BACHELOR OF MEDICINE AND BACHELOR OF SURGERY

STUDENT GUIDEBOOK
Levels 1-6

Student Name: ____________________________________________

Student Number: __________________________________________
The purpose of this guidebook is to provide you with an overview of the MBBS course as offered by UWA. It contains information on Student Conduct, Infection Control Policy and other information as relevant to each Level. This general guidebook complements individual Unit Guidebooks which will be made available to you. Unit Guidebooks will provide detailed information on how each particular unit is run and assessed.

Information in this publication is correct as at January 2011, but is subject to change. The University reserves the right to change the content and/or the method of presentation and/or the method of assessment of any unit of study, to withdraw any unit of study or programme which it offers, to impose limitations on enrolment in any unit or programme, and/or to vary arrangements for any programme.

This guidebook will be made available online as will annually updated versions.

http://www.meddent.uwa.edu.au/students/guides
Today I do not want to be a doctor

Today I do not want to be a doctor.
No one is getting any better.
Those who were well are sick again
And those who were sick are sicker.
The dying think they will live
And the healthy think they are dying.
Someone has taken too many pills
Someone has taken not enough.
A woman is losing her husband
A husband is losing his wife.
The lame want to walk.
The blind want to drive.
The deaf are making too much noise.
The depressed are not making enough.
The asthmatics are smoking.
The alcoholics are drinking.
The diabetics are eating chocolate.
The mad are beginning to make sense.
Everybody’s cholesterol is high.
Disease will not listen to me
Even when I shake my fist.

Today I want to be a doctor

Today I am happy to be a doctor.
Everyone seems to be getting better.
Those who were sick are not so sick
And those who are well are thriving.
The healthy are grateful to be alive
And the dying are at peace with their dying.
No one has taken too many pills
No one had taken too few.
A woman is returning to her husband
A husband is returning to his wife.
The lame accept chairs.
The blind ask for dogs.
The deaf are listening to music.
The depressed are tapping their feet.
The asthmatics have stopped smoking.
The alcoholics have stopped drinking.
The diabetics are eating apples.
The mad are beginning to make sense.
Nobody’s cholesterol is high.
Disease has gone weak at the knees.
I expect him to make an appointment.

From Playing God by Glen Colquhoun
Publishing Press, Auckland 2002
Glen Colquhoun is a New Zealand GP and poet.
FOREWORD

The Faculty of Medicine, Dentistry and Health Sciences at UWA welcomes you to your chosen course of study. We trust that your studies within Medicine will be both challenging and rewarding. Our current approaches to the selection of students and the content of curricula have been developed to address the needs of the health professions as identified by the community. Programmes are integrated, problem-based and linked to assessment which ensures that the knowledge, skills and attitudes expected by the community are achieved. The course allows breadth of study with a range of options and time for in-depth commitment to disciplines of interest. The staff members in the Faculty will offer support and look forward to contributing to your success.

All the best

Winthrop Professor Ian Puddey
Dean
Faculty of Medicine, Dentistry and Health Sciences
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BACHELOR OF MEDICINE AND BACHELOR OF SURGERY

Overview

Being a doctor is a privilege. Where else can one meet people from a wide range of backgrounds and experiences, be trusted to know about their lives, concerns and intimate thoughts, and be allowed to help them have a better life through preventing disease, treating disease, or simply relieving suffering. The work is hard but stimulating and offers a wide range of areas from which to choose. These include general practice, hospitals, government health departments, the military forces and educational establishments such as medical schools, where members of the academic staff have responsibilities for teaching and research as well as, very often, patient care. You may choose to work with patients, work in laboratories, in research, or in education – or do all at once. The beauty of Medicine is the vastness of opportunities it offers. There is something stimulating to suit all interests. A range of personalities and skills are catered for within the medical profession and we are lucky to be able to look, try and choose an area that suits us as individuals and our families and lifestyle choices.

Today you are starting on your pathway to becoming a doctor. Following successful completion of this four and half or six year course, you will be required to satisfactorily complete a further twelve months’ pre-registration internship in an approved hospital, before obtaining the full registration, with the Medical Board of Australia, which is necessary to practice in the community.

The course at UWA is delivered within the Faculty of Medicine, Dentistry and Health Sciences and the W.A. health services, both of which aim to offer high quality care, and an environment of active and rigorous research. You will see the importance of research as it underpins our knowledge about health and disease; it is this knowledge that is translated into better care for patients. In addition, you will experience a course which responds to changes in our knowledge, and our health system, aiming to produce doctors that are not just fit to practice in the next 10 years, but who can respond to the rapid changes in knowledge and apply it to patient care. This course also aims to inspire the next generation of teachers, researchers and leaders in medicine which will ensure a quality health service for our community into the future.

Students will learn from academics, from clinicians, from each other and patients. Most clinicians will be working, caring for patients, at the same time as they are teaching. The word doctor comes from the Latin ‘doctore’, meaning to teach, and most clinicians see it as part of their professional duty to give up their time to teach, supervise and mentor students and junior doctors. They will teach not only the knowledge which is the base of patient care, but the professional values which are important to maintaining high quality and ethical care. It is hoped you, the student, will continue this tradition and pass on your knowledge to the next generation of doctors.

Some of you will enter the current UWA medical course in level three instead of level one as graduates, by recognising your prior learning. To ensure you are equipped with adequate foundation skills a compulsory Bridging Course has been developed, which provides a learning environment for you to meet the desired undergraduate Level 1 and 2 learning outcomes. The GEMP Bridging course recognises the generic abilities you (graduates) will have gained through varied education and work experiences, together with the assumed level of competencies in: humanities and social sciences, together with written communication and reasoning in biological and physical sciences.(which are assessed in the GAMSAT.)

Balancing your life

Medicine can be an all consuming vocation and unless you are consciously aiming for a balance in life you will find it more and more difficult. Balance is an important part of life as a medical student as it is as a working adult. Some of you have entered the course after finishing school; some of you will have completed degrees or worked in other areas and may have joined the course as graduate entry students. Remember, getting into Medicine is a privilege, as there are many people who would have hoped to be in your position, and would probably make excellent doctors, but don’t have the chance. Hard work and dedication is required. However, medicine is not everything in life. Friends, pastimes, and other interests are just as important and a balanced approach is what you need. Don’t lose sight of all those other important things in life.
Recognise when you need to work, and do it steadily, and when it is time to keep up with friends and non-study related activities.

If you want to think more about Medicine and Life, literature offers wonderful insights. Here are a few good places to start:

**Berger, John., “A Fortunate Man”** This is a story about a doctor who becomes a country GP and who is transformed through his insights into the community.

**Williams, Carlos W., “The Doctor Stories”** Carlos Williams is a famous poet who used his insights and experiences from his “day” job (as a doctor) to stimulate his writing. Wonderful stories about people, their lives, and patients he liked and didn’t like.

**Cronin, A J. “The Citadel”** Cronin preaches many lessons: hard work, conscientious patient care and intellectual curiosity are the keys to success in medicine; knowledge and integrity count for much more in life than money; doctors need continuing education to remain current and to serve their patients well. In each of Mason’s professional endeavours, he befriends a colourful colleague whose lack of material success belies a keen intellect and great personal integrity.

**Le Fanu, R. “Rise and Fall of Modern Medicine”** A description of major events in modern medicine and ideas for the future.

**Bliss, Michael, “William Osler A Life in Medicine”** A wonderful biography about the best know physician in the English speaking world at the turn of the last century.

**Medical Curriculum**

Everything is changing; the health of the community, our health system, our knowledge of what causes disease and how to treat it, the ethical issues related to provision of care diagnosis. We need doctors able to care for patients in a compassionate and caring way in the face of all these challenges. You need the skills to approach problems, acquire information and apply it appropriately to the clinical, research or other health-related settings in which you will eventually practice. Additionally, you need to acquire the skills to ensure new knowledge is critically appraised and continually integrated into practice—a process of life-long learning. Therefore the course must ensure you have all these skills.

It is useful for you to understand the key principles of the design of the medical curriculum. We have a vertically and horizontally integrated curriculum; this is important because patients may present problems that have many facets and for which you need an integrated approach. This is achieved through organisation around four major teaching themes and the use of systems-based and problem-based learning. The four themes, *Scientific Basis of Medicine; Doctor and Patient; Doctor, Health and Society* and *Personal and Professional Development*, extend throughout the four and half or six year programme to ensure the goals of the curriculum are covered. Definition of these themes allows you to understand the context in which medical care is delivered in all its complexity. In general, you learn in an integrated fashion and not under these separate theme headings.

There are also spirals within the curriculum. In one spiral you learn about normal structure and function, abnormal structure and function and then revisit these topics again in the context of patient care. Similarly clinical problems and patient contact will be present in the early years and these become more complex in the later clinical years, as your knowledge increases. The inclusion of options also allows you to undertake in-depth study in areas of interest throughout the course.

Teaching and learning methods focus on student-centred learning, particularly through the use of problem-based learning, interactive computer-based learning activities and a greater emphasis on self-directed learning. These methods will commence in Level 1 but gradually increase as you progress through the course. Continuing self-education is an important skill to learn especially in the face of rapidly changing knowledge, you will not be graduating with everything you need to know, but will be able to know where to get help when you face new
problems. Embarking on a medical career is embarking on a lifetime of learning; it does not stop upon graduation.

The strong University and Faculty research environment is closely linked to the undergraduate course. This occurs by two means: firstly because most of your teachers will be active researchers and will bring their knowledge and experience to their teaching; secondly you will undertake a research project in fourth year with any school in the Faculty or in the Faculty of Life and Physical Sciences which contains many disciplines important to your learning such as, anatomy, biochemistry, physiology and microbiology.

**Outcomes for the UWA Medical Graduate**

The UWA medical course aims to produce doctors who will:

- Understand the meaning and application of the social determinants of health and their implications for the health and health care needs of individuals, families and communities.
- Have sufficient knowledge and understanding of human structure and function, and behaviour to extend this understanding to the management of health and disease.
- Have the appropriate skills and attitudes to provide responsible clinical care within their professional limitations.
- Demonstrate knowledge and ability to engage in continuing self-education and further learning in their chosen field of medicine.
- Apply ethical standards of behaviour and knowledge of legal responsibilities to professional practice.
- Can apply understanding of population health issues to the health needs of individuals, families and communities.
- Have the ability and motivation to contribute to the advancement of medical and scientific knowledge, and
- Have sufficient knowledge of the health care system to understand its impact upon the delivery of sustainable health care services.

The undergraduate medical programme has been developed around the four main themes. They provide the framework for the learning outcomes across and within all years, and for the development of the curriculum and for assessment. Each theme is made up of several strands. Students must demonstrate satisfactory performance in all eighteen strands, which are taught and assessed on a variety of ways.

The Themes are:
- Scientific Basis of medicine
- Doctor and Patient
- Doctor, Heath and Society
- Personal and Professional Development
Outcomes for the UWA Medical Graduate

Course Map Medicine

Strands | Themes
--- | ---
Scientific Basis of Medicine | The Scientific and Evidence Base of Medicine | Normal Structure and Function | Disordered Structure and Function | Pathological and Clinical Features | Therapies
Doctor and Patient | Patient Assessment and Management | Practical Procedures | Communication | Health Maintenance, Promotion and Disease Prevention
Doctor, Health and Society | Organisation of Health Care | Population Perspective on Health | Aboriginal and Torres Strait Islander Health | Health in a Diverse Society
Personal and Professional Development | Research, Learning, Teaching and Continuing Education | Self Care | Career Development | Professionalism and Ethics | Legal Responsibilities

The course map can be accessed from [https://mappedout.meddent.uwa.edu.au](https://mappedout.meddent.uwa.edu.au)

LEARNING OUTCOMES FOR MEDICAL CURRICULUM

Scientific basis of Medicine
1. Apply the scientific/evidence based approach to medicine and practice
2. Demonstrate an in depth knowledge of normal human structure, function and behaviour
3. Evaluate and discuss disordered structure, function and behaviour of the human in response to internal and external factors
4. Apply knowledge of pathological and clinical features of disease

Doctor and Patient
5. Apply knowledge of therapies to health, illness and disease
6. Provide effective, safe and quality patient assessment and management
7. Perform and practice practical procedures effectively and safely
8. Use effective communication skills and styles
9. Apply and evaluate health maintenance, promotion and disease prevention approaches to clinical practice

Doctor, Health and Society
10. Apply knowledge of the organisation of the health care system and delivery in Australia
11. Apply a population perspective to health and health care in the community
12. Demonstrate a working knowledge of the socio-cultural context of health care of Aboriginal and Torres Strait Islander peoples and an ability to plan and provide comprehensive, multidisciplinary culturally secure care
13. Provide sensitive care to diverse patient groups in clinical situations

Personal and Professional Development
14. Apply the principles of life-long learning, research, teaching and continuing education
15. Apply principles of self care
16. Engage career development pathways
17. Demonstrate professionalism
18. Know own legal and professional responsibilities
Structure of the Undergraduate Medical Programme

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Teaching & Learning Methods

The aim of the medical course is to encourage you to be an adult learner, to make discoveries for yourself and to think inventively about your learning. This is what will be required in your future practice as a doctor. As you move from secondary to tertiary education you will find you need to take more responsibility for your own learning, monitoring your progress and seeking help. Multiple opportunities will be given to provide you with feedback; in laboratory classes, Problem Based Learning (PBL) sessions, communication skills sessions and formative exam sessions. Teaching in various units will utilise the following methods:

Lectures and Laboratories
Lectures and tutorials are a key component of your learning and aim to provide, either a framework on which to build learning, an exploration of a complex topic or exposure to people or ideas not easily found elsewhere. Web-based support material rarely replaces what can be gained from a lecture or personal contact with your teachers. It has been shown the most effective way to use lectures is to take your own notes based around the key outcomes/objectives of the session. Please be respectful of the staff delivering lectures by turning up on time and paying attention. Many lecturers give up their time for free as many are not UWA employees. Laboratories provide a practical way to extend and apply your knowledge. Attendance is encouraged for all sessions but is mandatory, for laboratories, tutorials and clinical attachments and lateness may make it difficult for you as you may miss the key introduction.

Laboratory and Tutorial Groups
NOTE: GROUP CHANGES ARE NOT ALLOWED.

For special circumstances, requests should be forwarded in writing to the Unit Coordinator and Associate Dean (Teaching and Learning) for approval.

PBL Sessions
Problem Based Learning aims to put you, the student, in the role of the doctor, to make you test yourself, do the clinical reasoning, work out what you know and don’t know and where you go to sort out the problem. The problems are written to suit your level of clinical knowledge and are coordinated with the systems-based teaching to allow you insight into the relevance of normal and abnormal structure and function to disease. You will be guided by your tutors as to how to sort out the problem, where to go for information, and in how much depth you need to learn the material.
Computer based material
This is written to support the face-to-face teaching programme or provide you with self-
assessment; it is not a replacement for it. In addition, it will provide you with some
administrative details required for the course.

You will need to take responsibility for finding out what is going on in the Faculty. All students
should check the faculty noticeboards when possible. Group email will be used for urgent
notices and will be sent to UWA student email accounts only. Students are expected to
logon onto the WebCT site at least twice a week for administrative notices. You will also
need to behave as a professional from the start of your Medical course. This includes the
manner in which you use forums and emails. You will learn many advanced Personal and
Professional Development skills throughout your course, but the basic attitudes of courtesy,
consideration for others and being responsible for your own decisions, will be expected from
the onset.

Personal & Professional Development - PPD

The Practice of Medicine is an art, not a trade; a calling, not a business; a calling in which
your heart will exercised equally with your head.

Osler W. Aequanimitas: With other addresses to medical students.
2nd ed. (Philadelphia: Blakiston’s Son, 1920 (page 386)

Personal and Professional Development has been clearly defined in the curriculum to ensure
that you graduate with all the qualities and skills required of a caring doctor, that you can
approach difficult ethical issues and that you can care for yourself.
PPD issues will arise out of PBL cases and from many of the patients you see on the wards
and elsewhere. You should take the opportunity to observe, think about the issues and talk
them over with your consultant. In addition there will be separate, specific tutorials, dealing
with issues such as breaking bad news, dealing with grief and ethical decisions. Associate
Professor Paul McGurgan, Unit Coordinator will provide an introductory session during the
course.

In Level 3 you will be either allocated a PPD Mentor or you can select your own mentor. You
must meet with them at least once during that year. This meeting will enable you to introduce
yourselves and give you and your Mentor an opportunity to discuss how to make the most of
PPD Portfolio and Interviews in Level 4, 5 and 6. You will also be able to discuss with your
Mentor any other issues related to your progress and development as a medical student.

(For further details please refer to the annually updated PPD Guidebook available ONLINE).
Combined Degrees
A small number of students may have a strong interest in either pursuing research or other academic areas in the Arts and may have the opportunity to complete a combined degree or a concurrent enrolment in a Diploma. Although allowing students a greater opportunity to follow their interests, these degrees involve an overload of units in some of those years and potentially an extra year of study. Thus they represent a more challenging course than the MBBS course. Full details and rules are available from the Manager (Student Affairs). If you are interested, please make contact as early as possible to discuss the options.

Bachelor of Medical Science (BMedSc) and MBBS course
The MBBS is a professional degree comprising a range of skills from the basic sciences through to clinical practice. Students interested in spending more time on research can undertake a Bachelor of Medical Science course (BMedSc) where they will personally get the opportunity to undertake original research. The course has been historically offered as a one year full-time Honours course, but from 2011 commencing students can only undertake it as a combined course with the MBBS course, through an intensive period of study and research, and complete both courses within the six year timeframe. Details concerning the course is provided in the UWA Undergraduate Handbook.

Those interested in enrolling in a BMedSc should first consult the Honours Coordinator and/or potential supervisors in the School in which they wish to study. Students must also meet with the Associate Dean (Student Affairs) to discuss any potential enrolment. Scholarships are available for students undertaking the BMedSc course, and details of these may also be obtained from the Manager (Student Affairs). Students wishing to undertake the course must have completed Level 1 units and have a project which is longitudinal in nature and would suit part-time research over a three year period. Research can be undertaken within schools both in the Faculty of Medicine, Dentistry & Health Sciences or in schools in Faculty of Life and Physical Sciences that teach in the medical course.

Bachelor of Medicine and Bachelor of Surgery and Diploma in Modern Languages or Diploma in Arts
The Diploma in Modern Languages and the Diploma in Arts allows students the opportunity to broaden their knowledge and interests in the languages and arts; pursue areas that will enhance their future practice (such as languages or philosophy); broaden their skills in the medical community though wider exposure to the humanities; and to pursue two areas of great interest at the same time. Those selected will enrol concurrently in both the MBBS and Diploma courses, taking arts units as an overload to the regular medical units. At the end of their studies students will be awarded two degrees, assuming satisfactory progress, the MBBS and the Diploma in Modern Languages or the Diploma in Arts. Those interested in enrolling in a Diploma should first consult the student advisor in the Faculty of Arts and must also meet with the Associate Dean (Student Affairs) to discuss any potential enrolment.

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The hardest conviction to get into the mind of a beginner is that the education upon which (s)he is engaged is not a college course, not a medical course, but a life course, for which the work of a few years under teachers is but a preparation.

Sir William Osler (1849-1919)
IMPORTANT DATES

Holidays for 2011

Australia Day:  26 January
Good Friday:   22 April
Easter Monday: 25 April
Anzac Day:    26 April

Census Dates for 2011

Semester 1:  31st March
Semester 2:  31st August

2011 Last Dates for Withdrawing From and Adding Units:

Last date to withdraw from Semester 1 Units:   15th April
Last date to withdraw from Semester 2 Units:   16th September

These dates are the last date to withdraw without academic penalty. Students who withdraw after the dates shown will be classified as “FN” i.e. Fail Due to Non-Completion.

If you wish to add a unit to your enrolment, you must do so on or before the last day of the third week of instruction in the unit.

NB: Please check the following website for future important dates and any date changes.

http://www.studentadmin.uwa.edu.au/welcome/important_dates/important_dates_2011

Please check Faculty website for term dates. http://www.meddent.uwa.edu.au/
LEVEL 1

Introduction to Level 1

The aim of Level 1 is to provide you with a solid foundation in the sciences underpinning the practice of Medicine with the emphasis being on understanding of normal structure and function of the body from molecules to whole organs and systems. In addition, level 1 will introduce you to clinical care, communication skills with patients and basic examination skills. You will visit a patient within an aged care facility. You will be introduced to health and illness in an Australian society and develop a basic understanding of the organization of health care and the principles underlying health promotion and disease prevention. You will learn about working in teams, planning your own study and managing information, and looking after yourself at University and in life.

In Semester 1, you will begin the following Units; Foundations of Animal & Human Biology and Foundations of Medical Chemistry. You will also commence Molecules, Genes & Cells which continues in 2nd semester, and these units focus on the theme: Scientific Basis of Medicine. The Foundations of Clinical Practice, which runs for the whole year and through into Levels 2 and 3, focuses on the themes Doctor, Health and Society, Doctor and Patient. The Personal and Professional Development theme runs through all of your units in level 1.

In Semester 2, teaching based around body systems commences with the Cardiovascular & Respiratory systems. Systems-based teaching continues into Level 2.

You will be studying significant components of the Foundations and Normal Systems Units with Dental and podiatry students, which we hope provides you with insights into the role Dentists and other professionals have in health care.

A significant set of exams will occur at the end of Semester 1 in addition to assessment throughout the semesters. Therefore it is essential you work steadily and monitor your progress.

Personal & Professional Development Programme – Level 1

You will have a series of Personal & Professional Development sessions throughout Semester 1 supplied by web based packages and some sessions held during the first semester. The sessions will be focused on developing skills to help you make the transition from secondary to tertiary learning. You will be receiving guidance on essay writing, note taking, time management, how to make the most of assessment, stress management and exam techniques. All of these activities will be related to what you are studying in your Core Units so they are aimed at assisting you in getting the best possible grades in your subjects.

Logon to WebCT and enter the CY1 Personal and Professional Development (PPD) unit to access all online modules offered by BRAIN – Beginner Research and Information Network.

If you have any queries about the Personal and Professional Development programme in Level 1, please contact:

Ms Erica Yeh
Manager (Teaching & Learning)
The Education Centre, Faculty of Medicine, Dentistry & Health Sciences
Tel: 9346 2412  Email: erica.yeh@uwa.edu.au
# LEVEL 1 UNITS

<table>
<thead>
<tr>
<th>Unit Code</th>
<th>Unit Name</th>
<th>Point value</th>
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<tbody>
<tr>
<td><strong>Semester 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMED1106</td>
<td>Foundations of Animal &amp; Human Biology</td>
<td>4</td>
</tr>
<tr>
<td>IMED1107</td>
<td>Foundations of Medical Chemistry</td>
<td>3</td>
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<td></td>
<td>Option (including Physics)</td>
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<tr>
<td><strong>Semester 2</strong></td>
<td></td>
<td></td>
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<tr>
<td>IMED1100</td>
<td>Normal Systems</td>
<td>12</td>
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<td><strong>Full Year</strong></td>
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<tr>
<td>IMED1113/IMED1114</td>
<td>Molecules, Genes &amp; Cells Pt 1 &amp; Pt 2</td>
<td>9</td>
</tr>
<tr>
<td>IMED 1111/IMED1112</td>
<td>Foundations of Clinical Practice Pt1 and Pt2</td>
<td>14</td>
</tr>
</tbody>
</table>

Students are required to pass each unit in order to proceed to level 2.

For Unit Coordinator details please check Faculty and E-Learning website and unit guidebooks.

http://www.meddent.uwa.edu.au/students/unit-info/mbbs
LEVEL 2

Introduction to Level 2

Exploration of the body and its normal structure and function continues in Level 2 alongside learning how, as a doctor, you talk to patients, pick up clinical symptoms and signs, and understand what disease means in the broadest sense.

In level 1 you looked at the respiratory and cardiovascular systems and now will move to the gastrointestinal system, reproductive system, endocrine system, renal system, musculoskeletal system and nervous system (peripheral and central) and beyond.

Teaching and learning methods in Level 2 are similar to Level 1 with Normal Systems Units using lectures, tutorials and laboratories as their primary method of delivery. In Foundations of Clinical Practice, problem-based learning (PBL) remains the primary method of delivery using the same model as outlined in Level 1. There are also fixed resource sessions to support PBL’s and a clinical skills stream. General Practice and patient visits also continue. By the end of this year you will have a solid foundation in understanding how the normal body functions and will be expected to be beginning to apply this in the context of clinical examination.

Optional Units
The Option gives you the opportunity to explore a particular area of interest in depth, this time within the Faculty and related to your future profession. You will be required to undertake your Optional Unit in either Semester 1 or Semester 2. Assessment will vary for each Unit. Assessment details will be provided in the Unit Guide provided.

Please contact the Administrative Officer at the Faculty Office as detailed below should you have any queries or concerns regarding the Year 2 Options Units. Details pertaining to the allocation process and timeframes for Options allocations will be made available upon request.

Please note that permission must be sought from the Faculty Office if a student wishes to change their Options Units.

