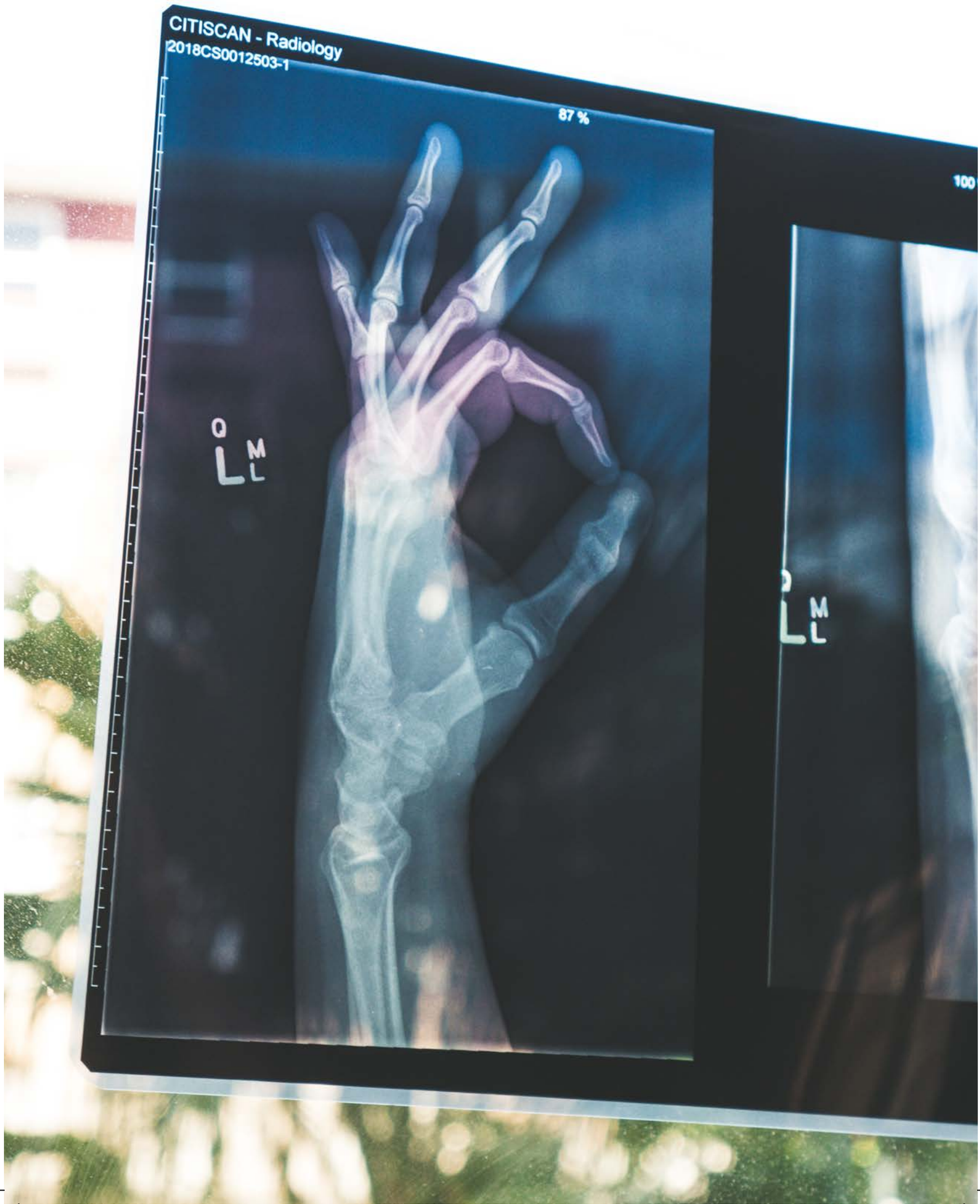
2021 | VOL 1

PLACEBO

HEALTHCARE INEQUITY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FOREWORD

Welcome to the first issue of Placebo for 2021: Inequity in Healthcare

As the next generation of doctors, COVID 19 is no doubt a conversation that is far from over for us. The development of the vaccine (choose your fighter) has provided a hesitant sense of comfort despite the current nationalistic approach to its distribution. In the face of the fact that no country is safe until all countries are safe, it's interesting to see universal healthcare be influenced by international politics. If anything, the vaccine's efficacy will play a large part in determining the projection of the pandemic in years to come. To know that we'll be on the front lines when these effects come to light is both a humbling and daunting thought. Whilst one could look at our success at hindering COVID, the collateral damage to our wellbeing go on under recognised. This issue looks to illuminate other disparities we endure closer to home, as well as those at a broader level.

Being in the first year of my medical school journey, I joined the Placebo team in hopes to actively take part and educate myself on perspectives different to my own. I hope that this issue allows you to do the same. Additionally, the support network I find myself invited into could not be more welcoming and I look forward to playing a part in how Placebo evolves in times to come.

As always, thank you to the contributors and Angeline Seow for single-handedly putting this semester's edition together, Placebo would not be possible without your efforts.

We would like to acknowledge the Kaurna people, who are the traditional custodians of the land Flinders University is built upon. We recognise their continuing connection with country and pay respects to Elders both present, past and emerging.

Anushka Ghorpade

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TURN AROUND YOU'LL COST TOO MUCH

An honest reflection of Australia's history exposes a past with more than a few blemishes. For the country 'with boundless plains to share', our track record really calls into question how welcoming we are as a country. From our original and continuing shameful mistreatment of indigenous populations, to the white Australia policy that was only officially ended in 1973, to more recent low points in our treatment of refugees, we need to seriously reflect on how Australia's humanitarian record. But despite this legacy of maltreatment, I was startled to learn about the crude and cruel migration policies as they relate to those with health conditions, particularly children.

Simply put, citizenship can be denied to permanent residents on the basis of 'health concern'. While there is certain some justification for this when considering certain communicable diseases, the relevant legislation has been used to deny citizenship on the grounds that someone's long-standing chronic conditions might make them a tax burden. While I can understand the financial rationale behind this policy, it nonetheless seems like a pointedly cruel system that treats individuals like liabilities rather than people.

NSW residents Varun and Priyanka Katyal were told that their application for citizenship had been cancelled because they just had a child who was born (in Australia) with cerebral palsy. This is especially egregious given that they had already been living and paying taxes in Australia for eight years, paying into the pot of money for social services that the government now hopes to restrict their access to just when they need it.

In 2008 there was an attempt to deport a German couple and their child with Down's syndrome. The government later granted a special exemption to the child and their family after acknowledging that their father was filling a regional doctor shortage in Victoria. I'm sure in the government's ideal game of bookkeeping they could deport the child but keep the parents, but it seems that is still considered distasteful.

Australia's current laws regarding immigration are manifestly unjust when it comes to how we treat individuals with medical conditions. Within the Disability Discrimination Act (1992), a special exception was made to say that the government is allowed to discriminate against people with disabilities when it comes to migration decisions. In 2019, the UN released a report critiquing various aspects of our current migration policies, raising concerns with the level of state-sanctioned discrimination. It is well known that most of the average person's health care costs will be from the last few years of their life. We have accepted that certain demographics will cost more. Are we unable to tolerate that of the hundreds of thousands that migrate to Australia every year, that some will have children during the citizenship application process that require additional support?

I understand that Australia has limited resources to help people, and the government needs to balance humanitarian needs with practical constraints, but this really seems like an unnecessary and cruel policy that is punishing people for their health conditions. In a country that, as a 2019 IMF report found, subsidies fossil fuels to the tune of billions of dollars a year, surely we can find the resources to maintain a basic standard of humanity.

Ramy Robin

RURAL EDUCATION INEQUITY AND HEALTH

The quality of education determines the quality of one's health in multiple ways, as it influences socioeconomic status, employment, health literacy, health decision-making capacity and perceived self-efficacy [1]. Thus, whilst being a social determinant itself, education actively influences other social determinants entailing somewhat of a compound effect.

This issue of Placebo Magazine contains many articles describing the presence, or results of health inequities across Australia, yet it is important to recognise that some health inequities do indeed sprout from areas beyond healthcare. Education is one of these areas. So, to achieve true equity in health we must witness the forest from the trees and begin to apply focus to the peripheries. The incidence or prevalence of disease and gaps in lifespan are focal points of discussion, but they're just meant to report data. They tell us what, not why. We cannot say that by improving healthcare access in rural areas we would mend this obvious hole in the data. Rather, we would see a positive yet incomplete trend towards improved health outcomes. This is not to say that improving access to primary and tertiary care services would not improve health outcomes, as Australians in remote or very remote areas are 6 times as likely to report GP accessibility as a barrier to seeing one [2], in turn leading to a 2.5-fold increase in potentially preventable hospitalisation rates. Further, whilst 6.0% of Australians in Major Cities report 'not having a specialist nearby' as a barrier to accessing specialist healthcare services, 58% of people in remote or very remote areas report this as a problem; thus, for remote or very remote Australians, the inaccessibility of specialist healthcare is of a different order of magnitude.

