I was happier


hiding in the nurses' room. It did not however prevent an overbearing 17-year-old from cannulating everything that stepped into her path, and several other teenagers assisting in a complicated surgery. Some might say they were learning and taking the opportunities offered to them – I can't help but see it as hubris. Knowing your limits might seem like a platitude, but in the world of medicine where lives are at stake, it is a golden rule.

One might even say that it doesn't really take much skill to stick on plasters and hold retractors, so what's the harm? The harm, in my eyes comes from an unspoken agreement between patient and carer being violated. When I go to my doctor, I go with the understanding that they know what they are doing, and trust them because of it. However, in the scenario of the pre-medical volunteer no such understanding can exist.

The patient might even place their trust in a volunteer, inadvertently believing that the person treating them is a doctor – and Western-trained at that – a high accolade in many of the countries where these schemes run. So, if I were faced with the choice again I don't think I would go. There are so many opportunities to volunteer in meaningful ways at home. Although they might be lacking in glamour, I'm sure they are more rewarding.

# *The Whole Story?*

**By Benedicte Sjøflot**

To get some different perspectives on student volunteering experiences, we interviewed three students who volunteered three different countries.

**Thailand**

I worked for the Christian Care Foundation for Children with Disabilities in Thailand: an amazing charity that works in the orphanages and communities of Thailand to improve the lives of disabled people.

I worked in the Women's department helping to run the daycare centre, taking girls swimming and organising day trips. I ran errands and I took over a basic first aid role.

I got a day of training which was about safeguarding, disability awareness, Thai culture and a few words and phrases of Thai language. I think it was all that could be offered before arriving. Much of what I learnt to be effective at my job was not possible to learn beforehand in the UK.

When I arrived I got a very good introduction and all the staff and other volunteers are so friendly and helpful, you will always have someone to guide you if you're lost.

I think it was more responsibility than I had expected, and maybe more than I was equipped for, but I managed it. Personally, everything I did at CCD taught me a lot about my own abilities. When I landed in Thailand I did not even know the word for 'Hello' (sawadhee kha/krap if anyone is wondering) and I would never have believed that when I left I would be able to hold a basic conversation with my colleagues and the women I worked with. There are many other things that I learnt at this job that I would never have even dreamt of having the privilege of doing before.

Without sounding pathetically cheesy, I cannot describe how much I loved working there. I feel confident that I did a good job and that I managed, in my own little way, to make a difference. They are a very successful charity in that they use their resources to best of their ability and it makes such a massive difference. It has left a lifelong impression on me and I will definitely be back as soon as I can!

***Freya Miller, 2nd Year***

**Zambia**

I volunteered in Zambia, in a school in the slum of Ngombe, Lusaka. I didn't volunteer through an organisation; I had a contact through church who I stayed with and ran the school. I worked as a school teacher for ages 3-15, teaching mathematics, science and English.

I didn't receive any training before-hand. When I arrived, they showed me around the school (one room) and let me sit in on one lesson, then I was teaching on my own. I felt I was prepared as I had been warned by email that I would be teaching whole classes. There were generally people around who could answer my questions.

I felt I succeeded in teaching the students some basics. Having sat A levels, I was more qualified than the other teachers there, so I could help put together some better classroom plans and teach the students more efficiently.

I loved my time there, and although it was difficult seeing such poverty, it was great to be able to get involved in the local community and help out. I am very happy I went.

***Ceci Pow, 2nd year***

**India**

Through private contacts I got an opportunity in a tribal hospital in India, working as an anaesthetist's assistant.

I was taught on the job as there were new things to learn each day; it would have taken too long to learn everything beforehand! I did get a bit more responsibility than I was ready for, but I was well supported the whole way so didn't feel too out of my depth.

It was a fantastic experience and hopefully I managed to help!

***Kate Hyde, 2nd year***

# Volunteering as a Qualified Doctor

*25 Years of the Tropical Health and Education Trust (THET)*

**By Olivia George**

This summer I was fortunate enough to be able to work with some truly fantastic people in THET's the London offices. THET was set up by Sir Eldryd Parry, along with his wife and good friends, in 1988, and has grown from sending textbooks to medical schools in Africa to having over 150 Health Partnership Schemes in various countries and larger Country Programmes in Somaliland and Zambia. Both schemes depend on the involvement and enthusiasm UK health workers, helping to improve health services through the reciprocal exchange of skills, knowledge and experience.

Manchester Health Partnerships facilitated by THET include:

UHSM with Gulu University and Gulu Region Referral Hospital, Uganda; and Greater Manchester University Hospitals with Ruby Nelson Memorial Hospital, India.

Parry explains that, "the THET philosophy is to work out how we can help our partners to reach their goals from a position of respect and humility and not from a position of pride and authority." In other words, THET aims to be responsive and not prescriptive, engaging with the people and healthcare needs of a country, so as to address their specific needs.

*For more information about THET go to: http://www.thet.org/*

# "Learn what you can, read what you can and don't be an amateur. Don't give up."

**By Olivia George**

Quite accurately named a 'lifelong visionary in global health' by The Lancet, Sir Eldryd Parry, KCMG, OBE, is not only a true inspiration but also a delight to talk to, and I feel very lucky to have been able to interview him for this Global Health issue of Pacemaker. Aside from having undertaken years of important and interesting work in Sub-Saharan Africa, he is senior editor of Principles of Medicine in Africa (revised edition, 2004), and founded the Tropical Health and Education Trust (THET). *(For more info on THET see p5)*

**Did your parents (both GPs) play a part in your decision to become a doctor? Who/ what have been your greatest inspirations?**

Yes – I had their example at home. They were selfless in their work: always available and very good clinicians. In one of my father's books, which he bought long after he qualified (on the heart by McKenzie, who invented the venous polygraph) he wrote the names of patients he was seeing next to descriptions in the text – he was a very thoughtful physician.

The assumption was I would always be a doctor, but I wobbled for a time when at school. I loved my student years; Cambridge was quite difficult because I went at 17 and was a bit out of my depth initially. When I went onto Cardiff to do my clinical work I was academically and intellectually inspired by my professor of medicine, Harold Scarborough. He was one of three authors of one a standard physiology textbooks in the 50s, 60s & 70s, and he was an outstanding person. Inspiration is possibly slightly the wrong word – guide and pattern model is better. He taught me to think about mechanisms and across ideas, rather than in a very linear fashion.

