101 Things to Do with Spare Moments on the Ward
To Tina and Tony Evans, who have been both blessed and cursed by never having had a bored moment with nothing to do. Without them, this book would never have been written.

Dason Evans

To my wife, sister and parents for their everlasting love and support.

Nakul Gamanlal Patel
# Contents

Foreword vii
Abbreviations and Medical hierarchy viii
Introduction x
Acknowledgements xiv
Table of tasks xix

## Section 1 Teaching, Testing and Learning 1
Memory aids and mnemonics 2
Building quizzes 5
E-learning resources 8

## Section 2 Clinical Communication 12
Narrative – the patient’s story 15
Preparation 20
History taking 22
Observing communication 26

## Section 3 Physical Examination 31
Peer practice for physical examination 33
Examining patients – systems examinations 36
Examining patients – holistic assessments 40
Spot diagnosis 44
Exploring around the patient 45

## Section 4 Practical Procedures 49
Know your equipment 50
Peer practice of practical skills 55
Hidden teachers, hidden opportunities for practical skills practice 63
Infection control 70

## Section 5 Prescribing 75
Navigating around the drug chart 77
Preventable human errors in prescribing 83
Your peripheral brain – the BNF (British National Formulary) 86
Hidden teachers in pharmacology 90
Transition to junior doctor 93
## Section 6 Being Curious
A doctor’s best friend: the nurse
Who are the players?
Communication

## Section 7 Data Interpretation
Patient notes
Patient ECGs (Electrocardiogram)
Imaging

## Section 8 Getting Teaching
Motivating people to teach you
Finding other teachers

## Section 9 Effectiveness and Efficiency
Knowing your own motivation
Fun and flippant suggestions
Never too early to think about your future
Organisation and efficiency

## Section 10 Over to You
Task 101

Index
Foreword

This is an extraordinary book built around quotations from medical students and turned into a beautifully woven catalogue of learning opportunities around the ward. Walking to the wards to teach medical students, I often ask ‘what did you learn yesterday?’ The answer is often ‘I went home as the teaching was cancelled and there was nothing to do’. A source of great sadness to me and, dare I say it, almost equivalent to a child saying ‘I am bored’ with the hidden implication of ‘. . . entertain me’. There is just so much going on in both the hospital and primary care settings that I am often left speechless. But, was I too harsh in my judgement? If students did not know what the learning opportunities were, or indeed, how to find them, then their reply to me was hardly surprising.

This book aims to redress this gap and made me realise that my irritation was, indeed, harsh. It carefully points out the opportunities available but often so invisible to a young student’s inexperienced eye. Quietly surveying the hive of activity from the end of a ward makes it easier to spot points of interest, almost like a game – the nurses giving out medications, pharmacists doing chart rounds, doctors doing ward rounds, the social worker enquiring about the domestic situations of patients about to be discharged, the ECG technician or junior doctor doing an ECG, the F1 doctor looking at an X-ray, and above all, patients lying in bed, dying for someone to chat to them about their condition or just about anything! All useful opportunities that cannot be learned from textbooks, but which could make the learning easier with practical examples from real life.

What I liked most about this book is that the suggestions for these learning opportunities came mostly from medical students themselves. They had discovered them on their own and were passing them onto other student colleagues as suggestions for that spare moment that should not be wasted! The chapters address communication, examination and procedures to prescribing, data interpretation and how to motivate people to actually teach you. A host of useful hints and suggestions set out in a most readable way and suggested by student peers. Suggestions that you could follow up alone, or indeed learn in a two-way conversation with a friend.

I think this book will certainly have a niche in the texts available for students to buy. It is well set out, eminently readable and, fun! There is so much to learn and so little time to do so, so why not spend it on the wards and learn from clinical practise? The authors of this book tell you how!

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# Abbreviations and Medical hierarchy

## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>ABG</td>
<td>Arterial Blood Gas</td>
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<td>ABPI</td>
<td>Ankle–Brachial Pressure Index</td>
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<td>Abx</td>
<td>Antibiotic</td>
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<td>ADL</td>
<td>Activities of Daily Living</td>
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<td>AFP</td>
<td>α-Fetoprotein</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>BBB</td>
<td>Bundle Branch Block</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
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<tr>
<td>BNF</td>
<td>British National Formulary</td>
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<tr>
<td>BP</td>
<td>Blood Pressure</td>
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<td>BPM</td>
<td>Beats Per Minute</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>CT</td>
<td>Computerised Tomography</td>
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<td>CTPA</td>
<td>Computerised Tomography Pulmonary Angiogram</td>
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<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
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<tr>
<td>ERCP</td>
<td>Endoscopic Retrograde Cholangiopancreatography</td>
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<tr>
<td>EWTD</td>
<td>European Working Time Directive</td>
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<tr>
<td>FBC</td>
<td>Full Blood Count</td>
</tr>
<tr>
<td>U&amp;Es</td>
<td>Urea and Electrolytes</td>
</tr>
<tr>
<td>GALS</td>
<td>Gait, Arms, Legs, Spine examination</td>
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<tr>
<td>GI</td>
<td>Gastrointestinal</td>
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<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HAI</td>
<td>Hospital-Acquired Infection</td>
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<td>HR</td>
<td>Heart Rate</td>
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<td>IM</td>
<td>Intramuscular</td>
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<td>INR</td>
<td>International Normalised Ratio</td>
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<td>ITU</td>
<td>Intensive Therapy Unit</td>
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<tr>
<td>IV</td>
<td>Intravenous</td>
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<td>IVP</td>
<td>Intravenous Pyelogram</td>
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<td>JVP</td>
<td>Jugular Venous Pressure</td>
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<td>MAU</td>
<td>Medical Assessment Unit</td>
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<td>MDT</td>
<td>Multidisciplinary Team</td>
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<tr>
<td>Abbreviation</td>
<td>Definition</td>
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<td>--------------</td>
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<tr>
<td>MI</td>
<td>Myocardial Infarction</td>
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<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>MRSA</td>
<td>Methicillin-Resistant Staphylococcus Aureus</td>
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<td>NG</td>
<td>Nasogastric</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NPSA</td>
<td>National Patient Safety Association</td>
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<td>NSAID</td>
<td>Non-Steroidal Anti-Inflammatory Drug</td>
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<td>OGD</td>
<td>Oesophago-Gastro-Duodenoscopy</td>
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<td>OSCE</td>
<td>Objective Structured Clinical Exam</td>
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<td>PACS</td>
<td>Picture Archive and Communication System</td>
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<td>PALS</td>
<td>Patient Liaison Service</td>
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<td>PE</td>
<td>Pulmonary Embolus</td>
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<td>PMH</td>
<td>Past Medical History</td>
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<td>PPE</td>
<td>Peer Physical Examination</td>
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<td>RPM</td>
<td>Rate Per Minute</td>
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<tr>
<td>RR</td>
<td>Respiratory Rate</td>
</tr>
<tr>
<td>SALT</td>
<td>Speech And Language Therapy</td>
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<tr>
<td>SSC</td>
<td>Student-Selected Component</td>
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<tr>
<td>STEMI</td>
<td>ST-Elevation Myocardial Infarction</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TEDS</td>
<td>Thromboembolic Deterrent Stockings</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>

**Abbreviations and medical hierarchy**

<table>
<thead>
<tr>
<th>Pre MMC Training System</th>
<th>Post MMC Training System</th>
<th>Outside Commonwealth</th>
</tr>
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<tbody>
<tr>
<td>PRHO</td>
<td>F1 or FY1</td>
<td>Intern or First-Year Resident</td>
</tr>
<tr>
<td>SHO</td>
<td>F2 or FY2</td>
<td>Resident up to Chief Resident</td>
</tr>
<tr>
<td>SHO</td>
<td>ST1</td>
<td></td>
</tr>
<tr>
<td>SHO</td>
<td>ST2</td>
<td></td>
</tr>
<tr>
<td>REG/SPR/STR</td>
<td>ST3 up to ST9</td>
<td></td>
</tr>
<tr>
<td>CON</td>
<td>CON</td>
<td>Attending</td>
</tr>
</tbody>
</table>

CON – Consultant
F1 or FY1 – Foundation Year 1
MMC – Modernising Medical Careers
PRHO – Preregistration House Officer
REG – Registrar
SHO – Senior House Officer
ST3 – Specialist Training Year 3
STR – Specialty Registrar
SPR – Specialist Registrar
Introduction

The idea behind this book was born some years ago, when one of the authors was talking to a tutee. When asked about what he had done the day before he said:

I went home early, as teaching was cancelled, nothing was happening and I was bored.

On talking to other students and, indeed, from our own recollection of medical school, this was clearly a common phenomenon. This student was surrounded by possibilities for learning, but didn't see any of them; nothing was happening. This anecdote is not, in any way, meant as a criticism of this student, or even students in general; it is just the way that things are. It was thanks to this student that the idea of this book was formed.

In this book, students, medical school staff, hospital staff and a wide range of other people from around the world have submitted ideas for ‘things to do’ when students might find themselves ‘bored’ or ‘with spare moments’ in the clinical environment. We took hundreds of suggestions, tried to cluster them into themes, and clustered the themes into sections including teaching, testing and learning, clinical communication, physical examination, practical procedures and a host of other topics.