Using the Organisation for Economic Co-operation and Development's (OECD) Programme for International Student Assessment, Sullivan, McConney and Perry identified that Australia has a larger gap in urban to rural education than both New Zealand and Canada [3]. One paper presented at the 2014 ACER Research Conference used NAPLAN results to show that Year 3 students in major city areas of Victoria had a mean reading score that was 20 points higher than other areas, with a gap of 22 points representing around 7 months of learning [4]. Clearly, then, there is a gap in education outcomes between rural and non-rural areas in Australia and the reason is likely multifactorial in nature, including a lower average level of education achieved by rural students' parents, lower socio-economic status, smaller school sizes leading to less teacher specialisation with teachers generally teaching a broader range of classes, and so on. Another important consideration is individual student tutoring; this is impeded by

the decreased density of people offering individual tutoring in rural areas along with the average lower socio-economic status of families.

Unfortunately, whilst we may raise awareness of this problem, there is no clear obvious solution. The multifactorial nature of this problem demands the employment of multiple initiatives to influence change, some of which may not be reasonable. For example, to improve teacher specialisation in rural areas we may establish a significantly unbalanced student-to-teacher ratio. Further, this would entail significant economic strain, which in turn would decrease funding to other areas. Thus, the point of this article is not to solve the rural education inequity, but rather is to broaden our understanding of what informs the health inequity faced by people in rural areas and to suggest that the roots of this issue are indeed buried beyond the fact that major hospitals are located in major cities.

Brandon Wadforth

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HUMAN RESOURCES FOR HEALTH

how immigration widens global health inequities

In an era where knowledge, communication and technology are more developed than ever before, how is it that health standards vary so drastically between high-income countries (HICs) and low-and-middle-income countries (LMICs)? In the post-colonial era, globalisation, urbanisation, climate change and conflict both exacerbate existing inequities and create new ones, leading to significant differences in health standards, resources/infrastructure and access to care across the globe. Furthermore, the epidemiological and demographic transitions are placing new and emerging strains on populations and health systems in LMICs and HICs alike.

This shift in healthcare needs, in conjunction with increasingly demanding health technologies, require significant human resources for health (i.e. doctors, nurses, midwives). However, the World Health Organisation (WHO) estimates that we currently face a global shortage of almost 4.3 million healthcare workers (HCWs). Sadly, this shortage is most pervasive in areas with both the highest burden of disease and weakest health systems. For example, 1.5 of the 4.3 million HCWs are needed in Sub-Saharan Africa (SSA) alone – whilst home to only 10% of the world population, SSA suffers 24% of the global burden of disease with only 3% of the global health workforce.

In 2006, the WHO estimated the minimum number of trained clinicians sufficient in delivering basic services to be 2.5 per 1000 people. As a result, 57 countries across the globe were identified as having a "critical shortage" of HCWs. While HICs like the United

States have approximately 2.7 HCWs per 1000 people, SSA averages as low as 0.1 (suggesting even lower ratios in rural/remote areas). Despite this discrepancy, the rising burden of healthcare needs in HICs still requires an increasingly larger and better-trained workforce. Instead of filling domestic shortages internally, many high income government and employment agencies actively recruit skilled workers from LMICs - what is known as "pull-up migration". Over the last 10 years, there has been a 60% increase in the number of migrant HCWs working in OECD countries.

For HICs, this is an incredibly clever financial model; they welcome a ready-made workforce that requires minimal (if any) training, and hence retain the money and resources that would have otherwise been spent on education. Employing migrant workers also makes for more diverse teams, enhancing the efficacy, adaptability, cultural sensitivity and linguistic variety of their workers in an increasingly globalised world.

However, while pull-up migration benefits HICs, it strains resources in LMICs and drastically increases existing inequities. As human resources are lost, insufficient clinicians and reduced worker capacity cause further weakening of already fragile health systems. This destabilisation manifests in inconsistent, under-resourced and sub-optimal quality service delivery, leading to detrimental short- and long-term health outcomes. The shortage of HCWs has particularly devastating consequences for SSA, where many countries already suffer the highest burden of resource-intensive diseases (such as HIV/AIDS, malaria and TB). International skilled migration is particularly devastating for remote communities, given that clinicians migrating from attractive city-based positions drain the already limited rural workforce.

A logical argument emerges - should skilled HCWs be allowed to migrate from countries already struggling to fill local needs? Despite all evidence surrounding the harms of health workforce migration from low- to high-income settings, freedom of movement (and hence of migration) remains a fundamental human right. The international movement of HCWs in not a new phenomenon, and many "push" and "pull" factors, such as differences in working/living conditions, training and promotion opportunities, and personal security, will continue to motivate individuals to leave their home country. Hence, both ethically and practically, it is near or perhaps even impossible to prevent migration.

As a result, actions that mitigate the harmful effects of pull-up migration need to address the structural causes in both LMICs and HICs. Though not all push and pull factors can be overcome, solutions should continue to target those that are created or amplified by organisations and/or governments across the globe. For example, given that understaffing remains the predominant cause of foreign recruitment, HICs need to increase the intake of local HCW students to meet existing and future domestic requirements.

But, what exactly is being done on a global scale, for such a global problem? At the 63rd World Health Assembly in 2010, all 193 United

Nations member states adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel. This code proposes various structures that render HCW recruitment more ethical, in the hope of minimising the short- and long-term consequences of pull-up migration whilst simultaneously strengthening health systems. Though this represents a monumental step forward, the code is non-binding; meaning that actions must be self-adopted by signatories, with no consequences for non-compliance. Amongst rapidly evolving political, cultural and economic climates, compliance of member states is easily reduced in the presence of conflicting priorities. Such frameworks need to be strengthened to reinforce agreements and hold countries accountable for their actions.

To summarise, the strength of healthcare systems, accessibility of healthcare services and resultant health of populations are detrimentally affected by pull-up migration. Despite momentous evidence demonstrating the harmful consequences of high migration rates from fragile or under-resourced settings (particularly when actively recruited from HICs), freedom of migration remains a fundamental human right. As such, measures should continue to address the structural circumstances that drive this workforce shortage from LMIC, HIC and global perspectives, to ensure equitable access to care and optimal health standards in all countries.

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CLOSING THE GAP IN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH AND SOCIAL INEQUITY

the challenge for us all

On December 20th 2007, the Council of Australian Governments (COAG) under the then Rudd Government committed to "Closing the Gap" across a range of health and social measures, between Aboriginal and Torres Strait Islander Peoples and Non-Indigenous Australians within a generation, and for State, Territory and Federal Governments to be held accountable for achieving these targets. Initially six CTG targets were set in consultation with (largely) Indigenous and non-Indigenous health bodies and experts via the National Indigenous Health Equity Council and adopted by COAG through the National Indigenous Health Reform Agreement in 2008.

These six targets included steps toward reducing inequalities in: overall life expectancy, childhood mortality, early childhood education, reading/writing and numeracy, Year 12 attainment and employment outcomes.

In 2018 (the most recent data available from CTG Reporting), and after over a decade of this initiative, improvements in early childhood education enrolments, child mortality, and Year 12 completion rates can be demonstrated. However, some improvements are modest with child mortality (141/100,000) improving only 7% across the decade and sitting at twice the rate for non-Indigenous children

(67/100,000). With all other indicators, no significant improvement has been demonstrated.

Many of the challenges of the CTG policy and initiatives are now well known. Significantly, and as can be seen above, a reliance on "statistical gaps" to define policy targets and identify "success and failure" results in deficit approaches to "problems" rather than strengths-based approaches in defining success and opportunity. The heavy reliance on statistics is criticised as it defines success or failure as a derivative of governmental needs, not community needs, with government policy and funding refined according to such metrics.

Statistical approaches to understanding health inequity mask regional variability (urban, regional, remote) and negates the need for differentiated policy responses that are dependent on a community's starting position and actual needs. This runs the risk of blanket approaches to reducing health inequity, and position Indigenous peak health bodies, many of whom are largely funded by the government, in an invidious position of meeting funding guidelines that may be in opposition to local community needs. This results in inefficient use of scarce resources, and Indigenous peak bodies potentially held responsible for policy implementation failures.

Statistical approaches to health inequity position and measure Indigenous People's health against non-Indigenous people, with the corollary being "*Indigeneity*" labelled a risk factor for, and therefore cause of, ill-health.

One portion of the population is then seen to exhibit poorer health behaviours than another, which ignores centuries of past and continuing colonising policies and practices that have embedded race, racism, and governmental paternalism at the core of social and health policies. Policies such as the NT "Emergency Intervention", that generate and perpetuate the very health inequity we see today, and which do little to eliminate it.

After a decade of policy failure, over two centuries of paternalism, systemic social, policy and institutional exclusion, government has finally realised that central to "closing gaps" and eliminating health inequity is Aboriginal and Torres Strait Islander Peoples central and leading position at the tables of power that not just form policy, but that lead, direct and implement health and social policy at the local level.