Over the years different people at different times have inspired me, and now I'm inspired by committed younger colleagues.

**It is difficult for British students today to imagine a life without the NHS – what was it like studying to be a doctor at the time of the naissance of the NHS?**

I knew nothing different. The NHS began in 1948, the year I went to do my pre-clinicals, and my parents' work from the inside didn't change at all. In hospital we just worked; we weren't aware of the NHS, as such, because the system was established and was working well. One of the great differences between then and now is that bureaucrats did not interfere, and there were no rigid time restrictions – no European Working Time Directive! The concept of lifestyle and time off didn't arise. It was not very many years since the end of the war, when people had realized that they had to pull their weight in society, and we didn't expect extras, didn't look for time off, but just to do your job. It was no hardship; we were tremendously well looked-after as part of a small team. Of course, we had time off, and we played hard – being in Wales we played rugby. I still follow the rugby very closely!

**Can you tell me a bit about your academic and clinical work in Nigeria, Ethiopia and Ghana?**

From 1960 to 1963 I was a senior registrar – seeing patients, teaching and doing research in Ibadan, Nigeria. I was seconded from the Hammersmith Hospital where at my interview I was asked whether I'd be prepared to spend a year in Nigeria and I said yes. Six days after our marriage my wife and I left – we spent our honeymoon in single bunks in the Bay of Biscay! The work was so interesting and our research was very fruitful so that I stayed for two and a half years: I learned an immense amount of clinical medicine in that time. I returned to London well-equipped.

Five years later, during the Nigerian Civil War, I was invited to be Head of Medicine at a new university in the north of the country. There was no money in the kitty, but, because my previous work had gone quite well, the Medical Research Council and the Wellcome Trust were prepared to support people to work in my department. We started classical clinical teaching – history, physical signs, logical reasoning etc. But I also insisted on looking at the context of the patient within the society.

In a way the excitement was starting something new – providing doctors where they were badly needed and doing all sorts of interesting studies of diseases. Probably the most exciting thing was gathering together a group of outstanding young clinical scientists and letting them get on with it.

There were downsides inevitably; that in a different culture, it was hard if one was misunderstood, got things wrong or behaved as one should not have behaved. Making mistakes in someone else's country is hard and I made plenty. It hurts because you're a stranger in a strange land. I learnt some very painful lessons. On the other hand, the highs were very high and I absolutely loved my work. The research side in Ethiopia absolutely blossomed and I was able to go back to the Hammersmith and ask for someone to come out and work with me to study the Jarisch-Herxheimer reaction in louse-borne relapsing fever. The young scientist who was sent out was David Warrell – Emeritus Professor of Tropical Medicine at Oxford University. Those were his first steps into medicine in the tropics. The word privilege is a hackneyed word now but I still use it – it was a huge privilege to be trusted to do something for another country, to unlock some of the unknowns of medicine, to make things better for poor people and to see young students getting really skilled themselves and being able to carry on and teach others. I've had a wonderfully rich and fulfilling clinical, professional and home life.

**I understand that you distinguish between tropical medicine and medicine in the tropics – can you explain this further? Do you think that the medical school curricula in the UK include these concepts adequately?**

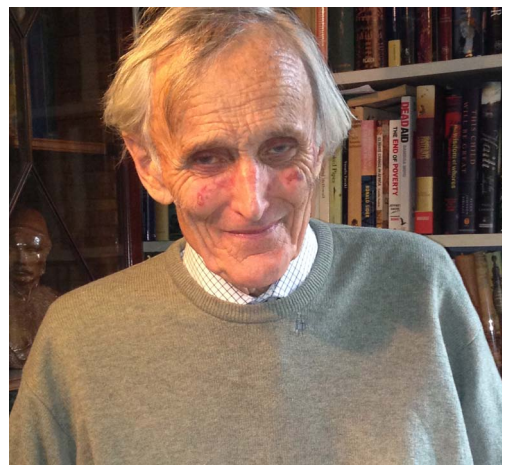
Classically tropical medicine was considered to involve certain parasitic diseases or what are now called the 'great neglected diseases' such as trypansomiasis, schistosomiasis, sleeping sickness, as well as malaria. We believed that what we were practising was general medicine in the tropics. I wasn't the first to say this and others had already written in this way, for example Professor Michael Gelfand had written The Sick African in 1943.

To work in tropical medicine you need the skills and method of a really good clinician – if it is difficult to get a good history you need to be very skilled with your hands and your eyes. I don't believe that you can understand medicine if you only approach it from a biomedical standpoint. You must consider the patient in the context of their culture, environment, home and seasons. All my teaching now aims to get this message across. Medical school curricula are getting a bit more liberal, but it's important that the students themselves push for more time for "global" health. Its only when students push that this will happen. And you should be pushing in Manchester!

**In your opinion, what are the greatest global health challenges at the moment?**

We could debate this all day long. If you look at it economically, it's resources; climatically – climate change and its effects on the environment and therefore the security of food and of water. In education, the situation in Northern Nigeria is worse now than when we worked there, it has moved backwards. And in neighbouring Niger the number of babies per mother has increased there – currently standing at almost 8 – and this in a country marginal for resources, rainfall and food. There are appalling problems in countries of the Sahara – very poor education, especially for girls, high fertility, rapid growth of population, low rainfall, and then poor harvests and nearby conflict. I don't know which the greatest challenge is. But you cannot dissociate all of these challenges – economic, human, services – they are all inextricably interrelated.

**What advice would you give to a young medical student or trainee doctor with ambitions of undertaking work or volunteering in developing countries?**



Be enthusiastic – learn what you can, read what you can and don't be an amateur. Don't give up. Take a long view. Don't be peripatetic. If you do some work for your elective, get fixed with that country and for those people – don't jump to another country. Medicine is not travel; medicine is serving people in a different environment. The first time you go you're a nuisance, the second time, you're less of a nuisance, the third time you begin to cross a few boundaries. Be utterly professional, be informed, keep at the same thing and don't give up. And recognize that it's going to change you as much as you learn. We are different people from the ones who went to Africa in the first place. We were changed by our experience in the poor world. I often tell those who come and see me to be ready to be different. If you work overseas, people will probably see that you have courage and strength of character.

For the full interview visit
http://manmedsoc.com/sirparry

# The English Patients

Ever wondered what it's like to experience healthcare in a developing country? Here Pacemaker's Features Editors tell you of their experiences.