Faculty Office, Administrative Officer
Ms Bridgid Dennis Tel: 9449 5169 Email: bridgid.dennis@uwa.edu.au

LEVEL 2 UNITS

<table>
<thead>
<tr>
<th>Unit Code</th>
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<tr>
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<td>Normal Systems</td>
<td>7</td>
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<tr>
<td>IMED2202</td>
<td>Normal Systems</td>
<td>7</td>
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<td>IMED2231/IMED2232</td>
<td>Normal Systems Pt 1 &amp; Pt 2</td>
<td>14</td>
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<tr>
<td>IMED2211/IMED2212</td>
<td>Foundations of Clinical Practice Pt1 and Pt2</td>
<td>14</td>
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</tbody>
</table>

Students are required to pass each component of each unit in order to proceed to level 3.

For Unit co-ordinator details please check Faculty and E-Learning website and unit guidebooks. [http://www.meddent.uwa.edu.au/students/unit-info/mbbs](http://www.meddent.uwa.edu.au/students/unit-info/mbbs)
GEMP Bridging Course

Introduction to Graduate Entry Medicine Program (GEMP)

The GEMP bridging course is for those who enter the medical course already having completed a degree. The GEMP Bridging Course (25 weeks duration) integrates material from the subjects of Anatomy, Physiology, Biochemistry, Population Health, Behavioural Science, Aboriginal Health and Clinical Skills. It prepares students with a prior degree for entry into the third year of the standard MBBS course. Case-Based Learning (CBL) tutorials are used weekly to illustrate the relevance of, and stimulate learning in the subjects included. The programme will use a similar integrated systems approach to the current undergraduate course but is more streamlined. While learning is supported by lectures and tutorials, self-directed learning is also important.

The GEMP bridging course will consist of a notional 24 contact hours per week.

Each week is a discrete learning block with a Case-Based Learning presentation at the beginning of the week. Many learning outcomes for the week emerge from the CBL case. There will be a tutorial presentation and wrap up session at the end of the week.

Other learning environments (small group teaching and laboratories) are discipline specific, but relevance to the week’s case and future clinical contexts are emphasised. This ensures that the knowledge and skills provided by teaching staff is contextual.

The overall GEMP Bridging Course timetable includes a three week orientation/foundations block with scenarios involving cell and molecular biology. There will then be 22 weeks of systems blocks comprising; musculoskeletal (5 weeks), cardiovascular (4), respiratory (2), GIT (3), endocrine and reproductive (3) and neurological (5).

<table>
<thead>
<tr>
<th>3 Weeks</th>
<th>12 Weeks</th>
<th>3 Weeks</th>
<th>10 Weeks</th>
<th>2 Weeks</th>
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<td>Foundations</td>
<td>Systems</td>
<td>Non-teaching study breaks</td>
<td>Systems</td>
<td>Exam Period</td>
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On the Orientation Days you will be introduced to the core structure, teaching and learning methods, outcomes, Faculty policy, procedures and key staff. Orientation will be conducted over 3 days, including 1 day on campus and 2 days at an Orientation Retreat, in which you are required to spend 2 nights.

BRIDGING COURSE UNITS

<table>
<thead>
<tr>
<th>Unit Code</th>
<th>Unit Name</th>
<th>Point Value</th>
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<tr>
<td>IMED2203</td>
<td>Bridging Unit</td>
<td>36</td>
</tr>
</tbody>
</table>
LEVEL 3

Introduction to Level 3

A few years ago the first animal was cloned, now it has arthritis. The Human Genome project is nearing completion, but optimism about the impact on individuals’ health has waned a little. Gene therapy for cystic fibrosis doesn’t work (but maybe will). Again you can see this is a complex changing world we live in and by the time you graduate, much information that was relevant at the beginning of the course may be redundant. As a result, the focus is on learning how to tackle and solve problems and use information.

Level 3 introduces you to the abnormal, the diseases, the causes behind those diseases, and will consolidate your clinical skills ready for learning in Levels 4, 5 and 6 which is largely in the clinical setting. As in previous years the curriculum focuses on the four Themes (Scientific Basis of Medicine, Doctor and Patient, Health and Society and Personal and Professional Development). Through understanding of pathology, microbiology and pharmacology, alongside the continuing FCP programme, which includes patient contact, Public Health and Ethics, we hope you find this year, as it moves to studying disease, rewarding, and allows you the vision of what it is to be a Doctor.

Personal & Professional Development - PPD

In Level 3 you will be asked to select a clinical mentor, you must meet with them at least once during the year. The PPD Admin Officer can assign you a mentor if you cannot find your own. This meeting will enable you to introduce yourselves and give you and your Mentor an opportunity to discuss the PPD programme, and to discuss with your Mentor any other issues related to your progress and development as a medical student. There will be an introductory session early in your third year, and you will be given the PPD Unit Guidebook for more information on the PPD unit including mentoring.

Administrative Contact
Email: ppdmed-fmdhs@uwa.edu.au

PPD Coordinator
Associate Prof Paul McGurgan
paul.mcgurgan@uwa.edu.au

Optional Units

The option unit gives you the opportunity to explore an area of interest in depth, this time within the Faculty and related to your future profession. You will be required to undertake your Optional Unit in either Semester 1 or Semester 2. Assessment will vary for each Unit and the Unit Coordinator will provide assessment details in the Unit Guide.

If you need advice concerning Options units you should contact the Administrative Officer at the Faculty Office. They will be able to explain to you the allocation process and when your option allocations will be available. Students wishing to change their options MUST seek permission from the Faculty Office.

Contact
Faculty Office, Administrative Officer
Mrs Bridgid Dennis Tel: 9449 5169 Email: bridgid.dennis@uwa.edu.au

For more information on your year 3 units, see the unit guidebooks on WebCT.
LEVEL 3 UNITS

<table>
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<th>Unit Code</th>
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<td>IMED3342/IMED3343</td>
<td>Foundations &amp; Systemic Pathology Pt 1 &amp; Pt 2</td>
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<td>IMED3344/IMED3345</td>
<td>Medical Pharmacology Pt 1 &amp; Pt 2</td>
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<td>Foundations of Clinical Practice Pt1 and Pt 2</td>
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**Semester 2**

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<td>Option</td>
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Students are required to pass each unit in order to proceed to level 4.

For Unit Coordinator details please check Faculty and E-Learning Website and unit guidebooks. http://www.meddent.uwa.edu.au/students/unit-info/mbbs

This is my vow. To perfect my medical art and never to swerve from it so long as God grants me my office, and to oppose all false medicine and teachings. Then to love the sick, each and all of them, more than if my own body were at stake. Not to judge anything superficially but by symptoms and signs. Not to administer any medicine without understanding, nor to collect any money without earning it. Not to guess but to know.

*Paracelsus,*
1493-1541
*Swiss Physician*
Introduction to Level 4

The Medical Course has prepared you for this time, when you will be in a phase of rapid learning. Your learning from the “classroom” will shift to the patient and as such you will need to adapt to new learning opportunities and challenges. You will be part of the medical team and patient care, not an observer. Over the next three years, you will gradually take more responsibility for patient care in readiness for the transition to being a doctor. This is an exciting, challenging, rewarding and difficult time as you immerse yourself in patients’ lives.

At the end of Level 4, you will be confident working with patients, talking to them, examining them and formulating their problem, even if you feel uncomfortable about establishing a provisional diagnosis or a management plan in other than the common problems in our community. To do this, Level 4 provides a broad coverage in the areas of general medicine, surgery and psychiatry, as well as infection, geriatrics and ophthalmology. These attachments all allow you to consolidate basic clinical skills and gain confidence working in the clinical setting. Particular areas, such as communication, Aboriginal health and Evidence Based Medicine will lead on from Levels 1-3.

As an introduction, IMED4403 Preparation for Practice will provide you with skills training and workshops designed to put you in a position to make the most of your clinical learning opportunities. In addition, para-clinical sciences (Infectious Diseases, Clinical Pathology & Laboratory Medicine and Clinical Pharmacology & Therapeutics) continue, allowing you to learn these sciences whilst seeing the problems in patients. You will reapply your EBM skills with a strong clinical focus, and as you have prepared a research topic, this project will be completed throughout the year. Most will be gained from being with patients and the doctors and nurses who care for them, backed up by reading. This is where you should focus your energies.

Teaching and Learning Methods

Clinical Attachment

In year 4 most of your learning will occur though clerking, ward rounds, general practice sessions, bedside tutorials, case presentations, workbooks and computer based tasks. You should immerse yourself in the clinical situation and make the most of the learning opportunities that arise. What you see and hear will provide the stimulus for much of your learning. Your learning occurs at the same time as patients are receiving their care and whilst your teachers are caring for their patients. Most of your teachers in the clinical settings are not academics but put considerable time, effort and interest into your learning. They take the Hippocratic oath seriously. They will reward enthusiasm but are unlikely to go out of their way for disinterested students. You will learn if you have seen the patients, have thought about them and present them to the consultant.

Doctors are also very busy, with high workloads and emergencies arise at inconvenient times. Although they try hard to ensure students have a top priority, patients do come first. So students should find ways to make delayed starts to tutorials a useful time rather than just “hanging around”. Obtaining a page so the RMO can contact you when the ward round is to start, and going off to see patients, carrying a text so you can read whilst waiting, practicing skills with fellow students, the possibilities are endless.

Answering clinical questions – using Evidence Based Medicine (EBM)

Many patient-centred clinical questions cannot be answered from prior knowledge or textbooks. The practice of EBM teaches you to answer real clinical questions by bringing together the best available scientific evidence, clinical experience, and the situation, values and priorities of the patient to deliver optimal health care. During the past decade there has been an increasing emphasis on ensuring that medical care is actually evidence based. Information literacy and
the ability to find, evaluate and apply this evidence quickly and efficiently is increasingly important. Accordingly, the skills associated with practicing evidence based medicine should be considered a core clinical skill that will be used throughout your medical career.

The EBM program uses self-directed learning via the UWA EBM online resource, ‘Answering Clinical Questions’. The four learning modules – ‘Formulate a clinical question’, ‘Find the best evidence’, ‘Appraise the evidence’, and ‘Apply the evidence’ – allow you to learn the principles of EBM which you will need to understand in order to complete assessments throughout the next three years and to achieve year IV learning objectives. Most clinical attachments will incorporate a clinically relevant EBM component into teaching or assessment. ‘Answering Clinical Questions’ includes a range of resources that will allow you to increase your understanding of EBM over the next three years. Resources include worked examples, guides, and worksheets which may be used in completion of assessments, a comprehensive EBM glossary, and links to other relevant sites.

The aim of the year IV EBM program is to further develop your skills in answering clinical questions. Particular emphasis should be placed on identifying your clinical knowledge gaps and locating and using synthesised information and clinical guidelines. As your clinical knowledge and experience increases you will be expected to integrate additional concepts of EBM in levels five and six. In other words, your understanding of EBM progresses over the three clinical years and integrates with the clinical curriculum. The material in ‘Answering Clinical Questions’ is also assessable and may be included in written examinations.

The ‘Answering Clinical Questions’ website is accessible at www.meddent.uwa.edu.au/acq

EBM Co-ordinator
Dr Anna Nowak
anowak@cyllene.uwa.edu.au

LEVEL 4 UNITS

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<td>Full Year</td>
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</tr>
<tr>
<td>IMED4401/IMED4402</td>
<td>Science &amp; Practice of Medicine Pt 1 &amp; Pt 2</td>
<td>8</td>
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<tr>
<td>IMED4403/IMED4404</td>
<td>Preparation for Practice Pt 1 &amp; Pt 2</td>
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<tr>
<td>IMED4411/IMED4412</td>
<td>Clinical Skills Pt 1 &amp; Pt 2</td>
<td>8</td>
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<tr>
<td>IMED4421/IMED4422</td>
<td>Personal &amp; Professional Development Pt 1 &amp; Pt 2</td>
<td>2</td>
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<tr>
<td>IMED4431/IMED4432</td>
<td>Infectious Diseases Pt 1 &amp; Pt 2</td>
<td>1</td>
</tr>
<tr>
<td>IMED4441/IMED4442</td>
<td>Clinical Pathology &amp; Laboratory Medicine Pt 1 &amp; Pt 2</td>
<td>2</td>
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<tr>
<td>IMED4451/IMED4452</td>
<td>Clinical Pharmacology &amp; Therapeutics Pt 1 &amp; Pt 2</td>
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<td>IMED4471/IMED4472</td>
<td>Psychiatry Pt 1 &amp; Pt 2</td>
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<td>IMED4481/IMED4482</td>
<td>Surgery Pt 1 &amp; Pt 2</td>
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<td>IMED4491/IMED4492</td>
<td>Medical Specialties Pt 1 &amp; Pt 2</td>
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<td>IMED4501/IMED4502</td>
<td>Research and Discovery Pt 1 &amp; Pt 2</td>
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Students are required to pass each component of each unit in order to proceed to level 5.

For Unit co-ordinator details please check Faculty and E-Learning website and unit guidebooks.

http://www.meddent.uwa.edu.au/students/co-ordinators
**IMED 4421/22 Personal & Professional Development - PPD**

In Level 4 PPD material is covered in a series of seminars (see below), communication tutorials, PBLs and through discussions with mentors. These issues include personal self care and stress, breaking bad news, informed consent, confidentiality, ethical legal issues, reflective practice and critical incident debriefing. You will also meet with your PPD mentor at least once. You are encouraged to meet more often (if your mentor agrees), perhaps after each clinical attachment to monitor your progress.

In the meetings with mentors, it is useful to reflect on the PPD aims in respect to your experiences and your own strengths and weaknesses. You should take the opportunity to observe, think about the issues and talk them over with your mentor. In addition these topics should be explored with your consultants and tutors.

**Students whose mentors do not return the Interview Record Sheet will fail IMED4421/4422 PPD, it is YOUR responsibility to ensure that the record sheet is completed and returned to the Education Centre by the due date.**

There will be a range of seminars scheduled in the Yr 4 Campus Week. Topics may include:

- End of Life
- Confidentiality and Privacy
- Informed Consent
- Error, Safety, Communication and Team-work
- Career Pathways/ Work-Life Balance/ Stress Management / Self-Care

Please note that attendance is mandatory. The PPD theme is a core theme in your medical curriculum and as such there is an expectation that you will cover the content of the theme in these seminars as well as in your clinical terms. Furthermore, elements of PPD may be assessed in summative exams at the end of Level 4.

**Administrative Contact:**
Email: ppdadmin-fmdhs@uwa.edu.au

**PPD Coordinator**
Associate Prof Paul McGurgan
paul.mcgurgan@uwa.edu.au

**IMED4491/IMED4492 Medical Specialties Pt 1 & Pt 2**

5 Points  Full Year
This Unit covers the following areas:

**Geriatric Medicine**
Consists of a clinical attachment and a problem-based learning stream. Both parts develop a broad range of skills including history taking and physical examination technique with elderly people, and the assessment of abnormal mental states and disability; problem solving and clinical reasoning with regard to the common symptoms, clinical signs and syndromes seen in elderly people; and the construction of a management plan with emphasis on allied health staff involvement and rehabilitation strategies.

**Musculoskeletal Disorders**
The module includes a lecture programme of common orthopaedic and traumatic conditions covered by region. Demonstrations of anatomical specimens and clinical examination of patients are provided and audio-visual teaching aids are available. Teaching of rheumatological conditions and lectures on metabolic bone disease are included. Students develop clinical skills by attendance at clinics and small group tutorials.
Level 5 Rural Clinical School

Interested students can apply to undertake Level 5 in a rural setting through The Rural Clinical School of Western Australia (RCSWA). You need to consider, apply and plan this in level 4, ready for level 5. The Rural Clinical School curriculum provides a year long intensive and prolonged rural experience, primarily aimed to encourage students to work in rural areas in the future. Many will already have looked for rural experiences through SPInRHEX, electives and John Flynn Scholarships.

The Rural Clinical School was established in 2002 with its headquarters in Kalgoorlie and additional centres are based in Albany, Broome, Bunbury, Busselton, Carnarvon, Derby, Esperance, Geraldton, Karratha, Kununurra, Narrogin and Port Hedland. Students study the RCSWA integrated curriculum and learning opportunities are equivalent to those received in Perth. Continuous assessment will be tailored to fit the rural experience, and learning will occur in an integrated fashion rather than being seen as discrete disciplinary attachments.

If students are interested in undertaking level 5 in a rural area, you should talk in the first instance to:

Head of School
Professor Geoff Riley
Rural Clinical School, Albany
Tel: 9842 0811
Email: Geoff.Riley@uwa.edu.au

Senior Administrative Officer
Rhonda Worthington
Rural Clinical School, Kalgoorlie
Tel: 9091 0666
Email: Rhonda.Worthington@uwa.edu.au

Medical education is not completed at medical school: it is only begun

William H Welch
LEVEL 5

Introduction to Level 5

Level 5 concentrates on specialty areas. You will be working in the community and the hospital settings. Level 5 aims to provide you with a broadening and consolidating year prior to your final year where you will be functioning as a trainee intern. Firstly, you will receive training in specialty areas, through attachments in Obstetrics and Gynaecology, Paediatrics, General Practice, Ophthalmology, Medicine and Cancer. Secondly, all clinical terms will help in consolidating clinical skills and evidence based medicine, with a focus on how to access and apply knowledge to patient care. Clinical Options provide you with the opportunity to explore some areas of interest in greater depth, and electives, the delivery of care in rural areas. Finally, the Personal and Professional Development Portfolio addresses important areas of your own development as doctors, getting you to draw on your experience as a student and reflect on the significance of these experiences for your future practice as a doctor and for your patients. Some of you will undertake all of level 5 in a rural area with the rural clinical school.

Teaching and Learning Methods

Answering clinical questions – using Evidence Based Medicine (EBM)

Many patient-centred clinical questions cannot be answered from prior knowledge or textbooks. The practice of EBM teaches you to answer real clinical questions by bringing together the best available scientific evidence, clinical experience, and the situation, values and priorities of the patient to deliver optimal health care. During the past decade there has been an increasing emphasis on ensuring that medical care is actually evidence based. Information literacy and the ability to find, evaluate and apply this evidence quickly and efficiently is increasingly important. Accordingly, the skills associated with practicing evidence based medicine should be considered a core clinical skill that will be used throughout your medical career.

The EBM program uses self-directed learning via the UWA EBM online resource, ‘Answering Clinical Questions’. The four learning modules – ‘Formulate a clinical question’, ‘Find the best evidence’, ‘Appraise the evidence’, and ‘Apply the evidence’ – allow you to build on the principles of EBM from year IV, with further depth and extension to achieve year V learning objectives. Most clinical attachments will incorporate a clinically relevant EBM component into teaching or assessment. ‘Answering Clinical Questions’ includes a range of resources that will allow you to increase your understanding of EBM over the next two years. Resources include worked examples, guides, and worksheets which may be used in completion of assessments, a comprehensive EBM glossary, and links to other relevant sites.

Whereas the learning outcomes in level 4 focused on basic principles, guidelines and synthesized information, the program in level 5 seeks to develop the required knowledge find and critically appraise the research literature related to therapy, diagnosis and prognosis. Emphasis should be placed on assessing study validity, interpretation of the results and applicability of the findings to clinical practice. Summative assessment will form part of the final examination for the unit IMED5501/5502 Science and Practice of Medicine.

The ‘Answering Clinical Questions’ website is accessible at www.meddent.uwa.edu.au/acq

Personal & Professional Development

The importance of your own development as a doctor, in regard to skills of life long learning, in terms of your ability to evaluate yourself, your knowledge and your practice, and in terms of your ability to care for yourself in a rewarding but challenging and stressful career, has been recognised as an essential graduate outcome. The Portfolio and Interviews, which you will complete in Level 5, will help you to reflect on these aims in respect to your experiences and your own strengths and weaknesses. (See separate PPD guidebook for further details – late submissions may affect progression to the next academic year)
LEVEL 5 UNITS

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<tr>
<th>Unit Code</th>
<th>Unit Name</th>
<th>Point value</th>
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<td>Science &amp; Practice of Medicine Pt 1 &amp; Pt 2</td>
<td>8</td>
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<td>IMED5511/IMED5512</td>
<td>Special Clinical Skills Pt 1 &amp; Pt 2</td>
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<td>IMED5521/IMED5522</td>
<td>Personal &amp; Professional Development Pt 1 &amp; Pt 2</td>
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<td>General Practice and Ophthalmology Pt 1 &amp; Pt 2</td>
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<tr>
<td>IMED5601/IMED5602</td>
<td>Options Pt 1 &amp; Pt 2</td>
<td>2</td>
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</tbody>
</table>

Students are required to pass each unit in order to proceed to level 6.

For Unit co-ordinator details please check Faculty and E-Learning website and unit guidebooks.

http://www.meddent.uwa.edu.au/students/unit-info/mbbs

IMED5601/IMED5602 Options Pt 1 & Pt 2

2 points Full Year
Options consist of two two-week blocks during the academic year designed to allow students to study areas of medicine in which they have an interest in greater depth than is possible in the core curriculum. Each option is offered to a limited number of students, with most attachments being for one or two students at a time. These units usually comprise an attachment to a clinical unit, time for self-directed learning and tutorial sessions with one or more supervisors. Contact time is normally expected to be about 24 hours per week, although this varies depending on the option.

Students may also design their own options in consultation with prospective supervisors which need to be approved by the Options Co-ordinator at the beginning of the academic year. Each option is marked as pass/fail although supervisors are encouraged to assign a grade for the efforts that a student has placed in completion of the unit. To receive a pass mark in an Option you must satisfy both the participation requirement and complete the relevant assessment task. The supervisor for each option is required to assess the students unless stated otherwise.

Unsatisfactory Performance
Students are required to undertake additional work in case of unsatisfactory performance in an option.

Student Requirements
Contact the School Administrative Coordinator at least three weeks prior to the commencement of your option for confirmation and details of placement. You can find more information regarding option allocation, information, term dates and contact information on the level 5 options website https://options.meddent.uwa.edu.au/ It is only under exceptional circumstances that change in an option is allowed by the Unit coordinator.

Contact
Administrative Officer (Options)
Ms Caroline Martin
Tel: 9346 2621 Email: caroline.martin@uwa.edu.au
Rural Clinical School
Students in the Rural Clinical School cover the same syllabus and assessment strategy as in the city. The year long course aims to provide a prolonged rural experience in clinical medicine that takes account of the unique health care needs of rural and remote communities. Students are assigned Medical Coordinators throughout the year who provides academic, pastoral and clinical leadership and support. A range of rural based options are available which, in previous years, have assisted students in the development of a range of procedural skills in rural and remote medicine.

Elective Term for Level 6

UWA MBBS student elective placements are categorised into 3 groups: International, Urban and Rural. At least 6 weeks (usually between December and February) is allocated to the Elective program. The prime objective of the Elective is to provide students with experience in specific areas of medicine of their own choice. The elective placement offers students an opportunity to undertake supervised experience in clinical or community work anywhere in the world. It may be seen as an opportunity to prepare for a particular career direction or to explore different experiences or to enhance skills in areas in particular areas. The placement is intended to provide practical experiences, awareness of professional practice, ability to function effectively as an individual and as a member of a team, and an understanding of professional responsibilities. Students usually organise their own elective terms but if advice or assistance is needed students can contact the Elective Coordinator in the Faculty of Medicine, Dentistry and Health Sciences.

Co-ordinator of Electives
Ms Leanne Lind
Tel: 9449 5175
Email: leanne.lind@uwa.edu.au

Medical education is to pass on a humanised medicine so that medical students may understand, experience and grasp the humanistic philosophy of medicine and thus establish their own value theory, ethical standard and eventually their own life philosophy. Only when we reach this goal can we say our education has succeeded.

A quotation from Dr BS Hsieh: Introduction to medicine. Taipei. Taiwan University Medical College, 1997:85)
LEVEL 6

Introduction to Level 6

THE HIPPOCRATIC OATH

I swear by Apollo, the Physician, by Asclepius, by Hygeia, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out according to my ability and judgement, this oath and this indenture. To hold my teacher in this art equal to my own parents to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture. I will use treatment to help the sick according to my ability and judgement, but never with a view to injury or wrong-doing. I will keep pure and holy both my life and my art. In whatsoever houses I enter I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm. And whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me.

Translation by
William Henry Rich Jones (1817-1885)

Outline of the Pre-Intern Year

Level 6 has always been rated highly by all students as the year they enjoy most overall. Your approach to learning and care this year will take you beyond medical school, in your continuing education. The focus has shifted very much from rote learning facts with big end of year examinations to one which enhances the skills you will need in this changing world, namely, solving problems, knowing where up to date information is kept to solve these problems (electronic papers, people!) and so forth. We believe you will have a richly rewarding year and look forward to working with you now, and as your colleagues next year.

The knowledge aims of the Pre-Intern Year are outlined under the four themes of the curriculum. As a level 6 student, you should have a broad understanding of the pathological and psychopathological mechanisms of those areas already covered in the curriculum. You should be able to take a history, examine a patient, identify problems, formulate a reasoned hypothesis with a differential diagnosis for common disorders and suggest options for management. You already have clinical experience in the hospital and community setting. However, much of this would have been as an observer or as part of a group. At the end of the Pre-Intern Year you should have a realistic idea of the pressures and responsibilities involved in ward care and decision making in the intern year. You should be able to:

- Work independently at a level, which is appropriate to the start of the intern year.
- Work as a member of a team and understand the hospital system where you will complete your intern year.