The appointment of Australia's first Aboriginal Federal Cabinet member and Minister for Indigenous Australians, Ken Wyatt has been broadly welcomed as a rightful step toward shared decision making. The core of which is the newly established "Joint Council on Closing the Gap" working with the "Coalition of Peaks" of Indigenous health to establish Indigenous governance at the core of policy, processes, and implementation.

A core element is the "National Agreement on Closing the Gap" (2020), which includes 11 additional CTG targets. It seeks to position Indigenous communities, peak bodies, experts and people within a strengths-based framework that drives genuine partnerships between Indigenous Peoples and

government, to ensure that Indigenous Peoples and communities are central to leadership, development and implementation of the revamped CTG Strategy.

The core focus of this agreement include;

- ***Shared decision making (finally!!)***
- ***Building the Community controlled sector***
- ***Reforming mainstream institutions***
- ***Indigenous led data***
- ***and socio-economic outcomes***

The refreshed CTG strategy is not finalised until July 2021, but if the spirit of Aboriginal and Torres Strait Islander-led, and shared decision making at both the national and local level is realised, significant progress may finally be made in reducing the range of health and social inequalities.

This necessarily involves removing the firm hand of paternalism from Indigenous led programs and oversight of them. It involves changing the way we work, individually and institutionally to realise Indigenous empowerment. It will involve greater recognition and development of Indigenous resilience and capacity. And it will involve a greater trust by all to generate actual, meaningful, and sustainable change. In your capacities as medical students and future professionals, in the spirit of new and hopeful partnerships you are invited, and indeed required to play your part in ensuring that Aboriginal and Torres Strait Islander Peoples can enjoy the same opportunities in life as every other Australian. We are excited to work with you through your medical training to help realise our communities rights and aspirations.

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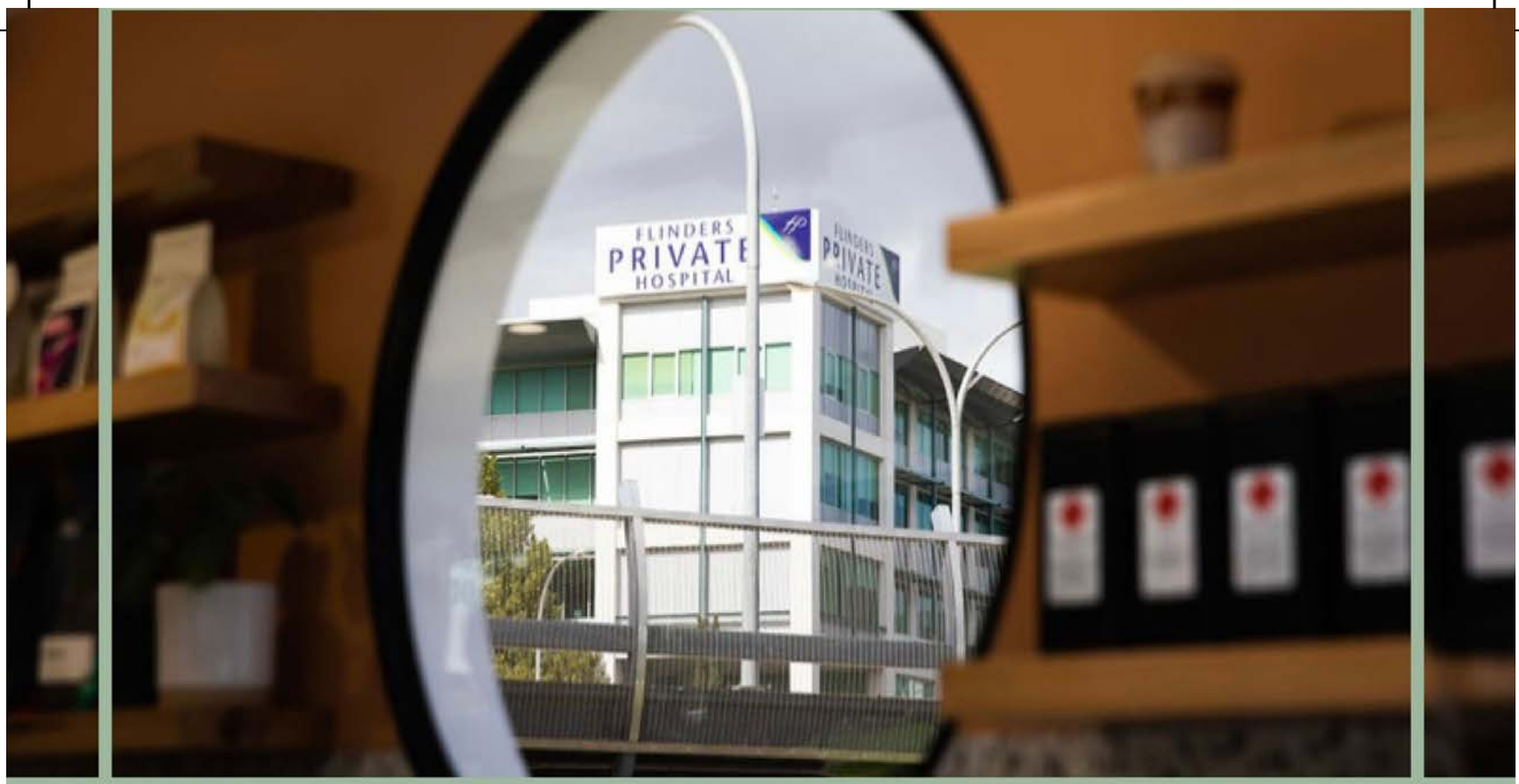

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THE POWER OF MEDICAL STUDENTS IN ADDRESSING RURAL HEALTH INEQUITIES

"Why is there always at least a 2-week wait to book in with you Doctors? It's so frustrating"

I hear this comment every day from the patients I see in my placement-assigned rural GP clinic. Often, it's tongue-in-cheek, but I can't help but detect undertones of frustration in their voices.

"Your doctor's so popular, everyone's clambering to see them!"

This is my go-to response to ameliorate the tension. It usually works and we all laugh it off.

However, interactions like this contribute to my growing awareness of the health inequities I see out here in my rural town.

They're right.

Why do rural patients wait 2-3 weeks for medical appointments, when their metropolitan counterparts can often get a same day? Even more so, how can Australia currently have "Too many doctors" (Former SA Health CMO Professor Brendan Murphy) - but still not meet patient needs? [1]

These pressing questions are simply answered. Call it idealistic, but health professional distribution across Australia needs fixing.

The most current recent AIHW medical workforce survey shows that the doctor-patient ratios in metropolitan areas are 4.1:1000 compared to 2.5:1000 rurally [2]. Combine that with the lower health quality (i.e., greater patient need) in rural areas, and the gap in health inequities expands. The perpetuation is painfully obvious. Fewer doctors means: Less patient access → worse health outcomes → greater health needs → less patient access, and the cycle continues.

So where do we, as medical students, come in?

I think there are two areas where we can help with the rural health gap phenomenon; Participation and advocation.

Participation and experiences

Explore rural health avenues! Get involved in the programs available to us. The John Flynn Placement Program and Flinders-own PRCC Parallel Rural Community Curriculum are fantastic ways to start. Who knows, maybe you'll find your passion. If not, the worst that can happen is you end up with more experience anyway. Talk to your course coordinator, is there anything else available? The more you get involved, the more you may inspire others to get involved. The only way to find out if rural medicine is a good fit for you is to participate and expose yourself to it.

Advocation

Okay, you have gained some rural health experience. What did you think of it? Did you like it? Why are you telling me? Go tell the world! Find every avenue you can.

Make a podcast. Write an article in placebo. Go to your old high school and talk to them. Inspire people. Raise awareness. Sometimes, people don't know what's out there until someone makes it tangible by discussing it.

Alright, enough telling you what to do – what have I done to address rural health inequities?

Participation and experiences

With no rural experience whatsoever - I grew up in Adelaide's CBD - I recognised the need to learn the rural side of medicine before I could appropriately advocate for it. Due to this, I've been on a hyper-focused mission to experience rural medicine as much as possible. I joined the John Flynn Placement Program – spending several weeks with the Royal Flying Doctors in rural and extremely remote locations. I also applied to enter the Parallel Rural Community Curriculum cohort. Due to this, I'm spending my 3rd year of medicine in a rural GP clinic and various rural hospitals. I've learned an incredible amount. I speak to patients in my own office and then hand them over to doctors (aka parallel consulting). There has also been an incredible amount of hands-on learning – dozens of cannulations weekly, countless inspections, palpations, percussions, and auscultations. Most of all, there has been that ever-growing health disparity awareness. Alongside that, there has also been a burning passion in my core, begging a call to action in reducing rural health inequities.

Advocation

So, what kind of advocation have I done?

