The AU Final-Year OSCE Checklist

A practical, station-by-station checklist for Australian and NZ medical students sitting university clinical finals. Built around the 5 station types you will actually see, the named frameworks that pick up marks, and the AU-specific items that get skipped by candidates who study from US/UK resources.

Written by an anaesthetics registrar in rural NSW who has examined OSCEs and watched a lot of capable students lose marks on the same mechanical items. Not a textbook substitute. Use it the week before exams as a confidence pass, and during practice as a marking grid.

How OSCEs actually get marked in AU medical schools

The marking grid for any AU OSCE station has three layers:

1. **Process items** (introduction, consent, structure, safety-netting) — the bottom 30-40% of the marks. Easy to get, easy to lose by forgetting.
2. **Content items** (the actual clinical task, named differentials, named investigations, named management) — the middle 40-50% of the marks.
3. **Excellence items** (the third differential, the AU-specific framework, the contextual extra most candidates skip) — the top 10-20% of the marks, and the difference between pass and high pass.

Failing candidates almost always fail on layer 1, not layer 2. The fix is mechanical: never skip the universal items below, every station, every time, until they are reflexive.

The universal opening (every station)

Use this exact sequence in the first 60 seconds of every station. Mechanical. No deviation.

1. **Wash hands** at the station entrance. Even if there's no sink. Mime it if needed.
2. **Introduce yourself with full name and role.** "Hi, I'm Jay, I'm a final-year medical student. Are you Mrs Smith?"
3. **Confirm the patient's identity** by name and DOB.
4. **Establish what they understand they are here for.** "Can I check what you've been told about today's visit?"
5. **Get explicit consent for the task.** "Is it okay if I ask you some questions about [the pain / your medications / etc] and then examine you?"
6. **Position the patient and yourself.** Sit at 45 degrees, not opposite. Same eye level.

Marks lost when you skip these: ~5-10 per station, every time.

The universal closing (every station)

Last 60 seconds of every station. Reflexive.

1. **Summarise back to the patient** in one sentence. "So you've come in with a 3-day history of left-sided chest pain after a long flight, with some shortness of breath."
2. **State your working diagnosis and the most important differential.** "I'm worried about a possible blood clot in the lungs called a pulmonary embolism, and we need to rule that out today."

3. **Explain the immediate plan in plain English.** "We'll do an ECG, a chest X-ray, and a blood test called a D-dimer. If those raise concern, we'll do a CT scan of your lungs."
4. **Explicit safety net.** Always. Word it like this: "If you develop [worsening shortness of breath / chest pain / coughing up blood / feeling faint], call an ambulance immediately or come straight back to ED."
5. **Ask if they have any questions.** "Is there anything I haven't explained well, or anything you wanted to ask?"
6. **Thank the patient.**

Single most-skipped item: explicit safety net. Verbally name the symptoms that should trigger return. "Come back if you feel worse" is not a safety net. "Come back if you develop severe pain, fever above 38.5, or can't keep fluids down" is a safety net.

Station type 1: History-taking

Time budget: 8 minutes typically. 1 minute opening, 5 minutes history, 1 minute summary + working diagnosis, 1 minute safety net.

Named frameworks to use out loud:

- **SOCRATES** for pain: Site, Onset, Character, Radiation, Associated symptoms, Timing, Exacerbating/relieving, Severity (0-10).
- **OPQRST** is the US version of the same thing. Either is fine, name whichever you use.
- **ICE** for context: Ideas, Concerns, Expectations. "What do you think might be going on? Is there anything specific you're worried about? What were you hoping we could do today?" — these three sentences pick up 3-5 marks and most candidates skip them.
- **PMHx / FHx / SHx / DHx / Allergies** as separate sections. Name each section as you start it. "I'm now going to ask about your past medical history."
- **HEADSS** for adolescent psychosocial: Home, Education/Employment, Activities, Drugs, Sexuality, Suicide/Self-harm.
- **CAGE** for alcohol screen: Cut down, Annoyed, Guilty, Eye-opener.
- **AUDIT-C** is the better-marked alternative if your school teaches it.