One tries to give students the vision of medicine not so much as a trade... but as a satisfying discipline of thought which requires of them accurate observation, critical constructive thinking, humility and human courage.

Eric Saint
Foundation Professor of Medicine
University of Western Australia
Teaching & Learning Methods

In Level 5, problem based learning was used to put you in the hot seat, in the role of the doctor, so your knowledge and skills could be challenged. Now in Level 6, you must put yourself in the role of a real doctor, as a pre-intern. As you will have discovered in Level 5, the course becomes less structured and requires you to plan your learning, and make the most of opportunities, which may arise. Most of your learning does not occur in structured settings and requires you to monitor your progress and address deficiencies. The provision of the Core Cases in Clinical Practice, feedback during the clinical rotation, and individual unit Guidebooks as well as guidelines on how you should spend your time will all aid your self-directed learning. The aim of the medical course is to encourage you to be an adult learner, to make discoveries for yourself and to think inventively about your learning. This is what will be required in your future practice as a doctor.

Core Cases in Clinical Practice

This is a multidisciplinary summary of the “Knowledge, Skills and Attitudes” members of the medical school have agreed students should know on graduation. It is used by Faculty to guide teaching programmes and assessment; it should be used by you to guide your learning and to review omissions. This is included as an appendix in this guidebook. Teaching in various units will utilise the following methods:
- Clinical attachment - With clerking, ward rounds, bedside tutorials, case presentations, workbooks etc.
- Tutorials (small groups), seminars and CATs (critically appraised topics)
- Computer based cases and tutorial summaries

Personal and Professional Development

A series of seminars have been planned around a range of topics which include health systems (including Medical Board, Office of Health Review), careers, medicine in society, health and law (including medical defence) and advanced ethics. The focus of the seminar is practical and aimed at preparing junior doctors for issues they face in the immediate future as well as in the longer term.

You will be required to submit an ethics essay to your mentor for evaluation and comment. You should meet with you at least once. Any further meetings with your mentor can continue on the initiative of the student or mentor.

(Check WebCT for seminar dates and the annually updated PPD Guidebook available online for further information.)

LEVEL 6 UNITS

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<thead>
<tr>
<th>Unit Code</th>
<th>Unit Name</th>
<th>Point value</th>
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<tbody>
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<td>IMED6671/IMED6672</td>
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<tr>
<td>IMED6681/IMED6682</td>
<td>Surgery Pt 1 &amp; Pt 2</td>
<td>10</td>
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For Unit co-ordinator details please check Faculty and E-Learning websites and unit guidebooks.

http://www.meddent.uwa.edu.au/students/co-ordinators
Elective Report

**IMED 6603** Elective Placement (International)
**IMED 6604** Elective Placement (Urban)
**IMED 6605** Elective Placement (Rural)

On completion of an Elective, students write an elective report highlighting their achievements from the elective and what they learned from the experience. Also some reflection is given on the practice of medicine in the location where they spent the elective and how it relates to their current medical experiences to date. The Consultant Supervisor(s) are also required to complete a report form ranking the student's performance over various fields during their elective period. Both reports are a compulsory requirement of the elective placement and are needed to satisfy the evaluation requirements of the elective term. Reports should be returned to the Elective Coordinator. The elective unit's record results of Ungraded Pass (UP) or Ungraded Fail (UF) as appropriate.

**Co-ordinator of Electives**
Ms Leanne Lind
Tel: 9449 5175 Email: leanne.lind@uwa.edu.au

**IMED6661/IMED6662 Medicine Pt 1 & Pt 2**
8 Points Full Year
This Unit covers many areas including:

**Palliative Care**
Palliative Care is taught during the first week of the medicine term as a specialty area. The attachment focuses on the care of patients with a progressive life-threatening illness, who are confronting death in the foreseeable future. The fundamental concepts are significantly different from other areas of medical practice as the relief of suffering, rather than the cure of disease, is the paramount consideration.

**Sexual Health Day**
This workshop is an opportunity to consolidate previously learnt skills so that the elements of history taking, examination, investigation and management can be reviewed. Previous years have covered the microbiology, history taking and genital examination but this is a chance to link these various elements so that STDs presenting in a primary health setting are effectively managed.

It is intended that groups will rotate through the activities in the afternoon. Case histories will allow as many syndromic presentations to be covered in the tutorial as possible. Examination will take place on mannequins and dildos. This will be the interactive section of the workshop and allow for direct observation of practices to ensure effective management.

**IMED6681/IMED6682 Surgery Pt 1 & Pt2**
8 Points Full Year
This Unit covers many aspects of Surgery including:

**Anaesthesia**
Anaesthesia is a one-week attachment that is carried out during the Surgery term. This attachment has a focus on practical skills related to management of the unconscious patient, airway management and ventilation, intravenous cannulation and intravenous infusion and drug administration. Students are expected to take an active role in these important aspects of patient management, while supervised by anaesthetic staff. In parallel, it offers the opportunity to observe and understand principles of preoperative patient assessment, administration of general and regional anaesthesia, management of pain and management of the severely ill patient.
ANSWERING CLINICAL QUESTIONS (ACQ)

ACQ is a UWA FMDHS online resource to assist you to develop best practice clinical skills. The clinical content is structured into four sequential learning modules:

- Formulate a clinical question
- Find the best evidence
- Appraise the evidence
- Apply the evidence

ACQ is available via the Faculty of Medicine, Dentistry, and Health Sciences website at [http://www.meddent.uwa.edu.au/teaching/acq](http://www.meddent.uwa.edu.au/teaching/acq).

Resources include a glossary, clinical examples, direct links to UWA information resources (such as Dynamed, Clin-eguide and Medline), printable guides, and worksheets to assist with critical appraisal and completion of assessments in addition to patient-focused care.

Comments on ACQ are welcome. Please email feedback to medlib@library.uwa.edu.au
POSTGRADUATE MEDICAL COUNCIL OF WESTERN AUSTRALIA (PMCWA)

The PMCWA is Ministerial Council established in August 2003 to provide leadership for early postgraduate medical education and training in Western Australia. The PMCWA has taken on the roles and responsibilities previously undertaken by the Prevocational Training and Accreditation Committee (PTAC), which was dissolved on 30 June 2003. The PMCWA has representation from a wide cross-section of the medical profession in Western Australia, including junior medical officers, and has policy responsibility for:

- education, training and supervision of junior medical officers and other non-vocational doctors;
- setting standards and the accreditation of training positions receiving postgraduate doctors (including PGY1, PGY2 and PGY2+); and
- monitoring the supply and demand for pre-vocational workforce in Western Australia.

The PMCWA has three sub-committees addressing each of these policy areas.

Accrediting training positions for pre-vocational doctors is an activity the OCMWA undertakes on behalf of the Medical Board of Western Australia. In order to achieve unconditional registration with the Medical Board, you will need to complete your intern training in one of these accredited positions.

The Council has a number of initiatives underway that may impact on you as an Intern, including:
- reviewing of the current training requirement for internship, prior to recommendation for unconditional registration with the Medical Board of Western Australia; and
- streamlining of the application process for internship.

The PMCWA will keep you updated on the progress of these initiatives.

The PMCWA also sponsors the Western Australian JMO Forum, which was formed in late 2002 to contribute toward the progressive improvement of JMO training and workplace conditions throughout Western Australia. The Forum has already had success in achieving improvements for junior medical officers and has identified a number of issues to be tackled in the future. You are encouraged to become involved in this Forum during your early postgraduate years, either through your representatives or by becoming a representative yourself.

The PMCWA can be contacted on (08) 9222 2175 or see their website at [http://www.pmcwa.health.wa.gov.au/home/](http://www.pmcwa.health.wa.gov.au/home/)
RESOURCES

Medical and Dental Library

Buildings

The Medical and Dental Library and the Science Library (buildings) offer you a place where you can study and access resources and services.

The libraries have:
- books
- journals
- computers
- laptop computers (Medical & Dental Library only)
- lockers
- private study rooms
- silent study areas
- group study rooms
- audiovisual equipment

If you can’t find books or journals that you need please contact library staff and we will try to get it for you. We welcome your suggestions and feedback.

The Medical and Dental library is adjacent to the OHCWA (Oral Health Centre of Western Australia) building, at the corner of Monash Avenue and Hospital Avenue, Nedlands.

The Science Library is located on the southern part of the main campus, at the western end of Prescott Court, between the Physiology and Agriculture buildings.

Readings recommended by your Lecturer

Most readings recommended by your lecturer are available via Course Materials Online (CMO).

Some of the resources on CMO include:
- full text articles
- books (in the Library Reserve Collection) and ebooks
- newspaper articles
- web pages
- examination papers

Log in to CMO via the link on the library homepage: http://www.library.uwa.edu.au/

Online Services

Many of our resources are available online via our catalogue, from any computer in the world.

Online resources include:
- databases
- ebooks
- subject specific guides
- referencing guides

Access our online resources at http://www.library.uwa.edu.au.
Access our guides at http://libguides.library.uwa.edu.au
Librarians

Librarians are here to help you develop your information finding and management skills. For example we can assist you with:

- finding relevant information for your assignment
- referencing your citations
- using EndNote to manage your references
- tracking research trails
- developing and refining search strategies to find information for more complex projects

Contact us via:

Phone: 08 9346 7576
Fax: 08 9346 7588
Email: med-lib@uwa.edu.au

NB: Email reference enquiries are responded to usually within 24 hours (Mon-Fri), so if you need a quicker response please just pick up the phone or drop in to see us.

What if the UWA Library doesn’t have what you need?

There are a few options:

- **Ask us to purchase it** - we are always looking for resources to support your learning and your suggestions are welcome.

- **Borrow it from another university library** - you can visit other Perth university libraries and register as a reciprocal borrower. More information, including where you can borrow, is available at [http://www.library.uwa.edu.au/visitors/reciprocal](http://www.library.uwa.edu.au/visitors/reciprocal)

- **Request it via Get It** - If you are a fourth year (or above) medical student you can request material from other libraries, including other UWA subject libraries on campus. Articles can be delivered electronically as pdf documents (when possible); print materials are forwarded to your address. Log into Get It at [http://www.library.uwa.edu.au](http://www.library.uwa.edu.au).
Learning Management System, WebCT.

The University uses WebCT as its Learning Management System. Unit coordinators vary in their use of the system. Many provide supplementary materials and resources.

To access WebCT you need to have activated your Pheme account (authentication management system at UWA). During this process you will be asked for your student number and date of birth. If you have not activated your Pheme account, or require further help to do this you should contact the Student Internet Support Officers (SISO): by phone on 6488 3814 or by email: support@student.uwa.edu.au.

You can access WebCT directly using the following web address: http://webct.uwa.edu.au

This link can also be found on the Faculty Current Students webpage.

Username Login will be your student number. Password will be your Pheme password.

Support for WebCT

The WebCT student support website is maintained by eLearning development and support staff at the Centre of the Advancement of Teaching and Learning, while direct support for student WebCT login problems is provided by the Student Internet Support Officers located in the Reid Library.

For technical issues contact the SISO. For unit content related issues contact your Unit Coordinator. WebCT Units are populated with information from studentConnect. Please note changes to unit enrolments can take 24 – 48 hours to filter through into WebCT

Computing Resources & Facilities

Computer Access
Before you are able to login to the computers in the Student Computer Labs you will need to activate your Faculty computer account by completing the online Account Activation Form at http://www.meddent.uwa.edu.au/students/computing/account-activation

As noted before computers and computer-based material will provide an important information source for you on administrative matters, can provide communication between you and Faculty and you and fellow students, provide a link to resources such as the library, the web, and other units, learning material in some of the units and support for your word processing needs.

The Faculty has 13 computer labs where you can use:

- the Microsoft Office productivity suite
- EndNote
- internet facilities if you have a full service student account
- CD/DVD burning software
- Pharmacology applications

All computer labs have identical computers with the same configuration and 17" monitors, Core2 Duo processors, 2GB of memory and internet access.

Detail location of each student computer lab is available at the following link http://www.meddent.uwa.edu.au/students/computing/labs

Internet Access
Access to the Internet at UWA is controlled by UWA IT Services (ITS) and not Faculty IT.
To be able to access the Internet using the computers in the Student Computer Labs, ITS require you to upgrade your Central Student account to a Full Service Student account. ITS have an online presentation/tutorial at http://www.its.uwa.edu.au/student/accounts/fullservicestudaccount/fullpresentation that will guide you through the account upgrade process.

After successfully activating your Student Computer Labs accounts, along with upgrading your Central Student account to a Full Service account, you will be able to use your Pheme account to login to the computers and browse the Internet.

Activating your Pheme account was part of your enrolment process at UWA, and can be done online from the Pheme homepage.

Email
We suggest that you use MyUWA, University’s online service portal to access your student email account, as correspondence sent to students will be sent to student email accounts only. The address for MyUWA is http://www.uwa.edu.au/myuwa
Many students prefer to use hotmail (or similar) or existing private email accounts rather than their student email accounts. Students are discouraged from forwarding email to external accounts.

Printing
In most student computer labs there is a dedicated laser black and white printer. To use the printers, each student account has been allocated $50 worth of page printing credits annually. This equates to 500 pages at 10c per page. Print credit allocated by the Faculty cannot be redeemed for cash.

Prior to printing you will be ask to confirm the document to be printed and current balance is also displayed. If you do not have enough balance to print the document, it will not be printed.

If the print credit is exhausted and need to be topped up, please come in to see the Faculty Receptionist during office hours at N Block, QEII Medical Centre in Nedlands.
Printer Page size and type are limited to A4 and manual feeders are not accessible as their use often results in paper jams.

A log is maintained which details each print job sent for printing. This is used to identify each transaction and is generally used to clear up any discrepancy with print charging that may occur down the track.

**Contacts**  
IT Help Desk  
Phone: (08) 9346 7325  
Email: ithelp-students@meddent.uwa.edu.au

If you encounter any IT issues, need advice or generally need to communicate with the IT Unit, email is the best method.
Seeking Advice and/or Assistance
There are a number of people who will be able to assist you with different aspects of your course during the time you are studying medicine at UWA. This faculty spends a lot of resources caring for its students, many faculties do not allocate the same time and resources as the Faculty of Medicine, Dentistry & Health Sciences.

Associate Dean (Student Affairs)
If you have problems relating to your course or personal issues which are impeding your progress and need some advice, or would like to talk it over with someone, you may like to make an appointment to see the Associate Dean (Student Affairs) who has a wealth of knowledge and experience and can offer some useful advice and arrange ongoing support if that is necessary. You will need to see the Associate Dean to obtain permission if you are seeking leave of absence from the course, returning to the course after a period of absence, or applying for special consideration or deferred exams (see below). You will also need to obtain the Associate Dean’s permission if you wish to take leave during term time for a period of three days or longer.

Associate Professor Roland Kaiser
Associate Dean (Student Affairs)
Tel: 93484 8633 Email: roland.kaiser@uwa.edu.au

Manager (Student Affairs)
The Manager (Student Affairs) can assist you with course advice and advice on procedural matters related to your enrolment and University requirements such as special consideration/deferred exams, leave of absence and appeals against academic assessment. The Manager (Student Affairs) is a good person to contact initially if you are having problems. In many cases she will be able to advise the most appropriate person to assist you or provide some interim support until you can see the Associate Dean, if that is necessary. The Manager (Student Affairs) can also provide advice on the appropriate steps to take if you are considering a change to your course (such as transfer to another course or enrolment in the Bachelor of Medical Science or a Diploma).

Dr Jan Dunphy
Manager (Student Affairs)
Tel: 9449 5143 Email: jan.dunphy@uwa.edu.au

Professor of Medical Education
The Professor of Medical Education ensures that students in the Faculty of Medicine, Dentistry and Health Sciences are taught to the highest national and international standards in preparation for their role in the community as doctors, dentists and health professionals. He is responsible for the implementation and monitoring of the curriculum. If you have any queries or concerns about the actual content or structure of the Curriculum, you could contact the Professor of Medical Education through EdCent.

Winthrop Professor Tony Celenza
Tel: 9346 4355 Email: tony.celenza@uwa.edu.au
Sub-Deans
The Faculty has appointed Sub-Deans with responsibility for particular years, to assist students. It is hoped that this arrangement will be more convenient for students and alleviate the need to contact the Faculty Office for minor concerns. For instance, if you need short-term leave from your course for a period of less than three days you may seek permission from the Sub-Dean.

The Sub-Dean will advise the Faculty of your request and their subsequent approval. The Sub-Deans can provide you also with advice related to your course and other interim counselling. They can also liaise for you with other members of staff. They cannot give approvals for such things as extended leave of absence or special consideration/deferred exams or advice on University regulations or procedures. These issues are dealt with by the Associate Dean (Student Affairs) at the Faculty Office. The Sub-Deans can, however, facilitate your requests for extended leave, special consideration, deferred exams and other significant issues by liaising with the Faculty Office. You should therefore make an appointment to see them initially. Their details are below.

Although you should initially approach the Sub-Dean who is assigned to deal with your particular year, if the matter is urgent, feel free to approach another Sub-Dean or the Associate Dean (Student Affairs) or Manager (Student Affairs) if they are available.

Asst/Prof Helena Iredell
Sub-Dean& Academic Year Monitor (Level 1-3)
School of Population Health
Tel: 6488 1274 Email: helena.iredell@uwa.edu.au

W/Prof Christobel Saunders
Sub-Dean (Level 4)
School of Surgery
Tel: 9346 2146 Email: christobel.saunders@uwa.edu.au

A/Prof Di Carmody & A/Prof Lexi Tregonning
Sub-Deans (Level 5)
School of Women's and Infants' Health
Tel: 9340 1323 Email: di.carmody@uwa.edu.au
Lexi.tregonning@uwa.edu.au

A/Prof Neil Boudville
Sub-Dean (Level 6)
School of Medicine and Pharmacology SCGH
Tel: 9346 2325/3822 Email: nboudvil@cyllene.uwa.edu.au

Please Note: Levels 4 - 6
Sub Deans may be subject to change.

Course Difficulties
If for some reason you are having difficulty completing your course requirements, contact the Unit Coordinator in the first instance or the relevant Sub-Dean. If a solution cannot be worked out at that level contact the Faculty Office and talk to Manager (Student Affairs) or the Associate Dean (Student Affairs) (see above). You don't have to go into lots of detail, but you do need to tell someone and get some advice as soon as possible.

Alternative Sources for Help
If you think something is having a bad effect on your academic performance, get appropriate help as soon as possible. Negotiating deferred exams or special consideration at the last minute or after the exam has been held will require very clear and strong supporting evidence. It is amazing how much difference early intervention can have. By dealing with the problem as soon as it arises, you will, hopefully, prevent it developing into something much larger.

There are a number of ways in which you can be assisted and you may be surprised at how simple the solution can be, but we cannot help you unless we know that you are encountering difficulties, so please tell someone. You can contact your unit coordinator, the Sub Dean, the Associate Dean (Student Affairs) or the Manager (Student Affairs).
Health Problems
Health problems can have an adverse effect on your performance. See your doctor and explain your difficulties. If you don’t have one, see the medical staff at the University Medical Centre on the main campus. They are experienced in dealing with students and familiar with University procedures. If you are going to apply for special consideration on the basis of your health problems you will need to obtain a doctor’s certificate and attach it to your application or ask your doctor to complete the medical part of the Special Consideration form. If as a result of your health problems, some adjustment needs to be made to your course you will need to see the Associate Dean (Student Affairs) as soon as possible.

University Medical Centre
Tel: 6488 2118

Counselling services
The professional counsellors at Student Services on the main campus can assist with other personal problems. Appointments can be made by telephoning them. The counsellors there are experienced in providing written support for applications for deferred exams and special consideration and, if necessary, can provide ongoing help in resolving difficulties quickly before they badly affect your studies.

Two counsellors have been assigned to look after students in our Faculty. One counsellor comes to the Faculty Office at QEII once a week to provide sessions that may be more convenient for students in the clinical years to attend.

Student Services
Tel: 6488 2423

Other Contacts
Ms Sue Pougnault
Student Support Coordinator
Faculty of Medicine Dentistry and Health Science
Tel: 9449 5177 Email: sue.pougnault@uwa.edu.au
Sue provides mentoring and support for rural, interstate and international undergraduate and graduate entry students.

WAMSS
Through WAMSS, the West Australian Medical Students Society there are many opportunities to get involved in health education in the community (Dr Yes), peer teaching (Student Grand Rounds), support of health services in third world countries (elective programme) and much more. See WAMSS website: www.wamss.org.au

Supplementary Exams
The Faculty Rules state:
“8.2.2.12(1) In determining whether or not to provide a student with an opportunity for supplementary assessment in a unit, the Board of Examiners will take into account a student's entire academic record.
(2) Students who fail at the first attempt in more than two of the units for which they are enrolled are not provided with the opportunity for supplementary assessment in the failed units.
(3) Students repeating a year are not provided with the opportunity for supplementary assessment.
(4) Students who fail a deferred examination in a unit are not provided with the opportunity for supplementary assessment in that unit.
[(1), (2) and (3) are approved additions to University General Rule 1.2.1.25 and (4) is an approved exception to University General Rule 1.2.1.25]”

Supplementary exams for semester one examinations will normally occur mid-year whereas the supplementary exams for semester two are held in January of the following year. It is
It is important to be aware of the dates for the exams – please see the Student Admin website at http://www.studentadmin.uwa.edu.au/welcome/assessment/dates. It is your responsibility to check the timetable for the exact date and time of your supplementary exam. This can be done via Student Connect. A lack of knowledge about the date/time of the exam is not an excuse for missing the exam. Should you fail to sit the supplementary exam the original result for the unit will hold. Supplementary exams cannot be deferred, except for exceptional circumstances, as approved by the Associate Dean (Student Affairs).

**Deferred Exams**

The University General Rules state:

"1.2.1.24(1) The Registrar may permit a student to take a deferred examination in one or more units if the faculty is satisfied that, for medical or other exceptional reasons, the student was either—

(a) substantially hindered in preparation for an examination; or

(b) absent from or unable to complete an examination.

(2) The format of a deferred examination may be different from that of the initial examination.

(3) A student applying for a deferred examination must arrange for the application to be submitted to the faculty on the appropriate form, including any relevant medical certificates or other appropriate documentary support, no later than three University working days after the date for which the relevant initial examination was scheduled.

(4) A candidate for a deferred examination in a unit must sit the examination in a venue on the campus on which the initial examination in the unit was scheduled to take place, unless the Registrar, after receiving advice from the faculty concerned, authorizes otherwise in recognition of extreme mitigating circumstances."

Students who wish to request a deferred exam must submit an Application for Special Consideration to the Faculty Office as soon as possible. The forms are available from the Student Administration forms web page at www.studentadmin.uwa.edu.au/welcome/forms or from the Faculty Office.

It is your responsibility to check the timetable for the exact date and time of your deferred exam. This can be done via Student Connect. A lack of knowledge about the date/time of the exam is not an excuse for missing the exam. Deferred exams cannot be deferred further, except for exceptional circumstances, as approved by the Associate Dean (Student Affairs).

**Something to Think About**

It is worth noting that deferred exams are not necessarily the best option. Students generally achieve better results by sitting the original exam. Deferred exams usually occur in late January and your situation may not have improved by that time. In some cases they may be held earlier at the discretion of the Department or Faculty concerned. Deferred exams are not a substitute for inadequate study in the first instance. Despite their best intentions students often still fail deferred exams. THERE ARE NO SUPPLEMENTARY EXAMS OFFERED TO THOSE WHO HAVE SAT DEFERRED EXAMS. Please note that exceptional circumstances require special approval from the Associate Dean (Student Affairs). Students are not allowed to selectively defer an individual exam or combination of exams in the standard university exam period. If you require a deferral, it is likely that you will need to defer all of your exams from that examination period.

**Special Consideration**

As an alternative to applying for deferred exams, you can apply for special consideration. Special consideration may be appropriate if you think some aspect of your academic performance was seriously affected by illness or other exceptional reasons. "Other exceptional reasons" refers to things outside your control that have interfered with your ability to apply yourself to your studies and which may have a serious effect on your final mark. For example; the serious illness or death of someone close to you; serious relationship or family
conflict; a recent traumatic experience; sudden or uncontrollable changes in your living circumstances.

Requesting special consideration alerts the Faculty to the fact that something has happened to interfere with your ability to apply yourself to your studies as you usually would. The Faculty then takes this into account in making decisions regarding your academic progress (e.g., extensions for assignments, withdrawing or changing course, determining your final grade in a unit).

Special consideration requires you to sit the exam/s at the normally scheduled time. Special consideration is not a guarantee that you will avoid the consequences for poor academic performance, but it allows the Faculty to make informed decisions regarding how to treat your case within the scope of the regulations.

The steps you take are similar to those listed for deferred exams. Contact the Associate Dean (Student Affairs) or the Manager (Student Affairs) as soon as possible (not later than three days after an examination) and provide a medical certificate or other written support. As mentioned previously, if you think something is having a bad effect on your academic performance, get appropriate help as soon as possible. It is very difficult to negotiate deferred exams or special consideration at the last minute, or after the exam has been held, without very clear and strong supporting evidence.