I'm quite vocal when it comes to advocating for rural health. Due to this, I have been lucky enough to receive several opportunities to provide me a forum to amplify my voice. These have included newspaper, radio, and podcast appearances. I am also a part of a rural health research project, where I'll likely soon be presenting my findings in various symposiums, seminars and conferences. I have also started two podcasts, one about discussing exam study tips for med school and another all about rural health. In the next few months, I'm also aiming to visit some high schools to discuss rural health avenues.

With all these actions, I genuinely hope to inspire our next generation to at least consider a career in rural health. Change is slow, but it's got to start somewhere. How great would it be if we were the catalyst that started the movement?

Harrison James

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HEALTHCARE INEQUITY: MEDICAL EXPERIMENTATION ON VULNERABLE INMATES AT HOLMESBURG PRISON

Introduction

In the November 2020 issue of Placebo that was themed 'Pandemic', concerns were expressed regarding the equitable distribution of any potential approved COVID-19 vaccines. [1] Since that issue of Placebo, we have been fortunate to have had not one but two COVID-19 vaccines that have been provisionally approved for use in Australia by the Therapeutic Goods Administration (TGA). The Pfizer-BioNTech mRNA vaccine (tozinameran, the proposed international non-proprietary name; Comirnaty®, the trade name) and the AstraZeneca viral vector vaccine (codenamed AZD1222; sold under the trade names Covishield® and Vaxzevria®) were provisionally approved on 25 January 2021 and 15 February 2021, respectively. [2]

Given the theme of healthcare inequity in this issue of Placebo, there would likely be no dearth of articles from fellow medical students who wish to talk about inequity pertaining to COVID-19. As such, I have decided to focus on something apart from COVID-19 in this article. Healthcare inequity has manifested and continues to manifest in a myriad of ways. In this article, as the title suggests, I shall keep my focus on the historic medical experimentation on vulnerable inmates at the now-defunct Holmesburg Prison.

Before homing in on the specific example of healthcare inequity in this article, it behoves us to discuss the issue of healthcare inequity broadly. What exactly is meant by 'healthcare' and 'inequity'? Fortunately, Google's English Dictionary (which is in turn powered by *Oxford Languages*) saves the day. According to Google Dictionary, the words 'healthcare' and 'inequity' may be respectively defined as 'the organized provision of medical care to individuals or a community' and 'lack of fairness or justice'. Does this ring a bell (hint: the 'Ethics' component of HPS)?

Beauchamp and Childress

Ideally, any discussion on healthcare inequity should be done with participants being aware of Beauchamp and Childress' work. Thomas Beauchamp and James Childress are American philosophers and are best known for their work on medical ethics. Their seminal work, *Principles of Biomedical Ethics*, which they co-authored, was first published in 1979 and is currently in its fifth edition. Shortly after the publication of the book's first edition, it became a must-read for medical students, academics, and researchers. [3] It was in this significant work that the four principles of biomedical ethics were established. They are, in no particular order of importance: respect for autonomy, beneficence, non-maleficence,

and justice. The lack of this last of the four principles of biomedical ethics is precisely how inequity is defined.

One might ask: what prompted the writing of *Principles of Biomedical Ethics*? A single word: 'Tuskegee' gives us a clue. *Principles of Biomedical Ethics* had been written in the wake of some highly unethical biomedical experiments, the most well-known of which would be the Tuskegee Syphilis Study (Tuskegee is a city within Macon County in Alabama). In this study, many black men and their immediate family members were deliberately infected with treatable syphilis. Some experiment participants even died from treatable syphilis. [3] Unfortunately, what happened at Tuskegee was not the only instance of unethical medical experimentation. One only needs to surf page and page on Wikipedia to realize that there have been far too many instances of such unethical experimentation.

A brief look at the Holmesburg Prison experiments

Recently, I finished reading Allen M. Hornblum's *Acres of Skin: Human Experiments at Holmesburg Prison.* [4] As I trudged through the cycles of recto and verso, egregious examples of healthcare inequity stared right back at me. These were stories of how vulnerable inmates concealed within the walls of Philadelphia's Holmesburg Prison were exploited for a gamut of non-therapeutic medical experiments that were ultimately directed by the late esteemed dermatologist Albert Kligman. [5] In fact, the opening words of the title of Hornblum's book is a reference to Kligman's reaction upon seeing hundreds of inmates when he visited Holmesburg Prison ("All I saw before me were acres of skin…It was like a farmer seeing a fertile field for the first time"). [4]

From the mid-50s to the mid-70s, Holmesburg Prison inmates were used as guinea pigs in a myriad of medical experiments in exchange for sums of money that a typical non-inmate would deem insufficient. For this to have occurred, doctors, Holmesburg Prison officials, the University of Pennsylvania, and other people connived to establish Holmesburg Prison as a medical testing ground.4 The practices at Holmesburg Prison stood in far contrast with what is required today by ethics boards.

A whole range of medical experiments was available to participation by the prisoners. Experiments involved eyedrops of unknown substances, being deliberately infected with pathogens, exposure to dioxin (the contaminant responsible for Agent Orange's toxicity), and even testing psychoactive drugs. [4] Generally, the greater the risk of material harm to the prisoner, the greater the financial incentive associated with that particular experiment. One recurring theme that I encountered as I read *Acres of Skin* was how the financial incentive was indeed the main driving force for prisoner participation in these experiments.

We might ask: "Why would the prisoners consent to these experiments? Did greed blind them?" In *Acres of Skin*, former prisoner Allan Lawson had this to say about the reasons inmates were attracted to the experiments:

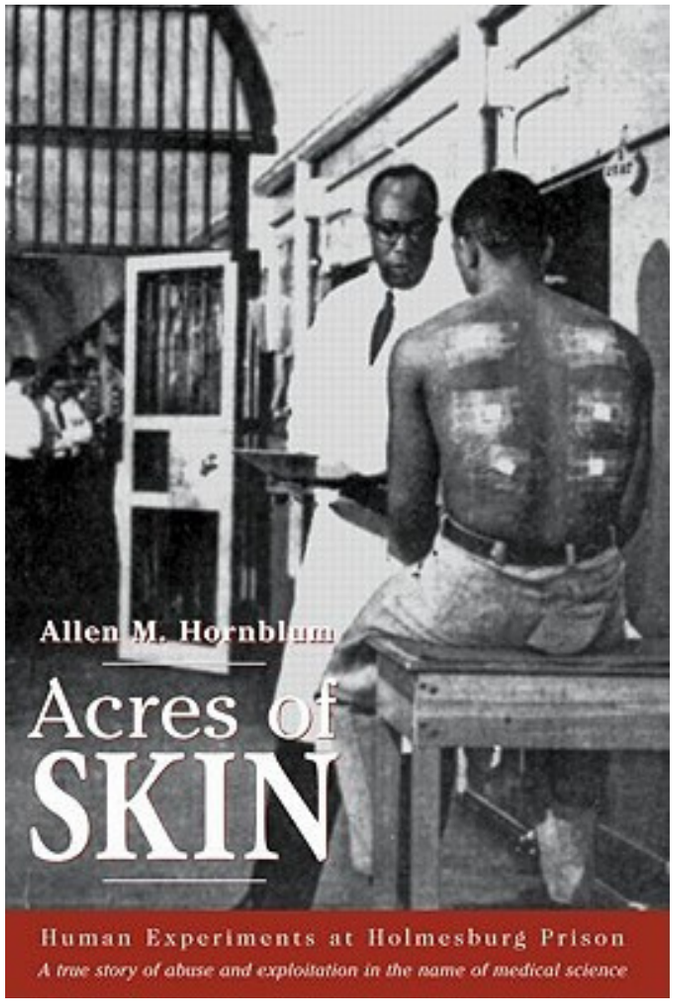
most prison inmates were untried defendants who were waiting an average of about nine months for a court date. Most of them came from circumstances such that they could not afford bail, and the few jobs available in prison paid no more than 50 cents per day. Moreover, the prison had failed to provide basic necessities. [4]

Prisoners would use any money they had for getting an attorney and providing for their families. Even within the prison itself, the following "litany of wants and needs" required money: "toothpaste, toothbrush, facecloths, soap, deodorant, letter-writing materials". It was subsequently concluded in a Philadelphia court hearing that the only meaningful way a prisoner could earn money was by participating in the medical testing program conducted in prison. [4]

In order to shield the researchers, experimenters, and all associated staff from any liability, inmates were made to sign predatory consent and waiver forms which were written at a level of English where it would have been unreasonable to expect the typical inmate, most of whom had a third-grade level of reading comprehension, to comprehend the meaning of the form. Verbal explanations of the procedures, if any were given, were often vague. Although the exculpatory language of such consent and waiver forms would eventually be declared unlawful by US government agencies, the legal subterfuge absolutely succeeded in forging an atmosphere of individual vulnerability, a dearth of lawsuits, and a more comfortable level of autonomy for the researchers. [4]

What a cruel mockery of the concept of consent indeed.

For the sake of brevity, I would encourage readers interested in the whole saga to read *Acres of Skin* for more details on the experiments that had been conducted at Holmesburg Prison.