**Burma**
**By Olivia Holtermann Entwistle**

This summer whilst travelling in Burma the front tyre of the motorbike my friend and I were on exploded in spectacular fashion and we careened into the oncoming traffic, missing a lorry by a hairsbreadth. As we lifted ourselves out of the ditch by the side of a busy highway I looked down to see his inner thigh torn open- I can only describe the sight as something akin to uncooked pork. I am ashamed to say the first thought that came to me was 'I hope to God no-one expects me to know what to do- I'm only a student'. With his blood-curdling cry still ringing in my ears, I doused it in water and wrapped a scarf, of very questionable cleanliness, around the gaping wound. Then we hightailed it, with the help of some kind strangers, to the local hospital.

I don't know if it was because we were totally caked mud, our clothes ripped, or our melodramatic pleas for pain relief but the doctor definitely didn't take kindly to us. The first thing I noticed, from all angles, was a complete lack of urgency. I'm sure the doctors there see worse things everyday, but to us this was an event worthy of flashing lights and trauma calls. I don't doubt that had we been at home things would have moved a lot faster. The cries of agony would at least have spurred someone to provide some pain relief, but here a cursory tetanus shot to the bottom was all he would get until later, when the doctor mercilessly plunged local anaesthetic into the jagged edges of his wound. The lack of a common language meant we really had no idea what was happening. There certainly wasn't any shoehorning in a Calgary-Cambridge on this little encounter. There was very little eye contact and very few attempts at explanation.

When we finally found our way to the right place, a (thankfully) spotlessly clean and very sparse room (see pic), they set about crudely stitching the wound together with thick black string. Definitely not the cosmetically pleasing work we would have expected at home. We left an hour later, antibiotics in hand, leg intact, all feeling like we had cheated death. It may not have been pretty and they certainly don't do bedside manner, but I'm very grateful to them all (and even more grateful to George for avoiding that lorry!).

*"Arriving at the hospital I was lifted out of the car and placed in a wheel chair. I was wheeled to an operating room, acutely aware of the pain, which was not only in my leg but my entire body. I was becoming more and more certain that the only relief I was going to get was local anaesthetic. After cleaning my wound one last time, my friend pinned me down on the bed and the doctor began the ten-injection operation. I can't quite say how painful it was, certainly beyond tears, perhaps best described as a sort of pain which makes you indescribably angry but entirely helpless. Luckily, the pain was ephemeral, and my leg went from feeling like the bowels of a volcano to being limp as a dead body. I lay back and watched the doctor sew the leg back together. It was a peculiar feeling; the bizarre tug of two bits of one leg being united."* – George Parker (Lifesaver)

**Uganda**
**By Jemima Heap**

Waiting for a flight from Johannesburg back to Uganda, I felt sick. I phoned my mum as I waited to board. 'You're just lovesick,' she said- I had been visiting my boyfriend in the middle of our gap years and now had to fly back to Uganda to volunteer for another four month stint. I was not convinced that the rising nausea was due to emotion.

As soon as the seatbelt light went off I started vomiting, which would continue every ten minutes for the rest of the flight. I sat on the floor next to the flight attendants with paper bags. They thought I was afraid of flying and kept asking me to go back to my seat. Just before we landed they called for a doctor, who set

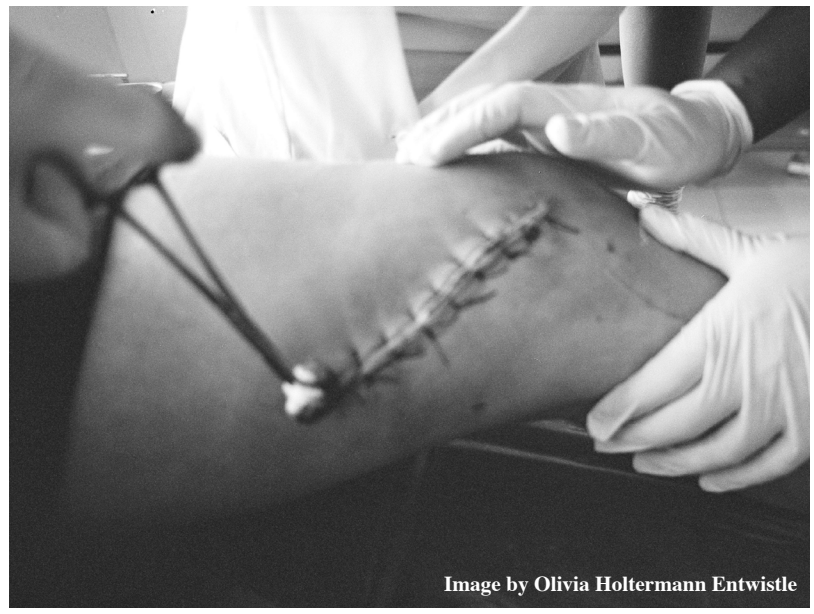


Image by Olivia Holtermann Entwistle

up a drip and gave me anti nausea medication so I could be wheeled off the plane and through customs to an ambulance (read: van with wooden plank for patient to lie on in the back).

I was taken to A&E where I was diagnosed with typhoid (I had been vaccinated against this). The ambulance driver waited with me. He told me that he had been stranded in Rwanda during the genocide and had depended on the kindness of strangers, so now he would wait with me to make it look as though I had a relative, otherwise they would think I could not pay and might not treat me. Eventually I asked the nurse to turn off the light so that I could try to sleep, but she replied that I had to stay awake and watch my drip so that she could sleep and promptly got into the next bed. As she lifted the covers I saw her child was already sleeping in there.

When I was transferred to hospital in the morning they could not believe that I had not brought my own loo paper, bed sheets, pyjamas, or drinking water. I was given a bed in a small room divided by drapes hanging from strings across the ceiling. Next to me was a woman groaning in agony.

Her family was sleeping in the 'drape cubicle' with her. More tests, and I was told that I did not have typhoid, but bacterial dysentery, as the Widal test they used often detects previous vaccination or salmonella. To top off an excellent stay, I was presented with a bill for 46 000 Ugandan shillings (about £15) and given my hospital notes to take home with me and bring back next time.

# *Should doctors speak out and bear testimony to political conflicts?*

**By Jemima Heap**

My Facebook newsfeed often reads like the Guardian, sometimes like The Daily Mail, more often like Reddit; but it is always an entertaining abstraction of the state of the world. I'm used to my friends tearing into each other's posts because they disagree, but I was surprised to see a fellow medical student criticize the Lancet's open letter for the people in Gaza. She argued that doctors should not support either side, because this would prevent them from treating both sides equally.