For further information can be found on the following:

- Deferred & Supplementary Examinations: www.studentadmin.uwa.edu.au/page/54350
- Special Consideration: www.studentservices.uwa.edu.au/page/95004

Appeals Against Assessment
Information regarding appeals against academic assessment and sanctions and grievance resolution can be found in the University Handbook and on the University Policies web page: http://www.secretariat.uwa.edu.au/home/policies/appeals. You can also contact the Manager (Student Affairs) for further information.

SHORT LEAVE
If you wish to be away for any period of time during your course, you must apply for Short Leave. It is your responsibility to inform your unit coordinators and/or clinical teachers and consultants about any possible absences so that they are aware of your leave and you must make arrangements to catch up with any work missed, including any assessments. This is a condition of short leave being approved. You can apply for short leave by emailing Associate Professor Roland Kaiser or Dr Jan Dunphy. You must clearly state the following:

- Full Name and Student #
- Your course and year
- Your address
- Your clerkship rotation (if applicable)
- Dates you will be away
- Detailed reason for your absence
- Any assessments that you are aware of that may be affected by your leave
- Whether you have discussed this with your Unit Coordinators

You will then be given a response in writing as to whether your leave has been approved or not. Please note that short leave has the capability to inconvenience your tutors/unit coordinators greatly if there are assessments while you are away. Please consider this when you apply for short leave, and decide whether your absence is more important than your assessment.

Absence for Religious Reasons
The University supports students who are required to be absent for Religious Reasons. If you are aware of certain dates that you are not going to be able to attend classes/assessments, please let your unit coordinator know and liaise with Dr Jan Dunphy as soon as possible at the start of the semester. This can ensure that assessments are not set for when you are likely to be absent.
Calculator Policy
All students must ensure that they have purchased an approved non-programmable or graphic calculator. Please refer to the following website for the list of approved calculators, http://www.universitypolicies.uwa.edu.au/page/117132. You must arrange to have an “approved” sticker attached to it. Calculators without the “approved” sticker cannot be taken into any examination or test. Please see the Faculty office to obtain your sticker for your calculator.

Student Loans and Bursaries
The Faculty, through the generous bequest of funds from the late Margaret C.G. Milne-Robertson and Mrs Elsie May Webb, established the Henry Maxwell Lefroy and Alexander Milne-Robertson Memorial Fund for student bursaries and the Elsie May Hewson Medical Student Loan Fund. Students experiencing financial difficulties which could prevent them from successfully completing their course should contact the Manager (Student Affairs) to discuss the possible application for the bursary or a loan. Note that only in exceptional cases are loans approved for purposes other than books/equipment, rent, gas/electricity, medical/dental and general living expenses. The Faculty has a policy limiting the amount of financial assistance that can be offered and can only accept applications at specific times during the year.

Etiquette
The standard courtesies of clinical medicine are very important and you must show due consideration for the patients and their relatives and friends. Patients trust us as doctors and students, initially strangers, with information about themselves and their lives, that they would often not consider divulging to their close friends. You must acknowledge and nurture that trust for the benefit of your patient. As with all members of the health profession, maintaining confidentiality is essential and the use of patients’ names at any time including in presentations or discussions with colleagues, or discussions in lifts or public places should be avoided. In some cases, patients will tire of repeated visits from students or will be in a condition which precludes anything other than essential medical and nursing care. If you are seeing a patient outside your assigned Unit, you should seek prior permission to see patients from the medical and/or nursing staff responsible for their care. This is best done in pairs. Any complaints regarding unsatisfactory student behaviour on the wards will be taken very seriously indeed.

Standard of Dress
Students are required to comply with hospital regulations on dress and grooming which states that clothing must be safe, clean and in a good state of repair and hair should be clean, tidy and safe. Protective clothing should be worn where appropriate. Professional clothing is neat, modest (e.g. no midriff exposed) and well fitting. Examples of non-professional attire include clothing that is too casual (such as jeans, shorts, sweat shirts, thongs, crop or halter tops) or too trendy (such as excessive jewellery or logo shirts). Dress requirements for all clinical attachments and visits will require neat attire. In the case of male students, this will include a collared shirt and tie. Remember, as a medical student many patients will regard you as being “virtually a doctor” and they have expectations of your dress, personal grooming and behaviour that affect their confidence in the medical care that they are receiving.
APPENDICES
APPENDIX A

Code of Conduct
APPENDIX A

Code of Conduct for students in the Faculty of Medicine, Dentistry & Health Sciences

The Hippocratic Oath
I swear by Apollo, the Physician, by Asclepius, by Hygeia, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out according to my ability and judgement, this oath and this indenture. To hold my teacher in this art equal to my own parents to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture. I will use treatment to help the sick according to my ability and judgement, but never with a view to injury or wrongdoing. I will keep pure and holy both my life and my art. In whatsoever houses I enter I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm. And whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me.

PREAMBLE
This Code of Conduct is aimed at ensuring the best learning environment for students and staff alike within the Faculty of Medicine, Dentistry & Health Sciences. It sets out material applying to Medicine, Dentistry and Podiatry students, some of which is taken from the UWA Charter of Student Rights, the UWA Guidelines for Conduct in the Workplace, Statute No 17 (Discipline), the Faculty of Medicine, Dentistry and Health Science Rules and the University Policy on Ethical Scholarship, Academic Literacy and Academic Misconduct, and some of which has been formulated by staff and students of the Faculty. The purpose of this document is to make clear the kinds of conduct from students and teachers which should be promoted and those which are prohibited and/or regarded as unacceptable within the University and the Faculty, and the expectations that the Faculty has of its students. It is also aims to assist students to understand the rights and responsibilities that they take on they enrol at UWA and become a member of the UWA community.

This Code of Conduct has been endorsed by the Faculty of Medicine, Dentistry & Health Sciences, the West Australian Medical Students’ Association (WAMSS) and the University Dental Students’ Society (UDSS).

Ethics and Patient Care and Confidentiality
As a student of the Faculty, ethics, patient care and confidentiality are extremely important. The standard courtesies of clinical medicine are very important and one must show due consideration for the patients and their relatives and friends. Patients trust doctors and students, initially strangers, to keep confidential information about themselves and their lives, information they would often not consider divulging to their close friends. Students must acknowledge and nurture that trust, for the benefit of their patients. As with all members of the health profession, maintaining confidentiality is essential and the use of patients’ names at any time including in presentations or discussions with colleagues, or discussions in lifts or public places should be avoided. Students must also obtain informal consent from patients when visiting their homes or when not in a teaching hospital.

1. RIGHTS OF STUDENTS
Students at UWA have many rights and responsibilities of which they need to be aware. The Faculty recognises that all students have the right to be treated with respect by staff members and taught in a supportive and non-threatening environment. In the preamble of the Charter of Student Rights (website: www.secretariat.uwa.edu.au/home/policies/charter ), it is stated that students have a primary responsibility to “recognise the rights of others, including the rights of every other student covered by this Charter, the rights of staff and the rights of the University”.

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Every student has the right to have their opinion heard and there is a process in place for Appeals against Assessment. Students who feel that they have not been treated fairly are encouraged to seek advice from the Faculty Office or the UWA Student Guild.

2. RESPONSIBILITIES OF STUDENTS

2.1 Teaching sessions
Those who have endorsed this document agree that students are expected to respect other students and staff members by:
- Attending class sessions
- Not disrupting class sessions by talking or moving about at inappropriate times, for example, during a lecture
- Arriving on time for class sessions
- Bringing a Medical Certificate for regular lack of attendance, especially for practical classes.
- Using an appropriate level of language in communication such as emails and on the Forum

Students should also be aware that it has been resolved by the Academic Council that, in Lecture Theatres and Computer Laboratories:
- The consumption of any food or beverages apart from bottled water is forbidden. Bottled water may not be permitted in rooms with computer equipment.
- University computers and audio visual equipment are not to be operated by unauthorised people and are not to be used for any purpose that is not in support of a teaching or research activity.
- Furniture is not to be removed from the venue.
- Mobile phones should not be operated.

Actions of Misconduct are outlined in Statute No. 17. Some working examples of Misconduct are:
- To wilfully obstruct or attempt to obstruct or deter a member of staff in the performance of their duties.
- To use abusive or insulting language.
- In the case of a course for a degree leading towards a professional qualification, behaving in a manner which is unprofessional in that profession

All actions of misconduct are liable to disciplinary action under Statute No. 17 (website: http://www.uwa.edu.au/students/current/assistance/student_discipline). A possible outcome of an action of misconduct would be that the Head of School or Executive Dean may choose to fine the student, suspend the student for a period not exceeding seven calendar days or require the student to do further work or repeat work within the unit or subject area in relation to which the misconduct occurred. Other examples of misbehaviour and the possible penalties applied on the above website.

Students should be aware of the University Policy on Ethical Scholarship, Academic Literacy and Academic Misconduct. This policy is available at:
http://www.teachingandlearning.uwa.edu.au/tl4/for_uwa_staff/policies/student_related_policies/academic_conduct The University of Western Australia strongly supports teaching and learning that promotes academic literacy and ethical scholarship for all students.

Medical and Dental students should also be aware that much teaching in the Faculty is provided as part of professional courtesy (the Hippocratic Oath) and is unpaid, therefore a mutual commitment from teachers and students is important.

2.2 General Behaviour
Part 11 of the Human Resources Policy and Procedures Manual on Guidelines for Conduct in the Workplace states:

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“People work best in a setting marked by mutual respect, personal dignity and support, which utilises one’s skills and abilities, and encourages further learning. Students and all members of staff, therefore may reasonably expect to pursue their work and studies in a safe and civil environment, free from discrimination, harassment, sexual harassment, threatening or violent conduct, or offences against property.”

The Guidelines for Conduct in the workplace make clear that the following behaviour is considered as intimidating and inappropriate:
- Insults, name calling and put downs
- Shouting
- Invasion of personal space including entering someone's office without knocking
- Using private information to ‘bully’
- Blocking someone's exit
- Crude language (including that used in email and the forum)
- Rifling through personal files or drawers; reading material on someone's desk without permission
- Overly forceful language in meetings or tutorials
- Passive non-cooperation

These guidelines apply to all staff members of the university, including tutors.

2.3 Cheating and dishonesty
Cheating, in any form, is seriously dishonest behaviour, which the University deplores. In order to benefit from the experience offered to students, they must do their own research, thinking and writing throughout the course. At UWA, plagiarism (to steal and to pass off the ideas, words or work of another as one's own without crediting the source), whether deliberate or unintentional, is serious misconduct. Penalties for plagiarism are dealt with under the University Policy on Ethical Scholarship, Academic Literacy and Academic Misconduct. Serious plagiarism may be penalised by cancellation of privileges such as attendance at classes and laboratories or attendance at an examination. Serious incidents may result in the failure of the unit in which the plagiarism occurred. Some examples of plagiarism in written work are:
(i) Failing to acknowledge the source of all quotations or paraphrased ideas, whether these be facts, details, figures, opinions, interpretations or speculations;
(ii) Quoting directly, or rewriting with only minimal paraphrasing, the work of another person without indicating that they are quoting and without acknowledging the source, rather than using their own words;
(iii) Pretending the work of someone else is his or her own. This is the worst form of plagiarism and is treated as a very serious offence at UWA (and includes using material from the internet or other similar sources).

In addition: it is an offence to submit the same material for assessment in more than one unit, even if the topic or field of interest is similar.³

2.4 Course-related obligations
The Faculty of Medicine, Dentistry & Health Sciences also has regulations specific to the Faculty and courses Rules that must be adhered to. For students studying the MBBS, BDSc and BPodM the Faculty General Provisions state that:

Faculty's Clinical and Practicum Placement Policy
8.2.1.1 Students must comply with the requirements of the Faculty's Clinical and Practicum Placement Policy.

2.4.1 MBBS Course related obligations
For students studying the MBBS, the Medicine Rules state:

Requirement to Attend and Complete Prescribed Work

² Undergraduate Handbook 2006, University of Western Australia,
³ What you should know about Plagiarism, Student Services pamphlet, 2001.
8.2.2.7 Students must attend lectures, seminars, tutorials, demonstrations and teaching and other sessions and do clinical and practical work as required at the University and at teaching hospitals and other institutions approved by the Faculty.

Faculty's Infection Control Policy
8.2.2.8 Students must comply with the requirements of the Faculty's Infection Control Policy, which is contained in Appendix C of this guidebook.

Faculty's Senior First Aid Certificate Policy
8.2.2.9 Students must comply with the requirements of the Faculty's Senior First Aid Certificate Policy, which requires that students hold a valid Senior First Aide certificate.

2.4.2 BDSc Course related obligations
For students studying the BDSc, the Dentistry rules state:

Requirement to Attend and Complete Prescribed Work
8.2.7.6(1) Students must attend lectures and demonstrations, carry out laboratory and clinical work, pass examinations, and do any other work that the Faculty may determine.
(2) The work to be done by a student must be carried out within the University or in an institution approved by the University.

Failure to Attend or to Complete Prescribed Work
8.2.7.7 The Faculty may prohibit a student from sitting an examination in a unit if the student—
(a) has not performed satisfactorily in clinical and laboratory classes and semester and class examinations for the unit; or
(b) has not had satisfactory attendance at lectures, clinical, laboratory or other practical sessions for the unit.

Restriction on Location for Prescribed Practical Dental Work
8.2.7.8 A student who does or causes to be done any prescribed practical dental work in any place other than that allocated for that work will not be permitted to present for examination in that year.

Faculty's Infection Control Policy
8.2.7.9 Students must comply with the requirements of the Faculty's Infection Control Policy for the period of the course. Infection Control Policy is in Appendix C of this guidebook.

Faculty’s First Aid Certificate Policy
8.2.7.10 Students must comply with the requirements of the Faculty's Senior First Aid Certificate Policy, which requires that students hold a valid Senior First Aide certificate.

The University General Rules also state that:

Requirements for Completion of Unit
1.2.1.15(1) To complete a unit a student must—
(a) meet the faculty's requirements with respect to attendance at prescribed classes, lectures, seminars, tutorials, practicals and clinical practice, and to the sitting of examinations; and
(b) complete assignments and other prescribed work of the unit at a standard acceptable to the faculty; and
(c) obtain a grade of Pass or higher for the unit.
(2) A faculty, on the recommendation of the relevant head of school, may exempt a student from attendance or from part of the prescribed work.
1 A 'Completed' status for a unit in the Student Information Management System (SIMS) means only that the student has attempted the unit and has not withdrawn. It does not indicate that a unit has been completed in terms of Rule 1.2.1.15.

Failure to Attend or to Complete the Prescribed Work of a Unit
1.2.1.16 A student who fails to attend or to complete work in accordance with Rule 1.2.1.15(1)(a) or (b) may be prohibited by the faculty from undertaking further study or examinations in the unit concerned.

3. OTHER ISSUES

There are also a few other matters that students in the Faculty should be aware of in order to successfully complete their course.

3.1 Part-time Work

It is recommended by the University Learning Skills Centre that students in the Faculty of Medicine, Dentistry and Health Sciences aim to do no more that 10 hours part-time work. Part-time work can have an impact on a students ability to perform and it is expected that course commitments will be put before work commitments. A full-time University course should be treated as equivalent to a full-time job, which is a minimum of 40 hours a week. It is recommended that the majority of University work is done between Monday and Friday (8:00am to 5:30pm), though some students may need to work longer than this depending on weekly commitments and workload. This, however, is only a guide and students will need to adjust their hours of study to suit individual needs. It is also very important for students to schedule “down time” and to rest. It is recommended that one day per week is without study or work, at least for the bulk of the academic year. An important factor of time-management is to ensure that time is spent on reflection and evaluating how ones time is being used. Students should aim to concentrate on activities that enhance understanding and retention of material.

References:
All students are encouraged to read the following.

UWA Policy for Ethical Scholarship, Academic Literacy and Academic Misconduct

UWA Guidelines for Conduct in the Workplace

UWA Charter of Student Rights (Appendix A)
http://handbooks.uwa.edu.au/undergraduate/poliproc/policies?childfx=on

UWA Statute No 17 (Appendix B) in the University Calendar
http://www.uwa.edu.au/students/current/assistance/student_discipline/statute_17Appeals

against Assessment and / or progress status

Undergraduate Handbook and Interfaculty Handbook at
http://www.publishing.uwa.edu.au/handbooks

Cooper, Geoff. Learning at the University of Western Australia – available for free from Student Services. The Student Services website is at www.studentservices.uwa.edu.au/

Clinical Practicum and Placement Policy
APPENDIX B

FACULTY OF MEDICINE, DENTISTRY AND HEALTH SCIENCES

Policy on Allocation of Students to Clinical and Practicum Environments

The education program in the Faculty of Medicine, Dentistry and Health Sciences at UWA is grounded in the principles of experiential learning, with an emphasis on learning by participating in the health and human sector industries. A significant amount of teaching and learning occurs in teaching hospitals and other clinical and allied health environments.

The particular health issues available for learning in each environment vary. A general principle is that students need to be exposed to a range of environments to ensure they receive the diversity of experiences required to achieve the stated objectives of the graduate outcomes for each course.

- Bachelor of Medicine and Bachelor of Surgery (course codes 90110 and 90160)
  In the Bachelor of Medicine and Bachelor of Surgery, the majority of teaching of Level 1 and 2 units is completed on the main university campus (at Crawley). For a small portion of time, students undertake a placement in a community based clinical environment (e.g. a general practice) within the Metropolitan area.

  During Level 3 of the course, students spend the majority of their time on the Sir Charles Gairdner Hospital campus, but also complete a community based clinical placement within the Metropolitan area.

  During Levels 4, 5 and 6, almost all teaching is conducted in hospitals and clinical environments which are located in Perth and elsewhere in Western Australia, including rural locations. In all Levels of the MBBS course, students are required to travel to various clinical environments associated with UWA. This includes at least four weeks in a non-metropolitan setting and for some students involves 12 months in a non-metropolitan setting during Level 5.

- Bachelor of Dental Science (course code 80150)
  In the Bachelor of Dental Science (80150) the teaching of Level 1 and 2 units is split between the main university campus (at Crawley) and the undergraduate clinics in the Oral Health Centre of Western Australia (OHCWA).

  During Levels 3 and 4 of the course, students spend the majority of their time at the OHCWA, with a small portion of time spent in teaching hospitals across the metropolitan area.

  During Level 5 the placements are split between the OHCWA and other teaching hospitals, community Dental Clinics and Private Practice. Options are undertaken in a range of environments including rural and remote areas, interstate and overseas.

- Bachelor of Podiatric Medicine (course code 90130)
  The Podiatric Medicine course is undertaken at the Crawley campus of the University. In Levels 2-4, students undertake the in-house clinical component of their training at the UWA Podiatry Clinic, located at the Park Avenue building.

  During Level 1, students make visits to community podiatry clinics, private podiatry practices and orthotics and specialist shoe manufacturers.

  During Level 2, students are placed for clinical training at the UWA Podiatry Clinic, and undertake specialist placements in senior citizens centres/other community facilities.

  During Levels 3 and 4 of the course, students continue their clinical training at the UWA Podiatry Clinic and on external placements in metropolitan teaching hospitals, secondary hospitals, community podiatry clinics, and private podiatry practices.

  During the break periods in Level 4, students undertake a rural placement within Western Australia, in another
Bachelor of Health Science (course codes 50260, 91010, 91020, 91150 and 21100)

In the Bachelor of Health Science courses (course codes 50260, 91010, 91020, 91150 and 21100), the final requirement of the Bachelor of Health Science is a semester long placement (450 hours) in the health industry.

1. Clinical and practicum environments associated with the Faculty of Medicine, Dentistry and Health Sciences

Below is a listing of the clinical and practicum sites used by the Faculty of Medicine, Dentistry and Health Sciences.

Clinical Sites

- Royal Perth Hospital
- Sir Charles Gairdner Hospital
- Fremantle Hospital
- King Edward Memorial Hospital for Women
- Princess Margaret Hospital
- Osborne Park Hospital
- Armadale Health Campus
- Rockingham Hospital
- Swan Districts Hospital
- Joondalup Hospital
- Rural Clinical School
  - Albany
  - Broome
  - Bunbury
  - Busselton
  - Carnarvon
  - Derby
  - Esperance
  - Geraldton
  - Kalgoorlie
  - Karratha
  - Narrogin
  - Port Hedland
  - Any other site deemed suitable by the Rural Clinical School and in consultation with the Faculty and the Department of Health and Ageing
- A range of privately owned clinical environments including private hospitals and primary care practices in both urban and rural locations throughout WA
- Oral Health Centre of Western Australia
- UWA Podiatry Clinic
- Community based Dental Clinics
- Community based Podiatry Clinics
- Any site deemed suitable by the Head of School of Dentistry in a rural, metropolitan, interstate or overseas location (80150 course only)
- Any site deemed suitable by the Head of the Podiatric Medicine Unit in a rural, metropolitan, interstate or overseas location (90130 course only)

Practicum Sites

- Non-Government Organisations
- Local Councils
- Department of Health and other State Government Organisations
- Commonwealth Organisations
- Private Aged Care providers
- Any site deemed suitable by the Dean of the Faculty, students may complete a practicum elsewhere.

2. Aims of the policy on allocation of students to clinical and practicum environments

2.1 The process of allocation of students to clinical and practicum locations should be transparent.
2.2 The policy must allow the Faculty to meet its objectives to:
   (a) ensure each student obtains a range of experiences;
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(b) balances student allocations with the 'placements' available at each location; and
(c) meets any required targets set for UWA by the Australian Government.

2.3 Subject to 2.2, the Faculty will generally attempt to meet an individual student's first preference; however this cannot be guaranteed (see Section 5).

3. Awareness and acceptance of the policy

3.1 The Faculty has a responsibility to ensure that students are aware of the allocation policy prior to their entry into, and during their progress through their course. Students have a responsibility to understand the policy and to sign off on it during the first ten weeks of their course.

3.2 The number and composition of 'placements' available at each location is determined by the Faculty, based upon factors such as teaching resources, availability of supervisors and patient case mix, and may vary from year to year.

3.3 Decisions about the allocation of students to clinical and practicum environments is the responsibility of the Faculty, and students have a responsibility to accept and abide by these decisions.

3.4 In accepting a place in any courses within the Faculty of Medicine, Dentistry and Health Sciences, students accept that they may be required to undertake a 'placement' at a location or locations other than their first preference. Furthermore, in accepting a Commonwealth supported MBBS place, MBBS students will be aware that they may be required to undertake up to 12 months of clinical learning in a rural environment.

4. Student participation in allocation decisions (not relevant to BPodM)

4.1 Each student will be given the opportunity to indicate his/her personal preferences for allocation to particular locations by submission of the appropriate preference form.

4.2 It will be assumed that a student has no particular preferences if he/she does not submit a preference form.

4.3 The Faculty will provide each student with information on its teaching/supervisory environments to assist him/her in indicating preferences.

4.4 A student who provides false or misleading information, especially about his/her residential address during university sessions, will have preferences ignored.

5. Allocation decisions

5.1 The following factors will be considered in allocation decisions:
(a) number of available 'placements' at individual locations.
(b) student preferences as indicated on the submitted form (not relevant to BPodM).
(c) a student's previous clinical/practicum location.
(d) where relevant, ensuring a balance of gender and academic levels between locations.
(e) when allocating to extended rural clinical experiences, whether or not the student is a local Commonwealth supported student (see Section 7) (not relevant to BDS, BHlthSc, or BPodM).
(f) special consideration as detailed in 5.2 below, details of which must be submitted at the same time as the preference form.

5.2 Special consideration may include (in respect of the student):
(a) major health problem(s) requiring frequent and ongoing specialised treatment which is only available in certain locations.
(b) being a parent of a dependent child or children.
(c) involvement in sport or music at an elite level (state or national).
(d) being a primary or secondary carer for a dependent.

5.3 Examples of circumstances concerning the student that are not classed as special consideration:
(a) lack of access to a motor vehicle or inability to drive.
(b) other transportation issues.
(c) relationships without dependents.
(d) religious grounds.
(e) ownership or rental of accommodation.
(f) other accommodation issues.
(g) employment.
(h) financial issues.

As UWA is a publicly funded university, it is also subject to various government requirements. One such requirement of the Australian Government, the Rural Health Enhancement Policy, requires UWA to achieve the following outcomes:

6. With respect to admission of students to the MBBS

Approximately 25% of local Commonwealth supported student admissions to the Program should be students of rural ‘origin’, as defined in the guidelines of the Rural Student Entry Scheme.
6.1 With respect to rural clinical placement whilst undertaking studies:
(a) 25% of local Commonwealth supported UWA medical students must undertake a minimum of 12 months of their clinical learning in residential rural environments, termed Extended Rural Clinical Experience (ERCE).
(b) All other students must undertake a minimum of 4 weeks of community-based clinical learning in a rural location.

7. Extended rural clinical experience for MBBS students
As stated in Section 6, the Australian Government has a Rural Health Enhancement Policy that requires 25% of local Commonwealth supported UWA medical students to undertake a minimum of 12 months of their clinical learning in structured residential rural environments. The format and structure of this Extended Rural Clinical Experience (ERCE) is determined by the Faculty in consultation with the School of Primary, Aboriginal and Rural Health Care.