This book has two aims. First, it gives a list of possibilities for ‘things to do’ when nothing seems to be happening. These possibilities were submitted by students and staff who have been in exactly this situation, so these ideas represent tried and tested opportunities for learning. We have tried to make the book small enough to fit in a pocket, and have given various different ways of accessing the task (see below in ‘How to use this book’), to make it as easy as possible to find an inspiring idea of something to do that fits with your mood of the moment.

The second aim is a little more subtle: we hope that this book not only gives you a list of things to do, but will also help you spot other opportunities around you, will help you to try out these opportunities and will encourage you to share these with others. To this aim we have included lots of suggestions for ‘taking things further’ and have tried to select suggestions and a commentary that highlight some of the skills that will make your life easier – giving it a go, dealing with rejection, utilising ‘cheek and charm’.

How to use this book

We would recommend that you read this introduction before starting, particularly this section, and the section on ‘What you will need’ and ‘A word on professionalism’ – these apply to the whole book. After that, it’s really up to you. We have written the book in such a way that you can start at the front and work your way through,
or you can dip in and out to sections that seem relevant to you today. We imagine that, if dipping in, you will find the table of contents (which lists all the themes in each section), and also the table of tasks useful (page xix). The latter contains icons that allow the student to quickly spot possible tasks that will fit with their mood, availability of people and time.

This is not, of course, a book for the bookshelf. Flick through it in spare moments, highlight ideas that you want to try, keep it handy on the wards, on the bus, add your own ideas – just not in the library copy!

**For students**

This is not the kind of book that you will have seen before. There are plenty of textbooks for medicine, loads of exam guides and cramming books; one or two books on how to study at medical school, but nothing quite like this.

Professor Geoff Norman is a well-known Canadian medical educationalist; he specialises in the topic of the development of medical expertise (he is an expert in expertise, if you will, which has to be a niche market!) and in a keynote lecture at a large medical education conference a few years ago he reviewed the literature on the development of expertise. It takes 10 years, roughly 10,000 hours of deliberate, reflective practice to become an expert. He asked the audience what the expert gets from these 10 years of experience, and answered ‘10 years worth of experiences’. This book aims to help you fill spare moments with experiences that will help you become a better doctor, and also help you enjoy your studies. All those spare 10 minutes, half-hours and half-days add up.

**What you will need**

We suggest that you need a couple of simple things in addition to this book to get the most out of it. You probably have them already.

A **diary** is a must for a clinical medical student, or at the least a timetable with the next month ahead planned out. Imagine that you pop down to the ECG department (Task 43) when teaching has been cancelled, but they can’t take you then. They are impressed at how keen you are and ask if you can make it in 2 weeks’ time – you need to quickly know when you might be free. Similarly you might put in your diary to look up a patient’s results or find out how they did in theatre, or even read about the anatomy of the thyroid the night before theatre next week (Tasks 7 and 88). A diary puts you in control. If you don’t have one, now is the time to buy one!

You will also need a **notebook**. Many of the suggestions require a little bit of follow-up, or maybe some ongoing discussion with your colleagues; you will need a notebook that is small enough to fit in your pocket and large enough to have a separate page or two for each task. If you like stationery as much as us, then spend some time finding something that you like – perhaps with different colour sections. Start one section, perhaps right in the centre of the book, to write down your own ideas for things that students could do in their spare moments. Try them out, share them with others and even consider submitting them at [www.101things.org](http://www.101things.org).
We suggest that you keep some kind of Portfolio to keep track of your learning. If you school does not give you one, or if you do not find their’s useful, why not create your own?

A word on ethics and professionalism

It is necessary to highlight that these submissions were written with some fundamental premises in mind, and these are so fundamental that they are often not mentioned explicitly:

- **Informed consent is mandatory.** Your role in the clinical environment is to learn, and patients must know this so that they can freely decide whether or not to give the gift of their consent. The good news is that most patients are more than happy to help students learn. Your medical school will have formal teaching and expectations around consent, and it is also covered in books such as *How to Succeed at Medical School* (Evans and Brown, 2009 pp. 47–8) and the BMA’s *Medical Ethics* today (English et al. 2004).

- **You should be competent enough** at whatever you practise. Some of the suggestions, e.g. practising phlebotomy, require a degree of competency to practise with patients or peers even when supervised. Clearly you should do these tasks only if you are competent enough. Some tasks in the book will be suitable for first year medical students, others will not.

- You should ensure that you have adequate supervision for whatever tasks you are practising. If looking through the equipment cupboard to see what you do and don’t recognise (Task 36) this might be as simple as just asking the nurses if that’s OK, but if rewriting a medication chart (Task 53) for the first time then you want to make pretty sure that someone will supervise and check your work thoroughly.

- **Knowing when to stop** can sometimes not be as simple as it might sound. The patient might say ‘Don’t worry, have [yet] another go at taking blood’, but if you suspect that you are beginning to abuse their generosity, you probably are.