The Lancet described an ethical compulsion to denounce 'the aggression of Gaza by Israel' as morally indefensible. However, in condemning Israel's behavior, does this letter compromise doctors' ability to fairly treat injured Israelis?

**<u>Key Issues For:</u>**

Doctors should care for the world's population and advocate for their safety;

Doctors are ethicists with a moral obligation to respond and raise awareness;

As researchers and scientists we should provide unbiased information, especially when working in regions that the media cannot access;

Being impartial and having an opinion are not mutually exclusive, also impartial treatment applies to individuals not political regimes;

Neutrality is the same as passive complicity.

**<u>Key Issues Against:</u>**

Supporting one side or the other is inappropriate for doctors: we protect patients not the world's populations as we are not military;

Taking sides could isolate patients and prevent them from seeking help;

Criticising political regimes could jeopardize patient safety and the safety of health workers;

Neutrality is necessary for the presence of medical aid workers to be accepted by all parties.

A famous example of this debate is the foundation myth of Medicins Sans Frontiers (MSF), as an offshoot of the Red Cross (ICRC). It is thought that MSF wanted to speak out about the Biafran War of the late sixties, but in reality MSF and ICRC are not so neatly polarized on the issue.

MSF do not believe that bearing witness is at odds with their core principles of neutrality and impartiality. Whilst ICRC state that 'neutrality allows the agency to best protect and assist victims of armed conflicts and internal disturbances, whereas publicly bearing witness obstructs the goal of helping victims and is rarely ever a stepping stone to peace.' They believe silence preserves open communication with warlords and enables access to patients.

ICRC is a unitary organization, which generally advocates silence as part of neutrality, but will make some public statements like appealing to both sides to deliver promises. In contrast, MSF represents several groups that do not operate under a centrally agreed covenant of silence, but they do have a charter that discourages 'publicly expressing an opinion– favourable or unfavourable– with regard to events and to the forces and leaders that accept their aid'. Indeed in 2009 when the Sri Lankan government attacked the Liberation Tigers of Tamil Eelam and allowed only the ICRC into the country to evacuate patients, MSF withheld criticism of the regime until health workers were safe.

What if healthcare workers are targeted? What about terrorism? Dr Rony Brauman, former MSF president and director of UoM's Humanitarianism and Conflict Response Institute, spoke last year on the complexity of bearing witness. He described how Al Qaeda, despite their international pariah status, provided MSF with safe passage; and how MSF have publicly denounced the use of chemical weapons as weapons of terrorism.

The BMA's Dr Vivienne Nathanson believes that international scrutiny is a vital force for curbing human rights violations. When Syrian authorities targeted health workers, the BMA wrote to demand their protection. Dr Nathanson writes:

'Doctors are frequently among the first to witness fundamental violations of health rights. They are often the first to speak out about them. All too frequently though doctors [..] themselves become targets [..] We will continue to be vigilant and speak out whenever and wherever medical neutrality is abused.'

Dr Jack Piachaud of Medact extended the debate beyond ethics, stating 'that we must act is no longer a matter of moral imperative, but one of self-interest [..] If we don't respond to this suffering, it will give rise to a movement of hate which will eventually return the suffering to us.' He described medical students as 'a critical group of people' for this process, and propounded the importance of proper education about global health and the developing world.

Pacemaker wants to hear your opinion! Head to the Facebook page to vote in our poll, or submit your letters to editormanmedsoc@gmail.com

# *A Day in the Life of*
# Manchester's Senior Clinical Lecturer in Public Health

**By Mátyás Jakab**

Our interview this month is with Dr. Arpana Verma, who in addition to being a Senior Clinical Lecturer and Hon. Consultant in Public Health heads more than a dozen projects, ranging from local to international in scope. She tells us about the details and the perks of a career in public health, as well as providing insights into current themes in the field. We thank Dr. Verma for accepting to be interviewed and are confident that her contribution will widen the horizon of current medical students.

**Dr. Verma, could you tell us a little about your career and how you got to where you are today?**

After I left University I did my house jobs at Hope hospital and from that I went into Respiratory Medicine at Wythenshawe and that led me into a staff grade post in adult cystic fibrosis, which was where I did my PhD. Whilst collecting data for the PhD I really started looking at epidemiology as one of the key things I was interested in from the point of view of looking at populations and how we can improve individuals' health and wellbeing using the evidence base. Rose, one of my public health (PH) heroes, describes PH physicians as needing to have 'clear minds and dirty hands' i.e. asking the right question, using the best methodology to answer that question and then disseminating it to the right audiences.

**What is your current position? What do you do now?**

I'm senior lecturer in PH and I am also consultant in PH at Salford Royal Foundation Trust, previously at NHS Bury. As of this month, I've been doing this job for 5 years.

**And as a PH consultant what sort of tasks and challenges do you face and how is PH as a specialty different from other specialties?**

PH is a clinical specialty and I think some people may not appreciate that. Even though we're not looking at investigating an individual, what we're using is our medical training to understand how to think through problems at a population level, whether that's looking at epidemiology (the studies that you'll read about in medical journals) all the way to analysing and interpreting data and critically appraising the evidence. In my previous role, when I was working at NHS Bury, I was commissioning sexual health services, cancer services, looking at infection prevention and control issues, we were increasing the uptake of vaccines and immunisations & screening programmes. We looked at the whole package, so we would work with hospital doctors, GPs, health care professionals across the board together with communities. We organise international conferences and have lots of research grants. We are heavily involved in teaching the next generation of PH professionals from undergraduates to PhD students and consultants in PH. Why not get a taste for PH by doing one of our PEPs, project options or intercalated degrees? We have had 10 years of medical students on our masters in global PH and our brand new BSc coming in 2015.

**Could you give an outline of a normal week for a PH consultant?**

So, at the moment, because my role is research, teaching as well as PH, my typical week is mostly based around the 18 different research projects that we have here in the department. I'm also the lead for undergraduate teaching within our institutes, and we have been doing a lot of teaching on the medical undergraduate programme, in addition to offering the PEPs and the project options. A typical week is research and teaching, and when I was working in the primary care trust and local authority, I'd actually have half my week there, where I would be doing data analysis and interpretation of the evidence base to commission effective services. I'd be running everything from focus groups through to trying to do large scale programmes, looking at increasing uptake to screening programmes and primary prevention.