Unless otherwise stated, the following clauses only apply to local Commonwealth supported students.
7.1 Allocations to an ERCE will be made according to the general principles described in this policy.
7.2 Students considering undertaking an ERCE are strongly encouraged to liaise with the School of Primary, Aboriginal and Rural Health Care, which organises information sessions about the School, conducts student rural excursions, and supports the students’ Rural Health Club.
7.3 International (fee paying) UWA medical students can apply for an ERCE as part of their clinical training, but the Faculty will allocate local Commonwealth supported students to an ERCE to achieve the government-imposed target of 25% of students per year cohort before considering applications from International Students.
7.4 Students wishing to undertake an ERCE must submit an application form during Level 4, which should be completed in consultation with an appointed staff member of the School of Primary, Aboriginal and Rural Health Care.
7.5 All applications for an ERCE will be considered by a committee consisting of:
   Head of the Rural Clinical School
   Two academic staff members of the Rural Clinical School
   One undergraduate student representative nominated by SPINRPHEX (the rural student club)
7.6 Students applying for an ERCE will be interviewed by the selection committee prior to a final decision being made.
7.7 The following factors will also be considered in allocation decisions:
   (a) student preferences.
   (b) a student's commitment to serving their allocated community
   (c) preferred study partners if indicated by the student.
   (d) issues such as rural background and knowledge of or demonstrated interest in rural health.
7.8 Acceptance into an ERCE guarantees allocation to a rural location for 12 months only.
7.9 If there is still a shortfall in ERCE placements, then the Faculty will decide which other students will fill those places. Although the Faculty anticipates receiving more applications for ERCEs than available ‘placements’, if insufficient applications are received to achieve the targeted number of ’placements’, the Faculty reserves the right to allocate any local Commonwealth supported student to an ERCE.
7.10 If the government-imposed target of 25% of students per year cohort is not filled, the allocation will be randomly selected from the remaining students in the cohort, excluding International students.

I ……………………………………………………………………………………………………………………………
I acknowledge that I have read and fully understand and agree with the policy on allocation of Students to Clinical and Practicum Environments prior to my entry into, and during my progress through, my chosen course in the Faculty of Medicine, Dentistry and Health Sciences.

Signed ……………………………………………… Date …………………
APPENDIX C

Infection Control Policy
APPENDIX C

INFECTION CONTROL POLICY

FACULTY OF MEDICINE, DENTISTRY AND HEALTH SCIENCES

The aim of the Faculty Infection Control Policy is to minimise as far as possible the risks to both students and patients from coming to harm by passing infections between each other. By adhering to the requirements of the Policy, you will also be complying with policies established by the Health Department of Western Australia, the Medical Board of Western Australia and those of the teaching hospitals in which you will be working.

The Policy has been designed to deal with a range of particular infections that are well known to pose risks to both patients and health care workers and as such it is very comprehensive. In order to make the Policy work effectively it is important that all students understand it and support it.

I. Summary of the Policy

All students enrolled in the Faculty of Medicine, Dentistry and Health Sciences, and who will have patient contact during their course, are expected to comply with specific requirements set out in the Policy in order to proceed beyond their first year in the course. The specific requirements are:

1. All students must attend a lecture given by the Infection Control Officer early in the year to explain the Policy and to provide information about particular infections. All students are required to sign for attendance at the lecture. Completion of an online exercise based on the Infection control policy will also be compulsory.

2. All students must have a blood sample taken to determine if they are immune to the following infectious diseases, and then vaccinated if they lack immunity:
   a) Hepatitis B
   b) Measles
   c) Mumps
   d) Rubella (German measles)
   e) Varicella (chickenpox)

   See section II.1 for further details.

   Note. If students can supply appropriate documentation confirming they have fulfilled vaccination requirements for health care workers (according to The Australian Immunisation Handbook, 9th Edition 2008), they may not require testing or vaccination.

   For dental students, it is a requirement that hepatitis B testing (surface antigen, sAg) is performed prior to enrolment. Active hepatitis B infection may preclude training or working as a dentist. If the blood test is not performed prior to enrolment and you are subsequently found during further screening tests to be HBsAg positive (indicating current Hepatitis B infection), you may be excluded from the course.

3. All students must provide documentary evidence of up-to-date immunisation against:
   a) Diphtheria
   b) Tetanus
   c) Pertussis

   Immunity against these infections cannot be determined by blood testing. If not previously vaccinated, or if vaccination records are incomplete, vaccination may be necessary. Documentation of previous
polio vaccination is no longer an Infection control policy requirement, though up to date vaccination is still recommended. See section II.2 for further details.

4. It is the responsibility of individual students throughout their course to be aware of their infection status for the blood borne viruses (BBVs) HIV, hepatitis B and hepatitis C. A student infected with one of these viruses must not perform exposure-prone procedures and must seek expert advice from a specialist in the field of infectious diseases.

See section III for further details.

5. All students must have a Mantoux test (Tuberculin skin test) or a Quantiferon-TB blood test to determine evidence of past exposure to tuberculosis.

See section II.3 for further details.

6. Any student who has been in a hospital (either working or as a patient) outside Western Australia, in the 12 months prior to starting work in a Western Australian hospital, must have swabs taken to determine whether they are carriers of Methicillin-resistant Staphylococcus aureus (MRSA). Work in hospitals cannot be commenced until swabs are shown to be MRSA negative or until eradication treatment is prescribed by the Infection control team (for those with positive results).

See section II.4 for further details.

7. Sharps injuries and other body fluid exposure incidents must be reported by the student involved to their supervisor immediately. The Infection Control Officer should also be notified via the Incident Report Form.

See section VII.1 for further details

II. Further details regarding tests and vaccinations

1. Hepatitis B, measles, mumps, rubella and varicella

You must have evidence of immunity or otherwise to these infections, in the form of a recent laboratory report performed in a WA laboratory. The relevant tests are:

a) Hepatitis B surface antibody (HBsAb)
b) Measles IgG antibody
c) Mumps IgG antibody
d) Rubella IgG antibody
e) Varicella IgG antibody

The Faculty will arrange for students to be reviewed by a GP at the UWA medical centre, and if documentary evidence of previous vaccination or serological results cannot be supplied, appropriate blood samples will be taken and tested. This will be discussed further at the Infection Control Lecture and students will be informed through their year representatives of the dates when this will be done. Testing will not be performed before the Infection Control Lecture is given. Depending on your results, you may need immunisation or boosting against these infections and retesting after 2 months (in particular HBsAb).

Note that live virus vaccines (measles, mumps, rubella and varicella) should not be administered to those who are pregnant. If pregnancy is being planned, it should be delayed for at least 28 days after last being administered one of these vaccines. If you have any concerns regarding this, or other issues with vaccination and potential side effects or complications, please contact the Infection control officer.
A small number of people receiving the varicella vaccine may develop mild infection with the vaccine strain of the virus during the six weeks following administration. Those developing a rash during this period should not come into contact with patients for a week following the onset of the rash.

**The cost of testing and vaccination is met by the student.**

2. **Diphtheria, tetanus, and pertussis.**

Blood testing for immunity to these agents is not routinely available. You should try to obtain your vaccination records from childhood or adolescence. Depending upon your past immunisation history, a Medical Officer at the University Medical Centre will determine whether you need to have a primary vaccination course or boosting against these infections. This process will be greatly assisted, and unnecessary vaccination avoided, if you have records of you past vaccinations.

**The cost of vaccination against these agents is the responsibility of the student.**

It is important that the testing and vaccination is carried out early in the year so that the vaccinations can be given and immunity achieved before you start to have patient contact. Students of OHCWA must meet the requirements of the Policy before the mid first semester break. Health Sciences students in fourth year must meet the requirements prior to their first patient contact.

3. **Tuberculosis**

Tuberculosis is becoming more common in this community. Students may be at risk of acquiring this infection if they come into contact with a patient who is coughing up this bacterium. All students are expected to undergo a Mantoux test (small subcutaneous injection) or Quantiferon-TB blood test in order to detect evidence of possible past infection with tuberculosis.

A Mantoux test should not be done within 4 weeks following immunisation with the following live vaccines as they may suppress the tuberculin response and result in an inaccurate result:

- measles
- mumps
- rubella
- varicella

Mantoux test should also be delayed for 3 weeks following a febrile illness for similar reasons.

The Faculty will arrange Quantiferon-TB testing for students at the same time as the other screening blood tests are performed. This will be discussed further at the Infection Control Lecture and students will be informed through their year representatives of the dates when this will be done.

**The cost of Mantoux/Quantiferon testing is the responsibility of the student.**

Once students have complied with items 1-3 of the policy, they will be given a letter by the UWA Medical centre stating as such. This needs to be taken to the Faculty of Medicine and it will be recorded on the student record that the infection control policy requirements have been fulfilled. Failure to do so may result in exclusion from end of year exams.

4. **MRSA (Methicillin-resistant Staphylococcus aureus)**

Because of its isolation and stringent screening procedures multi-resistant strains of this bacterium have largely been kept out of hospitals in Western Australia. All hospitals in this state have policies to screen new staff for possible carriage of the bacterium. If you have been in a hospital anywhere outside Western Australia within the last 12 months, either working or as a patient, then you must be screened before working in a hospital in this state. This involves having a swab taken from your nose, throat and any broken skin and waiting 2-3 days for the results.

MRSA screening swabs can be performed through PathWest at the QEII Medical Centre, at either “E” Block: Mon - Thurs, 8.00am - 5.00pm or “J” Block: Mon - Fri, 8.00am-5.00pm.

**The cost of MRSA screening is the responsibility of the student.**
III. Students infected with blood-borne viruses (BBVs)

Students of the Faculty are expected to comply with the same policy applied by the Medical Board of Western Australia to medical practitioners. A copy of this policy is included in the Appendix 1. In short:

- Students are expected to be aware of their infection status for HIV, hepatitis B and hepatitis C.
- Testing for infection with these viruses should be carried out should the student experience a potential exposure to these viruses (such as a sharps injury) or if the student engages in any behaviour likely to involve risk of infection.
- Students infected with a blood borne virus must not perform exposure prone invasive procedures on patients. These procedures are described in Appendix 2.

It is not a responsibility of the Faculty nor part of its Infection Control Policy to test or monitor students for evidence of infection for BBVs with the exception of testing required after sharps injuries or other potential exposures from patients. See section VII.1.

IV. Data collection

The Faculty Office will maintain a record of student compliance with the various components of the Infection Control Policy.

V. The Infection Control Officer

The Infection Control Officer (ICO) is a medically qualified member of the Faculty with specialist qualifications in the field of microbiology/infectious diseases. The ICO is there to give you advice at any time regarding concerns you might have about catching infections from patients; or conversely, about passing on an infection to a patient. You can contact the ICO through the Faculty Office should you need to.

The ICO is Associate Prof Ben Clark, who can be contacted at QE II Medical Centre on 08 9346 4658 or through the Faculty Office on 08 9346 7323.

VI. Confidentiality

The specific information obtained from the blood tests will be available only to the requesting medical officer at the University Medical Centre, the Faculty Infection Control Officer or where necessary to the Associate Dean for Student Affairs, the Clinic Coordinator at the Oral Health Centre of Western Australia or the Sub-Dean of Health Sciences.

Students who approach the ICO for advice will have their queries treated with respect and confidentiality.

There may be situations where infection in a student or patient has placed others at risk and in order to deal with the situation other Faculty or hospital staff members may need to be informed. This will only be done after consultation between the ICO and the student concerned.

Remember always that while confidential information is being collected, it is being done with the clear goal of protecting both students and patients from harmful situations.

VII. Situations requiring action

If any of the situations listed below occur, they need to be dealt with as soon as possible by your supervisor and the Infection Control Officer (or by the contacts listed if a needlestick/body fluid exposure occurs out of hours). Make a note of:

- the date, time and duration of the contact
- the name and date of birth of the contact (ie. if patient or classmate)
- the nature of the contact

The Infection Control Officer will need to have this information in order to best advise you and others what to do.
1. Needlestick or other body fluid contact

If you are accidentally pricked by a needle or sharp object which has been used on a patient or possibly been used on a patient or if any body fluid from a patient makes contact with your mouth or eyes, chapped skin or open wound on your body, cease work and inform your immediate supervisor without delay. You, or your supervisor, should then contact one of the following urgently:

Students at Sir Charles Gairdner Hospital:
- During working hours contact SCGH Immunology Department: ex. 2833
- After hours page Immunology Registrar through switchboard: 08 9346 3333

Students at Princess Margaret Hospital/KEMH:
- During working hours contact Accidental Inoculation Nurse: page 2711
- After hours contact PMH Emergency Department: ex 8353 OR after hours Nurse Manager, page 8840

Students at Fremantle Hospital:
- During working hours contact Infection Control: page 4168
- After hours contact Emergency Department Senior Registrar/Consultant.

Students at Royal Perth Hospital and other hospitals not listed above:
- During working hours contact the Immunology Clinical Nurse Specialist: ex. 3420
- After hours Immunology Registrar through switchboard: 9224 2244

_It is important that you do not delay seeking advice and help following an exposure. In the situation where the source is known to be, or at high risk of being infective for HIV, your risk of acquiring this infection can be substantially reduced if you are administered antiretroviral drugs within several hours, the earlier the better._

Once you have done the above and appropriate management is underway, you must fill out an Incident Report Form (Appendix 3). You should give one copy to your supervisor and another to the Infection Control Officer.

2. Contact with rubella, chickenpox, shingles, mumps or measles

If you come into contact with a case of any of these infections (at home, amongst your friends or in a patient) you should contact the Infection Control Officer as soon as possible. As a result of compliance with the Policy you should be immune to these infections and at no risk of acquiring the infection and passing it on to patients or your classmates. However it is best to discuss this with the ICO to ensure that this is the case. See sections VIII.1-4.

3. Contact with any illness with a rash

If you come into contact with anyone (at home, a friend, or a patient) who has an illness with a rash, you should try to find out what the cause of the infection is. If it is something that you believe you are not immune to you should contact the Infection Control Officer to discuss the situation.

4. Potential MRSA contact

If you come into contact with a patient with MRSA while in a hospital in WA you should discuss the necessary course of action with the hospital’s Infection Control Department. You may need to have swabs taken to determine whether you have become a carrier. See also section II.4.

5. Contact with Tuberculosis

If you come into contact with a case of active pulmonary or laryngeal tuberculosis, then you are at risk of acquiring this infection yourself. Tuberculosis patients who have been on appropriate antimycobacterial therapy for several weeks are no longer infective to others. Following contact with an infective patient you should contact the Infection Control Officer immediately. You may need to have a Mantoux test performed and another in 2-3 months. See section VIII.10.
6. Contact with Encapsulated Bacteria

If you have significant contact with somebody who has invasive disease with either Neisseria meningitidis or (less likely) Haemophilus influenzae you may be at risk of being colonised with this bacterium, subsequently becoming ill with it or passing it on to someone else. Significant contact is:

- kissing contact
- close household contact
- having your face, mouth or eyes come into contact with vomit or respiratory secretions from an infected patient

Following such a contact you can be protected by receiving prophylactic antibiotics, usually in just a single dose. If you have such a contact you should get in touch with the Infection Control Officer immediately. See section VIII.12.

VIII. Reference information

This section contains information about a number of organisms and topics which are relevant to a better understanding of the Infection Control Policy.

1. Measles

Measles is a virus which infects primarily the respiratory tract. It is not common because of widespread vaccination but cases are still seen in those without immunity who come into contact with a case, usually introduced from outside the community. It is highly infectious. The infection consists of fever, red eyes, runny nose, cough and a widespread red blotchy rash. Pneumonia may develop and middle ear infection is a common complication. Mortality is significant in those under 5 years.

Incubation period: 7 - 18 days, typically 10
Period of infectivity: from 4 days before rash onset, to 4 days after rash onset

2. Mumps

Mumps is a viral infection causing painful enlargement of the salivary glands (parotid, sublingual, submaxillary). It may also affect the testes, ovaries and mammary glands and uncommonly may result in sterility.

Incubation period: 14 - 25 days
Period of infectivity: from up to 7 days before parotitis onset to 9 days after onset

3. Rubella

Rubella is an infection caused by a virus. It is a very common infection in childhood and in this age group it usually causes no problems. Symptoms of the illness include fever, tiredness, loss of appetite, swollen glands in the head and neck and a rash. When the infection occurs in adults it may produce a more significant illness and complications like arthritis and encephalitis (inflammation of the brain, a rare complication) are more common than in children. The infection is most serious when it occurs in pregnant women because it can be transmitted to the developing fetus with disastrous effects. If the affected baby is born alive it may suffer from the congenital rubella syndrome, a collection of birth defects including microcephaly (abnormally small head), mental retardation, abnormally small eyes, blindness, deafness, bleeding disorders and abnormal heart valves. For this reason, a pregnant woman who is not immune to rubella must avoid contact with the virus at all costs. Even a woman who is immune should avoid contact as reinfections can sometimes occur.

Rubella is spread in the form of droplets from the respiratory tract. The incubation period (time between first contact and first symptoms) ranges from 14 to 23 days. Infection may be asymptomatic. It is important to realise that a person infected with the virus may be infectious to others even before
the onset of symptoms. An infected person is infectious for about a week before the onset of symptoms until at least 4 days after the onset of the rash.

Infection with rubella produces immunity to further infections. In addition, immunity may be achieved by vaccination. Rubella is currently part of the childhood vaccination schedule in WA. Reinfection with rubella has been described but is uncommon and is more likely to occur in someone who has achieved immunity through vaccination rather than by natural infection.

Incubation period: 14 – 21 days
Period of infectivity: from 1 week before to 4 days after onset of rash

4. Varicella-Zoster

This virus causes chickenpox and shingles. Chickenpox is a common infection of children and usually produces only tiredness, low grade fever, loss of appetite and a very itchy rash consisting of small blisters. Adults who become infected with this virus may suffer from more severe symptoms and are more likely to get complications of pneumonitis (infection of the lungs) or encephalitis. Once a person has been infected with this virus it stays in their body forever, usually causing no further problems. The virus remains hidden in the dorsal root ganglia, small structures of the nervous system close to the spine. In some people, later in life, the virus can become reactivated and travel down the nerve to the skin where it produces a red and blisterly skin rash called shingles or zoster. This very painful condition affects only that segment of the skin supplied by the nerve involved.

Two main groups of people should avoid contact with varicella-zoster virus (VZV) if they are not immune to it. These are the immunocompromised (people whose immune systems are impaired by things such as cancer or drugs or HIV infection) and pregnant women. Immunocompromised people if infected by VZV can get an overwhelming and fatal infection. Pregnant women if infected by the virus may experience a number of problems. Firstly, they may get a more serious infection than nonpregnant people would, sometimes resulting in a severe and potentially fatal pneumonitis. Secondly, the developing fetus may be infected and suffer from the fetal varicella syndrome, a collection of birth defects including scarring of the skin, abnormally small limbs, abnormal eyes and mental retardation. Thirdly, if a pregnant woman comes down with chickenpox within several days before or after birth, her baby may suffer from a severe chickenpox infection after birth with a high mortality.

VZV is spread by respiratory droplets or by contact with virus from the skin rash. It is highly infectious. The incubation period ranges from 2-3 weeks. The period of infectivity is from 2 days before the onset of the rash until 5 days after the appearance of the last lot of vesicles (blisters).

It should be noted that a non-immune person can get chickenpox from another case of chickenpox or from someone with shingles. A person can only get shingles from reactivation of their own latent VZ virus.

Immunity is gained from either natural infection or from vaccination.

Incubation period: 2 – 3 weeks, commonly 14 – 16 days
Period of infectivity: from up to 5 days before onset of rash until all lesions are crusted

5. Diphtheria

This infection, caused by the bacterium Corynebacterium diphtheriae, is rarely seen in this community because of vaccination. The bacterium infects the superficial tissue of the nasopharynx and sometimes further down the airways. It results in production of a very thick exudate or "membrane"; this, and associated inflammatory swelling, may result in death by asphyxiation. It may uncommonly produce skin ulceration. The bacterium also produces a toxin which is absorbed into the body to produce effects in the heart, (myocarditis leading to heart failure) and peripheral nerves (difficulty breathing, swallowing; muscle weakness).

Incubation period: 2 – 5 days
Period of infectivity: 2 weeks, sometimes 4
6. Tetanus

This infection occurs when hardy spores of the bacterium *Clostridium tetani* are introduced into a wound contaminated by soil, faeces or other organic matter. Deep puncture type wounds provide the type of anaerobic environment which favours the growth of the bacteria in the soft tissues. The bacteria produce a powerful neurotoxin which blocks inhibitory nerve impulses to skeletal muscle. This results in unopposed muscle contraction manifesting as muscle spasms. Affected patients develop “lockjaw” (spasms of the jaw muscles), facial spasms, neck stiffness, difficulty swallowing, trunk and leg spasms and convulsions. Muscular spasm can result in the inability to breathe, one of the causes of death in those with the infection. The spasms can continue for months requiring prolonged intensive care management. Mortality is significant, particularly in those parts of the world where intensive hospital care is not available. The disease can be actively vaccinated against using tetanus toxoid. In addition, tetanus immunoglobulin (TIG) can be used prophylactically in individuals who have not been vaccinated and who sustain a tetanus prone wound.

Incubation period: 3 - 21 days, average 10
Period of infectivity: Not transmitted from person to person

7. Pertussis

Pertussis, or whooping cough, is a respiratory infection caused by the bacterium *Bordetella pertussis*. Bacterial toxins damage the ciliated cells of the trachea, resulting in a severe coughing illness which may persist for months. Classical whooping cough is described in young children as having three stages: the catarrhal stage in which increased upper respiratory tract secretions are present, the paroxysmal stage, in which severe bouts of coughing may lead to respiratory arrest, and the convalescent phase, in which coughing episodes persist for months before gradually diminishing. The mortality of whooping cough is significant, particularly in infants less than 1 year of age. In recent years, whooping cough has become increasingly recognised as an adult infection. Routine vaccination of children between 2 months and 4 years of age has shifted the peak incidence of the infection into the adolescent years but with the majority of cases spread across adulthood. This results from a waning of vaccine induced immunity. A booster is now given to 15-17 year olds. Whooping cough in adults does not usually manifest in the classical manner described in infected children and may thus be unrecognised. Maintenance of adult immunity is important, as infected adults are source of life threatening infection to infants who have not yet been vaccinated.

Incubation period: 7 – 20 days
Period of infectivity:
  - highest during catarrhal stage (up to a week before coughing paroxysms) and during the following 3 weeks; for 5 days after commencement of effective antibiotics

8. Polio

Polio is a paralytic disease caused by a member of the enterovirus group. The infection is spread by the faecal-oral route and is common in developing countries where poor social conditions and low standards of hygiene are prevalent. A generation ago the infection was common in Western communities but it has essentially been eradicated in such populations by vaccination. In its most common form the illness consists of symptoms of meningitis which are then followed by the onset of muscle pain and paralysis. This may range from weakness of a single muscle to complete quadriplegia. Disability is common after symptomatic infection, but the bulbar form of the disease results in high mortality due to respiratory and circulatory collapse. Maintenance of immunity in health care workers is important, particularly those contemplating working in developing countries.

Incubation period: 3 – 35 days, commonly 7-14
Period of infectivity:
  - difficult to assess but most infectious for several days before and after onset of symptoms; virus may be found in faeces for 3-6 weeks after infection
9. Blood borne viral infections

Included in this group are a number of viruses which circulate in the blood of an infected person, in some cases for many years, and which can be transmitted to other people when they come into contact with this infected blood. The main viruses of importance in this group are the human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV). Health care workers are potentially at risk of acquiring these infections as they are in frequent contact with blood and other body fluids which may contain the viruses (Refer to Section VIII.13 on Standard Precautions).

a) Human Immunodeficiency Virus

This virus is found in the blood of an infected person and in the following bodily fluids: breast milk, semen, cervical and vaginal fluids, saliva, tears, cerebrospinal fluid, urine, alveolar fluid and joint fluid. However, not all of these fluids have been implicated in the transmission of the virus. Most cases of transmission have been associated with blood (contaminated blood transfusions, blood products, contaminated needles in IV drug users) and with sexual intercourse. In developing countries, mother to infant transmission is a significant mode of transmission.

In the occupational setting, health care workers have become infected with HIV primarily from contact with blood or blood-containing bodily fluids. This is most likely to occur following penetration of the skin by a needle ("needle stick injury") or by another sharp instrument which is contaminated with blood from an infected patient, or by contact of such infected blood with mucous membranes (eyes, mouth) or nonintact skin. The estimated risk of acquiring HIV infection from a needlestick injury from an infected patient is 0.3%. Following mucous membrane contact with infected blood the estimated risk of infection is 0.09%.

Following HIV infection the virus may enter a number of different cells in the body, but those most susceptible are lymphocytes, a type of white blood cell important in the immune response. Following entry of the virus into these cells, the genetic material of the virus inserts itself into the genetic material of the cell. After 3 to 6 months antibodies against HIV are produced by the infected human host and these may be measured by laboratory tests. The period following infection and the point in time when these antibodies can be detected is called the "window period". At the time of the appearance of these antibodies the host may experience a nonspecific flu-like illness called the "seroconversion illness".

The effect of HIV infection on the host is that the cells of the immune system are gradually destroyed, leaving the host less able to fight off infections and particular types of cancer. For a period averaging ten years, the "latent period", the untreated patient may remain outwardly well while the virus continues to replicate and destroy the immune system. When the immune system is damaged beyond a particular point the host begins to experience infections, often caused by microorganisms which do not usually cause problems in people with healthy immune systems. In addition, unusual types of cancers may be seen when these events begin to take place, the patient is said to have AIDS, the Acquired Immunodeficiency Syndrome.