Lessons for us

The case study of Holmesburg Prison is a grim reminder of how inequalities can manifest and lead to tangible adverse consequences for those on the unfortunate end of these experiments. Many of us are or will be involved with research directly or indirectly. Whether we are a participant, investigator, or research assistant, we ought to keep abreast of the specific ethical guidelines of the research in which we are involved and respect the rights of everyone involved in the research. We must not start treating participants with prejudice if they cease their participation in a research study prematurely of their own accord at any stage of the study. Participants should not feel obligated to provide any explanation, and we perhaps ought not to ask unless necessary for evaluation (e.g. re-evaluation of the expected risk-benefit ratio) and reporting purposes.

Though easier said than done, I urge us all to constantly remind ourselves of the historical basis of contemporary biomedical ethics guidelines. It is easy to feel that dealing with 'ethics' limits our productivity and stymies scientific progress. It can feel like it just exacerbates the red tape in research. Well, what I would say is that we need to be careful with such a line of reasoning.

After all, even if history does not repeat itself, it often rhymes.

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INEQUITY IN A LOOMING DISASTER

April 22nd marked Earth Day for 2021. A day dedicated to the acknowledgement of anthropogenic climate change and the continuing effect of human activity towards the deterioration of our planet's biosphere.

Climate change is a well-studied process resulting in record-breaking temperature extremes year after year. It has brought about the acidification of rising sea levels and an increased incidence of extreme weather events (World Meteorological Organization, 2019). It has long been recognised that the drivers of anthropogenic climate change are highly complex - the major culprit being agriculture, transport and energy production related CO2 emissions. The cause for such high level emissions mostly stem from irresponsible and unsustainable human consumption of non-renewable resources (IPCC, 2014).

This theme of overconsumption has led to the development of "Overshoot Day", a day in the year recognised as the point where the world consumes all ecological resources that the Earth is able to regenerate within a year (Earth Overshoot Day, 2021). Overshoot day fell on the 22nd of August in 2020.

The concept of Overshoot Day can be individualised to countries by calculating the number of days it would take to reach Overshoot Day if the world's population were to consume resources at the same rate as an individual country's population would. Unsurprisingly, more resource-privileged countries would reach Overshoot Day a lot faster than others. For example, should the world consume at levels similar to Qatar, the years allotted resources would be consumed within 40 days. The United States and Australia are not far behind at 73 and

81 days respectively. In contrast, less developed, largely agricultural and underprivileged countries such as Guinea and Chad push Overshoot Day to 348 and 350 days. This vast disparity is further evidenced in greenhouse gas emissions across the globe. Africa hosts 16% of the world population yet contributes 4% to total annual CO2 production whereas North America is home to just 5% of the world population represents 16% of total CO2 production. Ultimately, the richest 50th percentile of the world's population contribute to 86% of total CO2 emissions (Global inequalities in CO_2 emissions, 2018). Hence, climate change is fundamentally a process driven by developed nations who bear the greatest responsibility for exponentially increasing ecological and atmospheric instability.

Climate change represents an existential threat to human survival in the near future and its effects are far-reaching across all life on Earth. Increasing atmospheric CO2 has led to the saturation of oceanic carbon sinks and acidification of water, resulting in increasingly fragile marine ecosystems. Increased temperatures have been related to decreasing crop yields, worsening global food insecurity and diminishing GDPs of nations that rely on agriculture for economic productivity (IPCC, 2014). Climate change has further been closely associated with an increase in annual extreme weather events from wildfires to tropical cyclones, representing significant risks to infrastructure and population health (World Health Organisation, 2018). Soaring temperatures have been observed to directly result in increased mortality rates during summer months (Robine et al, 2008).

Simultaneously, increasing air pollution combined with increasing surface ozone levels contribute significantly to an increased incidence of mortality from respiratory diseases (World Health Organisation, 2018). Finally, it has been demonstrated that climate change is expected to cause a significant rise in infectious disease activity, particularly climate-sensitive protozoa, helminths, foodborne, soilborne and waterborne pathogens. As such, climate change represents an increased frequency of outbreaks (McIntyre et al, 2017) and the potential for escalating public health emergencies (CDC, 2021). Climate change does not recognise borders, and its effects on medical systems will be felt worldwide.

While climate change will affect every nation on the planet, the burden will be far from equal. Less developed nations and health systems are more likely to suffer the deleterious effects of climate change than those of more developed nations (Füssel, 2010). Climate change represents a large economic burden as increasing climate instability creates food shortages, reduces arable land, diminishes marine food supplies and damages infrastructure (World Health Organisation, 2018). Therefore, countries with lower economic output are less equipped to fund initiatives to surmount the present and future economic challenges represented by climate change. Additionally, populations with lower levels of education are at a significantly higher risk of infectious disease outbreaks related to climate change (Anwar et al, 2020). In particular, these populations would not have access to health infrastructure sufficient enough to handle surges in infectious disease

epidemics or extreme weather events related to climate change. Indeed, the great majority of the near half-million people directly killed by extreme weather events within the last two decades were in less developed countries (Eckstein, Künzel and Schäfer, 2021). Ultimately the synergistic effects of increased vulnerability to the effects of climate change alongside inadequate infrastructure to mount effective responses would ultimately leave developing nations with a significantly higher sensitivity to the adverse effects of climate change.

Climate change perpetuates inequity on a global scale - it was driven by developed nations, but its effects are most harshly felt by populations who minimally contribute to the ecological disasters to come. The onus to ameliorate the disparity lays with privileged nations yet, we see continued subsidisation of fossil fuel usage, a failure to incentivise renewable energy production, and continued climate inaction in Australia (The Australia Institute, 2021).

The ultimate question is now this: how much damage can we tolerate before the responsibility of addressing climate change is properly accepted by the nations that contribute to it, for the sake of those who will suffer most.

Kurt Bierlein

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SEEN BUT NOT HEARD

Most people would look at me and think, she looks healthy. No problems. She looks fine. And I am. I'm fine. I wake up in the morning and I feel fine. I study or work and I feel fine. I go to sleep at night feeling fine. I think I finally realised what fine meant. Or at least, fine in the way I use it. Because it's never good, never great. Always fine. I eventually realised that fine is the absence of something – that there was meant to be something better than fine, something that I never reached no matter how hard I tried.

It's like every day I'm thrown into a deep pool and told to tread water, to keep breathing in that pool where I could so easily drown. I want to leave the pool, but there's a fence surrounding it, with a gate that locks every morning. So, I tread water. I used to try new things – maybe I'd swim around or do that starfish thing where you lie on your back that I used to do in swimming lessons as a kid. Or I'd pull myself up to the edge of the pool and rest my head on my arms, my legs floating lifelessly in the water. None of it really made a difference. So, I just tread water. Then every night, the gate is unlocked and someone pulls me out of the pool, tired and sore, so everyone in my life can ask me why I'm so tired, and tell me that I should get more sleep, or spend less time on my phone, as if ignoring the water dripping from my hair. Maybe that's a bit harsh. It's more that they just can't see it, no matter how hard they try. That's not their fault. But I feel the heavy burden of the water weighing me down, hear the sound of it hitting the floor, a constant reminder of what tomorrow will bring.

While the fatigue and the headaches are hard, one of the hardest things is the fact that no one ever sees them. The perception that there is nothing wrong with me robs me of the simplest support I can receive – empathy. No one is empathetic because why would they be? Why would I require their empathy? Best not to waste it on me, they think, I should give it to the most deserving person in my life. And I'm not saying that I am the most deserving person – I know there are countless people out there who are more deserving than me.

But I don't even make it on most people's list, and even if I am, I only rank high enough for empathy when I say I need it. I understand that people can't read my mind, but I always feel dirty asking for it. Like I'm faking it, because it's not obvious enough. Maybe I should be crying on the ground in pain before I deign to ask. I never am though. It's never so bad that I cry, never so hard that I can't get out of bed, never so difficult that I have to go to the hospital. But it continues, nevertheless. That ache is always there, telling me that my body doesn't quite work the way it's meant to. It's so ingrained in my life that it is my base level – that feeling healthy is always being in pain or always being tired, even if it's only a little. I almost wish there was a little sign above my head, detailing the difficulties, so then at the very least people might understand that every day is harder than I wish it was. But at the same time, I don't want anyone to know, to see that I am different. Because I don't want to be different. Normal is what I strive for every day, a goal that is always just out of reach. It seems counterintuitive, doesn't it? That I want to receive empathy when I try so hard to appear healthy on the outside, hoping no one will notice the liar in the crowd. Maybe one day, if I try hard enough, I could convince my own body, the villain of this story, to believe that I'm healthy too. Wouldn't that be a grand feat?