**What's your favourite aspect of the job?**

I have a fantastic team and I am never bored. PH is a global specialty. Some days I am talking to somebody from the WHO about a global health issue and then I could be talking to one of our local researchers who is doing something very specific in a community in Manchester. Teaching is a real favourite aspect of my job. Seeing the look on people's faces when they finally understand epidemiology is fantastic! Being able to present your work is crucial so I do a lot of travelling where I'm able to present my research and I've been fortunate enough to be asked to speak at different events for WHO or the UN which has led to lots of different collaborations and really exciting developments in our research and teaching.

**What could a student do to gear him/herself towards PH and get some extra points for the time when they need to apply?**

We hope that what medical students are able to do is come to some of the PH teaching events and that ranges from lectures all the way through to our Year 4 study days, the PEPs and the project options, and also we have a fantastic opportunity for people who are interested to intercalate to do the Masters in PH and our new BSc. And a key thing for both the PEPs, the project options and definitely the Masters is to get you exposure to PH, but also a publication for your FPAS application and also some experience of presenting your work at our annual Festival of Public Health. We have had professors, Knights of the realm and the local community speak. Every year there are prizes for medical students. This year we had the wicked problems presented by key leading PH professors but also several medical students.

**I'm sure all of our readers would be interested in getting published. I know you're involved in a lot of local, national and international efforts. What would you say are the main challenges for PH at home and from a global perspective at the moment?**

I think there's not that much of a difference…so for the first time in August, the OECD have said how important it is to look at data from within countries, because the variation within a country is actually bigger than the variation between countries. So why should somebody in Manchester today, depending on their socioeconomic background have a difference in life expectancy that equates to the difference we see between the high income countries and low income countries.

Another one of my PH heroes, Prof Sir Michael Marmot says, 'Governments found billions to bail out the banks, why do they not find the money to end poverty and reduce inequalities'.

**As a last question, if you could give one piece of advice to medical students, what would it be?**

My biggest piece of advice is to enjoy your time at university. I think that the opportunities for you as a medical student are so vast. This medical school is really good at providing opportunities for medical students to really explore the vastness of the medical specialties. Maximise on all the opportunities that will be coming your way and think about where you will want to be in terms of your own career, and think of all the options. I never thought I would be a PH doctor when I was your age. All the choice we have is amazing, trust yourself that you know what you're doing is right and take lots of advice, because there is a phenomenal amount of support for you at each stage of your career and access it and use it and make use of the people that you trust to help you on your journey and it will be a fantastic journey. As a doctor we are so privileged to be allowed into the most private parts of people's lives, we can be their advocates, be the voice for those without one and actually make a difference. Not many people can say that! Good luck in all your endeavours.

For the full interview visit
http://manmedsoc.com/publichealthday

# *Auntie Inflammatory's Words of Wisdom*

Welcome to Auntie Inflammatory's excellent advice column. Every month I'll do my darnedest to help you out of whatever pickle you unscrupulous bunch have gotten yourself into. E-mail your problems to the editor.

*Dear Auntie Inflammatory*

I'm in quite the senior position at the medical school so I'll try to avoid giving myself away. Must always remember to maintain good medical practice. I always knew I was a little special. When my home planet was destroyed by The Portfolyoid Empire, I was the lone survivor. My parents packed me safely into their last funsize escape pod, and launched me into the vast expanse of space, where I travelled for many eons before happening upon Earth. I settled quickly into my newfound home, but the deep hatred I harboured for the race that exterminated my planet still burns deep within me. I will not forgive, I will not forget.

Anyways, I had barely been here a week before I was bitten by a weird, Braidioactive spider. I began developing strange new abilities (and a peculiar penchant for skin-tight, brightly-coloured bodysuits and capes). My senses have become heightened, people look nervous and shifty when I walk by them, and I'm suddenly able to sense poorly written reflective pieces before they're even written! Instead of sleeping in a bed, I build webs from thin strands of meticulously kept patient logs. Instead of food, I eat nothing but SWOT analyses that have been ground to a fine paste, and instead of my normal hobbies, I now do nothing but dangle from ceilings near large groups of students and hiss bizarre things like "GMC GUIDELINESSSSS" in their ears. Worst of all, my OkCupid profile reads exactly like a CV and I can't stop myself from rating every aspect of previous dates on a sliding scale. I know Gilbert, 35, from Slough doesn't want to know that he was a 3 out of 5 for charm, or that next time he should clarify that the date will be kept completely confidential between himself, my team, and I, but I just can't help myself!

Enough about me though, I'm really just here to make sure you write an action plan on how to improve this area of the Pacemaker for next month. Have it done in time for your review.

*Sincerely,*
*Braid-man,*
*Defender of Earth, staunch proponent of skin-tight lycra*

***Dear Braid-man,***

**This may be beyond my specialty. I would suggest that you primarily focus on really nailing that costume, and then decide whether you want to be a goody or a baddy. From the sounds of it, you have all the potential to be a moderately cool subvillain in a straight-to-DVD movie, but if you really worked at it, I reckon you could land a part as senior lackey to a mildly successful silver screen villain! Keep on reaching for those stars!**

***Sincerely,***
***Auntie Inflammatory***

*Dear Auntie*

I slept with 8 people during freshers. 8 medic freshers. Don't want any advice I just thought I'd let you know.

*A. SecondYear*

**Sure.**

***Yours,***
***Auntie Inflammatory***

*Dear Auntie*

Something has really been eating away at me lately. I'm not a medic, but why do people actually choose medicine as a degree?

I keep hearing that people want to care for others, or that they want to sink their teeth into understanding the human body. Who are these people?

Surely they are just out there to make as much money as possible from a never-ending pool of sickness and ill-health, like the rest of us? Apart from orthopaedics it doesn't seem to make any sense.

*Yours,*
*Dan Tist*

***Dear Dan,***

**Some people are just naturally caring and less cynical than others. Whatever you choose to do make sure you are happy doing it.**

**Unless its... car park warden-ing - then you need some urgent help.**

***Yours,***
***Auntie Inflammatory***

*Dear auntie*

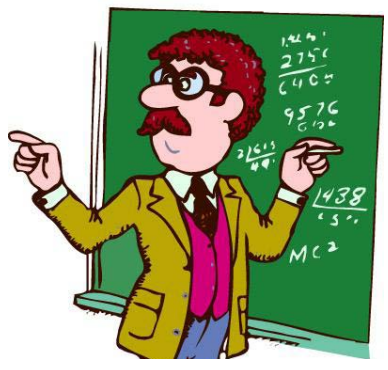
I need your help. I really have a thing for Matt Kean. He seems like a really good guy, unfortunately tasked with trying to teach hung over medical students about the real world. It just so happens that I too am a fellow EBM-er, and know how hard it is to educate people to a state of scientific literacy beyond that of the Daily Mail. Matt, if you're out there, you can double blind me anytime.