AU-specific must-asks (these are easy marks in AU schools):

- **Indigenous identity** in primary care / mental health / chronic disease histories: "Do you identify as Aboriginal or Torres Strait Islander? Asking because there are some specific health services that can help."
- **Smoking status with pack-years.** Not "do you smoke" — "have you ever smoked, how long for, how many per day."
- **Alcohol in standard drinks per week.** AU standard drink = 10g alcohol. Not US drinks (14g) or UK units (8g).
- **Australian medication history.** Ask "what medications, including over-the-counter and supplements" — Murtagh's framing.
- **Pregnancy status** for any woman 12-55 with abdominal pain, mental health, prescribing, imaging. "Is there any chance you could be pregnant?"
- **Vaccination status** for paeds and migrant adult histories: "Are your vaccinations up to date according to the National Immunisation Program?"

- **Centrelink / DSP / NDIS** in psychosocial histories where relevant. Don't pretend you don't know the systems exist.

Red-flag screens (must be asked explicitly, not just "any other symptoms"):

- **Back pain:** saddle anaesthesia, urinary retention, weakness in legs, fever, weight loss, night pain.
- **Headache:** thunderclap onset, fever + neck stiffness, focal neurology, visual changes, worse on Valsalva, history of cancer.
- **Chest pain:** crushing, radiating to jaw/arm, sweating, syncope, haemoptysis (PE).
- **Abdominal pain:** rigidity, bleeding, fever, pregnancy, recent surgery.
- **Mental health:** suicidal ideation, plan, intent, access to means, protective factors.

Common history-taking failure modes:

- Not naming the framework (SOCRATES, ICE) out loud. Examiner can't mark you for thinking it.
- Asking closed yes/no questions when an open one is expected. "What brought you in today" not "is it the chest pain again".
- Missing the ICE block entirely. 3-5 marks gone.
- Not asking about pregnancy in any woman of reproductive age.
- Not asking about allergies before discussing management.
- Forgetting to summarise back at the end.

Station type 2: Examination

Time budget: 8 minutes. 1 minute opening + exposure, 5-6 minutes exam, 1-2 minutes findings + plan.

Universal exam sequence:

1. **Wash hands, introduce, confirm identity, gain consent.** "I'd like to examine your [region]. This will involve [inspection, then touch, then movement]. Is that okay?"
2. **Adequate exposure with respect for dignity.** Drape, don't strip. Chaperone offer for breast, genital, or rectal exams.
3. **General inspection first, from the foot of the bed.** Comment out loud: "On general inspection, the patient appears comfortable at rest, in no respiratory distress, with no obvious peripheral cyanosis or oedema."
4. **Then close inspection of the region.** Out loud: "On closer inspection, no scars, no obvious deformity, no rashes."
5. **Then palpation, percussion (if relevant), auscultation, special tests** in standard order.
6. **Compare sides.** Always. Even when not asked.
7. **Offer to complete the examination** with related items not done in the time. "To complete my examination I would also like to perform [the relevant additional exam], and check observations, urinalysis, and weight."

Named exam routines that are expected verbatim:

- **Cardiovascular:** inspection (chest, hands for clubbing/splinters), pulse (rate, rhythm, character), BP both arms, JVP, palpate apex beat (5th ICS MCL), heaves and thrills, auscultate 4 areas with bell and diaphragm, dynamic manoeuvres (lean forward for AR, left lateral for MS), peripheral oedema, peripheral pulses.
- **Respiratory:** inspection (RR, accessory muscles, chest expansion, scars, deformity), trachea, expansion, tactile fremitus, percussion, auscultation (anterior + axillary + posterior, top to bottom,

compare sides), vocal resonance.

- **Abdominal:** inspection (scars, distension, masses, hernial orifices), light then deep palpation in 9 regions, liver, spleen, kidneys (ballotting), AAA, bladder, percussion (organomegaly, ascites), auscultation (bowel sounds, bruits), offer PR + external genitalia + hernial orifices + groin nodes.
- **Cranial nerves:** I (smell, offer), II (acuity, fields, fundoscopy, pupils), III/IV/VI (eye movements + accommodation), V (sensory 3 divisions + motor + corneal reflex + jaw jerk), VII (facial movements + taste + corneal reflex), VIII (whisper test + Rinne + Weber), IX/X (palate, gag, swallow), XI (shrug, head turn), XII (tongue inspection + protrusion).
- **Peripheral neuro (UL or LL):** inspection, tone, power (MRC grades), reflexes, coordination, sensation (light touch + pinprick + proprioception + vibration), gait.
- **MSK (use look-feel-move-special tests-function):** common ones are knee, shoulder, hip, hand, spine.
- **Mental state exam:** appearance/behaviour, speech, mood (subjective) + affect (objective), thought form, thought content (including risk), perception (hallucinations), cognition (MMSE / MoCA if asked), insight, judgement.
- **Paediatric:** developmental age (gross motor, fine motor, language, social — name them out loud), growth chart plotting, hydration status, fontanelles in <12m.