I like my doctor, I do. I see him once every so often, which seems like not enough and too much all at once. Because I have nothing new to say; nothing ever changes. But at the same time, I wish I were the patient that saw him more often. Then at least I could imagine that something was happening, that things might change, that they might get better. They won't though. There is no cure for my condition, and there won't be in my lifetime. So, I take my medication and I survive. As a young person, I know I'll outlive my doctor, and be passed on to countless more, for them to all tell me the same thing. That I'll climb this mountain for the rest of my life, without ever reaching the top.

So, people are right. I do look fine. But looks don't tell the whole story.

MATERNITY CARE TRAUMA

As midwives and students, it is within our scope of practice to be non-judgemental and fair; providing our best care to each and every woman no matter her story. Too often women are disadvantaged in their maternity care as a result of health inequity- race, gender and sexual preference, education, disability and income. The majority of this inequity can be put down to Australia's maternity care system, and frankly how backwards it is set out! Pregnancy and birthing in Australia is based on an 'illness' model of healthcare, not the 'wellness' model in which it should be.

One of the primary examples of health inequity in midwifery is geographical location. As soon as a woman becomes pregnant in Australia it is custom that she is connected to her local hospital in which she will endure the systematic and too often impersonalised care of that hospital and their specific policies. Unless she has the means and the private healthcare insurance, she gets no choice in this. Her pregnancy will be more or less mapped out for her. If she has any pre-existing medical condition or disability; she will be classified as high risk and the majority of her freedom of choosing her own care and leading her own pregnancy will be taken out of her hands.

If the woman is low risk, with no pregnancy complications at all she may be selected to partake in MGP (midwifery group practice) which is an amazing service in which she gets allocated a group of 2-3 midwives who will continually care for her throughout her antenatal, intrapartum and postnatal experience. Only a small handful of women are selected for this model of maternity care each month, and to be accepted you must be very low risk and healthy. It is one of the best and most beneficial forms of maternity care, as through the continuity of care of having the same midwife each visit, getting continuous education and empowerment, and ultimately feeling safe and comfortable sets the woman up for better success for a positive birthing experience.

As we know, different people can say different things and give conflicting advice. This goes for health care professionals in maternity care too. Each hospital has their own unique set of policies, and doctors have varying modes and methods for how to manage different situations. This means that two women with exactly the same pregnancy complications could receive very different care and ultimately be faced with diverse outcomes depending on which hospital or health care service they are allocated to.

For women in rural settings this geographical inequity is substantial, as there are less options and more limited maternity care resources. Hundreds of rural birth centres have been closed, in fact there is a 41% decrease in rural maternity services since 1990. Alongside this is a 47% increase in babies that are born prematurely. This puts women living in rural areas in extreme distress and they are forced to leave their hometown to birth, or for many, to birth on the side of the

road or in the back of their car on the way to their closest hospital!

Birth trauma is a term which relates to the birthing experience of a woman; in which she associates negative feelings towards. She may describe her experience as disempowering, being violated, scary, being unsupported or having a lack of trust and power. This experience is way too common and as a result society is raised to believe that birth is scary and that these traumatic experiences are normal. I believe that as young and passionate midwives and students we have the opportunity to make a difference. We cannot stand by and mould into the current maternity care systems and accept the social norms of birth. Recently, a very inspiring and moving documentary has been made. 'Birth Time' is a film and movement made by 4 women who are passionate about changing the face of maternity care in Australia. It highlights the current system of care in Australia, with stories by many strong and beautiful women of their trauma and birth. It also explores the ways in which we could make a difference; through funding, politics and practice. FUNMSA are hosting a screening of this film on the 8th of July at 6.30pm at Event Cinemas Marion. Tickets and info on FUNMSA Facebook and Instagram, and also on the Birth Time website. "Our birth and birthing experiences deeply shape the way we navigate the world". Read more at https://www.birthtime.world

Lucy Mount
on behalf of the FUNMSA

THE CRIPPLING AMBULANCE SERVICE

Priority 2 Trauma case Blackwood – Uncovered
Priority 2 Collapse case Belair – Uncovered
Priority 2 Chest pain Seacliff – Uncovered
Priority 2 Collapse case Norwood – Uncovered
Priority 2 Collapse case St. Marys – Uncovered
Priority 2 Psych case Oaklands Park – Uncovered
Priority 2 Abdo pain Morphett Vale – Uncovered

At 8pm on 16 February 2021, there were 20 emergency cases in South Australia-wide waiting for an ambulance, but not a single ambulance crew was available. The above transcript was notified to the South team through the radio, hoping a crew would be willing and available to maybe pick-up one extra call to an already jam-packed 12-hour shift. This crew will probably end up working 14 hours – maybe even more – and most likely only had one 30-minute break. And this crew will definitely be scheduled back the next day, starting at 6am or 8am to start their day all over again. This is unfortunately the reality of the physical stress our South Australian paramedics face every single day while they are at work. They are constantly faced with making a moral decision to either

pick-up one more of these calls and potentially save another person's life OR finish their shift on time for once.

I am no philosophy professor, but this is one heck of a decision to make EVERY. SINGLE. DAY. It is no wonder paramedic burn out rates are through the roof. How can you expect a human-being to endure this? How can you ask a human-being to choose between potentially saving a person's life and their own physical wellbeing? This is the current state of the workers in the South Australian Ambulance Service, and they are breaking.

I am a paramedic graduate who finished my studies at Flinders University last year in 2020. As a student, it was sickening witnessing how patients were treated (or lack thereof) by the under-funded ambulance service. A paramedic once told me on placement that there is only one emergency ambulance covering the geographical East of Adelaide during the night. I live in the East and it scares me to think that if that one ambulance was busy and one of my family members was having an emergency, the paramedics may not reach my family fast enough. Living in an advanced city like Adelaide, this is something that we should not have to worry about. The only way we can make a change is to speak out and make some noise.

Kirk Verano

How you can help:

Visit the following website and sign the petition:
https://www.aeasa.com.au/

WHAT'S DONE AND STILL TO COME WITH FCCS IN 2021!

Despite only being partway through the first semester, it's already been an incredibly busy year for us at FCCS!

We kicked off 2021 with a Welcome Lunch for the incoming cohort. In conjunction with the Paediatric Society, we introduced ourselves surrounded by Vietnamese salads and cold rolls (is there any better way?). This was followed by the Med Societies Expo, where Tilly and Jack, our Social and Academic Directors respectively, told everyone what we're all about while giving the MD1s their first taste of basic and advanced airway devices (but not literally...).

In March, FCCS was invited to run a station at Med Camp. We typically surprise the students with an ambulance visit from the local Yankalilla SAAS Station, but much to our dismay, we heard sirens over breakfast signifying the crew had been called out to a job. Thankfully, our team still managed to share some insight and knowledge into the exciting world of critical care. Jack taught the students about haemorrhage control and different splints used in trauma settings. I ran a BLS refresher and demonstrated how to use various airway adjuncts such as OPAs, NPAs, and LMAs. The Pre-Vocational Obstetrics and Gynaecology Society (PVOGS) also joined us, running a surprise pregnancy and birthing scenario.

Since then, FCCS has also held our first 'Dress Your Best for a Cause' for 2021. Social Directors Tilly and Josh organised the 90s themed dress-up day where we raised money for Sandpiper Australia and collected signatures for the Ambulance Employees Association (AEA) petition. Considering the topic of this Issue is 'inequity' I thought this would be a perfect opportunity to expand on these areas.

Sandpiper is a charity that provides emergency training and bags of medical equipment to doctors in rural Australia. This is invaluable when considering the delay, between remote locations, specialist pre-hospital services, and definitive care. When emergencies occur in such settings, hours can pass before appropriate help arrives. This could mean trauma victims suffering for longer without effective pain relief or advanced medical care, purely because of where they live. Sandpiper is a not-for-profit organisation working to ensure those who live in rural areas have equal access to out-of-hospital emergency assistance. If anyone is interested in hearing more about Sandpiper, their team has kindly offered to come to Flinders to show us the equipment in their bags and have a chat about pre-hospital care – watch this space!

The purpose of the AEA petition is to fight for increased funding for SA Ambulance Service. Unfortunately, SAAS is critically underfunded at the moment, meaning callers are left waiting too long for ambulances that simply aren't available, and staff are suffering through unfair work hours and conditions.

One of the most devastating outcomes to date has been the deaths of several patients while waiting for help to arrive. One case which particularly stood out to me was an elderly man who had to perform CPR alone on his wife of over 50 years, until an ambulance arrived FORTY minutes after he called. The normal response time for an urgent case is meant to be 16 minutes. Devastatingly, by the time the crew arrived, the man's wife had passed away. I listened to a heartbreaking interview on 5AA Radio with one of the paramedics who went to that scene. She described the experience as "horrendous" and relayed how the man's first words to the paramedics when they arrived were "I guess you were too busy after all". I'm not sure how much clearer it can be that we are in desperate need of more ambulances and paramedics.