*B. Goldacre*

***Dear B,***

**Keep at it. Repeating your advances may improve the reliability of your results. When it comes to asking him out, using the PICO method of question formulation will help.**

***Yours,***
***Auntie Inflammatory***



Compiled by Connor McLaughlin and Will Tsang

## The Headlines You Missed...

**Apple releases new pre-bent phone case for the iPhone 6.**
*Diehard fans of the tech giant praise its innovative approach to problem-solving.*

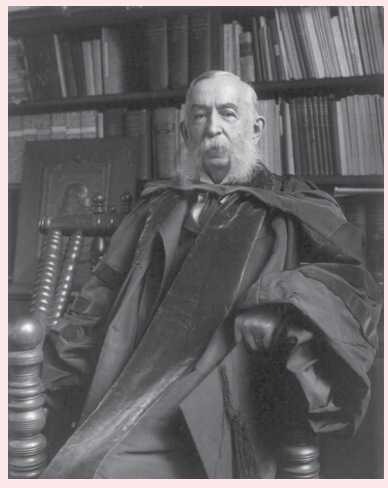
**Homeopathic remedy company issues nationwide recall:**
*Product contaminated with 'borderline effective' levels of a medicine.*

**Tories lambasted over recent decision to privatise sticky plaster industry.**
*Boo-boo rates expected to rise uncontrollably.*

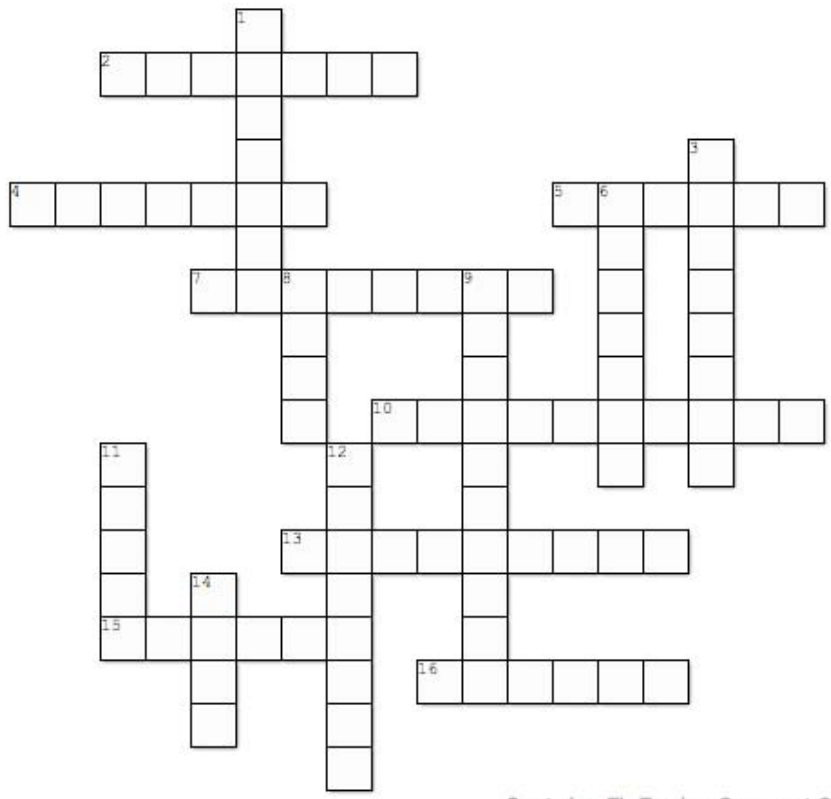
## Inspirational Quote of the Month

"The medical student is likely to be one son of the family too weak to labour on the farm, too indolent to do any exercise, too stupid for the bar and too immoral for the pulpit."

*Daniel Coit Gilman*
*(1831 – 1908)*



# PBL Break [add caffeine source of your choice]



Created on TheTeachersCorner.net Crossword Maker

**Horizontal**

**2.** Oseltamivir (7)
**4.** 1854 Broad Street outbreak (7)
**5.** Mosquito (6)
**7.** Disease spread across large populations (8)
**10.** Médecins Sans ..... (10)
**13.** The ability of an organism to invade the tissues of the host (9)
**15.** Severe illness, (lay) (6)
**16.** Created the vaccine for small pox (6)

**Vertical**

**1.** One of the sites of the current ebola outbreak (7)
**3.** Manchester's second most famous anatomist (8)
**6.** Infection maintained in a population without the need for any external input (7)
**8.** Friendly (4)
**9.** Induce immunity (10)
**11.** Experimental ebola drug (5)
**12.** Fuel wins (anag) (8)
**14.** Measure of disease burden (4)

From my point of view as a 'stay at home fresher': Positives: The Uni mummy+daddy scheme really makes you feel welcome and involved and gives you the opportunity to get involved socially - whether that be a curry, night out or casual coffee/ lunch, and helps you get to know the other freshers. As a 'mature' ?! student - there's also a mature group to meet others your age. Negatives? Really can't think of any negatives!
***Sophie Monkman, Year 1***

The Mummies and Daddies scheme is great – they have been really friendly and open to helping with anything we need. It would be good to see some pre-organised non-drinking events though. There is so much to do in Manchester and I haven't met any unfriendly students. At the moment I've got so many friends that reckon I can stand to lose a few when the work gets hard!
***Adrian Burman, Year 1***

Join and like all medical societies on Facebook, and keep up with the Manchester Medsoc FB page. It's a great way of finding out everything that's going on in the med school, whilst gaining new insights into different areas of medicine. Plus it's an opportunity to make more friends and add to your CV. Portfolio certificates are almost always given out.
***Cressie Moxey, Year 2***

Essential Skills fortnight: the prospect of sitting through hours of lectures about how medical school works may sound like a rather mundane way to spend your first 2 weeks at medical school - but it was actually very useful. At times it felt overwhelming trying to take in such a vast amount of new information. That said, although it wasn't the most riveting two weeks, it allowed us to reflect on all the exciting things we have to look forward to.
***Mary Corp, Year 1***