To date there is no vaccine effective against HIV. A number of antiviral drugs have been shown to slow the replication of the virus and to improve the health of those infected. Following a risk exposure such as a needle stick injury from an infected patient, the use of these drugs alone or in combination for a period of several weeks can reduce the odds of infection in the recipient by 80%. This is more likely to be effective if the drugs are given early after the exposure rather than later, so it is important to seek advice as soon as possible after such an injury.

Incubation period: Variable; to seroconversion illness, 5 – 70 days, typically 22 days; to onset of AIDS, typically 10 years.

Period of infectivity: Variable: from shortly after infection and for duration of life; influenced by viral load and effectiveness of treatment.
b) **Hepatitis B Virus**

This blood borne virus is more likely to be encountered by healthcare workers than is HIV, and it is also many more times infectious than is HIV. Fortunately however, infection with HBV can be prevented by vaccination.

HBV is a virus which infects the cells of the liver. Most infections do not cause symptoms, and in those who become ill with hepatitis most recover within 6 months. Symptoms of hepatitis may be severe or mild and include headache, malaise, fever, nausea, vomiting, jaundice and abdominal pain. About 1% of cases may be fulminant, that is severe liver failure and seizures, often leading to death. A small number of cases, perhaps 10%, will become chronically infected and of this group some will develop cirrhosis (a serious form of liver damage) and some will develop fatal cancer of the liver. Those with chronic infection are the major source of transmission to others.

As the virus replicates in the liver it spills out into the bloodstream and it can be detected here and in a number of body fluids. These are semen, cervicovaginal secretions, breast milk, saliva, urine, bile, sweat, tears, cerebrospinal fluid and joint fluid. HBV is transmitted by similar routes to HIV although is much more infectious. The most common routes of transmission are sexual intercourse, sharing of contaminated needles by intravenous drug users and from mother to infant. The virus may be transmitted on objects such as toothbrushes, eating utensils, razors, baby bottles and toys. Transmission in the hospital setting may occur from patient to healthcare worker and vice versa, and from patient to patient on contaminated equipment. The risk of transmission following a needlestick injury from an infected patient is estimated to be from 27-40% if the patient is HBeAg positive (see below).

A number of tests are used to diagnose hepatitis B or to show immunity to it. During active infection, two components of the virus are usually looked for in the blood, surface antigen (HBsAg) and ‘e’ antigen (HBeAg). Both of these indicate that the patient is actively infected and infectious to others. The presence of HBeAg indicates high infectivity. As disease resolves these components disappear from the blood and antibodies to them appear, namely HBsAb and HBeAb. Another antibody, HbcAb, is directed against the ‘core’ antigen which is found in the liver during active infection but not in the blood.

Those who become chronically infected do not clear the surface antigen (HBsAg) from their blood and do not develop antibody to surface antigen (HBsAb). They may also have HBeAg in the blood.

Infection with HBV can be effectively prevented by the use of a vaccine. The material used in the vaccine is in fact HBsAg, made in the laboratory by a harmless yeast which has been genetically engineered to produce this viral protein. The vaccine gives rise to HBsAb in those vaccinated. The course of vaccination consists of 3 injections, the second 1 month after the first and the third one at 6 months. Although the vaccine produces protective levels of HBsAb in over 90% of individuals, failure to respond to the vaccine occurs in some and is related to increasing age, obesity, smoking and injection in the buttock rather than the upper arm.

For those who do not have immunity to hepatitis B and who receive a needlestick injury or other risk exposure, protection from infection is available by other means. If a risk is thought to exist, then the person receiving the needlestick can be injected with hepatitis B immune globulin (HBIG). This is HBsAb derived from the serum of people who already have high levels of HBsAb, and the process is known as passive immunisation. Administration of HBIG must be carried out within 72 hours of the exposure to be fully effective, and it is followed by a course of the vaccine. The aim of this Policy is to ensure that all students will be immune to hepatitis B in advance of any such injury occurring, so that the process of passive immunisation is not necessary.

**Incubation period:** 45 – 180 days, average 60 – 90 days

**Period of infectivity:** As long as HBsAg is present in blood; from many weeks before onset of symptoms and during the period of the acute illness; for the duration of viral carriage in those chronically infected.
c) **Hepatitis C Virus**

This virus has been discovered relatively recently, although cases of so-called non-A, non-B hepatitis have been known about for many years. Most cases of non-A, non-B hepatitis are now known to be caused by HCV. Hepatitis C is transmitted mainly by contaminated blood or blood products, and many cases in the community were acquired from blood transfusions in the days before specific tests were available to screen blood donations for this virus. Another group at risk of acquiring hepatitis C infection is intravenous drug users sharing contaminated needles. Many people with the infection have no history of blood transfusion or IV drug use. Sexual transmission is not thought to be responsible for many cases. The infection may be transmitted from mother to baby but the rate of transmission is not high.

The illness caused by HCV is very similar to that caused by HBV. However, HCV is of major concern because 50-70% of infections will become chronic infections, unlike the 10% chronic infection rate with HBV. As in the case of chronic HBV infection, chronic HCV infection may lead to cirrhosis and hepatocellular carcinoma.

Laboratory tests for HCV are relatively limited in their scope. Following infection there is a window period before antibodies to HCV can be detected in the blood, and this averages 6 - 8 weeks. The presence of HCV antibodies in a blood test gives no indication as to when the infection occurred or whether the infection is active or inactive. Another test is available to detect HCV genetic material in the blood (the PCR test), and the presence of this indicates active viral replication in the liver.

There is no vaccine against HCV nor any form of passive immunisation.

**Incubation period:** 2 weeks to 6 months, commonly 6 – 9 weeks.

**Period of infectivity:** For several weeks before onset of symptoms and for duration of infection in chronic carriers.

10. **Mycobacterium tuberculosis**

*M. tuberculosis* is the cause of tuberculosis (TB), a bacterial infection usually involving the lungs but which may spread to many other tissues of the body. This bacterium is spread from actively infected patients in respiratory droplets, produced by coughing, sneezing or talking. The bacterium is highly infectious and may float in the air in the vicinity of an infected patient for a period of time even if the patient has left the area.

It is estimated that a third of the world’s population is currently infected with *M. tuberculosis*, most cases occurring in the developing world where spread is enhanced by crowded living conditions and disease results from poor resistance. In nineteenth century Europe tuberculosis was responsible for 30% of all adult deaths but the prevalence of disease has been steadily decreasing in developed countries in this century. In 1985 however epidemiologists were surprised to find that this trend was reversed and that tuberculosis was on the rise. This was attributed largely to the AIDS epidemic and to an increasing population of homeless poor in some developed countries. For these reasons, tuberculosis is still of concern to healthcare workers in this community. Another reason for concern is the increasing resistance of *M. tuberculosis* to the drugs used to treat it.

Tuberculosis is a chronic disease and may exist in the host for many years without causing symptoms. This can make infection difficult to diagnose unless the disease has reached a fairly advanced state. One of the tests which is used to help detect previous infection with *M. tuberculosis* is the Mantoux or tuberculin test. In this test a small dose of purified protein derived from *M. tuberculosis* is injected superficially under the skin. In those who have been previously infected by the bacterium the immune system will produce a reaction at the injection site consisting of redness and swelling. The diameter of the area of swelling is measured 48 hours after the injection and if it is above a certain value then this indicates past infection, which may still be active. False positive reactions may be seen in people infected with nontuberculous species of mycobacteria. Previous administration of BCG (Bacillus Calmette-Guerin) vaccination may also result in a reaction at the site of a Mantoux test.

BCG is a vaccine consisting of live Calmette-Guerin bacilli which are attenuated *Mycobacterium bovis* bacteria. The vaccine is mainly useful in infants and children in parts of the world where the risk of infection is high. It does not prevent infection with *M. tuberculosis* but in these children it is effective in
preventing clinically apparent disease and particularly deaths from tuberculous meningitis. Its usefulness in other populations is debated, particularly as the overall efficacy of the vaccine has been estimated to be only 50%. Additionally, administration of the vaccine makes interpretation of a subsequent Mantoux test difficult, as the test will usually become positive and thus not useful in those suspected of being infected with TB.

Incubation period: To first demonstrable lung lesion or Mantoux seroconversion, 2 – 10 weeks.

Period of infectivity: As long as viable bacteria are present in sputum, potentially for years. Infectivity ceases within several weeks of effective antimicrobial therapy commencing.

11. Methicillin-resistant Staphylococcus aureus (MRSA)

Staphylococcus aureus is a common bacterium which lives harmlessly on the bodies of many healthy people. It is often referred to by the press as the “Golden Staph”. S. aureus is also a virulent and dangerous pathogen and commonly causes infections such as boils and other skin infections, abscesses in many soft tissues, bone and joint infections, and infections of the blood to mention only a few. Most strains of S. aureus are resistant to penicillin because they can produce an enzyme called beta-lactamase which can destroy this antibiotic. Antibiotics such as methicillin, flucloxacillin and cephalaxin have been produced which are resistant to this bacterial enzyme, making treatment of the above infections possible.

However, there are strains of S. aureus which are resistant to even these special antibiotics and sometimes to a range of other antibiotics too. When they cause infection they may be very difficult to treat. These strains are common around the world and in the Eastern States of Australia but they are less of a problem in Western Australia because of its isolation and because of effective measures aimed at keeping them out of the state.

There are a number of types of MRSA named according to the range of antibiotics to which they are resistant and their epidemic potential within a hospital.

Some strains of MRSA have a tendency to spread if introduced into a hospital environment. The introduction of one of these strains into a hospital proves very costly. Contacts and carriers need to be traced and treated where necessary to eradicate carriage of the organisms and in the case of staff carriage may result in many weeks off work. It has been necessary in the past to close wards until the organism can be removed from the environment using labour intensive and expensive cleaning techniques. Not only does the spread of MRSA generate large costs but it creates the risk of hospitalised patients developing S. aureus infections which may be very difficult to treat.

For these reasons, any patient, staff member or student who has been in a hospital outside the state in the preceding 12 months needs to have swabs taken to check for the presence of MRSA before they can start work in the hospital. Patients are held in isolation until their swabs are shown to be negative.

12. Encapsulated Bacteria

Certain bacteria are surrounded by capsules which help them to evade the host’s immune defences, making these bacteria more able to produce serious infections. Two major organisms of concern are Neisseria meningitidis and Haemophilus influenzae type b. Serious disease with the latter is rarely encountered in this community now as it is vaccinated against in childhood. Neisseria meningitidis is a cause of life threatening septicaemia and meningitis which may occur in outbreaks. Invasive infection by these organisms is usually preceded by a period of asymptomatic nasopharyngeal carriage, although carriage does not mean that invasive disease will always follow. Carriers are responsible for passing the infection to others, who may develop invasive disease. The infections they produce may be severe and life threatening, particularly in debilitated people those with impaired immune systems and those who have had their spleens removed following trauma or for medical reasons.

Health care providers frequently come into contact with patients suffering from infections with these bacteria and run the risk of being colonised themselves and becoming carriers. They may then pass the organism on to others or may themselves suffer from invasive infection. In the case of N.
meningitidis and H. influenzae type b, health care workers and others who have had significant contact with a case of invasive disease may be given a very short course of antibiotics in order to eradicate the carrier state if it has been established. People who are considered to be significant contacts are:

- kissing contacts within the preceding 10 days
- household contacts within the preceding 10 days
- those who have had vomit or respiratory secretions from an active case splashed onto their faces.

For N. meningitidis:
- Incubation period: 2 – 10 days, commonly 3-4 days
- Period of infectivity: As long as bacteria are present in nasopharyngeal secretions; ceases within 24 hrs of commencing appropriate antibiotic therapy.

13. Standard Precautions and Additional Precautions

Standard Precautions are work practices required for a basic level of infection control. They include good hygiene practices, particularly washing and drying hands before and after patient contact, may include the use of protective barriers such as gloves, gowns, plastic aprons, masks, eye shields or goggles, appropriate handling and disposal of sharps and other contaminated or infectious waste, and use of aseptic techniques.

Standard Precautions are recommended for the treatment and care of all patients, regardless of their perceived infectious status, and in the handling of:

- blood
- all other body fluids, secretions and excretions (excluding sweat) regardless of whether they contain visible blood
- non-intact skin
- mucous membranes

Standard Precautions also apply to dried blood and other body fluids.

The main goal of following Standard Precautions is to minimise the risk of acquiring blood borne viruses from contact with patients. In order to make such work practices effective, it must be assumed that all patients are potentially infected with such viruses. To only follow these precautions with those patients who are known to be infected gives a false sense of security and engenders risky work practices.

Additional Precautions

Additional Precautions are used for patients known or suspected to be infected or colonised with epidemiologically important or highly transmissible pathogens that can cause infection:

- by airborne transmission (eg. Mycobacterium tuberculosis, measles virus, chickenpox virus)
- by droplet transmission (eg. mumps, rubella, pertussis, influenza)
- by direct or indirect contact with dry skin (eg. colonisation with MRSA), or with contaminated surfaces.
- by any combination of these routes.

Additional Precautions are designed to interrupt transmission of infection by these routes and should be used in addition to Standard Precautions when transmission of infection might not be contained by using Standard Precautions alone. Additional Precautions may be specific to the situation for which they are required or may be combined where microorganisms have multiple routes of transmission.

Additional Precautions implies a two tiered approach to infection control, and assumes that in cases where transmission of infection may not be contained by Standard Precautions alone. Additional Precautions will be applied in addition to Standard Precautions.

Appendix 1 to the Infection Control Policy:
Note, until the Medical Board of Australia (which replaced the medical Board of Western Australia in 2010) publishes guidelines on blood borne viruses, the following guidelines are still applicable to current students.

MEDICAL BOARD OF WESTERN AUSTRALIA
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MEDICAL PRACTITIONERS AND BLOOD BORNE VIRUSES
Medical Board Policy
Issued: August 2003

1 INTRODUCTION
The Medical Act 1894 confers on the Medical Board of Western Australia the responsibility for protection of the public. Recent developments in treatment of infectious diseases mean that the issue of infection of patients by health care workers is a major consideration in health care risk management. Of particular concern are infections with blood borne viruses, such as HIV, Hepatitis B and Hepatitis C.
This document represents the Medical Board Policy for the following:
• The principles upon which the Medical Board expects practitioners to discharge their obligations with public safety in mind;
• Medical practitioners who are infected with a blood borne virus; and
• Responsibility of medical practitioners with blood borne viruses.

2 DEFINITIONS
2.1 Blood Borne Virus
For the purpose of this Policy, the term ‘blood borne virus’ includes human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV).

2.2 Health Care Workers
Persons involved in the delivery of health services in health facilities (particularly where those persons have regular contact with patients or any contact with blood or body substances from patients).

2.3 Invasive Procedures
Include any surgical entry into tissue, body cavities or organs, or repair of traumatic injury.

2.4 Exposure Prone Procedures
Are a subset of invasive procedures which are characterised by the potential for direct contact between the skin (usually finger or thumb) of the health care
worker and sharp surgical instruments, needles, or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites (including the mouth).

Procedures where the hands and fingertips of the worker are visible and outside the body at all times, and internal examinations/procedures that do not require the use of sharp instruments, are not considered to be exposure prone and thus are unlikely to pose a risk of transmission of HIV, HBV or HCV from infected health care worker to patient.

3 PRINCIPLES
3.1 The Medical Board insists that all patients are entitled to good standards of practice and care from their doctors and other health care workers (including students) regardless of the nature of their disease or conditions.
3.2 Health care workers owe a duty of care to patients and are therefore responsible for the protection of patients against infection.
3.3 Doctors who become infected with blood borne viruses are entitled to expect the confidentiality and support afforded to other patients. Only in the most exceptional circumstances, where the release of a doctor’s name is essential for the protection of patients, may a doctor’s infection status be disclosed without his/her consent.
3.4 The Board acknowledges that future developments in treatment of blood borne viruses may render most infected practitioners non-infectious. Until such developments occur, protection of the public must be provided through appropriate policy. For this reason, this policy will be reviewed from time to time.

4 PRACTITIONERS WHO HAVE BECOME INFECTED WITH A BLOOD BORNE VIRUS AFTER REGISTRATION AS A MEDICAL PRACTITIONER IS GRANTED
4.1 The risks posed by practitioners in this category include:
- The risk of transmission of the virus; and
- The risk that the virus may impact on the doctor’s professional performance (physically or intellectually).
4.2 The Board has the responsibility to protect the public from both these risks. The risk of transmission can be almost completely eliminated by requiring that such practitioners do not undertake exposure-prone procedures. The categories of ‘infected practitioner’ most at risk are those who are:
- Hepatitis C antibody and PCR positive;
- Hepatitis B e antigen or HBV DNA positive; or
- HIV antibody positive.
4.3 The Board will use existing procedures for assessment of whether a medical practitioner is suffering from physical illness to such an extent that his/her ability to practise is or is likely to be affected. Similar procedures allow for the assessment of applicants for registration.

5 RESPONSIBILITY FOR ASCERTAINING VIRAL INFECTION STATUS
5.1 It is the responsibility of individual practitioners to be aware of their infection status for HIV, Hepatitis B, and Hepatitis C. Testing should be undertaken at the following times:
- If there is an incident where the medical practitioner is exposed to any
blood borne viruses; or
- If the medical practitioner engages in any ‘at risk’ category.

Any practitioner who fails to be aware of infection status may be guilty of misconduct in a professional respect, and may be disciplined by the Board.

5.2 A practitioner who discovers that he/she returns a positive test result in any of the following categories:
- Hepatitis C antibody and PCR;
- Hepatitis B e antigen or HBV DNA; or
- HIV antibody,

must immediately cease to perform exposure prone procedures and seek expert advice from a specialist in the field of infectious diseases.

Practitioners who fail to do so may be guilty of infamous or improper conduct in a professional respect, and may be disciplined by the Board.

5.3 There is no requirement for notification to the Board by any party of infection status, unless there are concerns that an individual is failing to comply with the policy, or if there are complications which may be affecting professional performance.

Practitioners who fail to notify the Board of a colleague who does not comply with the Board's policy, or in whom there are complications affecting professional performance, may be guilty of infamous or improper conduct in a professional respect, and may be disciplined by the Board.

6 MEDICAL STUDENTS

6.1 The Board expects medical students to comply with the principles and requirements of this policy.

The Medical Board of Western Australia thanks the Medical Board of Queensland for permission regarding the adaptation of their guidelines.

Appendix 2 to the Infection Control Policy
Appendix 2: Exposure Prone Procedures

The following information describing exposure prone procedures and the potential of BBV spread from HCW to patient is taken from:


Abbreviations:
HCW: Health care worker
BBV: Blood-borne virus (ie. HIV, hepatitis B, hepatitis C)

Transmission from HCW to patient

The risk of an infected HCW transmitting an infection to patients is of particular concern. The possibility of this happening is related to the types of procedures the HCW is involved in, their infection status and the types of patients they provide care for. The table below shows the level of risk to patients from HCWs infected with blood-borne viruses associated with various clinical procedures, from low-risk procedures (such as interview or non-invasive examination), to high-risk, exposure-prone procedures.

Invasive procedures carry a risk of infection and include any situation where an HCW enters the tissue, body cavity or organs of a patient. Operator factors may also increase the likelihood of transmission. These include technical competency (which may relate to skills training and education) and infectious status (eg. a high hepatitis B virus DNA titre.)

Exposure-prone procedures are invasive procedures where there is a potential for direct contact between the skin (usually finger or thumb) of the HCW and sharp surgical instruments, needles or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites, including the mouth (NSW Health 1995a) of a patient. An exposure-prone procedure is one in which there is potentially a high risk of transmitting a blood-borne disease between an HCW and a patient during a medical or dental procedure.

Levels of risk to patients from HCWs infected with blood-borne viruses, associated with particular procedures

<table>
<thead>
<tr>
<th>RISK CATEGORY</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH RISK (exposure-prone procedures: NSW Health 1995a)</td>
<td>Any submucosal invasion with sharp, hand-held instruments, or procedures dealing with sharp pathology/bone spicules, usually in a poorly visualised or confined space (eg. orthopaedic surgery, trauma, internal cavity surgery, oral surgery).</td>
</tr>
<tr>
<td>VARIABLE RISK*</td>
<td>Minor dental procedures (excluding examination), routine dental extractions, internal/instrument examination/biopsy (eg. endoscopy, vaginal examination, laparoscopy). Minor skin surgery.</td>
</tr>
<tr>
<td>LOW RISK</td>
<td>Interview consultation, dental examination. Noninvasive examinations or procedures (aural testing, electrocardiograph, abdominal ultrasound. Intact skin palpation (gloves not required, no pathology). Injections/venipuncture (gloves required).</td>
</tr>
</tbody>
</table>

*“Variable risk” refers to procedures where the risk may depend on training, experience, competence or other operator-specific factors related to the status of infection (eg. HBeAg, high levels of HBV DNA)

Where the risk to patients from HCWs infected with blood-borne viruses during specific procedures is unclear, consult with State/Territory professional advisory boards for further advice.
APPENDIX D

Core Cases in Clinical Practice
APPENDIX D

CORE CASES IN CLINICAL PRACTICE
December 2004

INTRODUCTION
The Core Cases in Clinical Practice summarise the main presentations, clinical conditions, and skills you should be capable of dealing with upon graduation. Use these cases to guide the clinical cases you see (checking for deficiencies) and your reading. A more detailed Curriculum can be found for each Clinical Attachment. Although not all conditions and procedures you need to be aware of are listed in detail, this highlights important areas or areas which may not be highlighted as essential in texts or other sources.

They include:

- **A** "The Big 30" presentations, skills and knowledge arranged by disciplinary area
- **B** Procedural and professional skills
- **C** Core Cases organised in disciplines, where the emphasis has been on common, life threatening, or treatable presentations or conditions. These have been rated as detailed below to guide the depth of study.

KNOWLEDGE  ++
Knowledge includes (+++) patient assessment, with being able to take a history (presentation) examination (clinical signs) and clinical management, with problem solving (differential diagnosis), decision making (management), communication and counselling. This requires knowledge of epidemiology and prevention.

AWARENESS +
Awareness would require knowledge of presentation and differential diagnosis, and a brief understanding of possible treatment.