Everyone has a right to timely medical care, and everyone deserves safe working conditions. In support of our ambos, FCCS has been collecting signatures for the AEA around campus. If you haven't caught us, you can print off the petition to sign, as well as read up-to-date information, at ambosunited.com.au.
Thankfully, FCCS still has so much to look forward to in 2021! Keep an eye on our social media pages for more Dress Your Best events, as well as for our Cardiac, Toxicology, and Advanced Airway nights.
I would like to close by saying thank you to the other members of the Senior Committee; James, Alicia, Max and Patrick, for being all-round amazing. We all look forward to welcoming our Junior Committee soon!

Lucymarie Silvestri
2021 FCCS President

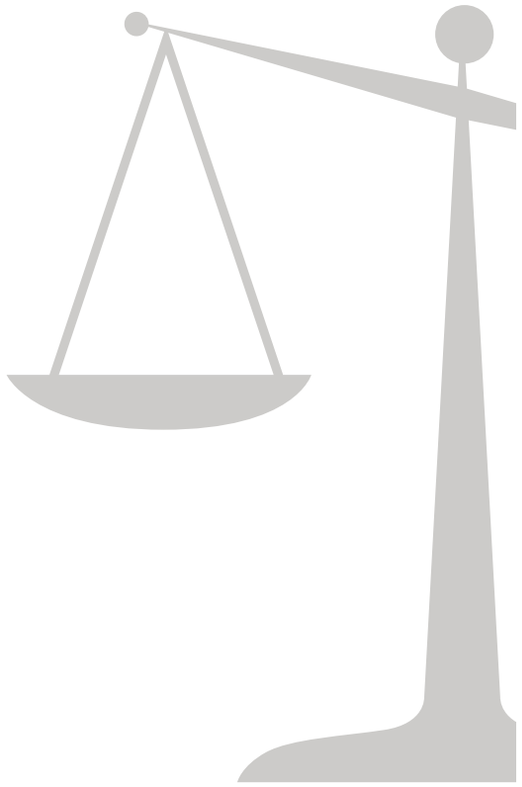
BALANCING THE SCALES

Flinders University Rural Health Society (FURHS) is a unique club that offers you an opportunity to network and socialise across the university with members from all health related degrees. One of FURHS's main goals is to expose university students to rural health and life. We host a range of social and formal events aimed to help you meet some amazing people and to provide countless, fantastic opportunities along with the lifestyle rural Australia has to offer.

FURHS has been busy this year as we have been able to actually hold events in person again - it's been great to see everyone! So far we have had our Welcome Night, MD1 Rural Doctors Workforce Agency (RDWA) lunch and our First 5-minutes of an Emergency. The Emergency night was a success, with an amazing turn out and engagement from students across many health degrees.

The plans do not stop there - we have more events coming up! We're excited to announce that we will be collaborating with Flinders University Museum of Art (FUMA) to hold our Arts in Health Night on the 13th May. Attendees will be led by artist Deb Twining to take a break from the books and bring forth their creative sides. Later in the year, we will also be holding a Tri-club quiz night with the rural health clubs of Adelaide University and University of South Australia. Additionally, the RDWA Flying Doctors ride along program has been greenlit for 2021 after being cancelled last year (more details to come). Lastly and most excitingly, for the first time ever, FURHS will be running a rural camp to the Riverland in August, again with more details to come. To stay updated for all upcoming events/activities, make sure to follow the FURHS page on Facebook.

In relation to the theme of this Placebo addition, inequality in healthcare is particularly relevant to rural health. Did you know, people living in rural/remote areas have poorer access to health care on average as compared to those who reside in metropolitan areas? This discrepancy is partly due to the geographical isolation of many rural communities from their nearest health clinic and has been shown to factor into an increased burden of disease/injury and a shorter life span (AIHW 2019). In 2016, the Australian Bureau of Statistics reported that the incidence of people reporting lack of access to a general practitioner as a healthcare barrier was 2.5 and 6 times greater in remote and very remote areas (respectively) as compared to in major cities. (AIHW 2019). These are just two of many statistics on this issue and they, with the accompanying reports can be found on Australian Institute of Health and Welfare's website.



These numbers paint a picture, highlighting the need for change in how we as future medical professionals ensure good continuity of care and improve healthcare access to those in rural/remote communities. FURHS is committed to this goal as we advocate for improved health care for rural areas through the National Rural Health Student Network (NRHSN) - the national body for rural health clubs.

Surprisingly, I've anecdotally heard of COVID-19 restrictions actually improving the delivery of rural health care. For example, the integration of telehealth has not only made local GPs more accessible but specialists, who prior to these restrictions would only be available once a month in the local community.

I hope that with continued education and advocation for change, the future generation of healthcare professionals can work to dismantle current healthcare access barriers.

All the best.

Hugo Keller
Medicine Co-president FURHS

G'DAY FROM DARWIN

My day starts as I jump on a pushie and ride a short 1.5km through the leafy enclave of North Darwin and into hospital - only one of the unique experiences part of what it's like to be a medical student on placement up in Darwin, Northern Territory.

Our journey began on the 5th of January with a marvellous commute from Adelaide to Darwin, right through the nation's raw and alluring Red Centre. For a week, it felt like we had stepped into a tourism brochure, passing by sights such as the Devil's Marbles, Mataranka Springs and Uluru. Not to mention the countless national parks, iridescent opal mines and salt flats all against a backdrop of sand dunes eclipsed by crimson sunrises and sunsets. The Australian desert landscape is a picture worth a thousand, if not a million words. To top it all off, the sights did not end even as we arrived at our NT home base: a huge, well kept 'Queenslander' with a balcony overlooking a sprawling rain forest coastline.

Even three months in, the exploring has not stopped. Having toured Litchfield three times, we've travelled to Kakadu, Kununurra and the East Kimberleys. Every weekend consists of finding the best laksa $8 can buy and going to festivals that give you enough of an outdoor lifestyle for a lifetime. The nightlife is no different, with sunsets over the Nightcliff esplanade rivalling a Bondi coastal walk.

To be able to talk so highly of our experiences in the NT so far is truly a testament to the exceptional organisation and support from the NTMP program staff. They have been nothing but understanding of the difficulties associated with the move up here; providing us with heavily subsidised accommodation adjacent to the hospital. From Day 1, they have prioritised providing us unabridged time to make the most of our studies during office hours and our unbelievable personal adventure outside of. That is why I am writing this, to appease those concerned about the support, both financial and academic, and ensure the NTMP is given the wrap it deserves. The decision to make the move up here is no doubt a big one. Speaking from personal experience, it will test personal resolve, but will also broaden your horizons and most importantly, provide you with an exceptionally rich, rewarding and worthwhile professional experience.

Our placements have been graced with the enviable student to doctor to patient ratios, with no shortage of weekly cohort teachings or rotation specific 'bedside' teaching. We, the NTMP student body, are treated respectfully, encouraged to take control of our own learning and have daily opportunities to practice clinical skills, obtain patient histories and conduct system exams. The number of students is often but a minor fraction of the treating team and as such ensures an environment as close to one-on-one teaching as I would have envisaged as part of any training pathway.