Top tips for first year:
Ask second years which books they liked, then test a couple to find the ones that work for you. Don't flounder around on Wikipedia too much for PBL - whilst it can be useful finding the right chapter in Martini is usually a stitch in time... Attend extra lectures etc that interest you throughout the year - it's easier to add to your portfolio gradually than in a mad panic at the last minute.
***Anonymous, Year 2***

# Medics in Transition: *Finding Our Feet*

**Phase 1**

**Phase 2**

The first few weeks in Preston have been fantastic. Our entire year got to know each other quickly, and friendships have formed between year groups too. Although the Introduction to Clinical Learning weeks were a little slow, I've appreciated this as it is a lot more intense than Phase 1. So far, all staff have been extremely friendly and eager to teach. It does take an effort to visit friends back in Manchester; but the occasions I do see them are even more enjoyable.
***Sam Haynes, Y3, Preston***

Highs: learning practical skills and getting to scrub up and go into theatre, as well as being taught whilst on a ward round. Lows: doctors not expecting us for scheduled teaching sessions; some teaching sessions were information overload and others dragged or were repetitive, so I felt I didn't learn anything from them.
***Anonymous, Y3, Salford***

My top tips for 3rd year:
Be enthusiastic! You will get more teaching and you will learn more yourself. Be proactive. See as many clinical signs as possible and seek out opportunities, rather than expecting them to come to you. Be balanced. Third year is hard, but you still need to enjoy yourself. You still have more free time than you will ever have so enjoy yourself and make time to relax and have fun!
***Charlotte Doddrell, Y4, Preston***

Prior to going to Preston it wouldn't be an overstatement to say I was pessimistic about Phase 2. In a month, it's been made apparent that the dePreston sympathy/mockery was misplaced. There's plenty to miss about Manchester but I don't envy the lengthy commutes / the cost of living; even the infamous grey scrubs have been embraced for their practicality! Preston has every thing I need: a group of friends, a well-managed hospital and an Aldi within walking distance.
***Mark Herbert, Y3, Preston***

The transition into phase 2 is enormous but we've been eased through it by the staff of Salford Royal. I realised that I needed to set 5 alarms to wake up on time and would come home with barely enough energy to jump in bed. Despite the exhaustion, it was a very rewarding week. We finally started putting the first 2 years of theoretical medicine to use. 'Learning by osmosis' as a friend of mine rightly said, there are plenty of opportunities to learn something by just being out there.
***Djamila Rojoa, Y3, Salford***

It takes time to settle in but the sooner you get used to it, the more enjoyable it becomes. It's more easily said than done, so follow these mantras: (1) Set a proper sleeping pattern (2) Always put some stuff on your iPad to read, and try to fit some portfolio work in while you commute (3) Cakes are the best way to befriend medical staff. (4) ENJOY YOURSELF as this is what you came to med school for
***Estelle How Hong, Y4, MRI***

Going into Phase 2 has been a mixed experience. There've been some tedious lectures where my mind can't help but drift to thinking about a desperately needed vanilla latte. However, there have also been some exciting glimpses of what the years to come will look like. I've spoken to more patients in the last few weeks than I have in the entirety of Phase 1, and sticking a needle in my clinical partner and seeing blood pour into the vacutainer was an absolute high.
***Jo Simpson, Y3, MRI***

I had a really interesting ICL week in which I had the opportunity to take blood with the guidance of a Phlebotomist and got involved in different clinics with different consultants. On Monday I started my rotation in GI surgery. We had the opportunity to witness a sigmoidectomy and a colonscopy. So far I have had an amazing time, it has by far exceeded my expectations and I hope it only gets better!
***John Doherty, Y3, South***

Make the most of spending a lot less time in the library and rather feeling like a doctor in training! Go on the wards in pairs for confidence. Although there are more demands on your time, I found PBL different and improved, facilitated by doctors who can help highlight the essentials. Preston may be a new place but with it come new friends, great support from staff, and you can live within walking distance from the hospital. ***Jess Presky, Y4 Preston***

Some lectures during ICL were very boring, but many were helpful, especially in terms of better understanding a how the hospital works, and the IPE shifts we did were great. We were also able to practise venipuncture and cannulation on each other, but as I have poor veins it wasn't very enjoyable! Overall, the experience was interesting and it gave me a real insight into how the ward works. I also enjoyed taking the time to talk to the patients and doing something to make them feel better.
***Abbey Ward, Y3, MRI***

Your learning in Phase 2 is made much more relevant when you see it in clinical practice - you're playing a role in patient care and seeing how medicine works in real life, not just in the books. The only negative I've encountered so far is the amount of travelling involved – unless you're in MRI then your classes are no longer a 10 minute Magic Bus away, but you quickly get used to that. Plus, perhaps the biggest positive of all: Healthcare discount. Enough said.
***Aiden Moore, Y3, South***

I always tell people moving to Preston that it's not where you live, it's what you do once you're there. No matter where you studied prior, once you enter clinical years, life changes and we all eventually accept the grown up world of working hours with less weeks holiday. With a smaller community, everyone bonds more here, and you get to know everyone. The surrounding area is stunning and there're loads of opportunities to be 'outdoorsie'. Overall, it is definitely a great place to make loads of friends, get excellent teaching, and enjoy a cracking 3 years.
***Kevin Stokeld, Preston Medsoc President (4th Year)***

# PACEMAKER

...at the heart of MMS news since 2014

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# *Freshers Failures: Mature Medics are People Too*

**By Matt Betts**

I am not your stereotypical fresher. This Sunday, for example, rather than toasting the end of another productive week in PBL and in the DR, I'll be taking my grandmother to her favourite Italian restaurant in her native Preston, where she will order a Hawaiian and a liqueur coffee, and will ask me the same questions that she asked last weekend. Following which, we will go back to her house and watch Downton, talk about how things ain't what they used to be, and that I better not fail medicine or I'm out of the will. By this point, she will be on to her third dry ginger and scotch, and will ask me, again, why I think my dad left my mum, and what I think of my mum's new partner (he lives on the unfashionable side of town, apparently). I've long since learned, though, that if I keep her sweet, she might just fold a slightly boozy tenner into my hand as I hug her goodbye. Who knows, this time it might be a cheque for a hundred. It never is.