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5. BREAST DISEASE
6. CARDIOVASCULAR MEDICINE
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8. DERMATOLOGY & PLASTIC SURGERY
9. EMERGENCY MEDICINE
10. ENDOCRINOLOGY
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12. GERIATRIC MEDICINE
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14. INFECTIOUS DISEASES
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18. NUTRITION & LIPIDOLOGY
19. OBSTETRICS & GYNAECOLOGY
20. OPHTHALMOLOGY (NOTE OVERLAP WITH NEUROLOGY)
21. OTORHINOLARYNGOLOGY
22. PAEDIATRICS (SPECIFICALLY RELATED TO PAEDIATRICS)
23. PALLIATIVE CARE
24. PLASTIC & RECONSTRUCTIVE SURGERY
25. PSYCHIATRY
26. RENAL & UROLOGICAL MEDICINE
27. RESPIRATORY MEDICINE
1. **THE BIG 30 PRESENTATIONS**

1. Loss of consciousness/collapse
2. Confusion/altered mental state (acute, chronic)/coma
3. Anxiety/depression
4. Falls
5. Headache
6. Visual loss
7. Dizziness
8. Injury
9. Fatigue/Weakness
10. Fever
11. Chest pain
12. Dyspnoea/wheeze
13. Oedema
14. Palpitations
15. Cough/haemoptysis
16. Abdominal pain
17. Haematemesis
18. Nausea/vomiting
19. Altered bowel habit/PR bleeding
20. Jaundice
21. Haematuria
22. Incontinence (urinary, faecal)
23. Altered urine flow/volume
24. Dysuria
25. Amenorrhea
26. Pruritus/rash
27. Pale, febrile child
28. Weight loss/weight gain in adults and children
29. Joint pain/swollen joints
30. Back pain
3. PROCEDURAL & PROFESSIONAL SKILLS

The newly graduated doctor should demonstrate a satisfactory pre-requisite knowledge for performing the skill and understanding its objectives, appropriate application, advantages, disadvantages, limitations and complications. The following categorisation is used:

E: Essential: Knowledge, Skill and Attitude
D: Desirable: Knowledge and Attitude, +/- Skill

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>SKILL</th>
<th>ATTITUDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication</td>
<td>Preparation</td>
<td>Patient Communication</td>
</tr>
<tr>
<td>Contraindications</td>
<td>Technique</td>
<td>Patient Comfort and Dignity</td>
</tr>
<tr>
<td>Pitfalls/Complications</td>
<td>- Dexterity</td>
<td>Realises when to get help</td>
</tr>
<tr>
<td>Prevention of Complications</td>
<td>- Tidiness</td>
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<tr>
<td></td>
<td>- Sterility</td>
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<td>- Safety</td>
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<tr>
<td></td>
<td>- Effectiveness</td>
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</tr>
<tr>
<td></td>
<td>- Aftercare</td>
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</tbody>
</table>

| G:P Emergency                |                              |
| MSIA Musculoskeletal, Injury & Anaesthesia |
| MNWH Maternal & Newborn, Women’s Health |
| O/ENT Ophthalmological/ENT   |                              |
| I/L Investigations: Laboratory|
| I/O Investigations: Other     |                              |
| P Professional               |                              |

GENERAL: PROCEDURAL

| G:P Measure height, weight, head circumference, calculate BMI, waist-hip ratio and utilise and interpret growth charts | E |
| G:P Vaccinate (child and adult) (indicators, precautions, side effects, response) | E |
| G:P Administer drugs by SC/IM/IV routes | E |
| G:P Perform venous blood sampling | E |
| G:P IV Cannula placement (avoiding forearm in renal patients) using aseptic technique | E |
| G:P Perform D and interpret E blood gases | ED |
| G:P Use a glucometer and interpret the results | E |
| G:P Set up and administer SC insulin | E |
| G:P Apply the use of universal precautions | E |
| G:P Gwen and glove aseptically and set up an aseptic field | E |
| G:P Collect a midstream urine specimen | E |
| G:P Dipstick test the urine for glucose, protein, nitrates, ketones, blood | E |
| G:P Perform vaginal pH testing | D |
| G:P Perform Urinary Pregnancy test | D |
| G:P Perform urine microscopy | E |
| G:P Insert a urinary catheter in patients of either sex | E |
| G:P Skin scrapings for fungal studies | E |
| G:P Observe and understand the principles of Prick skin testing and Mantoux testing | D |
| G:P Breast examination and teaching patients breast self examination | E |
| G:P Collect a microbiological swab | E |
| G:P Incision and drainage of abscess | D |
| G:P Lumbar punctures | D |
| G:P Insertion of nasogastric tube | D |
| G:P Relief subungual haematoma | D |
| G:P Set up and deliver controlled and uncontrolled oxygen therapy | E |
| G:P Understand the basics of intercostal catheter insertion and management | D |
| G:P Record fluid intakes/output and interpret fluid balance charts | E |
| G:P Be able to select appropriate fluids for infusion | E |
| G:P Manage transfusion of blood, blood components and plasma substitutes | E |
| G:P Establish patients performance status using the ECOG Scale | D |
| G:P Basic understanding of use and care of indwelling lines (Hickman, infusaport) | D |
| G:P Organise appropriate haematonic replacement therapy | D |
| G:P Initiate and monitor anti-coagulant therapy; risk-benefits in individual patients | D |
| G:P Perform a rectal examination | E |
| G:P Assess problems of incontinence | D |
| G:P Measure postural blood pressure | E |
| G:P Assess for malnutrition | D |
| G:P Assess problems of mobility and balance | D |
### GENERAL: DOCTOR & PATIENT

<table>
<thead>
<tr>
<th>Adult</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>G:D&amp;P</td>
<td>Assess global coronary risk in patients</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Assure adequate hydration, nutrition and give dietary advice</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Administer advice on a fat modified weight reducing or lipid lowering diet</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Assess physical function (activities of daily living)</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Pre and post test counselling for HIV disease</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Administer advice on a fat modified weight reducing or lipid lowering diet</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Provide a smoking cessation program</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Participate at the level of the primary doctor in cancer prevention, early diagnosis and education</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Knowledge of the organisation and availability of cancer services (medical, community and social) and to be able to make appropriate use of these</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Manage (including appropriate referral) the psychological and emotional needs of cancer patients and families</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Participate in continuing case follow up, rehabilitation and in the management of dying patients</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Understand and assist individuals in the process of bereavement</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Deal with psychiatric emergencies (suicidal/psychotic/dangerous patient, use of the Mental Health Act)</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Communicate with the patient and their family regarding diagnosis, prognosis and management</td>
</tr>
<tr>
<td>G:D&amp;P</td>
<td>Establish patient’s values and understand how they influence a patient’s management and decision for treatment</td>
</tr>
</tbody>
</table>

### EMERGENCY

| E | - Glasgow coma score (adult and childhood scales) |
| E | - Recognise the critically ill patient |
| E | - Basic life support in children and adults (airway, breathing and circulation procedure) |
| E | - Assessment and manage the multiply injured |
| E | - Demonstrate 1 and 2 person CPR |
| E | - Initiate immediate life support including defibrillation |
| E | - Manage an airway (use Guedel airway, manage a paediatric airway) |
| E | - Endotracheal intubation |

### MUSCULOSKELETAL, INJURY & ANAESTHESIA

| MSIA | Provide timely and effective analgesia including when the diagnosis is not known |
| MSIA | Basic first aid techniques - slings, splints and bandages/strapping |
| MSIA | Wound cleaning, apply a wound dressing and understand the indications for debridement |
| MSIA | Infiltrate local anaesthetic |
| MSIA | Insert undirected the principle of a femoral nerve block, digital nerve block and a Biers block |
| MSIA | Cryotherapy |
| MSIA | Suture a simple wound including 5e a knot using instruments |
| MSIA | Observe aspiration of a distended joint |
| MSIA | Observe a Colles’ fracture reduction, an anterior dislocated shoulder reduction, reduction and splint of a fracture/dislocation of the ankle |
| MSIA | Safely apply a forearm plaster backslab and below knee plaster backslab |
| MSIA | Safely apply a plaster hand splint in the functional position |
| MSIA | Apply a triangular broad arm sling, and a collar and cuff shoulder sling and understand the indications for use |
| MSIA | Safely remove plaster casts with power saw and plaster shears |
| MSIA | Supervise the care of patients with suspected unstable cervical or lumbar spine fractures |
| MSIA | Understand the principles of immobilisation and soft tissue traction |
| MSIA | Apply cervical collar |

### MATERNAL & NEWBORN, WOMEN’S HEALTH

| MNWH | Perform a sensitive vaginal speculum examination and perform a bimanual palpation, take pap smear, and collect urethral, vaginal and cervical swabs |
| MNWH | Examine a pregnant abdomen and estimate fetal stage of development in weeks |
| MNWH | Assess lie of the foetus |
| MNWH | Auscultate foetal heart |
| MNWH | Have practical skills required to assess normal labour (measure accurately blood pressure, pulse, temperature, frequency and intensity of contractions and foetal heart rate) |
| MNWH | Able to perform a normal delivery should the need ever arise. To be able to manage the third stage of labour safely in an emergency |
| MNWH | Able to assess the newborn at birth, assess any need for resuscitation, and initiate resuscitation and routine examination |
| MNWH | Emergency management of a seizure in pregnancy or labour |
| MNWH | Know the emergency management of Cord Prolapse and Shoulder Dystocia |
### Ophthalmological / ENT

<table>
<thead>
<tr>
<th>O/ENT</th>
<th>Adult</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Syringe an ear</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Use an auriscope and an ophthalmoscope</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Insert an ear wick</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Use nasal speculum</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Eye lid eversion</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Fluorescein staining of cornea</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Removal of foreign body from eye</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Pad eyes</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Visual testing using Snellen’s and log mar chart</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Instil local anaesthetic in the eye</td>
<td>E</td>
<td></td>
</tr>
</tbody>
</table>

### INVESTIGATIONS: LABORATORY

<table>
<thead>
<tr>
<th>I:L</th>
<th>Adult</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demonstrate cost effective use of laboratory investigations in diagnosis and management</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Request and interpret cost effective lipid profile</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Cost effective utilisation of the laboratory in immune disease – autoantibodies, immune function assessment, allergy testing (RAST and skin pride testing), HLA typing, immunophenotyping</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Interpret prostatic specific antigen (PSA) result and advise a patient accordingly</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Order and interpret synovial fluid laboratory studies</td>
<td>E</td>
<td></td>
</tr>
</tbody>
</table>

### INVESTIGATIONS: OTHER

<table>
<thead>
<tr>
<th>I:O</th>
<th>Adult</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Observe a mammogram</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Interpret the results of commonly used investigations in neurological disease such as CT and MRI scans and cerebrospinal fluid examination</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Interpret a CAR for major abnormalities</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Perform and interpret ECG (12 lead)</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Perform D and interpret E spirometry</td>
<td>DE</td>
<td></td>
</tr>
<tr>
<td>• Observe coronary angioplasty and lower limb angiography</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Understand a bone densitometry report</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Understand the indications for referral for endoscopy/colonoscopy and endoscopic retrograde cholangiography and the precautions/risks associated with these procedures</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Perform proctoscopy</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Observe an endoscopy of upper and lower GI tract</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Observe a colonoscopy</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Observe an abdominal paracentesis</td>
<td>D</td>
<td></td>
</tr>
</tbody>
</table>

### PROFESSIONAL

<table>
<thead>
<tr>
<th>P</th>
<th>Adult</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integrate knowledge from across disciplines and to critically appraise clinical data, diagnostic tests and the literature in order to assist with decisions to initiate or stop various investigations and therapy</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Demonstrate preventive steps to avoid physical, psychosocial, and emotional problems</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Efficiently use health system resources, in particular, community and pre-hospital services, emergency department, inpatient and outpatient hospital services</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Requesting organs for donation</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Able work in a medical/midwifery team</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Write drug orders and access information to ensure safe drug prescription</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• “Legal” skills such as notification of birth and perinatal death, completion of a death certificate and appropriate referral to the coroner</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Appropriate utilisation of community services</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Appropriate referral to other relevant health professionals/teamwork</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>• Access information from medical sources including Medline and support groups/education groups, paramedical professions</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>• Understand and interpret for patients and/or their families the results of specialist consultation</td>
<td>E</td>
<td></td>
</tr>
</tbody>
</table>

### 4. ANAESTHESIA

**The new graduate should be able to understand and deal with in a proactive fashion:**

- Interaction of pre-existing disease and drugs with anaesthetic ++
- Needs of patients in specific settings ++
  - obstetric ++
  - dental anaesthesia and other procedures where the airway is shared with the surgeon ++
  - day case anaesthesia ++
- Common complications of fluid infusion ++

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5 BREAST DISEASE

SYMPTOMS/CLINICAL SIGNS
- Nipple discharge ++
- Breast lump ++
- Impalpable/mammographic lesion ++
- Breast pain ++

COMMON, LIFE THREATENING OR TREATABLE DISORDERS
- Benign premalignant breast conditions ++
- Fibroadenoma ++
- Fibrocystic disease of the breast ++
- Breast carcinoma
  - staging of breast carcinoma and recognise its importance for further treatment ++
  - treatment of early breast carcinoma, and the role of adjuvant chemotherapy ++
  - treatment of advanced breast carcinoma including hormonal treatment and chemotherapy ++
  - screening and understanding of genetics ++
- Problems with breast feeding (ie cracked nipples, mastitis) ++
- Inflammatory diseases of the breast +

6 CARDIOVASCULAR MEDICINE

SYMPTOMS/CLINICAL SIGNS
- Breathlessness ++
- Peripheral oedema ++
- Chest pain ++
- Palpitations/irregular pulse ++
- Dizziness/syncope ++
- Heart murmur ++
- High blood pressure ++
- Low blood pressure ++
- Lower limb pain ++
- Carotid bruit +
- Cyanosis +

COMMON, LIFE THREATENING OR TREATABLE DISORDERS
- Ischaemic heart disease, including stable angina, unstable angina and acute myocardial infarction ++
- Heart failure ++
- Acute pulmonary oedema ++
- Major cardiac arrhythmias ++
- Cardiopulmonary arrest ++
- Vascular complications of diabetes ++
- Heart valve disease including bacterial endocarditis ++
- Systemic hypertension (including renovascular, accelerated) ++
- Peripheral vascular disease ++
- Varicose veins ++
- Leg ulceration ++
- Cardiogenic shock +
- Cardiomyopathy +
- Pericarditis/pericardial effusion +
- Aortic dissection & aortic aneurysm +
- Pulmonary hypertension +
- Most common types of congenital HD and their presentation +
- Differentiation of innocent murmurs, and congenital or valvular heart disease +

Adult Paediatric

- Initial management of emergencies – AMI, pulmonary oedema, cardiogenic shock or cardiovascular collapse, hypertensive crisis +
- Safely administer cardiac drugs in an emergency (nitroglycerine, thrombolytic drugs, lignocaine, atropine and adrenaline) +
7 CLINICAL IMMUNOLOGY

SYMPTOMS/CLINICAL SIGNS

- Recurrent infections
  - chronic and/or recurrent bacterial, protozoal, fungal and candidal infections
  - chronic diarrhoea
  - chronic and recurrent sinus, respiratory infection
- Chronic and recurrent nasal congestion and discharge
- Anaphylactic reactions
- Recurrent thromboembolism
- Cutaneous vasculitis
- Immune deficiency and assessment of immune function
- Acute and chronic urticaria
- Chronic and recurrent arthralgia and synovitis
- Recurrent pleuritic chest pain
- Raynaud’s phenomenon
- Recurrent mouth ulceration
- Photosensitivity
- Muscle weakness and fatigue - diplopia and ptosis

COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- Allergic (including examination for evidence of allergic disease)
  - Extrinsic asthma - investigation for precipitating factors only
  - Urticaria - acute and chronic
  - Anaphylaxis
  - Eczema
  - Food allergy
  - Insect allergy
  - Drug allergy
- Allergic and vasomotor rhinitis
- Angioedema
- Autoimmune disease
  - Systemic lupus erythematosus
- Immunodeficiencies
  - Cellular immunodeficiency (eg HIV)
  - Antibody immunodeficiency (eg IgA deficiency/common variable immunodeficiency)
- Autoimmune disease
  - Myasthenia gravis
  - Progressive systemic sclerosis and CREST syndrome
  - Sjogren’s syndrome
- Systemic vasculitides
- Organ transplantation (general principles)
  - Requirements for organ donation
  - Donor selection and matching
  - Factors affecting outcomes and therapies to improve outcomes

8 DERMATOLOGY & PLASTIC SURGERY

SYMPTOMS/CLINICAL SIGNS

- Pruritus
- Rash
- Localised skin lesions, lump/bump
- Blisters, bullous changes, ulceration
- Pigmentation and pigmented lesions
- Urticaria
- Redness of the skin
- Hair loss
- Nail changes
- Photosensitive rash

COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- Inflammatory dermatoses
  - acne Vulgaris
  - eczema – this includes endogenous eczema such as atopic eczema, pompholyx, discoid eczema, stasis eczema, and exogenous eczema (contact dermatitis)
| Skin infections and infestations | - Urticaria | ++ | + |
| - psoriasis | ++ | |
| - nappy rash | ++ | |
| Skin infections and infestations | - bacterial infections | ++ | ++ |
| - fungal infections | ++ | + |
| Skin tumours | - pre-cancerous lesions | ++ |
| - non-melanocytic skin cancers | ++ |
| - melanoma | ++ |
| Skin infections and infestations | - viral infections and exanthems | + | ++ |
| - arthropods and the skin | + |
| - HIV and the skin | + |
| Skin tumours | - vascular naevi | + | + |
| - benign pigmented lesions | + |
| Skin and systemic disease | understands the dermatological manifestations of systemic diseases in particular related to: | | |
| - autoimmune disorders | + |
| - bullous disorders | + |
| - cutaneous signs of internal malignancy | + |
| Burns | + | + |
| Skin trauma | + |
| Basic oral health | + |

## 9 EMERGENCY MEDICINE

### SYMPTOMS/CLINICAL SIGNS

- “Collapse” and the unconscious patient | ++ | ++ |
- Chest pain and palpitations (arrhythmia recognition and treatment) | ++ | |
- Shortness of breath and shock (including anaphylaxis) | ++ | ++ |
- Acute airway obstruction | ++ | ++ |
- The multiply injured patient | ++ |
- Poisoning: risk assessment and initial management | ++ | ++ |
- Environmental emergencies (hyperthermia, hypothermia, near-drowning, envenomation, electrocution) | ++ | ++ |
- Altered mental state and coma | + | ++ |
- Abdominal pain | + | + |
- Headache | + | + |
- Distal radius fracture | + |
- Burns | + |
- Soft tissue injury and infection | + | + |
- Seizures | + |
- Shoulder dislocation | + |
- Febrile infant | + |

### ISSUES IN EMERGENCY MEDICINE

- Role of emergency services | ++ |
- Patient prioritisation and triage | ++ |
- Ethicolegal aspects in the Emergency Department and Intensive Care Unit | ++ |
- Dealing with sudden death | ++ |
- Appropriate analgesia and sedation | ++ |
- Recognition of the critically ill patient and teamwork | ++ |

## 10 ENDOCRINOLOGY

### SYMPTOMS/CLINICAL SIGNS

| Adult \ Paediatric | |
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COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- Diabetes - IDDM ++ +
- Diabetes - NIDDM ++ +
- Hyperthyroidism ++ +
- Hypothyroidism ++ +
- Hypopituitarism ++ +
- Menopause ++
- Contraception ++
- Hypoadrenalism ++ +
- Cushing’s syndrome ++ +
- Osteoporosis, osteomalacia ++
- Hyperparathyroidism, hypocalcaemia ++
- Endocrine emergencies:
  - hypoglycaemia ++
  - diabetic ketoacidosis ++ +
  - the sick/perioperative diabetic ++ +
  - adrenal crisis ++ +
  - hyponatraemia ++
  - hypercalcaemia ++
- Multi-nodular goitre +
- Solitary thyroid nodule +
- Thyroid neoplasia - benign and malignant +
- Secretory pituitary tumours +
- Endocrine hypertension +
- Paget’s disease +
- Endocrine emergencies:
  - thyroid storm in the setting of surgery +
  - acute postoperative hypocalcaemia +

11 GASTROENTEROLOGY

SYMPTOMS/CLINICAL SIGNS

- Dyspepsia ++ +
- Dysphagia ++ +
- Abdominal pain ++ ++
- Diarrhoea ++ ++
- Gastrointestinal bleeding ++ +
- Jaundice ++ ++
- Gastroesophageal reflux ++ ++
- Nausea and vomiting ++ ++
- Weight loss ++ ++
- Constipation, soiling and encopresis ++ +
- Right iliac fossa pain ++ +
- Left iliac fossa pain +
- Excess alcohol use +
- Abnormal LFT +
- Acute perianal pain +
- Ascites +
- Failure to thrive ++

COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- Gastroesophageal reflux disease and Reflux oesophagitis in adults and children ++
- Malabsorption syndromes (including carbohydrate malabsorption) ++
- Acute infectious diarrhoea ++

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12 GERIATRIC MEDICINE

SYMPTOMS/CLINICAL SIGNS

- Delirium
- Dementia
- Depression
- Urinary incontinence
- Faecal incontinence
- Constipation
- Falls
- Immobility
- Adverse drug reactions and polypharmacy
- Postural hypotension
- Malnutrition
- Dizziness and syncope
- Pressure sores

CONDITIONS

- Hypertension
- Ischaemic heart disease
- Cardiac failure
- Head injury/subdural haematoma
- Osteoarthritis
- Fractures
- Visual disturbance
- Hearing loss
- Osteoporosis
- Temporal arteritis/polymyalgia rheumatica
- Parkinson’s Disease
13 HAEMATOLOGY

SYMPTOMS/CLINICAL SIGNS/ABNORMAL INVESTIGATIONS

- Anaemia ++
- Bleeding ++
- Splenomegaly +
- Hepatomegaly +
- Lymphadenopathy +
- Tiredness +
- Bruising +

COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- Thrombophilia ++
- Haematinic deficiency (iron, B12, folate) ++
- Hypersplenism +
- Indications for and management of splenectomy +
- Polycythaemia +
- Thrombocytosis +
- Thrombocytopenias +
- Hyperviscosity +
- Hypersplenism +
- Indications for and management of splenectomy +
- Polycythaemia +
- Thrombocytosis +
- Neutrophilia +
- Neutropenia +
- Acute leukaemias +
- Chronic myeloproliferative disorders +
- Chronic lymphoproliferative disorders +
- Multiple myeloma +
- Childhood anaemias +
- Myelodysplasia/aplasia +
- Know the haematological aspects of infections and systemic disease and the impact that age, pregnancy, diet and other medical conditions such as alcoholism have on the haematological system +

14 INFECTIOUS DISEASES

COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- Prevention of infectious diseases – immunisation ++
- The febrile patient in the following clinical settings:
  - the Sepsis syndrome ++
  - fever in the hospitalised patient ++
  - fever in the community setting ++
  - fever and headache and/or altered sensorium ++
  - the febrile infant ++
- The patient with the following important presentations of infectious conditions:
  - pneumonia in its various clinical settings (includes tuberculosis) ++
  - osteomyelitis/Septic arthritis ++
  - gastro-enteritis/infective diarrhoea/hepatitis ++
  - urinary/renal tract infection ++
  - rash in pregnancy ++
  - furuncle, carbuncles ++
- Sexually transmitted diseases:
  - pelvic pain ++
  - vaginal discharge ++
  - urethral discharge ++
- Immunisation ++
- The febrile patient in the following clinical settings:
  - the febrile infant ++
  - fever with rash (including common childhood exanthemata) +
  - fever in the returned traveller ++
  - fever in the surgical patient +

Adult    Paediatric

The patient with the following important presentations of infectious conditions:
- endocarditis
- thrombophlebitis/line sepsis device infections
- HIV infection
- infection in splenectomised patients

Specific infectious emergencies or problems of public health significance:
- bacterial meningitis
- septicemia
- neonatal sepsis
- hepatitis A
- food poisoning
- typhoid
- tuberculosis
- gonococcal ophthalmia in children and adults
- antibiotic resistant gonorrhoea

Surgical practice:
- understand preventable factors
- principles of antimicrobials prophylaxis and treatment
- specific infections (e.g., Clostridial infection, necrotising fascitis)

Sexually transmitted diseases:
- ulcerative lesions
- skin manifestations
- systemic STDs
- scrotal and penile pain

Travel Medicine:
- pre-travel advice
- evaluation of the returned traveller with fever, diarrhoea

Care of neutropenic septic patient

15 MEDICAL ONCOLOGY

SYMPTOMS/CLINICAL SIGNS/CLINICAL ASSESSMENT

- Abnormal bleeding
- Weight loss/anorexia
- Symptoms due to compression of hollow viscera (dysphagia, constipation, stridor)
- Organ dysfunction (hoarseness)
- Unexplained bone pain
- Tumour + lump (describe/measure)
- Lymphadenopathy
- Ascites/pleural effusion/pericardial effusion
- Hepatomegaly
- Focal neurological signs
- TWM classification (clinical staging, surgical staging, post-surgical staging), tumour markers and prognostic factors

COMMON OR TREATABLE MALIGNancies

- Colorectal
- Prostate
- Lung
- Breast
- Gynaecological malignancy
- Head and neck
- Melanoma and skin
- Lymphoma
- Leukaemia, myeloma, myelodysplastic syndromes

COMMON COMPLICATIONS OF MALIGNANCY OR THERAPY INCLUDING

- Metastatic disease eg raised intracranial pressure, spinal cord compression
- Pain
- Operative morbidity
- Predictable morbidity of cancer therapy:
  - Early - nausea/vomiting, alopecia
  - Late - carcinogenesis, sterility
  - idiosyncratic side effects eg conditioned vomiting
  - concept of acceptable and unacceptable morbidity
- Paraneoplastic disorders eg hypercalcaemia, hyponatraemia, cachexia
16 MUSCULOSKELETAL DISORDERS

SYMPTOMS/CLINICAL SIGNS

- Musculoskeletal pain - myalgia, arthralgia, arthritis, back pain, soft tissue pain syndromes (tendonitis, bursitis, enthesitis)
- Inflamed joint - single or multiple
- Swollen joint - single or multiple
- Reduction in function

Anthropometric signs

- Adult
- Paediatric

++
+

COMMON, LIFE THREATENING OR TREATABLE DISORDERS

In particular of the spine, shoulder, elbow, wrist and hand, hip knees, ankle and foot

- Septic arthritis
- Osteomyelitis
- Acute mono or polyarthritis
- Metabolic bone diseases
  - Osteoporosis ± fracture (spine, peripheral)
  - Hyperparathyroidism
- Generalised and local osteoarthritis, including facet joint dysfunction
- Common soft tissue disorders eg rotator cuff tendonitis, epicondylitis, carpal tunnel syndrome, plantar fasciitis, tendosynovitis
- Congenital dislocation of the hip
- Management of common orthopaedic injuries
  - wrist
  - ankle
  - femoral neck and femur
  - soft tissue (knee and shoulder)
  - elbow
  - clavicle
  - hand (including nerve, tendon, bone injury and loss of function)
- Role of plastic surgery, in particular in trauma, carpal tunnel, Dupuytren’s and rheumatoid disease
- Spinal injury
- Peripheral nerve lesions associated with dislocation and fractures
- Cervical and lumbar radiculopathies associated with neck and back pain
- Early rheumatoid arthritis and juvenile rheumatoid arthritis
- Metabolic bone diseases
  - Osteomalacia
  - Pagets
- Gout and other crystal arthropathies
- Spondyloarthropathies
- Post traumatic arthropathies
- Vasculitides
- Polymyalgic syndromes
- Henoch-Schonlein purpura
- Rheumatic fever
- Perthe’s disease
- Stress fractures
- Diffuse soft tissue pain syndromes
- Torsional deformity and other common orthopaedic variants
- Management of common orthopaedic injuries
- Compartment syndrome and crush syndrome
- Avascular necrosis in association with dislocations and fractures
- Orthopaedic emergencies
  - fat embolism and ARDS
  - haemorrhage and circulatory collapse
  - soft tissue injury
  - open fracture
  - gas gangrene and tetanus
  - major and multiple trauma
  - thromboembolism
- Bone tumours-radiological staging, bone biopsy
## 17 NEUROLOGY & NEUROSURGERY