AU/NZ-specific examination points:

- **Always offer urinalysis** at the end of a cardiovascular, abdominal, or diabetic exam.
- **Always offer to check observations** (HR, BP, RR, SpO2, temperature) at the end of any system exam if you didn't take them at the start.
- **Always offer to check the BGL** if diabetes is in the differential.
- **Always offer a fall risk assessment** in geriatric or balance/coordination stations.

Common exam failure modes:

- Not commenting out loud on inspection findings. The examiner needs to hear you.
- Standing on the wrong side. Always examine from the patient's right (cardio, resp, abdo). Neuro and MSK are bilateral.
- Skipping the "offer to complete" line. Free marks.
- Not comparing sides on neuro and MSK.
- Forgetting chaperone for breast/genital/rectal.

Station type 3: Explanation / Counselling

Time budget: 8 minutes. 1 minute opening + ICE, 4-5 minutes explanation, 2-3 minutes check + plan + safety net.

The structure that picks up the most marks:

1. **Opening with ICE.** "Before I explain, can I check what you already know about [condition / procedure / medication]?" + "Is there anything specific you're worried about?" + "What were you hoping to get out of today?"
2. **Signpost what you're going to cover.** "I'd like to cover four things: what the condition is, why it happens, what the treatment options are, and what we'd recommend."
3. **Plain-English explanation.** Avoid jargon. If you must use a medical term, define it the first time. "We call it heart failure, but it doesn't mean your heart has stopped — it means it's not pumping as efficiently as it should."

4. **Chunk and check.** After every 2-3 sentences, pause. "Does that make sense so far?" or "Just to check, can you tell me back what we've covered?"
5. **Use analogies for mechanism.** Asthma = narrow pipes + inflamed lining. Diabetes = key (insulin) not opening the door (cells) properly. Heart failure = a tired pump.
6. **Discuss risks and benefits in plain numbers.** "Out of 100 people who take this medication, about 70 will see [benefit], 5 might get [common side effect], and 1 in 1,000 might get [serious side effect]." Not percentages, not relative risks. Plain frequencies.
7. **Offer written information and a follow-up plan.** "I'll print out an information sheet from healthdirect for you to take home, and I'd like to see you again in 4 weeks to check how you're going."
8. **Explicit safety net.** Always.

AU-specific frameworks:

- **Health Direct** and **Better Health Channel** are the AU patient-facing references. Name them. "I'll give you the link to Health Direct, which is a government-run patient information site."
- **Medicare-funded items.** Where relevant, mention: "Your GP can do a Mental Health Treatment Plan which gives you up to 10 sessions with a psychologist subsidised by Medicare."
- **NDIS** for disability counselling.
- **Cultural safety:** offer interpreter explicitly even if patient appears to speak English. "Would you prefer to have this discussion with an interpreter present?"
- **Pharmaceutical Benefits Scheme:** know whether the medication you're discussing is PBS-listed and what the patient co-payment is. "This medication is on the PBS, so it costs about $30 per script."

Common counselling station scenarios (practice these):

- New diagnosis of T2DM, asthma, HTN, depression.
- Starting a new medication: metformin, statin, SSRI, oral contraceptive, warfarin/DOAC, methotrexate.
- Procedure consent: endoscopy, colonoscopy, joint injection, coronary angiogram.
- Breaking bad news: new cancer diagnosis, miscarriage.
- Lifestyle: smoking cessation, alcohol reduction.
- Pre-pregnancy counselling.
- Vaccination discussion (including hesitancy).

Breaking bad news framework: SPIKES

- **S**etting — quiet room, sitting, no interruptions, support person if patient wishes.
- **P**erception — ICE block, "what have you been told so far".
- **I**nvitation — "would you like me to go through the results in detail today, or would you prefer to wait until your partner is here?"
- **K**nowledge — warning shot first ("I'm afraid the news isn't what we'd hoped"), then plain language, then pause.
- **E**motions — sit in the silence. Don't fill it with information. "I can see this is very hard to hear."
- **S**trategy and summary — what happens next, written information, follow-up.