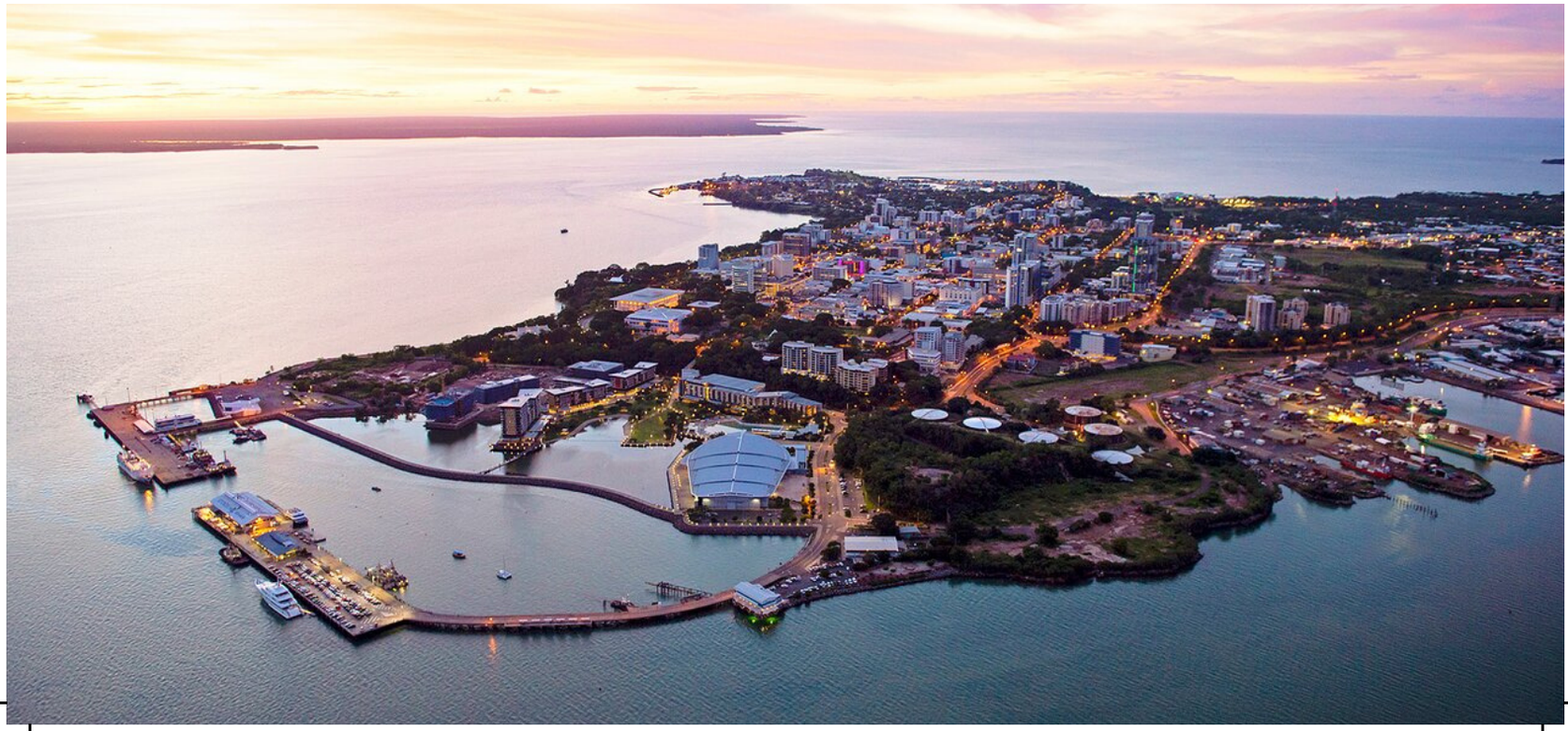
Having just completed an eight and four-week rotations on general surgery and psychiatry, respectively, I was given the opportunity to engage meaningfully with patients in a supervised manner. The time spent on general surgery was a generous balance between unlimited time spent in theatre and on the ward conducting focused histories and exams. On any given day we are graced with instances to listen to, examine and garner experience with an array of clinical presentations that would differ from those in major cities. I foresee the next eight weeks on the general medicine rotation being even richer in clinical opportunities, part of the job description including presenting patient cases and facilitating their admission. Not to mention next semester's once in a lifetime opportunity to gather clinical exposure to remote healthcare in a stunning setting, Nhulunbuy. If it's one thing that the NTMP has gotten right, it's the countless opportunities to improve one's medical skill set within a clinically and demographically diverse environment. Every case expands our skill-set, broadens our experience and depth of responsibility.

In summary, the Northern Territory is a daunting relocation with its distance from 'home'. The common misconception about the lack of tertiary hospital exposure couldn't be more inaccurate as the RDH effectively caters to the same level of speciality as the FMC. As the next generation of doctors, we should be focused on building our foundational clinical skills, humbly maturing within a demographically diverse patient cohort. At this point in our journey, there's vastly more than enough challenge and scope to allure and capture the imagination of any precocious medical student. If you value broad medical exposure with countless opportunities and the desire to explore Australia's most enviable outdoor lifestyle, I could not recommend relocating to the NT for MD3(&4) any further.

Please reach out if you'd like more information or just a yarn with how it's all going.

Take care, study well,
sleep better and cheers from Darwin.

Benny



DOCULES

FMSS MedRevue 2021

Do you like jokes satirising the bane of our existence? Music numbers? Watching your peers making a fool of themselves publicly? Are a Greek mythology nerd? Bored of watching Netflix? Well then, if you answered yes to even one of those questions, coming to Medrevue this year is going to be the highlight for you!

That's correct, you heard that right – Medrevue is back in 2021, bigger and better than ever! With our largest ever cast + crew of 73 people, the experience will be second to none.

We present to you DOCULES – the comedic rendition of Hercules brought to life. Follow us along the journey with Docules as he navigates his way through Flinders medical school, faced with FMSS elections, betrayals, daily struggles and even encounters with some of our most loved staff here at the FMC.

The showcase of some of the incredible talent we have here at Flinders Medicine will take place in mid-September. So, keep your eyes peeled on the Flinders Medical Students Society Facebook page for the opening of ticket sales so you don't miss out on the most hotly anticipated event in the Flinders MD calendar. We will also be livestreaming the performance if you can't make it in person, with all proceeds from livestream tickets going to our nominated charity.

Medrevue is certainly a show for everyone, whether you're a medical student, faculty member or even part of the greater community. It really brings everyone together!

Be there or be square!

Angelina Arora
Producer

- ANGELINE SEOW

O WEEK
PREP WEEK 2021

We hesitated when sitting down to write an article about Preparatory Week (previously known as O'Week) for this issue of Placebo, because the theme is "inequity" which is the last word we would use to describe the MD1s first two weeks of Medical School! The FMSS Prep Week Team, led by ourselves, strove to make everyone feel welcome as they began their journey at Flinders.

As much as we didn't want to bring it up, COVID-19 (sorry! – we promise we won't use the phrase "unprecedented times" though) still had a significant impact on our planning, so the process was full of challenges. We had to navigate strict rules and restrictions surrounding venues, equipment, numbers, and food. Our priorities were trying to involve students from other year levels to foster a supportive environment between cohorts, and organising varied events to suit different people's tastes, so everyone would have a chance to meet their peers. Thankfully between countless Zoom calls (and nearly the same number of breakdowns) we truly believe we managed to plan and execute this.

Our first event was the FMSS Welcome Lunch. We decided to continue the tradition of providing plant-based meals to promote a more sustainable and environmentally friendly approach. Bahn Mi and Vietnamese salads certainly didn't disappoint. That evening, the students attended Welcome Drinks at the Havelock Hotel with MD2s, 3s, and 4s - we even roped an intern into attending to assure everyone there is light at the end of the tunnel (we swear we didn't pay him...). A Bingo game was also organised as an icebreaker, but we were surprised and delighted to note that it wasn't really necessary. Everyone was already mingling and having a lovely time. The competitive streak still managed to motivate some people, however, with MD1 Nick Pavic taking out first prize. Nick also unsurprisingly won the "Always Gives 110% Award" at Med Camp, go figure!

A new event this year was the Society Expo, where each special interest group set up a stall so the MD1s could chat to them all and sign up to everything in one place. We thought this was a fantastic addition to Prep Week and hope to see it continue in the future. The next event was our Movie Night, which was a family-friendly evening with snacks, games, and bubbles under the Superscreen in the Student Plaza. We loved meeting everyone's families and watching Disney's Hercules under the open sky, making the event stand out as a personal favourite of ours. And frankly, I'm not sure who enjoyed the bubble machine more – the children or the MD students!

Finally, the annual Quiz Night at the Tonsley Hotel took place. This was an evening full of great food, laughter, and competition! Not only did the students go head-to-head in a battle of wits, we also had a planking challenge and a talent show. The winner took home a highly coveted supply of study resources for being able to fit her whole fist in her mouth. We're excited (and a little scared) to see all the other amazing things this year level will achieve. Kudos also to some of the more creative team names. We loved "MedSTAFF" and "Binoy's Boys" particularly. Congratulations to "Yeah the Girls" who took home first place.

We found the role of Prep Week Convenor to be incredibly rewarding. Not only did we get to witness a group of strangers become fast friends, we also learnt about the importance of communication, planning, and a looooot of problem solving, particularly during these unprecede... (just kidding!). Our Mahara Portfolios are also very full now, but we promise that's not why we signed up for this... On a serious note, we are endlessly grateful to the FMSS team, our sponsors, anyone else who contributed in any way, and most importantly to the MD1s for making our roles so enjoyable. We can't wait for everything else to come!

Lucymarie Silvestri and Nick Morfidis, 2021 FMSS Prep Week Convenors

NEW KIDS GO CAMPING

The beginning of Medical School can be quite a daunting experience. New faces, overwhelming amounts of material and being persuaded to join crypto trading were all part of the agenda of the first few weeks. MedCamp was an experience where a much-needed break of lecture material and IT problems could be achieved, whilst gaining an opportunity to familiarize ourselves with the people who will be future friends, colleagues, and support networks. With such a large ratio of the year attending, and an even larger ratio of alcohol being consumed, it was an opportunity to really break the ice with people within the cohort.

Despite challenges such as sitting through an hour of Hamilton on the bus, or having to work around temperamental weather, the organization from the second years was outstanding and all scheduled activities were able to proceed to give us the best possible experience. A special thanks must go out to Nick and Tara for their leadership and organization over the few days, as things would not have gone so smoothly without it.

Although there were rowdy moments with bushes, haystacks and T-shirt stealing, everyone was responsible and there was no need to whip out the recently acquired suturing skills. Both of us are excited for the future regarding the potential of MedCamp, as taking on feedback from the cohort as well as having such diversity in skill sets throughout the group makes us incredibly keen to make future experiences even more engaging and enjoyable.

Kosta and Maddi


FLINDERS MEDICAL
STUDENTS' SOCIETY