At 25, and a post-graduate medic, you could say I've been there and done that with the skylarking and shenanigans that people have come to associate with that very first week of libidinous license straddling the threshold from kidult- to adulthood. Either that, or, I'm just out of the loop. My hangovers - now from the merest whiff of a light lager, to barely a sip of a nice pinot - come as if forged in the fires of Mount Doom by Sauron himself, and the inaugural game of 'Ring of Fire' ahead of the Pyjama Pub Crawl might as well have been Risk, the labyrinthine rules and categories were so alien.

I did pre-med last year, so returned this September quite wary of curries, pyjamas and scavenger hunts. Previously, I went home from the curry mile at 9pm after a colleague was sick on herself and someone else's food, and didn't even bother with the pyjama pub crawl; I was a bit of a Scrooge, I'll admit that now. So, this year, I vowed to mellow slightly, and go with the flow. Hey, you only live once right? Sure, I'll go to the curry, but I'll be in control; I'll pop down to the pyjama pub crawl pre-drinks to show my face and be involved, but recognise my limits. It means I'm joining in, I'm being part of the team, I'm enjoying myself, sure? I'll let the other people push the boundaries, I'll let those of younger and sprightlier frame do the dancing on tables and pole vaulting, and arm wrestling.

The week pottered on by with nary a blip. At the curry, my poor 'mummy' must have come to regret asking me why I was doing Medicine (I think she wants that hour of her life back, and had no idea how we ended up talking about Batman and the socioeconomics of Gotham City), and my brothers- and sisters-at-arms in PBL 2 probably think I'm a total loser because I took along a rather smart bottle of Merlot and nibbles to pre-drinks and proceeded through it at a snail's pace.

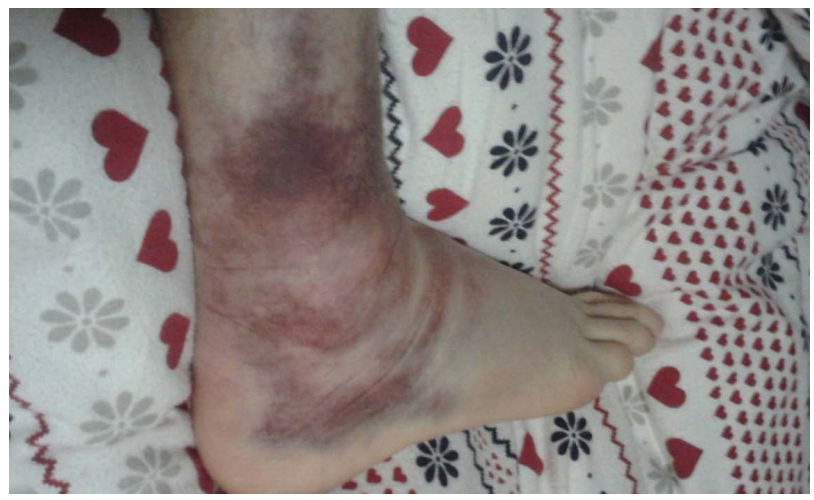
Yet, in the words of Heath Ledger's Joker, it was all part of the plan. I had secretly reserved one portion of the week that was not going to know what had hit it. There was one event at which I was going to let rip. One time where I would give it 110% and go, as they say, hell for leather. I was going to take the medics basketball world by storm, and rewrite the rules, reset the bar, reinvent the loaf, and every other metaphor beginning with 'r'.

Admittedly, I'm not that great at basketball. I knew this ahead of time but, broadly speaking, picked a sport that I thought wouldn't be too embarrassing, more than anything. Sportwise, I've come to know my place: the rowers all look like Bane in variously sized lycra vests, my rugby days are definitely over, and the footballers at the fayre hit upon the wrong guy when one opened with the gambit that they get the most drunk of all the sports clubs in the university. Well done you, I said in the most patronising tone I could muster as I patted him on his neatly arranged hair, which he hastily readjusted as I meandered on.

The Saturday of import was bright and breezy: no hangover, a good night's sleep, and a brief précis of the rules on wikipedia all contributed to a feeling of general well-being and a mounting sensation that I would be moderate-to-largely OK in the trials. I wore a deliberately toned down outfit as if to suggest I was an amateur but still regular partaker of exercise, including my ethically sourced cotton gym shorts, a generic university tee and - crucially - totally inappropriate footwear. I might as well have been wearing high heels, they were to be that structurally supportive as I threw myself around the court like Gollum after a slippery salmon. I did, however, pop a shade of masking tape over my mid-life crisis ear piercing: always prepared, as I am.

A healthy bunch of warriors came along to the Armitage. Everything was bosomy, warm and reassuring; we were to do some typical warm up exercises, then proceed to half court games when our limbs were limber and lithe. Soon, it was time for the half court. A few plays went well, I felt like I was ticking over OK. Then came the big challenge - go big or go home.

I went for the ball, splay-legged, energetically trying to block her off. She feinted, a veritable Viktor Krumian Wronski if there ever was one and I sailed over the tipping point of my right ankle with all the force of a diluvian deluge. I heard three almighty cracks one after another, as I turned over on my ankle and was



*My mum bought my bed covers #YOLO*

spread over the deck like Charlotte Humbert's brains.

Instantly, as I lay sat on the floor like a confused child, I became instantly aware that it felt like I had smuggled a golf ball under my skin over my right ankle, which was steadily growing in size and pain. 'Did anybody hear the cracks?' I asked feebly, more a question to the universe than anyone in particular.

And so, pride hurting just as much as my fall, I found myself cradled by an unforgiving plastic chair in the reception of the sports centre, ice pack dribbling all over my hurty ankle.

Fortuitously, one of the head honchos of the basketball team is an academic GP, so was able to perform some pretty awesome stuff on my quivering limb, whilst everyone wearing appropriate footwear carried on playing. You probably don't need an X-ray, but you could go for one because it'd be quite cool, was the ultimate diagnosis, with some probably torn ligaments. Feeling rather like Malfoy after his run in with Buckbeak - particularly after one of the female try-out attendees asked me why I wasn't crying - channeling Robbie Turner in Atonement, I was bundled into a taxi and driven to A and E.

At least, if I didn't make it to the team, I didn't cry.

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The following evening, foot raised on my grandmother's sofa, Downton flicking across the screen, dry ginger and scotch in hand, I folded a cheque for some new basketball trainers neatly into my wallet.

I wonder what she'd do if I crashed my car.

## Want to write for Pacemaker?

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