- **Knowing when not to start** can also be tricky for the enthusiastic student. Be aware of the climate. If the nurses are fuming after a heated exchange with one of the doctors or matron or an angry relative, now might not be the best time to ask them to show you how to set up an intravenous line, but, if you know them well enough, it might be a good time to offer to go and take patients’ observations for them.

For staff

The clinical learning environment is changing; patients are spending less time in hospital, and tend to be more ill while they are there. Changes resulting from the
European Working Time Directorate (EWTD) have resulted in a degradation of the traditional firm structure, prohibiting some of the educational relationships between students and juniors on the firms that used to be common (Spencer 2003; Nikendei et al. 2006). In addition, there has been a shift in clinical medicine toward more explicit accountability, job planning and formal outcome measures, which has affected the delicate balance of service, teaching and research (the ‘three-legged stool’ after Weisbord 1985).

In reaction to these challenges to clinical learning, some authors have called for students to spend less time on the wards, and more time in simulation, learning from manikins, computers and role-play. In this book we offer an alternative solution. We believe passionately that medicine is learnt with and from patients, and we have seen clearly that some students thrive in the clinical learning environment, seeking out varied learning opportunities that will help them develop into skilled and experienced junior doctors. This book aims to take the best tips from those students and staff, and share them with others, encouraging all students to make the very best use of those opportunities around them.

Staff, whether clinicians who teach or medical school staff, may find this text useful, both for giving students ideas on how to fill spare moments productively, and also for helping students to learn to spot those opportunities themselves. If you are the consultant or trainee with responsibility for students on attachment, why not start a book or folder of opportunities available while on attachment with your team, and encourage the students to take responsibility for adding new opportunities to the book as they arise and useful notes for the next set of students coming (’Fridays are a bad day for the ECG department, try to go down on any day other than a Friday!’).

If you find some suggestions missing from this book, then please highlight these to your students, and even consider making a submission to www.101things.org.

References


Acknowledgements

This book is unusual, perhaps unique, within medical education in its approach. The contents of the book are written by people just like you, students and staff who know that, at times, you can have bored or quiet moments when you are in the clinical environment. As authors we have clustered these submissions, selected the ones that seemed most useful, most interesting or at times even most amusing, and joined them together with some commentary. For this book, therefore, the largest acknowledgement must go to these people who submitted ideas for the book – the wealth of ideas and information that are collected between these covers is thanks to their enthusiasm, innovation and willingness to share.

We have listed all the contributors below, and also in the text when we quote them directly. It should be noted that sometimes many contributors suggested the same or a very similar idea. In these cases we have chosen one that seemed to be the most representative. In these cases we have not directly acknowledged the others who have suggested similar ideas, because this would have taken a lot of space and been rather dull to read. In listing the contributors below, we thank and acknowledge them for all of their submissions, whether they have been directly quoted or not.

Of course there are some people who we would like to particularly thank for their input into this book. Abigail Cole, a medical student at St George’s, University of London had a large input into writing the first section, and we thank her for her speed, efficiency and for the fantastic section. Catherine Joekes, lecturer in clinical communication at St George’s, University of London, was kind enough to read and critique earlier drafts of the section on clinical communication and give incredibly useful feedback, for which we are very grateful. Ammy Lam, Principal Pharmacist at Barts and the London NHS Trust, gave invaluable advice and insight for the section on prescribing including an innovative way to learn about medication errors. Barts and the London NHS Trust have also given their formal permission to use their medication cards for our examples, allowing us to make these examples as real as possible. Andrew Webb, Senior Lecturer/Honorary Consultant in Clinical Pharmacology at Kings College London and Clinical Pharmacology at St Thomas’ Hospital, London gave us permission to use his innovative way to thing about medicines – ‘Use your BRAINS before you AIMS’.

As this book represented such an innovative approach to publishing for medical education we have to thank Wiley-Blackwell for their support, particularly Martin Sugden, our commissioning editor, whose passion, enthusiasm and vision seemed to know no bounds. Elizabeth Johnston and Laura Murphy have looked after us during the long and complex process of working out the right way to present this book. This was a new process for all of us and, although we have tested their patience to the limit, their constructive advice and support have been invaluable.
Of course, the most useful feedback has come from a wide body of people, including some fantastic student reviewers for Wiley-Blackwell, and too many friends, colleagues and students to mention by name – we appreciate you all!

Below, we have listed the details that were right at the time that the contributors submitted their ideas, we realise that people have graduated, moved and may even have changed their names since then. As an aside, this book started as a project called '101 things to do on the wards when bored' and has subsequently been renamed. We mention this only because a significant number of the submissions, from both students and staff, mention being 'bored', and we would like to clarify that this is a reflection of the initial title of the project, rather than any reflection on the attitude of those who submitted the ideas.

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