### SYMPTOMS/CLINICAL SIGNS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Adult</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired consciousness</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Mental retardation</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Swallowing disorders</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Gait disorders</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Limb pain and sensory disturbances</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Fits and fainted</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Dementia/memory impairment</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Headache</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Visual loss</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Dizziness and loss of balance</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Muscle weakness and fatigue</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Raised intracranial pressure</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Childhood hypotonia</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Speech disorders</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Facial pain</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Involuntary movements</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Abnormal developmental milestones</td>
<td></td>
<td>++</td>
</tr>
</tbody>
</table>

### COMMON, LIFE THREATENING OR TREATABLE DISORDERS

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Adult</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Febrile seizures</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Transient ischaemic attacks</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Stroke</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Tension and combination headache</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Alcohol and the nervous system</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Essential tremor</td>
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<td>Benign intracranial hypertension</td>
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<td>Manage neurological emergencies including epileptic seizures, the unconscious patient, meningitis, stroke, raised intracranial pressure, spinal cord compression</td>
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<td>Developmental delay in childhood</td>
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18 NUTRITION & LIPIDOLOGY

SYMPTOMS/CLINICAL SIGNS

- Nutritional anaemias
- Iron, folate, B₁₂ deficiencies
- Osteomalacia and osteoporosis
- Alcoholism
- Nutritional deficiencies in patients on limited diets
- Nutritional diseases in infancy, childhood, pregnancy and in the elderly
- Dietary therapy of:
  - Obesity
  - Diabetes mellitus
- Arcus cornea
- Tendon xanthomata
- Eruptive xanthomata and palmar crease xanthomata
- Protein-energy malnutrition
- Kwashiorkor
- Marasmus
- Rickets
- Malabsorption disorders
- Liver diseases
- Renal disease and renal replacement therapy
- Anorexia, bulimia
- Dietary therapy of:
  - Gastro-intestinal disorders
  - Liver disease
  - Renal disease
  - HIV disease
  - Metabolic aspects of and general indications for parenteral nutrition
  - Complications of parenteral nutrition
  - Principles of nutritional support in the critically ill and surgical patients
- Normal/abnormal patterns of growth in childhood

COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- The more common primary hyperlipidaemias:
  - polygenic hypercholesterolaemia
  - familial hypercholesterolaemia
  - familial combined hyperlipidaemia
- Secondary causes of hyperlipidaemia:
  - visceral obesity
  - diabetes mellitus
  - hypothyroidism
  - alcoholism
  - nephrotic syndrome/chronic renal failure
  - drugs
- Be able to give advice on the following clinical scenarios:
  - Infant and newborn feeding patterns, and feeding problems in childhood
  - Patients with primary and secondary hyperlipidaemias described above
  - Hypercholesterolaemia in patients following myocardial infarction, post coronary artery bypass surgery and post cerebrovascular accident
  - A patient with severe hypertriglyceridaemia and abdominal pain
  - Asymptomatic female with moderate hypercholesterolaemia
  - Patient with mild hypercholesterolaemia and multiple cardiovascular risk factors
  - Elderly patient with marked hypercholesterolaemia
  - Indigenous people with lipid and nutritional problems

19 OBSTETRICS & GYNAECOLOGY

NORMAL PREGNANCY

- Be able to provide routine antenatal care, know what is normal
- Routine tests in pregnancy, including common tests for foetal abnormality
- To be able to explain these tests to a patient; to understand why explanation is necessary
- Routine management of the postnatal woman, including instruction of breast feeding and management of common problems
ABNORMAL PREGNANCY
- Detection and management of mild and moderate PET
- Emergency management of severe PET
- Management of chronic hypertension in pregnancy
- Management of bleeding in early pregnancy
- Common Postnatal problems, management
- Post natal depression, detection and management
- Diabetes in pregnancy, detection, risks, management in general
- Management of minor complications of pregnancy (varicose veins; haemorrhoids)
- Pain management options for labour
- Prediction and initial management of preterm labour and prelabour rupture of the membranes
- Tocolysis, indications, risks, detection and management of incompetent cervix
- Management of post-term pregnancy
- Management of Antepartum Haemorrhage
- Management of Primary PPH
- Management of Secondary PPH
- Management of anaemia in pregnancy
- A general understanding of Rhesus disease
- Detection and referral of isoimmunised patient
- Prevention of Rhi (D) isoimmunisation with anti-D
- Detection and initial management of Intra Uterine Growth Restriction
- Initial management of Unexpected Foetal Death in Utero
- Detection and management of abnormal progress in labour (use of oxytocin to augment labour partograms, 'active management of labour')
- Caesarean section, management of the patient with a previous caesarean
- Advice in and before pregnancy: exercise, alcohol, smoking, work, medications, drugs, folate
- Induction of labour, indications, risks
- Large fundus for dates, management
- High head at term, management
- Breech presentation, management options
- Episiotomy, perineal tears; management
- Postpartum fever: management
- Hyperemesis, management
- Asthma in pregnancy, management
- Cardiac Disease in pregnancy, management in general
- Pregnancy in an epileptic patient, management
- Appendicitis/acute abdomen in pregnancy, diagnosis
- Mastitis/ breast abscess, management
- Causes of perinatal mortality and morbidity; consideration of management to prevent
- Multiple pregnancy
- Opiate addiction and pregnancy

GYNAECOLOGY
- Management of vaginal discharge, in detail
- Detailed management of a woman with an abnormal Pap smear
- Management of abnormal bleeding; post-coital, post menopausal
- Contraception, management in detail; risks, benefits, side effects, contra-indications
- Management of PID, detailed management of acute, general management of chronic
- Management in detail of the woman asking for advice concerning the menopause and hormone replacement therapy
- Management of bleeding in early pregnancy, miscarriage, threatened abortion, ectopic
- Management of a woman requesting termination of pregnancy
- Management of sexually transmitted infections
- Detection, prevention and general concepts of management of cervical, endometrial and ovarian cancers and hydatidiform mole
- Management of a woman complaining of urinary incontinence or urgency
- Management of a woman complaining of heavy or frequent periods
- Management of a woman requesting sterilisation
- Management in general of the woman who has amenorrhoea
- Management of a woman complaining of problems with premenstrual syndrome
● Management of a couple presenting with infertility (this includes assessment of the male and treatment options generally where there is a problem with the male) ++
● Initial assessment and management options for a woman with prolapse +
● Management of an asymptomatic pelvic mass/ovarian cyst +
● Initial management of a woman complaining of pain on intercourse +
● Knowledge of medical and surgical options sufficient to adequately inform a patient of her options +
● Management of Painful Periods +
● Management in general of the woman who is not ovulating +
● Management in general of a woman who complains of hirsutism +

20 OPHTHALMOLOGY (note overlap with Neurology)

SYMPTOMS/CLINICAL SIGNS
● Acute or sudden loss of vision (unilateral or bilateral) ++
● Gradual visual loss (unilateral or bilateral) ++
● Acute painful eye ++
● Chronic ocular discomfort ++
● Red eye ++

COMMON, LIFE THREATENING OR TREATABLE DISORDERS
● Acute glaucoma (usually acute angle closure) ++
● Gradual loss of vision
    - aged related macular degeneration ++
    - glaucoma ++
    - cataracts ++
    - refractive errors ++
● Chronic infection such as trachoma ++
● Acute painful eye +
    - herpetic keratitis (prescribe and use appropriate anti-viral agents) ++
    - conjunctivitis (prescribe and use appropriate antibiotic agents) ++
    - anterior uveitis and appropriate steroid use ++
    - acute glaucoma (ocular hypotensive agents) ++
    - trauma ++
● Disfiguring ocular complaints
    - tumours of the eyelids including basal cell, carcinomas squamous cell carcinomas and melanomas ++
● Neuro-ophtalmology
    - basic ocular motor nerve dysfunction including third, fourth and sixth nerve palsies ++
    - visual field defects with the ability to diagnose a hemianopia, quadrantanopia and an altitudinal field defect ++
● Ocular disorders associated with systemic disease
    - Diabetes and diabetic retinopathy ++
● Injury (including management of ocular emergencies)
    - blunt eye injuries ++
    - penetrating eye injuries ++
    - foreign body ++
    - welding flash injury ++
● Acute central retinal artery and vein occlusions +
● Anterior uveitis +
● Retinal detachment +
● Chronic ocular discomfort
    - dry eyes +
    - lid mal-position, including entropion, ectropion and trichiasis +
    - trachoma +
● Disfiguring ocular complaints
    - lid dysfunction +
● Neuro-ophtalmology
    - Horner’s syndrome +
● Ocular disorders associated with systemic disease
    - AIDS +
    - inflammatory diseases such as rheumatoid arthritis and SLE +
● Paediatric ophthalmology
    - strabismus ++
    - amblyopia ++
    - orbital cellulitis ++
    - cataract +
    - retinoblastoma +
21 OTORHINOLARYNGOLOGY

SYMPTOMS/CLINICAL SIGNS

- Epistaxis
- Deafness: Sensorineural & conductive
- Vertigo of sudden onset
- Rhinitis - allergic and vasomotor
- Sinusitis
- Sore throat
- Ear ache
- Hoarseness

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COMMON, LIFE THREATENING OR TREATABLE DISORDERS

- Perforated tympanic membrane
- Otitis externa
- Otitis media - acute and chronic
- Impacted ear wax
- Orbital cellulitis
- Diseases of the pharynx - inflammatory and neoplastic
- Diseases of the larynx - inflammatory and neoplastic
- Mastoiditis
- Cholesteatoma

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22 PAEDIATRICS (specifically related to Paediatrics)

Please note that most areas related to Paediatrics are detailed under disciplinary areas.

CHILDHOOD ORIGINS OF ADULT DISEASES

- Implications for anatomical/physical/behavioural development

| ++    |

PROBLEMS OF THE NEWBORN

- Normal variations that may manifest at birth or at the 6 week “check”
- The presentations and initial management (including need for referral) for life threatening neonatal disorders such as respiratory distress, sepsis, neonatal seizures
- The presentations and initial management of important neonatal congenital anomalies such as cleft lip and palate, oesophageal atresia and intestinal obstruction
- Grief, ethics, death and decision making in relation to still birth and newborn deaths
- Normal neonatal behaviour patterns
- Basic intensive care management of the pre-term infant (requirements to be kept pink, warm and provided with energy)

| ++    |

GENETIC PROBLEMS IN PAEDIATRICS

- The principles of newborn screening programmes
- The presentations and significance of inborn errors of metabolism
- The principles of genetic inheritance
- Common chromosomal and malformation syndromes and have basic knowledge of their aetiological factors, including Down’s Syndrome, cleft lip and palate and spina bifida

| ++    |

OTHER

- Normal development
- Normal growth
- Physiology of puberty

| ++    |

23 PALLIATIVE CARE

SYMPTOMS/CLINICAL SIGNS

- Pain
- Nausea and vomiting
- Constipation
- Anxiety and depression
- Communication with patient and family
- Mouth care
- Anorexia
- Dyspnoea

| ++    |

| +    |

| +    |

| +    |
• Cough
• Sleep disorders

Adult  Paediatric
• Confusion
• The social impact of illness
• Cultural issues
• Spiritual issues
• Alternative/unorthodox therapies
• Death awareness
• Ethical issues
• Home care of dying patients

24 PLASTIC & RECONSTRUCTIVE SURGERY

PROBLEM SOLVING
• Appropriate management strategies for contaminated wounds
  - clean  
  - dressings  
  - debridement
• Principles of the management of
  - lacerations
  - burns
  - facial injuries including underlying bony skeleton
• Understand the principles of the management of hand conditions
• Understand the principles of
  - reconstructive surgery
  - post surgical management plans
  - infections in plastic and reconstructive surgery
• Congenital problems (cleft lip and palate, congenital hand and soft tissue deformities)

25 PSYCHIATRY

SYMPTOMS/CLINICAL SIGNS
• Changes in visceral/somatic functioning
• Changes in perceptual functioning
• Changes in personality, social and occupational functioning
• Disturbances of thought
  - form
  - content
• Disturbances of affect
• Disturbances of cognitive functioning
• Behavioural disorders in childhood

COMMON, LIFE THREATENING OR TREATABLE DISORDERS
• Affective disorders
  - dysthymia
  - major depression
  - bipolar affective disorder (and variants)
• Anxiety disorders
  - generalised anxiety
  - phobic anxiety (object, situational)
  - panic disorder
• Personality disorders
  - concept of personality and personality disorder
  - clinical description of classified personality disorders (cluster A, B and C)
• Psychotic disorders
  - schizophrenic disorders
• Organic disorders
  - acute organic brain syndrome (delirium state)
  - chronic organic brain syndrome (dementia)
• Somatoform disorders
  - somatisation disorder
- conversion reactions ++
- psychogenic pain ++
- hypochondriasis ++

**Adult Paediatric**

- Alcohol and drug abuse
  - facts and figures on drug abuse (alcohol, marijuana, narcotic, stimulant, petrol/glue and prescribed) ++
  - populations at risk ++
  - detection of drug abuse in clinical practice ++
- Psychiatric disorders associated with menstruation, pregnancy and childbirth
  - post-partum reactions ++
- Affective disorders
  - cyclothymia +
- Anxiety disorders
  - obsessive compulsive disorder +
  - post-traumatic stress disorder +
- Psychotic disorders
  - paranoid disorders +
  - schizoaffective +
  - reactive psychosis +
- Organic disorders
  - focal vs diffusive organic disorders +
  - anxiety, affective, delusional, personality disorders secondary to brain dysfunction +
- Adjustment disorders
  - coping styles +
  - maladaptive behaviour +
  - short lived psychiatric syndromes with rapid restitution +
- Dissociative reactions
  - psychogenic amnesia +
  - psychogenic fugue +
  - multiple personality +
  - depersonalisation +
- Alcohol and drug abuse
  - treatment facilities available +
- Eating disorders
  - obesity + +
  - anorexia/bulimia nervosa + +
- Psychosexual dysfunction
  - erectile dysfunction in men +
  - functional dyspareunia/vaginismus +
  - paraphilias +
- Psychiatric disorders associated with menstruation, pregnancy and childbirth
  - menarche, menopause +
  - mood changes associated with menstruation +

**A NEWLY QUALIFIED DOCTOR SHOULD BE AWARE OF THE FOLLOWING PROBLEMS**

- Suicide and self harm
  - various forms of self harm: self mutilation and other acts of deliberate self harm including attempted suicide ++
  - awareness of populations at risk for self harm/suicide ++
- Psychiatric disorders presenting a physical illness
  - somatisation as a general concept ++
  - anxiety/depression ++
  - somatoform disorders ++
- Child Psychiatry and behavioural disorders
  - the effect on the child or adolescent and family of adverse psychosocial factors such as physical and sexual abuse, divorce and separation, chronic illness and disability ++
  - the causes, course and management of disruptive behaviour disorders, such as attention deficit disorder and conduct disorder ++
  - the causes, course and management of anxiety disorders, in childhood, including separation disorder school refusal, sleeping disorder, post-traumatic stress and somatoform disorders ++
  - the causes, course, and management of depression and attempted suicide in children and adolescents ++
  - the presentations and approach to treatment of child and adolescent eating disorders ++
- Psychiatric disorders presenting a physical illness
  - dissociative reactions +
  - concept of illness behaviour and abnormal illness behaviour +
  - concept of factitious illness and related syndromes +
- Physical illness presenting as psychiatric disorders
- epilepsy, multiple sclerosis, endocrine disorders etc

- Psychiatric aspects of physical illness
  - the impact of physical illness (eg diabetes, epilepsy, pain malignancy, etc) on mental state/ personality

- Psychophysiological reactions
  - concept of psychophysiological/psychosomatic disorder
  - clinical examples: irritable bowel, headache, hypertension

- Special at risk populations
  - the migrant/ethnic group
  - the unemployed
  - adolescents
  - single parents
  - the bereaved
  - the retired
  - the aged

- Normal and pathological grief
- Cultural variation in perception/expression of psychiatric disorders

**26 RENAL & UROLOGICAL MEDICINE**

**SYMPTOMS/CLINICAL SIGNS**

- Prostatism
- Dysuria
- Haematuria
- Oliguria/anuria
- Scrotal swellings
- Incontinence
- Frequency
- Polyuria
- Non-specific presentation in children

**COMMON PROBLEMS/CONDITIONS**

- Severe hyperkalaemia
- Acute renal failure
- Urinary tract obstruction
- Renal stone disease
- Carcinoma of kidney or urinary tract
- Symptomatic chronic renal failure
- Diabetic nephropathy
- Nephrotic syndrome
- Cystitis, urethritis and urinary tract infection
- Asymptomatic raised serum creatinine
- Benign prostatic disease
- Prostate cancer, including screening
- Prostatitis
- Scrotal neoplasia
- Epididymo-orchitis
- Testicular torsion
- Urogenital trauma
- Vesico-ureteric reflux
- Proteinuria and/or microscopic haematuria
- Congenital malformations of the urogenital tract
- Nephritic syndrome
- A patient on chronic dialysis
- An ill patient with a renal transplant
## 27 RESPIRATORY MEDICINE

### SYMPTOMS
- Dyspnoea - acute or chronic
- Cough (± sputum)
- Chest pain
- Haemoptysis
- Noisy breathing (snoring, wheeze, stridor)
- Sore throat
- Nasal discharge

### CLINICAL SIGNS
- Cyanosis
- Percussion note
- Sounds (wheeze, crackles, rub, bronchial breathing)
- Forced expiratory time
- Clubbing

### COMMON, LIFE THREATENING OR TREATABLE DISORDERS
- Airflow limitation:
  - asthma
  - emphysema, chronic obstructive bronchitis, bronchitis
- Benign and malignant tumours of the lung
  - primary, secondary and pleural
- Manage a pulmonary nodule on CXR
- Infection
  - upper and lower airways
  - normal and immunocompromised host
- Venous thromboembolism (and pulmonary hypertension)
- Pleural effusion
- Sleep disorders
  - obstructive sleep apnoea
  - hypoventilation
- Respiratory failure
  - acute, chronic
- Drug induced pulmonary disease
- Respiratory problems in Indigenous patients
- Environmental lung disease (smoking, parental smoking, occupational, allergic)
- Chest trauma management
  - fractured ribs
  - fractured sternum
  - traumatic pneumothorax/hemothorax
  - ruptured aorta
- Airflow limitation:
  - bronchiolitis
  - stridor (laryngo-tracheo-bronchitis/ croup, epiglottitis, inhaled foreign body, laryngo-tracheo-malacia
- Mediastinal masses
- Bronchiectasis
- Cystic fibrosis
- Infection
  - tuberculosis (MTB and non-TBM)
  - empyema
  - age specific variations in infection
- Interstitial lung disease
- Pneumothorax
  - spontaneous and tension
- Treat respiratory conditions in an emergency (asthma, exacerbation of CAL, pneumothorax, anaphylaxis, pulmonary oedema, laryngeal obstruction, massive PE – different approaches depending on age))
APPENDIX E
INFORMATION TECHNOLOGY STANDARD NO. S10/0700

Title: Acceptable Use - Computing and Communication Facilities Standard

1. Standard
The use of Western Australian Government Health Services (WAGHS) computing and communication resources imposes certain responsibilities and obligations on all personnel employed by or contracted to the WAGHS (hereinafter termed “users”) and is subject to the provisions of the Public Sector Management Act and the Western Australian Public Sector Code of Ethics published by the Public Sector Standards Commission.

The standards of Acceptable Use prescribed, apply to every user, regardless of the technical means, location and access form by which that user has achieved access to the WAGHS network.

Users requiring access to WAGHS computing and communication facilities are required to complete a Request for Access to Computing Applications form HFN-030 and additional Request for Access forms for specific applications.

Use of computing and communication facilities may be subject to monitoring, logging and analysis.

Violation of the provisions of this standard may result in a recommendation to revoke access to computing and communication facilities, result in disciplinary action, and where appropriate, referral to the WA Police Service.

2. General Provisions
2.1. All use of WAGHS computing and communication facilities, including the Internet, must be consistent with the purposes of the WAGHS.
2.2. Access to, or use of, WAGHS computing and communication facilities, including the Internet, for illegal or inappropriate purposes, or in support of such activities, is expressly forbidden.
   - Illegal activities are defined as any act which constitutes a violation of State or Commonwealth laws; and
   - Inappropriate use is defined as any violation, of the conditions contained in the application forms or the terms and/or provisions contained in this Standard.
2.3. Users must not knowingly violate copyright, licences agreements, or other contracts.
2.4. Users must not interfere with the intended use of information resources.
2.5. Users must not seek to gain or gain unauthorised access to information resources.
2.6. Users must not use or knowingly allow another to use any computer, computer network, computer system, program or software to devise or execute any artifice or scheme to defraud or to obtain money, property, services, or other things of value by false pretences, promises, or representations.
2.7. Users must not without authorisation destroy, alter, dismantle, disfigure, prevent rightful access to or otherwise interfere with the integrity of computer-based information and/or information resources.
2.8. Users must not retain departmental Internet accounts once they cease to be employees of, or contracted to, the WAGHS.
2.9. In using WAGHS computing and communication facilities, normal record management and archiving practices must be adhered to as follows:
   - all correspondence produced or received by an officer in the course of their duties are deemed to be public records;
   - records created or received electronically are subject to the same conditions as paper based records; and
   - it is the responsibility of the individual officer to ensure all documents relating to the business operations of the WAGHS are forwarded to Records Management for recording.
2.10. Users must maintain a proper duty of care in terms of privacy, confidentiality, copyright, accuracy and timeliness of any information accessed from or distributed to external sources.
2.11. Users must use protective control measures aimed at preventing virus code from reaching computing facilities. These measures are applicable to computers used to access the Health Network externally and internally. Such measures include:
   - not interfering with virus control software which has been installed on the users computer by WAGHS IT staff. If the computer is not a WAGHS owned and managed computer then the user is responsible for ensuring virus control software of contemporary standard is installed and operational;
   - using installed software to check all new data, document and program files for viruses before loading them onto the computer; and
   - checking document and program files attached to email messages.
2.12. Users should only use WAGHS approved, or software which has been acquired by the organisation to support authorised business processes; this includes:
   - ensuring that you are using software which you can prove is the original (or the only back-up) copy which is licensed for the computer; and
   - not using software which has been obtained from unverified sources.
2.13. Users shall adopt security measures such as bootup passwords, password-protected screen-savers and disk locks to prevent the unauthorised loading of software on to the user’s computer without the user’s knowledge or consent.

2.14. Users are responsible for taking regular back-ups of their data files to permit recovery of information on the local hard drives.

3. **Security Provisions**

3.1. The transmission of confidential or commercially sensitive (see special note for explanation) information over the Internet is not permitted, except where that information is encrypted using a technique covered by a WAGHS standard.

3.2. Users are obliged to report to their Local Security Officer any security incidents or vulnerabilities of which they become aware.

3.3. Before any confidential or commercially sensitive information may be transferred using authorised means from a computer on the WAGHS Network to an externally connected computer, the person making the transfer must make sure that access controls on the destination computer are commensurate with access controls on the originating computer.

3.4. When a user is issued with a person-based logon to connect to the WA Health network, internally or externally, the user is personally responsible for ensuring that no one else uses the logon and the services and access that the logon provides.

3.5. A user must not advise anyone of their password, nor allow it to be accessible by anyone. The Logon Standard should be referred to for full details of password management.

3.6. A user must not at any stage leave a device unsecured whilst logged on with their personal logon-id.

The specific provisions stated above are not meant to be exhaustive. Users should seek guidance from their IT security manager on questions of acceptable use of WAGHS computing and communication facilities. Until an issue is resolved, questionable use should be considered unacceptable.

**Background**

WAGHS computing and communication facilities provide access to resources both inside and outside of WAGHS, as well as the ability to communicate with other users worldwide. Such access requires that individual users act responsibly. The increasing availability of Internet access to WAGHS users offers ready access to material that may not be acceptable in the workplace. In some cases it may be illegal and thus expose the Commissioner of Health and the WA Government to potential embarrassment and possible prosecution. The WAGHS is concerned that this valuable resource is not brought into disrepute in the workplace through its inappropriate use. This standard clearly sets out what is acceptable use and what is not acceptable use of WAGHS computing and communication facilities.

**Associated Policies**

- Information Systems Development & Implementation Policy
- Computing and Telecommunications Systems Facilities Management Policy
- Information Security Policy
- Network Access Standard
- Logon Standard

**Special Notes**

Confidential material is material that identifies, for example, a patient, or staff member and contains information that would not be generally considered as acceptable to be displayed in a public forum. Examples of this would be information about a staff member's salary, or work performance, details of a patient's course of treatment or other medical records.

Commercially sensitive material can be considered to be material that if placed in a public forum may affect a party's position, or reputation. Examples of this would be details of tender responses, proposal formats, contracts etc.

**References**

- *Public Sector Management Act 1994.*
- *Western Australian Public Sector Code of Ethics.* Public Sector Standards Commission
- *Policy 5.1 Connecting to and use of Internet or other Public Networked Information Services.* Information Policy Council, July 1995