Common counselling failure modes:

- Skipping ICE. Worst single mistake.
- Using jargon without defining it.

- Talking for 6 minutes without checking patient understanding.
- Quoting relative risks ("reduces your risk by 50%") instead of absolute frequencies.
- Forgetting to offer written information.
- Forgetting interpreter offer for CALD patients.

Station type 4: Procedural

Time budget: 8 minutes. Procedural stations are usually one or more of: explain the procedure, perform on a mannequin or simulated patient, interpret findings.

Universal procedural sequence:

1. **Consent.** "I'd like to explain what we're going to do, then take you through the steps."
2. **Indication and contraindications.** State both. "The indication is [reason]. The main contraindications are [list]. I'd want to check before we proceed."
3. **Equipment list, named out loud.** "I'd gather: sterile drapes, antiseptic skin prep (chlorhexidine 2%), local anaesthetic (1% lidocaine plain), an 18G cannula, saline flush, dressings, and a sharps bin."
4. **Patient positioning and exposure.**
5. **Asepsis: hand hygiene, gloves, drape, skin prep, sterile field.**
6. **The procedure itself, narrated step by step.**
7. **Post-procedure: dressing, observations, documentation, sharps disposal.**
8. **Complications to look for and safety net.**

Common AU final-year procedural stations to know:

- **IV cannulation:** select site (non-dominant, distal first), tourniquet, palpate, prep, insert at 15-30 degrees, advance after flash, retract stylet 5mm, advance catheter, flush, secure, dispose of stylet.
- **Venepuncture:** similar but using a vacutainer system, fill tubes in correct order (yellow, blue, red, green, lavender, grey).
- **NG tube insertion:** measure NEX (nose-earlobe-xiphisternum), lubricate, position upright, swallow water as you advance, confirm position by aspirate + pH (target <5.5), then chest X-ray confirmation if unsure.
- **Urinary catheter:** asepsis, anaesthetic gel, advance, balloon inflate, secure.
- **Lumbar puncture:** L3/L4 or L4/L5 below cord termination, lateral decubitus, knees to chest, aseptic technique, manometry.
- **Local anaesthetic infiltration:** check allergies, calculate max dose (lidocaine plain max 3 mg/kg, with adrenaline 7 mg/kg, but typically calculate from BNF / eTG).
- **Wound suturing:** asepsis, anaesthetic, irrigation, debridement, closure with appropriate suture (4-0 nylon for face, 3-0 for limbs, 3-0 absorbable for deep layers).
- **ECG performance and interpretation:** 12-lead placement, then systematic interpretation (rate, rhythm, axis, intervals — PR, QRS, QT — then look for changes ST/T, P morphology, conduction blocks).
- **Spirometry / peak flow:** technique, expected values, interpretation.
- **Suturing on a pig's trotter or banana:** asepsis, knot tying.

AU-specific procedural points:

- **eTG-aligned drug names and doses.** Lidocaine, not lignocaine in new eTG (both still accepted but use lidocaine). Adrenaline, not epinephrine.

- **National Standards for sharps disposal** — yellow rigid container at point of use.
- **Hand hygiene moments** — the 5 moments (before patient contact, before procedure, after procedure/body fluid exposure, after patient contact, after patient surroundings).
- **WHO surgical safety checklist** for any procedural station that touches operative context.

Common procedural failure modes:

- Not stating contraindications.
- Skipping the asepsis sequence.
- Forgetting to dispose of sharps.
- Not mentioning post-procedure observations.
- Not naming the equipment list out loud.

Station type 5: Ethics / Communication / Data interpretation

Time budget: 8 minutes. Often a mixed station: a difficult conversation, a colleague-related issue, or a results interpretation that you then explain to a patient.

Common ethics scenarios:

- **Patient confidentiality:** family member calling for results. Default = cannot discuss without patient consent.
- **Capacity assessment:** the patient refusing recommended treatment. Use the 4-part capacity test: understand, retain, weigh, communicate. Capacity is decision-specific.
- **Adolescent confidentiality:** Gillick competence / Mature Minor doctrine. Patient under 16 with capacity for the specific decision = competent.
- **Mandatory reporting:** child at risk (every state has different thresholds, default is "if reasonable suspicion, report"); notifiable diseases; impaired colleague (mandatory under AHPRA in some states).
- **Colleague concerns:** intoxicated, impaired, unsafe. Default escalation: registrar → consultant → DMS → AHPRA.
- **Disclosure of error / open disclosure:** acknowledge, apologise, explain, prevent. The AU Open Disclosure Framework expects all 4.
- **Refusing treatment / advanced care directives:** competent patient can refuse anything. Document. Discuss alternatives. Safety-net.
- **Withdrawal of treatment:** end-of-life discussions. SPIKES + early palliative care referral.

Frameworks for ethics stations:

- **Four principles:** autonomy, beneficence, non-maleficence, justice. Name them when discussing your reasoning.
- **4 quadrants:** medical indications, patient preferences, quality of life, contextual features.
- **Capacity (4-part):** understand information, retain, weigh, communicate decision.

AU-specific ethics references:

- **AHPRA** for professional conduct concerns and mandatory reporting of impaired practitioners.
- **State-specific Mental Health Acts** for involuntary treatment criteria. Know your state's name for the relevant section (e.g. Section 19 NSW, Section 9 VIC, ITO QLD).

- **State child protection legislation** (Children and Young Persons Act NSW, Children, Youth and Families Act VIC, etc).
- **My Health Record** consent settings.
- **Voluntary Assisted Dying (VAD)** legal in all AU states by 2026 with different eligibility criteria. Default position for finals: refer to VAD coordinator, do not initiate the conversation as a student.

Data interpretation stations (common):

- **ECG:** systematic — rate, rhythm, axis, intervals, ST/T changes, conclusion.
- **CXR:** ABCDE — Airway (trachea), Breathing (lung fields, costophrenic angles), Cardiac (size, borders), Diaphragm + Devices, Everything else (bones, soft tissues, lines).
- **ABG:** pH, pCO2, pHCO3, then compensation, then anion gap (Na - Cl - HCO3, normal 8-12).
- **U&E + LFTs + FBC:** comment on each abnormal value with a sentence on differential.
- **Spirometry:** FEV1, FVC, ratio, then reversibility.
- **Urinalysis:** dipstick interpretation + microscopy if given.

Common ethics/communication failure modes:

- Promising confidentiality before establishing safety. "I want to discuss something private" — your first move is "I'll do my best to keep what you say private, but if I think you or someone else is at risk of serious harm, I may need to involve other people."
- Skipping capacity assessment when a patient refuses.
- Not naming the framework you're using.
- Failing to escalate when expected. "I'd discuss this with my registrar / consultant" is almost always the right answer for a student.
- Being judgemental in a sensitive scenario (substance use, abortion, terminal illness).

AU-specific items examiners are looking for

The single biggest difference between AU finals and US/UK preparation: AU schools mark for AU-specific systems knowledge. Mentioning these picks up excellence-tier marks.

Drug names and dosing: - Generic names per AU usage. Paracetamol not acetaminophen. Salbutamol not albuterol. Adrenaline not epinephrine. Frusemide acceptable; furosemide also OK. - PBS knowledge for cost when counselling. "This is on the PBS, so it'll be the standard co-payment of around $32 (or $7.70 with a concession card)." - eTG as your prescribing reference. "I would check eTG for the current first-line treatment, which is..." - ANZCA / RACP / RACGP / RANZCOG / RANZCP guidelines by specialty.

Health system items to drop in: - **Medicare item numbers** at least conceptually (don't memorise numbers, but know "a GP can bill a MHTP under item 2700-series" for mental health stations). - **Mental Health Treatment Plan** — 10 sessions/year of psychology subsidised by Medicare. - **GP Management Plan / Team Care Arrangement** for chronic disease. - **NDIS** for disability supports. - **My Aged Care** for ACAT assessments. - **Closing the Gap** PBS co-payment scheme for Aboriginal and Torres Strait Islander patients.

Indigenous health framework: - **Social and Emotional Wellbeing (SEWB)** model for Aboriginal patients (mental health framing). - **Te Whare Tapa Whā** (Whānau / Hinengaro / Tinana / Wairua) for Māori patients in NZ. - **AMS / ACCHS** (Aboriginal Medical Services) for community-controlled health referral. - Offer culturally appropriate support. Don't assume preference, ask. Don't skip the indigenous identifier question because it feels awkward.

Cultural and language: - **Interpreter offer for any CALD patient.** TIS National 131 450 (free for GPs, hospital interpreters via in-house services). - **Family / collateral consent** for collateral histories. - **Aboriginal Liaison Officer** referral where appropriate.

Public health items: - **National Immunisation Program (NIP)** schedule. Know the major childhood ones (birth Hep B, 6 weeks pentavalent etc). - **Cervical Screening Program** — 5-yearly HPV-based screen, ages 25-74 (women / people with cervix). - **Bowel Cancer Screening Program** — 2-yearly FOBT, ages 50-74. - **BreastScreen** — 2-yearly mammography, ages 50-74.

The day before the exam — checklist

The night before, do not learn new content. Do these instead:

1. **Run the universal opening 10 times out loud.** Until reflexive.
2. **Run the universal closing 10 times out loud.** Until reflexive.
3. **Recite all 5 examination routines out loud** (CVS, resp, abdo, neuro, MSK).
4. **Recite SOCRATES, ICE, SPIKES, HEADSS, CAGE, SBAR.**
5. **Recite the 5 moments of hand hygiene.**
6. **Recite the 4-part capacity test.**
7. **Pack: stethoscope, pen torch, watch with second hand, name tag, ID, photo of your kid for the moment you need a deep breath.**
8. **Sleep.** Cramming new content costs more in tiredness than it adds in knowledge.

Morning of: arrive 30 minutes early. Use the bathroom. Get a glass of water at the candidate desk. Do not look at notes in the last 15 minutes. Talk to no one about content.

Between stations: 1 minute reading time. Do this in order: (1) what is the task, exactly; (2) what station type is this (Hx / Ex / Counselling / Procedural / Ethics); (3) what are the 3 most likely differentials; (4) what are the red flags I must screen for; (5) start with the universal opening.

If a station goes badly, you have 1 minute between stations to forget it. Stations are marked independently. One bad station does not contaminate the next one. Reset. Walk in. Universal opening.

Where to practice between now and exams

- **With a study partner**, timed, using a marking grid (your school's grid if available; otherwise a standard checklist). 30 stations across the clinical year is the target.
- **Video record yourself** on your phone doing 5 stations. Watch them back with the marking grid. Painful but the single highest-yield exercise.
- **Ask a junior doctor or registrar** to examine you. They've sat the exam recently.
- **Free patient story databases**: Geeky Medics (UK but mostly transferable), the AMC clinical handbook (AU-specific case structure).
- **AU OSCE simulator with marking-grid feedback:** primexstudy.com.au/medical-students has an AI-examiner OSCE simulator built for AU finals with 577 study notes and 11,485 flashcards, AU-context throughout. Free 7-day trial. Built by an anaesthetics registrar in rural NSW after watching too many capable students lose marks on the mechanical items in this checklist.

One-page reference (the night before)

Universal opening: wash hands, introduce, identify, establish context, consent, position.

History: SOCRATES + ICE + PMHx/FHx/SHx/DHx/Allergies + red-flag screen + summarise.

Exam: wash hands, introduce, consent, expose, general inspection, close inspection, palpation, percussion, auscultation, special tests, offer to complete, summarise.

Counselling: ICE → signpost → plain English → chunk + check → numbers not percentages → written info → follow-up plan → safety net.

Procedure: consent, indications + contraindications, equipment list, asepsis, narrate, dispose, complications, safety net.

Ethics: name the framework (4 principles / capacity / 4 quadrants), be specific, escalate appropriately, name AU references (AHPRA, MHA, AU Open Disclosure).

Universal closing: summarise, working diagnosis, plan in plain English, **explicit safety net** (verbally named symptoms), invite questions, thank.

Five AU items examiners look for in every station: offer interpreter / ask about Aboriginal or Torres Strait Islander identity / use generic AU drug names / mention eTG or AU guidelines / explicit Medicare/PBS context where relevant.

This checklist was written by an anaesthetics registrar in rural NSW. It is free to share with any AU/NZ medical student. If you want a marking-grid OSCE simulator with AU-context stations and written feedback per station, that lives at primexstudy.com.au/medical-students (7-day free trial). Good luck with finals.